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

Parkland Community Health Plan

Provider Handbook

TEXAS STAR Your Health Plan ★ Your Choice

CHIP We've got your kids covered.

www.beaconhealthoptions.com/providers/beacon

September 2022

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Chapter 1

Introduction

Introduction

BEACON/PARKLAND COMMUNITY HEALTH PLAN

Parkland Community Health Plan has contracted with, and will work in partnership with, Beacon Health Strategies LLC (Beacon), a Beacon Health Options company, to manage the delivery of mental health and substance use disorder services for the Children's Health Insurance Program (CHIP) and the Medicaid State of Texas Access Reform (STAR) program.

This partnership was established in response to meet the needs of Parkland Community Health Plan members for behavioral health services given the expertise that Beacon has in this area.

INTRODUCTION TO PARKLAND COMMUNITY HEALTH PLAN

Parkland Community Health Plan (PCHP) is a Dallas-based regional managed care organization that was created to serve as a bridge connecting the community's uninsured population to programs and services designed specifically for them, including Medicaid Managed Care (STAR) and CHIP. PCHP is an integral part of Parkland Health and Hospital System, which also includes Parkland Memorial Hospital, Community Oriented Primary Care, and the Parkland Foundation.

PCHP works with more than 3,000 health care providers and organizations, including 30 hospitals and medical centers, in a service area that covers Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties.

ABOUT BEACON

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

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

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

Beacon's mission is to help people live their lives to the fullest potential. Our values guide the way we treat our members, providers, clients, and each other. They are the heart of all we do. A number of Beacon's Service Centers or Engagement Centers sponsor consumer self-help groups, educational

programs, drop-in centers, advocacy programs, and other consumer-led activities that help people become actively involved in achieving their highest possible level of functioning in their communities. Beacon arranges for the provision of and access to a broad scope of behavioral health services for members through its provider networks, consisting of appropriately licensed and/or certified practitioners, facilities, providers, and programs offering varying levels of service.

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

About this Provider Manual

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

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

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

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

1. The member's benefit plan

2. The provider agreement

3. This handbook

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

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

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

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

Beacon Health Options

National Provider Service Line

800-397-1630

Mon. through Fri., 8 a.m. to 8 p.m. ET

Beacon Provider Quick Reference Guide

IMPORTANT CONTACT INFORMATION

Administrative Appeal	To request an *administrative appeal*, call the toll-free number included in the administrative denial letter received.
Adverse Incident	Report all adverse incidents to the CCM with whom the participating provider conducts reviews or call 800-945-4644 or email Corporate_PQOC@beaconhealthoptions.com
Changing your Provider Profile (e.g., name, address)	To change or update your Provider Profile, call Beacon's National Provider Service Line at 800-397-1630, Mon. through Fri., 8 a.m. to 8 p.m ET or email TexasProviderRelations@beaconhealthoptions.com **Note:** Updating a Tax ID requires an accompanying *W-9* form.
Claims	For general claim inquires, call 800-888-3944. For technical questions related to direct claim submission via *eServices* or batch submission, please contact the *EDI* Helpdesk at: • Telephone: 888-247-9311 from 8 a.m.-6 p.m. ET • Fax: 866-698-6032 • Email: e-supportservices@beaconhealthoptions.com https://www.beaconhealthoptions.com/providers/beacon/eservices-edi/ *For providers who are unable to submit a claim electronically, paper claims should be sent to:* Beacon Health Options Woburn Claims PO Box 1866 Hicksville, NY 11802

	Payspan - www.payspanhealth.com 877-331-7154
Clinical Appeals	To request a *clinical appeal* on a *member's* behalf, call the toll-free number included in the adverse determination letter received.
Complaints (Provider)	To file a complaint/grievance, call 800-945-4644 or email Texas.complaints@beaconhealthoptions.com Member Complaints would be submitted to Corporate_CnG@beaconhealthoptions.com
Fraud and Abuse	Report questionable billing practices or suspected *fraud* to: Beacon Health Options 1330 Amerigroup Way Virginia Beach, VA 23464 SIU@beaconhealthoptions.com Beacon's National Provider Service Line at 800-397-1630, Mon. through Fri., 8 a.m. to 8 p.m. ET.
Contracting/Credentialing	For groups or solo providers wishing to join the network or to add new clinicians to an already existing in network group Join Our Network | Beacon Health Options For facility enrollment contact TexasProviderRelations@beaconhealthoptions.com
Texas Provider Relations	TexasProviderRelations@beaconhealthoptions.com
Member Eligibility	For questions about *member* eligibility or benefits, providers can contact Beacon at 800-945-4644 or log into eServices https://providerportal.beaconhealthoptions.com/index.html#/login Medicaid Client Hotline 1-800-252-8263 CHIP Hotline 877-543-7669 or 800-647-6558 https://www.yourtexasbenefits.com/Learn/Home

	Use TexMedConnect on the TMHP website at www.tmhp.com Log into your TMHP user account and accessing Medicaid Client Portal for providers. Call the TMHP Contact Center or the Automated Inquiry System (AIS) at 1-800-925-9126 or 512-335-5986.
ICM / Care Coordination	800-945-4644
IMPORTANT FAX NUMBERS	Utilization Management 855-371-9227 Quality Management 855-371-9227 Network Management 781-994-7639
Beacon Provider Resources Website	For detailed information about working with Beacon, frequently asked questions, client articles, clinical practice guidelines, and links to additional resources. https://www.beaconhealthoptions.com/providers/beacon/ For provider training webinars: https://www.beaconhealthoptions.com/providers/beacon/important-tools/webinars/ Provider Portal: https://www.beaconhealthoptions.com/providers/beacon/provider-portal/
TTY	711
Beacon Administrative Forms • ***Billing and claims forms*** • ***Provider changes*** • ***Credentialing*** • ***Member forms*** • ***Site review forms***	https://www.beaconhealthoptions.com/providers/beacon/forms/administrative-forms/

Behavioral Health Program Goals

The primary goal of the program is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings. By ensuring that all PCHP members receive timely access to clinically appropriate behavioral health care services PCHP and Beacon believe that quality clinical services can achieve improved outcomes for our members.

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

CHIP and Medicaid Managed Care Covered Services

Beacon provides CHIP and STAR behavioral health services as outlined below. All STAR and CHIP providers must register through TX Medicaid.

CHIP COVERED SERVICES

- Inpatient mental health services: including serious emotional disturbance (SED), furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to:
    - Neuropsychological and psychological testing
    - When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of medical necessity and services must be presented to the court with jurisdiction over the matter for determination.
    - Does not require PCP referral
- Outpatient mental health services: including serious emotional disturbance (SED) for serious mental illness, provided on an outpatient basis, including, but not limited to:
    - The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility
    - Neuropsychological and psychological testing
    - Medication management
    - Rehabilitative day treatments
    - Residential treatment services
    - Sub-acute outpatient services (partial hospitalization or rehabilitation day treatment)
    - Skills training (psycho-educational skill development)
    - When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order services as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

    - A qualified mental health provider – Community Services (QMHP-CS) is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.
    - Does not require PCP referral
- Inpatient substance use disorder treatment services: include, but are not limited to:
    - Inpatient and residential substance use disorder treatment services, including withdrawal management and crisis stabilization, and 24-hour residential rehabilitation programs
    - Does not require PCP referral
- Outpatient substance use disorder treatment services: include, but are not limited to:
    - Prevention and intervention services that are provided by a physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders
    - Intensive outpatient services
    - Partial hospitalization
    - Intensive outpatient services are defined as an organized non-residential service providing structured group and individual therapy, educational services, and life-skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day
    - Outpatient treatment services is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training
    - Does not require PCP referral

STAR COVERED SERVICES

The following is a non-exhaustive, high-level listing of Acute Care Covered Services included under the Medicaid STAR Program. For a complete listing of the limitations and exclusions that apply to each Medicaid benefit category, STAR MCO's should refer to the current Texas Medicaid Provider Procedures Manual (online at: http://www.tmhp.com).

These services are subject to modification based on federal and state mandates.

A PCP referral is not required to access behavioral health services.

STAR covered behavioral health services include, but are not limited to, medically necessary:

- Inpatient mental health services for children (birth through age 20)
- Acute inpatient mental health services for adults
- Outpatient mental health services for children and adults

- When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, the court order services as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
- A qualified mental health provider – Community Services (QMHP-CS) is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.

- Psychiatry services
- Counseling services
- Outpatient substance use disorder treatment services including:
  - Assessment
  - Withdrawal management services
  - Counseling treatment
  - Medication-assisted therapy
- Residential substance use disorder treatment services including:
  - Withdrawal management services
  - Substance use disorder treatment (including room and board)

  *These services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service Medicaid coverage. The services may be subject to the MCO's non-quantitative treatment limitations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008.
- Hospital services, including inpatient and outpatient
  - The MCO may provide inpatient services for acute psychiatric conditions in a free-standing psychiatric hospital in lieu of an acute inpatient hospital setting.
  - The MCO may provide substance use disorder treatment services in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting.

Coordination, Treatment, and Scope of Services

BEHAVIORAL HEALTH SCOPE OF SERVICES

Beacon will coordinate the behavioral health services, which include, but are not limited to, the services listed in the CHIP and Medicaid Managed Care Covered Services section. These services include acute,

diversionary and outpatient services. For more detail on the behavioral health benefits, please contact us at 800-945-4644.

Beacon will work with PCHP and other participating behavioral health care practitioners, primary care providers (PCP's), medical/surgical specialists, organizational providers and other community and state resources to develop relevant primary and secondary prevention programs for behavioral health. These programs may include:

- Educational programs to promote prevention of substance use disorders
- Parenting skills training
- Developmental screening for children
- ADHD screening
- Postpartum depression screening
- Depression screening in adults

COORDINATION OF CARE

Behavioral health service providers are expected to communicate at least quarterly and more frequently, if necessary, regarding the care provided to each member with other behavioral health service providers and PCP's. Behavioral health service providers are required to refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment. Copies of prior authorization/referral forms and other relevant communication between providers should be maintained in both providers' files for the member. Coordination of care is vital to ensuring members receive appropriate and timely care. Compliance with this coordination is reviewed closely during site visits for credentialing and recredentialing, as well as during quality improvement and utilization management reviews.

Coordination between Physical and Behavioral Health

Beacon is committed to coordinating medical and behavioral care for members who will be appropriately screened, evaluated, treated and/or referred for physical health, behavioral health or substance use, dual or multiple diagnoses, mental retardation, or developmental disabilities. Beacon will designate behavioral health liaison personnel to facilitate coordination of care and case management efforts.

Coordination with the Local Behavioral Health Authority

Beacon will coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facilities regarding admission and discharge planning, treatment objectives and projected length of stay for members committed by a court of law to the state psychiatric facility. Beacon will comply with additional behavioral health services requirements relating to coordination with the LMHA and care for special populations. Covered services will be provided to members with Severe and Persistent Mental Illness (SPMI)/Severe Emotional Disturbance (SED) when medically necessary, whether or not they are receiving targeted case management or services through the LMHA

Severe and persistent mental illness (SPMI) means a diagnosis of bipolar disorder, major clinical depression, schizophrenia or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) accompanied by: • Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping or employment) due to the disorder. • Impaired emotional or behavioral functioning

that interferes substantially with the member's capacity to remain in the community without supportive treatment or services.

Severe emotional disturbance (SED) means psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking and feeling.

Coordination with Texas Department of Family and Protective Services (DFPS)

Providers must coordinate with DFPS and foster parents for the care of a child who is receiving services from, or has been placed in, the conservatorship of DFPS and must respond to requests from DFPS including;

- Providing medical records
- Recognition of abuse and neglect, and appropriate referral to DFPS
- Schedule appointments within 14 days unless requested earlier by DFPS

Coordination with Non-CHIP and Non-Medicaid Managed Care Covered Services

There are other services that are available to PCHP/Beacon members, which may not be accessible through the PCHP/Beacon network. The services listed below are available and accessible to members outside of the PCHP/Beacon network.

- Primary and preventative dental services (including orthodontia)
- Texas agency-administered programs and case management services
- Essential public health services
- School Health and Related Services (SHARS)
    - SHARS allows local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services provided to students in special education under IDEA that are documented in a student's Individualized Education Program (IEP).
- Early childhood intervention case management/services coordination and specialized skills training
    - Early Childhood Intervention (ECI) is a statewide program within the Texas Health and Human Services Commission (HHSC) for families with children birth, up to age 3, with developmental delays, disabilities or certain medical diagnoses that may affect development. ECI services support families as they learn how to help their children grow and learn.
- Case management for children and pregnant women
- Texas Health Steps medical case management
- Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
- Medical transportation services available through the Texas Health and Human Services Commission for STAR members only

- Environmental Lead Investigation (ELI) – Lead Screening and Testing

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women is a Texas Medicaid benefit for eligible patients who have medical-related needs that might affect their health care. The patients must be eligible for Medicaid and be either:

- A child birth through age 20 with a health condition or health risk.
- A woman of any age who has a high-risk pregnancy.

Texas Health Steps requires blood lead screening at the ages noted on the THSteps Periodicity Schedule. The screening must be performed as part of the medical checkup. Additionally, environmental lead risk assessments should be completed for any child between 24 months and 6 years with no record of a previous blood lead screening test. Providers may use the Lead Risk Questionnaire, Form Pb-110, which is provided at: https://www.dshs.state.tx.us/THsteps/forms.shtm or an equivalent form of their choice.
Texas law requires all blood levels, elevated and non-elevated, for members who are 14 years of age or younger be reported the Texas Childhood Lead Poisoning Prevention Program (TXCLPPP). Reports should include all information as required on the Child Blood Lead Reporting, Form F09-11709 or the Pb-111 Point-of-Care Blood Lead Testing Report form. These forms can be found at: https://www.dshs.texas.gov/lead/Forms.aspx

- Additional information, including follow up testing and care information and Centers for Disease and Control and Prevention guidelines can be found at: https://www.dshs.state.tx.us/lead/child.shtm

COURT-ORDERED COMMITMENTS

A "Court-Ordered Commitment" means a confinement of a member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C. Beacon is required to provide inpatient psychiatric services to members under the age of 21, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, related to Court-Ordered Commitments to psychiatric facilities. Beacon will not deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a Court-Ordered Commitment for members under age 21.

FOCUS STUDIES AND UTILIZATION REPORTING REQUIREMENTS

PCHP, along with 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 provided to PCHP members. A special focus of these activities is the improvement of physical health outcomes resulting from behavioral health integration into the member's overall care. PCHP and Beacon will routinely monitor claims, encounters, referrals and other data for patterns of potential over- and under-utilization, and target areas where opportunities to promote efficient and effective use of services exist.

MEMBERS DISCHARGED FROM INPATIENT PSYCHIATRIC FACILITIES

Beacon requires that all members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur

within seven days from the date of discharge. Beacon providers will follow up with Medicaid members and attempt to reschedule missed appointments.

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) of the American Psychiatric Association.

BEHAVIORAL HEALTH COVERED SERVICES

Behavioral health services that are offered to CHIP and STAR members are:

Covered Behavioral Health Services

A wide range of mental health and substance use services are available, such as

- Inpatient mental health services including partial hospitalization
- Attention Deficit Hyperactivity Disorder (ADHD)
    - ADHD covered services eligible for reimbursement include: outpatient counseling services for the management of ADHD symptoms to include coping skills, psychoeducation, etc. Medication management with psychiatric prescribers is also covered.
    - Primary care providers should have a strategy for diagnosing and long-term management of ADHD. Providers can discuss the efficacy of using medication to manage an ADHD diagnosis with their patients. Follow up appointments should be made at least monthly until the child's symptoms have been stabilized. Once a child is stable, AAP guidelines recommend an office visit every 3 to 6 months to assess learning and behavior.
- Substance Use Disorder Treatment including assessment, withdrawal management, residential treatment, and outpatient services.
- Therapy - individual, family, and group.
- Psychological & Neuropsychological testing
- Mental Health Targeted Case Management and Rehabilitative Services
- Medication Management and Education

Behavioral health services that are offered to STAR members are:

- Reasonable and necessary for the diagnosis or treatment of a mental health or substance use disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder
- In accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care
- Furnished in the most appropriate and least restrictive setting in which services can be safely provided
- The most appropriate level or supply of service that can safely be provided

- Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered
- Not experimental or investigative, and not primarily for the convenience of the member or provider

Other elements of members receiving behavioral health services are:

- Member may self-refer to any network behavioral health provider.
- Member has the right to obtain medication from any network pharmacy.
- A primary care provider may refer a member to a behavioral health provider.
- There will be coordination between behavioral health and physical health services.
- Member has the right to obtain a second opinion; medical records and referral information must be documented using the DSM-IV multi-axial classification.
- An authorization to release confidential information, such as medical records regarding treatment, should be signed by the patient or guardian prior to receiving care from a behavioral health provider.
- Members under the age of 21 will be provided inpatient psychiatric services, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction.
- Coordination will be conducted with the LMHA and state psychiatric facilities regarding admission and discharge planning, treatment objectives, and projected length of stay for members committed by a court of law to the state psychiatric facility.
- Assessment documents for behavioral health will be made available for the use of primary care providers.
- Beacon and PCHP will work together to ensure that quality behavioral health services are provided to all members. This coordination will include focus studies and utilization management reporting.
- Provider will make contact with the member within 24 hours of a missed appointment for the purposes of re-scheduling.
- Members who are discharged from an inpatient psychiatric facility will have a follow-up appointment within seven days from the date of discharge by the provider.

ACCESSIBLE INTERVENTION AND TREATMENT

Beacon promotes early intervention and 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 the DSM codes
- Inform members how and where to obtain behavioral health services
- Understand that members may self-refer to any behavioral health care provider without a referral from the member's primary care provider

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

PCHP offers benefits program to the STAR/CHIP populations. Under the Plan, the following levels of care are covered, provided that services are medically necessary, delivered by contracted network providers, and that the authorization procedures are followed:

MENTAL HEALTH REHABILITATIVE AND TARGETED CASE MANAGEMENT

(PRIOR AUTHORIZATION NOT REQUIRED FOR MHTCM-MHR)

MEDICATION TRAINING AND SUPPORT

PROCEDURE CODE	SERVICE	MODIFIER 1	MODIFIER 2
H0034	Individual services for adult		
H0034	Group services for adult	HQ	
H0034	Individual services for child/adolescent	HA	
H0034	Group services for child/adolescent	HA	HQ

CRISIS INTERVENTION

PROCEDURE CODE	SERVICE	MODIFIER 1	MODIFIER 2
H2011	Adult services		
H2011	Child and adolescent services	HA	

SKILLS TRAINING AND DEVELOPMENT

PROCEDURE CODE	SERVICE	MODIFIER 1	MODIFIER 2
H2014	Individual services for adult		
H2014	Group services for adult	HQ	
H2014	Individual services for child/adolescent	HA	
H2014	group services for child/adolescent	HA	HQ

Not a benefit for CHIP members

PSYCHOSOCIAL REHABILITATIVE SERVICES

PROCEDURE CODE	SERVICE	MODIFIER 1	MODIFIER 2
H2017	Individual services	TD	
H2017	Group services	HQ	
H2017	Group services rendered by RN	HQ	TD
H2017	Individual crisis services	ET	

Psychosocial rehabilitation is not reimbursable on the same day as mental health targeted case management or skills training and development
Not a benefit for CHIP members

MENTAL HEALTH TARGETED CASE MANAGEMENT

PROCEDURE CODE	SERVICE	MODIFIER 1	MODIFIER 2
T1017	Routine MH targeted case management (adult)	TF	
T1017	Routine MH targeted case management (child)	HA	TF
T1017	Intensive case management (child and adolescent ***not a benefit for members 21 years of age and older***	HA	TG

Intensive case management and routine case management are benefits for clients who are 20 years of age and younger. Intensive case management and routine case management are not payable on the same day.

Routine case management is a benefit for clients who are 21 years of age and older.

Providers must use procedure code T1017 and the appropriate modifier for MHTCM

Not a benefit for CHIP members

TRADITIONAL OUTPATIENT

SERVICE NOTIFICATION PROTOCOL	BENEFIT/SERVICE/CODE	NOTIFICATION REQUIREMENT
Prior Authorization Required	Neurobehavioral Testing 96116 / 96121	Prior authorization required after the 4 hours per day limitation has been met
	Psychological 96130 / 96131 and 96136 / 96137 Neuropsychological Testing 96132 / 96133 and 96136 / 96137	Prior authorization required after the 8 hours per calendar year have been met.
	Psychiatric Diagnostic Evaluation 90791 and 90792	Psychiatric diagnostic evaluation is limited to one evaluation per client, per provider, per rolling year. Additional units require an authorization
	Psychotherapy 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853	Psychotherapy is limited to 30 individual, group, or family psychotherapy visits per client, per calendar year. Additional units require an authorization.

SUBSTANCE USE

SERVICE NOTIFICATION PROTOCOL	BENEFIT/SERVICE	NOTIFICATION REQUIREMENT
Prior Authorization Required	Outpatient Withdrawal Management H0016, H0050, and S9445	Telephonic or eServices prior authorization required
	Outpatient treatment that exceed the benefit limitation H0004 and H0005	Outpatient treatment services are limited to 135 units of group counseling and 26 hours of individual counseling per calendar year when provided by a CDTF.

SERVICE NOTIFICATION PROTOCOL	BENEFIT/SERVICE	NOTIFICATION REQUIREMENT
Prior Authorization Required	Residential withdrawal management H0012, H0031, H0047, S9445, T1007	Telephonic or eServices prior authorization required
	Residential treatment services H2035 and H0047 ***Residential SUD treatment services may only be provided by a licensed CDTF***.	Telephonic or eServices prior authorization required

INPATIENT SERVICES

SERVICE NOTIFICATION PROTOCOL	BENEFIT/SERVICE	NOTIFICATION REQUIREMENT
Prior Authorization Required	Inpatient Mental Health (including eating disorder treatment) – Revenue Codes 114, 124, 134, 144, 154, 204	Telephonic or eServices prior authorization required
	Inpatient Substance Abuse Revenue Codes 116, 126, 136, 146, 156	
	Residential Treatment – SUD H2035 and H0047	
	Residential Treatment – Mental Health Revenue Code 1001	

OUTPATIENT DIVERSIONARY SERVICES

SERVICE NOTIFICATION PROTOCOL	BENEFIT/SERVICE	NOTIFICATION REQUIREMENT
Prior Authorization Required	Partial Hospitalization (PHP) Revenue Codes 905 and 906	Telephonic or eServices prior authorization required
	Intensive Outpatient (IOP) Revenue Codes 912 and 913	

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 disorder services by self-referring to a network provider, by calling Beacon, or by referral through acute or emergency room encounters. Members may also access outpatient care by referral from their primary care practitioner (PCP); however, a PCP referral is never required for behavioral health services.

INPATIENT BENEFITS

Beacon is responsible for authorizing inpatient hospital services, which includes services provided in freestanding psychiatric facilities for CHIP and STAR.

INITIAL ENCOUNTERS

Members are allowed a fixed number of initial therapy sessions without prior authorization. These sessions, called initial encounters (IEs), must be provided by contracted in-network providers, and are subject to meeting medical necessity criteria.

To ensure payment for services, providers are strongly encouraged to ask new patients if they have been treated by other therapists. Via eServices, providers can look up the number of IEs that have been billed to Beacon; however, the member may have used additional visits that have not been billed. If the member has used some IEs elsewhere, the new provider is encouraged to obtain authorization before beginning treatment.

The following services do count against the member's IEs:

1. One psychiatric diagnostic evaluation (procedure codes 90791 and 90792) per client, per rolling year, per provider (same provider)
2. 30 individual, family, or group psychotherapy (procedure codes 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, and 90853) visits per client per calendar year
3. 4 hours of psychotherapy services per client per day
4. 4 hours of neuropsychological testing (procedure codes 96116 and 96121*) per client per day
5. 8 hours of psychological, neurobehavioral, or neuropsychological testing (procedure codes 96130, 96131*, 96132, 96133*, 96136, or 96137*) per client, per calendar year

ESKETAMINE (SPRAVATO)

Esketamine (Spravato) is a benefit of Texas Medicaid for clients who are 18 years of age or older with prior authorization. Providers must submit claims for esketamine (Spravato) with procedure code S0013.

Esketamine (Spravato) nasal spray is an N-methyl-D-aspartate (NMDA) receptor antagonist that is indicated in conjunction with an oral antidepressant in adult clients for the treatment of the following:

- Treatment-resistant depression (TRD)
- Depressive symptoms in clients with major depressive disorder (MDD) with acute suicidal ideation or behavior

Esketamine (Spravato) must be prescribed by, or in consultation with a psychiatrist.

Esketamine (Spravato) is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).

Providers/health-care settings must be certified in the Spravato REMS program to administer Spravato to clients enrolled in the REMS program. Administration of the drug must take place in a health-care facility under the direct observation of a health-care provider.

PRIMARY CARE PROVIDER REQUIREMENTS FOR BEHAVIORAL HEALTH

Primary care providers may 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

Medicare and Medicaid Requirements

About this Chapter

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

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

Provider Requirements

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

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

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

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

The provider further acknowledges that:

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

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

Chapter 3

Provider Participation

3.1. Network Operations

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

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

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

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

Network Operations

Beacon's Network Operations Department is responsible for procurement and administrative management of Beacon's behavioral health provider network. As such, Beacon's role includes contracting, credentialing and network management functions. Representatives are easily reached by email TexasProviderRelations@beaconhealthoptions.com or by phone at 888-247-9311 between 8 a.m. and 6 p.m., Eastern Time (ET), Monday through Friday.

Contracting and Maintaining Network Participation

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

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

Providers must provide information, in writing, to Beacon, of any provider terminations. This information can be sent to the following address and needs to be received by Beacon within ninety (90) days of termination from the plan:

Beacon Health Options
PO BOX 989
Latham, NY 12110

Network limitations include 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 members served by Beacon, and shall not be paid for any items or services furnished, directed or prescribed after such exclusion.

For credentialed practitioners/organizations, in the event that Beacon receives a negative report, member complaint, disciplinary action, or evidence of serious quality deficiencies regarding the participating practitioner or facility/organization, an assessment of the circumstances (as well as related policies, procedures, and processes) is undertaken by Beacon.

This assessment allows Beacon to evaluate the nature and severity of the complaint/grievance/allegation, and to determine whether a formal credentialing action should be initiated, including but not limited to, potential reduction, suspension or termination of a provider's status in Beacon's network. Deficiencies that could lead to initiation of this process include, but are not limited to, Beacon's reasonable determination of any of the following:

- The practitioner's or facility/organization's failure to comply with legal and ethical requirements applicable to their profession or type of facility/organization
- The practitioner or facility/organization meeting the member complaint threshold of Beacon and/or the member complaint threshold of one or more of Beacon's customer plans
- The practitioner's or facility/organization's failure to meet or continue to meet Beacon's performance standards for care and service to Beacon's members as set forth in the Provider Services Agreement and the provider manual, and/or failure to comply with Beacon's credentialing policies and procedures
- The practitioner's or facility/organization's license, privileges, or accreditation has been revoked, suspended, or otherwise restricted by the appropriate state or federal licensing board, privileging board, or accrediting agency or the provider is excluded from Medicare or Medicaid, or a relevant state payor.
- The practitioner or facility/organization has issues with rendering appropriate professional services in a timely manner to Beacon's members as evidenced by member complaints/ grievances to Beacon, sentinel events reporting, and other quality data tracking.
- The information obtained from the practitioner or facility/organization for credentialing purposes is found to be, in Beacon's judgment, grossly inaccurate or cannot be verified with primary sources upon Beacon or its contracted agent's reasonable diligence.
- An evaluation of the practitioner, through Beacon's appeal process, by a peer (or peers) identifies concerns regarding the practitioner's professional competency and qualifications.
- Practitioner or organization/facility fails to submit recredentialing materials within the required recredentialing time frame after a recredentialing application has been sent to the practitioner and at least three follow-up attempts have been made to obtain this re-credentialing material

Beacon Provider Identification Numbers

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

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

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

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

Provider Satisfaction Survey

Beacon conducts an annual provider satisfaction survey to measure participating providers' opinions regarding Beacon's clinical and administrative processes. Data is aggregated, trended, and used to identify improvement opportunities. Results are shared with participating providers through the Corporate Quality Committee (CQC), Quality/Utilization Management Committee (QUMC), clinical advisory committees, Provider Stakeholder Committee, and provider newsletters. Corrective action plans, where appropriate, are managed through the Corporate Provider Relations Department and reported to the CQC.

Adding Sites, Services, and Programs

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

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

To add a site, service, or program, the provider should notify Beacon's Provider Relations team TexasProviderRelations@beaconhealthoptions.com of the location and capabilities of the new site, service or program. Beacon will determine whether the site, service or program meets an identified geographic, cultural/linguistic and/or specialty need in our network and will notify the provider of its determination.

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

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

Practitioner Credentialing and Recredentialing

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

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

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

Participating providers have the right to:

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

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

CREDENTIALING

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

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

This includes without limitation attestation as to:

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

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

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

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

RECREDENTIALING

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

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

Required documentation includes without limitation attestation as to

- Any limits on the participating provider's ability to perform essential functions of their position or operational status
- With respect to individual practitioner participating providers, the absence of any current illegal substance or drug use

- The correctness and completeness of the application (including without limitation identification of any changes in or updates to information submitted during initial credentialing)

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

STANDARDS

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

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

* Structured site visits are required for all unaccredited organizations.

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

- No adverse record of failure to follow Beacon's policies and procedures or quality management activities
- No adverse record of provider actions that violate the terms of the provider agreement

- No adverse record of indictment, arrest or conviction of any felony or any crime indicating potential or actual member endangerment
- No criminal charges filed relating to the participating provider's ability to render services to members
- No action or inaction taken by participating provider that, in the sole discretion of Beacon, results or may result in a threat to the health or well-being of a member or is not in the member's best interest.

SITE VISITS

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

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

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

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

UPDATES

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

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

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

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

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

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

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

DELEGATION

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

Organizational Credentialing

In order to be credentialed, facilities must be licensed or certified by the state in which they operate, and the license must be in force and in good standing at the time of credentialing or recredentialing. If the facility reports accreditation by The Joint Commission (JCAHO), Council on Accreditation of Services for Family and Children (COA), or Council on Accreditation of Rehabilitation Facilities (CARF), such accreditation must be in force and in good standing at the time of credentialing or recredentialing of the facility. If the facility is not accredited by one of these accreditation organizations, Beacon conducts a site visit prior to rendering a credentialing decision.

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

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

An employee or contractor within a hospital or mental health clinic licensed in Texas, and that meets all applicable federal, state and local laws and regulations

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 use disorder 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 call 800-397-1630 or email TexasProviderRelations@beaconhealthoptions.com.

Credentialing Processes

INDIVIDUAL PRACTITIONER CREDENTIALING	ORGANIZATIONAL CREDENTIALING
Beacon individually credentials the following categories of clinicians in private or solo or practice settings: ▪ Psychiatrist ▪ Physician certified in addiction medicine ▪ Psychologist ▪ Licensed Clinical Social Workers ▪ Master's-level Clinical Nurse Specialists/Psychiatric Nurses ▪ Licensed Mental Health Counselors ▪ Licensed Marriage and Family Therapists ▪ Licensed Chemical Dependency Professional ▪ Other behavioral healthcare specialists who are master's level or above and who are 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 withdrawal management 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

EXPEDITED CREDENTIALING

Providers joining an in-network group, currently under contract with Beacon, may apply for provisional status for payment purposes only. To qualify for expedited credentialing, the provider must:

- Be licensed in the state and in good standing with the Texas Board
- Submit all necessary documents required by Beacon for the Plan to start the credentialing process
- Agree to comply with the terms of current Beacon contract active with the provider group

For payment purposes only, Beacon will treat the applicant as a participating provider in the group when they provide services to Beacon members, including collecting copayments and payment for services rendered.

If Beacon finds the applicant does not meet credentialing requirements, Beacon may recover from the provider or group the difference between charges for in-network benefits and out-of-network benefits. The provider group may retain any copayments collected, or in the process of being collected for services, as of the date of the determination.

Appeals of National Credentialing Committee/Provider Appeals Committee Decisions

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

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

The NCC:

- Functions as a peer review body under NCQA standards
- Is made up of representatives from major clinical disciplines and includes participating providers
- Makes the final decision regarding:
    - Beacon credentialing/re-credentialing policies and procedures
    - Approval/denial/pending status for credentialing/re-credentialing applications
    - Determinations regarding possible participating provider sanctions identified above

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

Requests for appeals of adverse credentialing/re-credentialing decisions of the NCC should include an explanation of the reasons the provider/participating provider believes the NCC reached a decision to be in error and include supporting documentation. The PAC will review the explanation provided, the

information previously reviewed by the NCC, and any additional information determined to be relevant. The PAC may request additional information from the provider/participating provider in order to make a determination or decision. The PAC will support, modify, or overturn the decision of the NCC. Written notification of the PAC's decision, an explanation of the decision, and any appeal and/or fair hearing rights available for adverse decisions, will be sent to the provider/participating provider within 14 business days after the PAC's record is complete.

Sanctions

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

Chapter 4

Quality Management and Improvement Program

Quality Management/Improvement Program Overview

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

Provider Role

Beacon employs a collaborative model of continuous QM, in which provider and member participation is actively sought and encouraged. In signing the Provider Services Agreement (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 Program to continually assess quality of care, access to care and compliance with medical necessity criteria.

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
    - Communication with members' PCPs, other behavioral health providers, and government and community agencies
- Tracking of adverse incidents, complaints, grievances, and appeals
- Other quality improvement activities

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

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

Treatment Records

TREATMENT RECORD REVIEWS

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

- Use of screening tools for diagnostic assessment of substance use, adolescent depression and ADHD
- Continuity and coordination with primary care providers and other providers
- 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's access to the health plan member information should be directed to Beacon's Privacy Officer at, privacyincidents@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's 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 for all services, included ancillary services based upon NCQA standards. All documentation must be clear and legible. The use of electronic medical records must conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal laws.

Treatment Documentation Standards

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 use disorder issues with their parents ▪ Signed document indicates review of patient's rights and responsibilities
Medication Information	Treatment record contains 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	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 Use 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 was screened for depression ▪ If yes, was a suicide assessment conducted? ▪ Was the family involved with treatment?
ADHD Information	Documentation that members aged 6-12 were assessed for ADHD ▪ Was the 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 stated presenting problems, history, mental health status evaluation, and/or other relevant assessment information j. Diagnoses updated at least quarterly
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.) included in the treatment record ▪ Member's response to medication and somatic therapies
Coordination and Continuity of Care	The treatment record contains clear documentation of the following: ▪ Documentation of communication and coordination between behavioral health providers, primary care physicians, ancillary providers, and healthcare facilities (see Behavioral Health-PCP

	Communication Protocol later in this chapter and download 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

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

Practice Guidelines

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, substance use disorders, and child/adolescent depression, and posted links to these on our website. We strongly encourage providers to use these guidelines and to consider these guidelines whenever 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 800-945-4644.

Outcomes Measurement

Beacon and the health plan strongly encourage and support providers in the use of outcome measurement tools for all members. Outcomes 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.

Communication between Outpatient Behavioral Health Providers and Other Treating Providers

COMMUNICATION BETWEEN OUTPATIENT BEHAVIORAL HEALTH PROVIDERS AND PCPS, OTHER TREATERS	COMMUNICATION BETWEEN INPATIENT/ DIVERSIONARY PROVIDERS AND PCPS, OTHER OUTPATIENT TREATERS
Outpatient behavioral health providers are expected to communicate with the member's PCP and other outpatient behavioral health providers, if applicable, as follows	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

COMMUNICATION BETWEEN OUTPATIENT BEHAVIORAL HEALTH PROVIDERS AND PCPS, OTHER TREATERS	COMMUNICATION BETWEEN INPATIENT/ DIVERSIONARY PROVIDERS AND PCPS, OTHER OUTPATIENT TREATERS
▪ Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first ▪ Summary reports of a member's behavioral health status to the PCP at least quarterly (or more frequently as clinically indicated) to the PCP, during the course of treatment, with the consent of the member or the member's legal guardian ▪ 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, 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	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.

COMMUNICATION BETWEEN OUTPATIENT BEHAVIORAL HEALTH PROVIDERS AND PCPS, OTHER TREATERS	COMMUNICATION BETWEEN INPATIENT/ DIVERSIONARY PROVIDERS AND PCPS, OTHER OUTPATIENT TREATERS
▪ 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.	

TRANSITIONING MEMBERS FROM ONE BEHAVIORAL HEALTH PROVIDER TO ANOTHER

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

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

Reportable Incidents and Events

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

	ADVERSE INCIDENTS	SENTINEL EVENTS	OTHER REPORTABLE INCIDENTS
Incident/Event Description	An adverse incident is an occurrence that represents actual or potential serious harm to the well-being of a health plan member who is currently receiving or has been recently discharged	A sentinel event is any situation occurring within or outside of a facility that either results in death of the member or immediately jeopardizes the safety of a health plan member receiving	An "other reportable incident" is any incident that occurs within a provider site at any level of care that does not immediately place a health plan member at risk but warrants serious concern.

	ADVERSE INCIDENTS	SENTINEL EVENTS	OTHER REPORTABLE INCIDENTS
	from behavioral health services.	services in any level of care.	
Incidents/Events include the following:	▪ All medico-legal or non-medico-legal deaths ▪ Any absence without authorization (AWA) involving a member who does not meet the criteria above ▪ Any injury while in a 24-hour program that could or did result in transportation to an acute care hospital for medical treatment or hospitalization ▪ Any sexual assault or alleged sexual assault ▪ Any physical assault or alleged physical assault by a staff person or another patient against a member ▪ Any medication error or suicide attempt that requires medical attention beyond general first aid procedures ▪ Any unscheduled event that results in the temporary evacuation of a program or facility (e.g., fire resulting in	▪ All medico-legal deaths ▪ Any medico-legal death is any death required to be re-ported to the medical examiner or in which the medical examiner takes jurisdiction. ▪ Any AWA involving a patient involuntarily admitted or committed and/or who is at high risk of harm to self or others ▪ Any serious injury resulting in hospitalization for medical treatment ▪ A serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is subsequently medically admitted. ▪ Any medication error or suicide attempt that requires medical attention beyond general first aid procedures	▪ Any non-medico-legal death ▪ Any AWA from a facility involving a member who does not meet the criteria for a sentinel event as described above ▪ Any physical assault or alleged physical assault by or against a member that does not meet the criteria of a sentinel event ▪ Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization ▪ A serious injury, defined as any injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted ▪ Any unscheduled event that results in the temporary evacuation of a program or facility, such as a small fire that requires fire department response. Data

	ADVERSE INCIDENTS	SENTINEL EVENTS	OTHER REPORTABLE INCIDENTS
	response by fire department)	▪ Any sexual assault or alleged sexual assault ▪ Any physical assault or alleged physical assault by a staff person against a member ▪ Any unscheduled event that results in the evacuation of a program or facility whereby regular operations will not be in effect by the end of the business day and may result in the need for finding alternative placement options for member	regarding critical incidents is gathered in the aggregate and trended on a quarterly basis for the purpose of identifying opportunities for quality improvement.
Reporting Method	▪ Beacon's Clinical Department is available 24 hours a day ▪ Providers must call, regardless of the hour, to report such incidents ▪ Providers should direct all such reports to their Beacon clinical manager or UR clinician by phone ▪ In addition, providers are required to mail a copy of the *Adverse Incident Report Form* (for adverse and other reportable incidents and sentinel events) to: Beacon Health Options Quality and Compliance Department P.O. Box 1856 Hicksville, NY 11802-1856 ▪ All adverse incidents are forwarded to the health plan for notification as well ▪ Incident and event reports should not be e-mailed unless the provider is using a secure messaging system		
Provide the following	Providers should be prepared to present: ▪ All relevant information related to the nature of the incident		

	ADVERSE INCIDENTS	SENTINEL EVENTS	OTHER REPORTABLE INCIDENTS
	▪ The parties involved (names and telephone numbers) ▪ The member's current condition		

Provider Responsibilities

PRIMARY CARE PROVIDERS

The primary care provider (PCP) is important in the way that the members receive their medical care and serves as a "medical home" to STAR and CHIP members. To provide a medical home for the member, the PCP directs care coordination together with the client and family. Care coordination consists of managing services and resources for clients with special health needs and their families to maximize the members' potential and provide them with optimal healthcare. Notwithstanding the above, the member also may also elect to choose a specialist as his/her PCP, if this type of provider would best suit the needs of the member. The PCP for a member with disabilities, special healthcare needs, or chronic or complex conditions may be a specialist physician who agrees to provide PCP services to the member. The specialty physician must agree to perform all PCP duties required in the contract, and PCP duties must be within the scope of the specialist's license.

Provider Responsibility

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.

Availability and Access

Continuous access is an important feature to the member. Twenty-four-hour PCP availability enables a member to access and use services appropriately, instead of relying on ER's for after-hours care. Continuous access can be provided through direct access to a PCP's office or through on-call arrangements with another office or service. Members should be informed of the PCP's normal office hours and should be instructed how to access urgent medical care after normal office hours.

Updates to Contact Information

It is important and required to contact Beacon in writing at the address listed on your Provider Service Agreement, where notices should be sent, or by e-mail at TexasProviderRelations@beaconhealthoptions.com of any change of address, telephone number, group affiliation, etc. It is also essential that providers update their information with PCHP as well, within 30-days of the change,

PHARMACY PROVIDER RESPONSIBILITIES

When a member has been written a prescription for medication and has presented it to the pharmacy for dispensing, the pharmacy provider must:

- Adhere to the Formulary and Preferred Drug List (PDL)
- Coordinate with the prescribing physician
- Ensure members receive all medications for which they are eligible
- Coordinate benefits when a member also receives Medicare Part D services or other insurance benefits

Emergency Prescription Supply

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

The 72-hour emergency supply should be dispensed any time a prior authorization cannot be resolved within 24 hours for a medication on the Vendor Drug program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a prior authorization, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

Please contact Navitus Health Solutions at 877.908.6023 or go to www.navitus.com for information on prescription benefits.

Reporting Abuse, Neglect, or Exploitation (ANE)

MEDICAID MANAGED CARE

Report Suspected Abuse, Neglect, and Exploitation

MCOs and providers must report any allegation or suspicion of abuse, neglect, and exploitation (ANE) that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

Report to the Texas Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
    - Home and community support services agencies (HCSSAs)
    - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
    - Local Intellectual and Developmental Disability Authority (LIDDA), local mental health authority (LMHAs), community center, or mental health facility operated by the Department of State Health Services (DSHS)
    - A person who contracts with a Medicaid MCO to provide behavioral health services
    - An MCO

- An officer, employee, agent, contractor, or subcontractor of a person or entity listed above

- An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at 800.252.5400 or, in non-emergency situations, online at www.txabusehotline.org.

Report to Local Law Enforcement:

- If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, HHS, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

Report to the Department of Aging and Disability services (DADS) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities
- Assisted living facilities
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both the Department of Family and Protective Services (DFPS)
- Adult day care centers
- Licensed adult foster care providers

Contact DADS at 1.800.647.7418

Routine, Urgent, and Emergency Services

DEFINITIONS

Routine Care

Healthcare for covered preventive and medically necessary healthcare services that are non-emergent or non-urgent.

Urgent Behavioral Health Situation

A behavioral health condition that requires attention and assessment within 24 hours but that does not place the member in immediate danger to himself or others and the member is able to cooperate with treatment.

Emergency Services

Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the contract and that are needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition, including post-stabilization care services.

ACCESSIBILITY

Each provider shall provide covered services during normal business hours. Covered services shall be available and accessible to members, including telephone access, on a 24-hour, seven-day per week basis, to advise members requiring urgent or emergency services.

Specialists shall arrange for appropriate coverage by a participating provider when unavailable due to vacation, illness, or leave of absence. As a participating Beacon provider, you must be accessible to members 24 hours a day, seven days a week. The following are acceptable and unacceptable phone arrangements for contacting physicians after normal business hours.

Acceptable

1. Office phone is answered after hours by an answering service. All calls answered by an answering service must be returned within 30 minutes.
2. Office phone is answered after normal business hours by a recording in the language of each of the major population groups serviced, directing the patient to call another number to reach another provider designated to you. Someone must be available to answer the designated provider's phone. Another recording is not acceptable.
3. Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact another designated medical practitioner.
4. Members who "no-show" for an appointment are contacted within 24 hours in an attempt to reschedule them. NOTE: When a STAR member "no-shows," providers are expected to alert the member's Beacon/PCHP assigned service coordinator.

Unacceptable

1. Office phone is only answered during office hours
2. Office phone is answered after hours by a recording, which tells the patients to leave a message
3. Office phone is answered after hours by a recording that directs patients to go to an emergency room for any services needed
4. Returning after hours calls outside of 30 minutes
5. Failing to follow-up with members who "no-show" for an appointment

ACCESSIBILITY STANDARDS

Appointment Standards and After-Hours Accessibility

TYPE OF APPOINTMENT/SERVICE	APPOINTMENT MUST BE OFFERED:
General Appointment Standards	
Routine-Non Urgent Services	Within 14 calendar days, sooner if required by DFPS

TYPE OF APPOINTMENT/SERVICE	APPOINTMENT MUST BE OFFERED:
Urgent Care	Within 24 hours
Emergency Services	Immediately, 24 hours per day, 7 days a week
Aftercare Appointment Standards *(Inpatient and 24-hour diversionary service must schedule an aftercare follow-up prior to a member's discharge)*	
Non-24-hour Diversionary	Within 2 calendar days
Post-discharge from Acute Inpatient Hospital Stay	7 days
All Other Outpatient Services	Within 10 business days
Intensive Care Coordination (ICC)	Within 2 business days

SERVICE AVAILABILITY	HOURS OF OPERATION
On-Call	▪ 24-hour on-call services for all members in treatment ▪ Ensure that members in treatment are aware of how to contact the treating or covering providers after hours and during provider vacations
Crisis Intervention	▪ Services must be available 24 hours per day, 7 days per week. ▪ Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours. ▪ After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.
Outpatient Services	▪ Outpatient providers should have services available Monday through Friday from 8:00 a.m. to 5:00 p.m., CT, at a minimum ▪ Evening and/or weekend hours should also be available at least two days per week

SERVICE AVAILABILITY	HOURS OF OPERATION
Interpreter Services	▪ Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency.

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

EMERGENCY TRANSPORTATION

Parkland Community Health Plan does not require prior authorization or notification when Member presents with an emergency medical condition or an emergency behavioral condition for emergency room or ambulance services.

Ambulance Transportation

Parkland Community Health Plan covers emergency and medically necessary nonemergency ambulance transportation.

- Emergency Ambulance Transportation In the event a Member's condition is life-threatening or potentially life-threatening and requires the use of special equipment, life support systems and close monitoring by trained attendants while in route to the nearest medical facility, the ambulance transport is considered an emergency service and does not require Parkland Community Health Plan prior authorization.

  Facility to facility transportation is considered emergent when meeting the definition found in 1 TAC §353.2. Facility to facility transport is considered emergent when the service is not eligible at the first facility.

- Non-Emergency Ambulance Transportation Non-emergency ambulance transportation is defined as ambulance transport provided for a Parkland Community Health Plan Member to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the Member's home after discharge when the Member has a medical condition such that the use of ambulance is the only appropriate means of transportation. Non-emergency ambulance transportation services must be prior authorized and coordinated by Parkland Community Health Plan before an ambulance is used to transport a Member in circumstances not involving an emergency.

The Ambulance Provider is responsible for ensuring the prior authorization was approved prior to transport as nonpayment will result without a prior authorization. Retrospective review may be performed to ensure that documentation supports the medical necessity of the transport

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES

What is NEMT?

NEMT services provide transportation to covered health care services for members who have no other means of transportation. Such transportation includes rides to the doctor, dentist, hospital, pharmacy, and other places an individual receives Medicaid services. NEMT services do NOT include ambulance trips

What services are offered by NEMT?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered health care service. The ITP can be the Member, the Member's family member, friend, or neighbor.
- Members 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain covered health care service. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- Members 20 years old or younger may be eligible to receive the cost of lodging associated with a long-distance trip to obtain a covered health care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
- Members 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT services.

If you have a member needing assistance while traveling to and from his or her appointment with you, NEMT services will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health care services are being provided but may remain in the waiting room during the member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult.

Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent of a parent or guardian, or other authorized adult on file to travel alone. Parental consent is not required if the covered healthcare service is confidential in nature.

If you have a member you think would benefit from receiving NEMT services, please refer him or her to PCHP at 1-888-667-7890 (HEALTHfirst) or 1-800-357-3162 (KIDSfirst) for more information

Chapter 5

Provider and Member Complaints

Complaints

A Complaint is any dissatisfaction expressed verbally or in writing by a complainant to Beacon regarding any aspect of Beacon's operation. The term includes dissatisfaction relating to plan administration, about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights. The term complaint does not include:

> A provider's or member's verbal or written expression of dissatisfaction or disagreement with an adverse determination. [42 CFR 438.400]

Complaints will be designated in the following categories:

- Quality of Care or Service
- Accessibility/Availability of services
- Utilization Review or Management
- Complaint Procedures
- Provider Contract
- Marketing
- Claims Processing
- Miscellaneous

Beacon reviews and provides a timely response and resolution of all complaints that are submitted by members, a Legally Authorized Representative (LAR), and/or providers. All members and LARs have a right to report a complaint. Every complaint is thoroughly investigated, and receives fair consideration and timely determination. All documentation regarding complaints are retained by Beacon including letters, emails to and from the MCO and/or provider. Beacon maintains a log and files containing all communication regarding each complaint.

Complaints will be acknowledged within three business days of receipt of the complaint by Beacon. The complaint will be investigated and resolved within 30 days of receipt of the complaint. If the complaint is determined to be urgent, the resolution is communicated to the member and/or provider verbally within 24 hours, and then in writing within three calendar days of receipt of the complaint.

If the complaint is non-urgent, a preliminary review and investigation of the complaint is completed and reviewed by the Quality Department. This investigation may include consulting the following sources:

- Querying the source of the complaint (when appropriate)
- With authorization from the member, review of medical or other records (when appropriate)
- Interviews with appropriate parties to the complaint
- Requesting a response or explanation from the person/entity which is the focus of the complaint.

A complaint regarding a network provider is forwarded to Beacon's Credentialing Department, who enters information about the complaint and resolution in the provider's credentialing file for re-credentialing purposes.

Members may appoint a representative to act on the member's behalf with respect to a complaint by completing and signing a written Designation of Complaint Representative Form. Unless limited in writing by the member, law or judicial order, a representative will be granted all the rights of a member with respect to the complaint.

If a plan member or provider complains or expresses dissatisfaction regarding Beacon's procedures or services, plan procedures, covered benefits or services, or any aspect of the member's care received from providers, for reasons not related to medical necessity, they should be directed to **call Beacon's Member Services at 1-800-945-4644** for assistance in filing a complaint.

There is no time limit for filing a complaint.

Please Note: Member and provider concerns about a denial of requested clinical service, adverse utilization management decision, or an adverse action, are not handled as complaints. (See UM Reconsiderations and Appeals)

Complaint Resolution Process

A CHIP and STAR members' complaint are processed in the same manner and time frames. Their process differs when a complaint's resolution is not acceptable to the member or provider.

COMPLAINT RESOLUTION PROCESS – STAR (MEDICAID) ONLY

Dissatisfaction with Beacon's STAR Member's Complaint Resolution

If the member or LAR (a person acting on behalf of a member), or a member's provider of record, is not happy with the resolution of a STAR member's complaint, Beacon shall:

- Consider the expression of dissatisfaction or disagreement as an appeal of the complaint resolution; and
- Provide information to the member of his or her right to complain to the Health and Human Services Commission (HHSC) at the address below:

Texas Health and Human Services Commission (HHSC)
Office of Ombudsman, MC H-700
PO Box 13247
Austin, TX 78711-3247
Ph: 1-866-566-8989, Fax: 1-888-780-8099

Via email: HPM_Complaints@hhsc.state.tx.us

HHSC Online complaint form -

https://hhs.texas.gov/about-hhs/your-rights/hhs-ombudsman-managed-care-help

COMPLAINT RESOLUTION PROCESS – CHIP ONLY

Dissatisfaction with CHIP Member's Complaint Resolution

Beacon shall investigate and resolve a complaint or an appeal of a complaint concerning an emergency or a denial of continued hospitalization in accordance with the medical immediacy of the case and not later than one business day after Beacon receives the complaint; per Section §843.252(d).

In the case of an appeal involving ongoing emergency or continued hospitalization, Beacon shall ensure that the investigation and resolution of an appeal of a complaint relating to an ongoing emergency or denial of continued hospitalization shall be concluded:

- In accordance with the medical or dental immediacy of the case
- Not later than one business day after the complainant's request for appeal is received

COMPLAINT APPEAL PROCESS

If the member does not like the response to their complaint, they can contact Beacon and request a "complaint appeal" by asking for a hearing with the **Complaint Appeal Panel.** Every oral appeal received must be confirmed by a written, signed appeal by the member or his or her representative, unless the member asks for an expedited appeal. The complainant has the right to appear before a **Complaint Appeal Panel** where they normally receive health care or at another site agreed to by the complainant or address a written appeal to the complaint appeal panel. The **Complaint Appeal Panel** is a group of people that includes equal numbers of:

- Beacon Staff
- Physicians or other providers with experience in the area of care that is in dispute and must be independent of any physician or provider who made the prior determination
- Enrollees (enrollees may not be Beacon staff)

If specialty care is in dispute, the panel must include a specialist in the field of care related to the dispute.

Beacon will provide written acknowledgement of the Appeal, including a description of the substance of the Appeal and initial complaint, as well as a description of the **Complaint Appeal Panel** process, within five business days after receipt of the appeal. Beacon will provide to the complainant or the complainant's designated representative:

- Any documentation to be presented to the panel by the Beacon staff
- The specialization of any physicians or providers consulted during the investigation
- The name and affiliation of each Beacon representative on the panel

The complainant or designated representative if the enrollee is a minor or disabled is entitled to:

- Appear in person before the Complaint Appeal Panel
- Present alternative expert testimony
- Request the presence of and question any person responsible for making the disputed decision that resulted in the appeal

The **Complaint Appeal Panel** only serves in an advisory role to Beacon. Beacon will consider the findings of panel and render our final decision.

PROVIDER COMPLAINT RESOLUTION PROCESS

A **Provider Complaint** is an expression of dissatisfaction by a provider regarding Beacon operations, which may be submitted verbally or in writing. A provider complaint may arise when an inquiry is not resolved promptly or satisfactorily. At any point in the process of communication with Beacon a provider indicates that he or she would like to file a formal complaint, this request is honored and the complaint process is enacted.

Providers may file their own complaints and may also file complaints on a member's behalf. **Contact Beacon Member Services at** 800-945-4644to register a complaint.

Provider Complaint Appeal Process to HHSC

If a provider expresses verbally or in writing any dissatisfaction or disagreement with Beacon's complaint resolution, a complaint may be made to the Health and Human Services Commission (HHSC) at the address below:

Mail it to:

Texas Health and Human Services Commission
Office of the Ombudsman, MC H-700
P O Box 13247
Austin, TX 78711-3247

Call us: 1-866-566-8989

Fax it: 1-888-780-8099

Online complaint help and form:
https://hhs.texas.gov/about-hhs/your-rights/hhs-ombudsman-managed-care-help

If a provider files a complaint with HHSC, a letter that explains the specific reasons as to why they believe Beacon's complaint resolution is incorrect must be submitted along with:

- All correspondence and documentation sent to Beacon, including copies of supporting documentation submitted during the complaint process
- All correspondence and documentation received from Beacon
- All relevant reports of the claims/services in question, if applicable
- Provider's original claim/billing record, electronic or manual, if applicable
- Provider internal notes and logs when pertinent
- Memos from the state or Beacon indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the complaint
- Other documents, such as certified mail receipts, original date-stamped envelopes, in-service notes, or minutes from meetings if relevant to the complaint. Receipts can be helpful when the issue is late filing

Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)

Provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- The Explanation of Benefits (EOB) showing the original payment. Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- The EOB showing the recoupment and/or the plan's "demand" letter for recoupment. If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- Completed clean claim. All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

Chapter 6

Member Eligibility

Member Eligibility for the Medicaid Program (STAR)

Establishing member eligibility for benefits and obtaining an authorization before treatment is essential for the claims payment process. The Texas Health and Human Services Commission (HHSC) is responsible for determining Medicaid STAR eligibility. It is the responsibility of the network provider/ practitioner to monitor the member's ongoing eligibility during the course of treatment.

MEDICAID (STAR) ENROLLMENT AND MEMBER ID CARDS

The Texas HHSC is responsible for determining Medicaid eligibility. Contact Parkland Community Health Plan Member Services if you need information or locations of HHSC eligibility offices. The state's enrollment broker, Maximus, is responsible for enrolling individuals into the STAR program. Maximus can be contacted through the Texas Medicaid Program Help Line at 800.964.2777.

KEY ENROLLMENT INFORMATION

Until the actual date of enrollment with Parkland Community Health Plan, Parkland Community Health Plan is not financially responsible for services the prospective member receives, nor is Parkland Community Health Plan financially responsible for members who have lost their Parkland Community Health Plan coverage.

YOUR TEXAS BENEFITS MEDICAID CARD

When members are approved for Medicaid, they will get a Your Texas Benefits Medicaid Card. This plastic card will be their everyday Medicaid ID card. The card has a magnetic stripe that holds the Medicaid ID number. Having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's Medicaid eligibility and MCO enrollment for the date of service prior to services being rendered. There are several ways to do this:

- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Log into your TMHP user account and accessing Medicaid Client Portal for providers.
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at **1-800-925-9126** or **1-512-335-5986**

Medicaid providers can log into their TMHP user account and access the Medicaid Client Portal for providers. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). This information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be. The specific functions available are: Access to a Medicaid client's medical and dental health information including medical diagnosis, procedures, prescription medicines and vaccines on the Medicaid Client Portal through My Account.

- Enhances eligibility verification available on any device, including desktops, laptops, tablets, and smart phones with print functionality.
- Texas Health Steps and benefit limitations information

.

- A viewable and printable Medicaid Card.
- Display of the Tooth Code and Tooth Service Code for dental claims or encounters.

- Display of the Last Dental Anesthesia Procedure Date.

Additionally, an online portal is available to patients at www.YourTexasBenefits.com where they can:

- View, print, and order a Your Texas Benefits Medicaid card
- See their medical and dental plans
- See their benefit information
- See Texas Health Steps Alerts
- See broadcast alerts
- See diagnosis and treatments
- See vaccines
- See prescription medicines
- Choose whether to let Medicaid doctors and staff see their available medical and dental information

If a member does not want his/her provider to see his/her health history through the secure online network, he/she can call toll-free at **800-252-8263** and change his/her privacy settings.

The Your Texas Benefits Medicaid card has these facts printed on the front:

- Member name and Medicaid ID number
- The name of the Medicaid program the Member is in. This would be STAR
- The date HHSC made the card
- Pharmacy billing information Bin and Group number
- Member's enrolled health plan and the plan's phone number.
- Member's physician name and pharmacy name, if member is in the Medicaid Limited program.

The back of the Your Texas Benefits Medicaid card has a website you can visit (www.YourTexasBenefits.com) and a phone number you can call **800-925-9126** if you have questions about the new card.

New cards will not be issued if:

1. A client's plan changes from one managed care plan to another or when a client's plan changes from fee-for-service to an MCO or vice versa
2. A plan changes its name or contact telephone
3. A client's address change
4. Medicaid clients who have a Texas Benefit Medicaid card that previously stated "Limited" will now state "Locked in". These clients can only see the provider and pharmacy that they are assigned for their medical and prescription care.

Important: Do not send patients who forgot or lost their cards to an HHSC benefits office for a paper form. They can request a new card by calling 1-855-827-3748. Medicaid Members also can go online to order new cards or print temporary cards.

Medicaid (STAR) Disenrollment

PCHP STAR members are eligible through the Texas Medicaid program. When a member becomes ineligible for Texas Medicaid, the member is disenrolled from the STAR program and from PCHP. The HHSC is solely responsible for determining if and when a member is disenrolled and will make the final decision. Members can be disenrolled from PCHP but still be eligible for Medicaid. 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. PCHP requests notification 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 PCHP's member advocate for your service area.

Upon receipt of such request, staff may:

- Interview the provider/practitioner or his/her staff that 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
- 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 are 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

MEDICAID AUTOMATIC RE-ENROLLMENT

If a member becomes temporarily (for six months or less) ineligible for Medicaid and regains eligibility status during the initial six-month time frame, the member will be automatically re-enrolled in PCHP. PCHP and the State's enrollment broker, Maximus, will make every effort to re-enroll the member with the previous PCP.

SPAN OF ELIGIBILITY

Members can change health plans by calling the Texas Medicaid Managed Care Program Helpline at 800.964.2777. However, a member cannot change from one health plan to another health plan during an inpatient hospital stay. If a member calls to change health plans on or before the 15th of the month, the change will take place on the first day of the next month. If they call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If the member asks to change plans on or before April 15, the change will take place on May 1.
- If the member asks to change plans after April 15, the change will take place on June 1.

Medicaid (STAR) Newborn Enrollment

If a woman is a PCHP STAR member at the time of delivery, the newborn is automatically a PCHP STAR member from the date of birth. If the mother is not a PCHP member at the time of birth, the newborn must follow the enrollment process for the STAR program. The local HHSC office should be contacted to obtain Medicaid eligibility, and the STAR Help Line (800.964.2777) should be contacted for STAR enrollment information.

Member Eligibility for the CHIP Program

The Texas HHSC is responsible for determining CHIP eligibility via the State's contracted administrator (Administrative Services Contractor) for the CHIP program. Children under age 19 and whose family's income is at or below 201% of the federal poverty level (FPL) are eligible to enroll in the CHIP program if they do not qualify for Medicaid coverage.

The three CHIP eligibility categories are:

1. At or below 151% of FPL
2. Above 151% up to and including 186% of FPL
3. Above 186% up to and including 201% of FPL

Children of families with group health insurance or Medicaid coverage are NOT eligible for the CHIP program.

CHIP MEMBER ENROLLMENT, RE-ENROLLMENT, DISENROLLMENT, AND PLAN CHANGES

Once enrolled with PCHP, a member is enrolled for a period of 12 months (this applies to CHIP only). Members must re-enroll every 12 months. Members are only allowed to make plan changes once a year. Members may request to change plans for exceptional reasons or good cause. HHSC will make the final decision.

Re-enrollment begins at the beginning of the 10th month. CHIP will send a notice to the family outlining the next steps for renewal or continuation of coverage. Failure of the member to respond to the renewal notice will result in the member's disenrollment from the plan at the end of the 12-month enrollment period.

Disenrollment may occur due to:

- Change in family income

- "Aging out" when a child turns 19
- Failure to re-enroll at the conclusion of the 12-month eligibility period
- Change in health insurance status, such as a child enrolling in an employer-sponsored insurance plan
- Member's failure to meet monthly cost-sharing obligations
- Permanent move out of the state
- Enrollment in Medicaid
- Death of a child

Members are allowed to make health plan changes under the following circumstances:

- For any reason within 95 days of enrollment in CHIP
- For cause at any time
- During the annual re-enrollment period

Under no circumstances can a provider/practitioner take retaliatory action against a member due to dis-enrollment from either the provider/practitioner or a plan.

PREGNANT CHIP MEMBERS

Because of other CHIP program eligibility changes, most pregnant CHIP teenagers and their newborns, up to one year of age, may qualify for Medicaid. Since the Medicaid program provides a much more comprehensive scope of services for both the pregnant teen and her newborn, it is in the best interest of the pregnant teen to receive Medicaid coverage as early as possible. For this reason, it is critical that providers/practitioners notify PCHP immediately upon learning about a CHIP teen's pregnancy. PCHP will refer the family to CHIP to determine whether the teen is Medicaid-eligible. Pregnant CHIP teens who are Medicaid-eligible will be transferred from CHIP to Medicaid as soon as possible.

CHIP ENROLLMENT AND MEMBER ID CARDS

Until the actual date of enrollment with PCHP, PCHP is not financially responsible for services the prospective member receives, nor is PCHP financially responsible for members who have lost their PCHP coverage.

SPAN OF ELIGIBILITY

Members can change health plans by calling the Texas Medicaid Managed Care Program Helpline at 800.964.2777. However, a member cannot change from one health plan to another health plan during an inpatient hospital stay. If a member calls to change health plans on or before the 15th of the month, the change will take place on the first day of the next month. If they call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If the member asks to change plans on or before April 15, the change will take place on May 1.
- If the member asks to change plans after April 15, the change will take place on June 1.

Member Rights and Responsibilities

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

Beacon's Member Rights and Responsibilities Statement is available in English and Spanish for download from the website. Participating providers are encouraged to post the statement in their offices or waiting rooms or distribute the statement to members at their initial visit.

MEMBER RIGHTS:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.

2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."

3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.

4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.

5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.

6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.

7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.

8. Children who are diagnosed with special health care needs or a disability have the right to special care.

9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.

10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.

11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to CHIP Perinatal Members.

12. You have the right and responsibility to take part in all the choices about your child's health care.

13. You have the right to speak for your child in all treatment choices.

14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.

15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.

16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.

17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

19. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.

2. You must become involved in the doctor's decisions about your child's treatments.

3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.

4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.

5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.

6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.

7. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.

8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.

9. Talk to your child's provider about all of your child's medications.

Fraud Information

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

MEDICAID MANAGED CARE AND CHIP

DO YOU WANT TO REPORT WASTE, ABUSE, OR FRAUD?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care 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 or CHIP ID.
- Using someone else's Medicaid or CHIP 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:

- Call the OIG Hotline at 1-800-436-6184;
- Visit https://oig.hhsc.state.tx.us/ Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You may report directly to Beacon by calling the Beacon's Safe to Say Compliance & Ethics Hotline (Safe to Say Compliance and Ethics Hotline) at 888-293-3027
- Written fraud reports may also be sent via email to SIU@beaconhealthoptions.com

TO REPORT WASTE, ABUSE OR FRAUD, GATHER AS MUCH INFORMATION AS POSSIBLE.

To report waste, abuse or fraud, gather as much of the below listed 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 receives 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 7

STAR/CHIP Encounter Data, Billing, and Claims

Claims Procedures and E-Commerce Initiative

E-Commerce Initiative

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

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

To conduct these transactions referenced above, Beacon encourages providers to utilize the resources detailed further in the handbook sections titled "Electronic Resources," "Claim Procedures," "Re-credentialing and credentialing" and "Updating Provider Information." These resources will expedite claims processing and facilitate administrative tasks.

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

TIME LIMITS FOR FILING CLAIMS

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

- Within 95 days of the dates of service on outpatient claims
- Within 95 days of the date of discharge on inpatient claims

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the 95-day filing limit will deny.

CLAIM SETTLEMENTS

In the event of any dispute, the provider may use the dispute resolutions outlined in the provider services agreement.

REQUIRED CLAIM ELEMENTS

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

**All data elements noted as required must be provided, but they must also be current and match what the subscriber's employer has on file. If the member's ID on the claim is illegible, or does not match what the subscriber's employer has provided, we may not be able to determine the claimant. We strongly

recommend that you obtain a copy of the member's ID card, and validate that it is current at the time of each visit.

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

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

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

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

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

TAXONOMY REQUIREMENTS

A taxonomy code is an external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute, Accredited Standards Committee health care transaction.

All claims received for services rendered to all Texas MCO plan members, must be submitted with a billing taxonomy. Claims received that do not have this data element will be subject to denial. Claims received with a billing taxonomy that does not match the State of Texas Master Provider File will be subject to a denial. Please contact TMHP to ensure your billing taxonomy is active. Provider Taxonomy Code Billing Requirements: The Health Care Provider Taxonomy Code must be reported on all claims as of September 1, 2017. For paper claims, billing taxonomy should be reported in box 33b with qualifier zz. For EDI submissions more detailed information can also be found in the 837P/837I Claim Companion Guide which can be found by visiting https://www.beaconhealthoptions.com/providers/beacon/providerconnect/hipaa-837/

Electronic Billing Requirements

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 claims to Beacon.

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

- **Availity Essentials** supports electronic submission of claims in both batch format as well as direct claim entry. When submitting claims in batch format, the file must be compliant with ANSI X12 standards. The appropriate format for professional services (837P) is ASC X12N/005010X22 and for institutional services (837I) is ASC X12N/005010X223. Providers may submit claims using

EDI/837 format directly to Availity or through a billing intermediary that is configured to submit to Availity

- **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 claims submissions take less than one minute and contain few, if any errors.

About HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 in an effort to reduce the administrative costs of health care. The legislation requires health insurance payers to comply with the Electronic Data Interchange (EDI) standards for health care, as established by the Secretary of Health and Human Services. In order to achieve the potential administrative costs savings with EDI, standard transactions and code sets have been developed and will be implemented by all covered entities engaged in the electronic exchange of data. HIPAA mandates the use of standard transactions and code sets for covered entities that choose to conduct business electronically.

CLAIMS TESTING

Claims testing is available for ALL Providers and Trading Partners. Instructions can be found in Beacon's Companion Guide.

SUBMITTING COMPLIANT 5010 CLAIMS

Upon passing testing with Beacon, you can begin submitting HIPAA 837 claims.

If you currently use a Practice Management System (PMS), you will need the ANSI X 12N Implementation Guide and applicable addenda, which detail specific requirements for processing electronic data within payer systems.

HIPAA COMPLIANCE TESTING

According to the Centers for Medicare and Medicaid Services (CMS), you are responsible for ensuring that EDI transactions comply with HIPAA regulations.

To help you address your HIPAA EDI obligations as efficiently as possible, Beacon recommends Claredi™, the nation's leading provider of HIPAA transaction and code set testing and certification.

Claredi, an independent certifying agency, is the testing and certification entity selected by CMS for their own compliance. Using the same certification organization as Beacon reduces the potential for any transaction discrepancies.

For information on Claredi's services, just visit Claredi's Web site at www.claredi.com

Contact

EDI Helpdesk provides support for technical question about eServices

Phone: (888) 247-9311 from 8 a.m. – 6 p.m. ET (Monday-Friday)
Fax: (866) 698-6032
E-mail: e-supportservices@beaconhealthoptions.com

Mailing Address:
Beacon Health Options
Attn: EDI Helpdesk
PO Box 1287
Latham, NY 12110

Availity Client Services providers support for technical questions about Availity Essentials

Phone: 1-800-282-4548 from 8 a.m. – 8 p.m. ET (Monday-Friday)

Paper Claim Transactions

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

Providers are strongly discouraged from using paper claim 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 claim 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 CMS1500 or UB04 claim form. No other forms are accepted.

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

- Use machine print
- Use original red claim forms
- Use black ink
- Print claim data within the defined boxes on the claim form
- Use all capital letters
- Use a laser printer for best results
- Use correction tape for corrections
- Submit any notes on 8 ½" x 11" paper
- Use an eight-digit date format (e.g., 10212012)
- Use a fixed width font (Courier, for example)

Beacon Discourages Paper Transactions

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

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

PROFESSIONAL SERVICES: INSTRUCTIONS FOR COMPLETING THE CMS 1500 FORM

As a Beacon provider partner, we value the services you provide and it is important to us that you are reimbursed for the work you do. To assure your claim is not rejected or denied, we provide the tips below for accurately completing the CMS-1500 claim form.

https://s21151.pcdn.co/wp-content/uploads/Appendix-2C-6-Tips-for-completing-CMS-1500-052018.pdf

INSTITUTIONAL SERVICES: INSTRUCTIONS FOR COMPLETING THE UB04 FORM

As a Beacon facility partner, we value the services you provide and it is important to us that you are reimbursed for the work you do. To assure your claim is not rejected or denied, we provide the tips below for accurately completing the UB04 (CMS-1450) claim form. .https://s21151.pcdn.co/wp-content/uploads/Appendix-2C-8-Tips-for-Completing-the-UB04-052018.pdf

PAPER RESUBMISSION

- If the resubmitted claim is received by Beacon more than 95 days from the date of service for a clean claim and 120 days for appealing a denial for elements other than clean claims, 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 22 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.

- Resubmitted claims cannot contain original (new) claim lines along with resubmitted claim lines.
- Resubmissions must be received by Beacon within 120 days from the date on the EOB.

PAPER SUBMISSION OF 95-DAY WAIVER

- See earlier table for an explanation of waivers, when a waiver request is applicable, and procedural guidelines.
- Download the *95-Day Waiver Form* from https://www.beaconhealthoptions.com/providers/forms-and-resources/ - select state and health plan
- Complete a *95-Day Waiver Form* for each claim that includes the denied claim(s), per the instructions below.

Completion of the *95-Day Waiver Form*

To ensure proper resolution of your request, complete the *95-Day Waiver Form* as accurately and legibly as possible.

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 Children's Medical Center Health Plan member ID number.
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 95-day waiver request cannot be processed without a typed, signed, stamped, or computer- generated signature. Beacon will not accept "Signature on file."
9. **Date -** Indicate the date that the form was signed.

- 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:

Beacon Health Options
Claims Department
PO Box 1866
Hicksville, NY 11802

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 22 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:

  Beacon Health Options
  Claims Department
  PO Box 1866
  Hicksville, NY 11802

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.

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 60 days’ advance written notice to all in-network providers of such a change.

CATASTROPHIC EVENT

In the event that the carrier or provider is unable to meet the regulatory deadlines due to a catastrophic event (see definition at 28 TAC §21.2802(4)), then the entity must notify the Texas Department of Insurance and PCHP within five days of the event. Within 10 days after return to normal business operations, the entity must provide a certification in the form of a sworn affidavit, that identifies the nature of the event, the length of interruption of claims submission or processing, and a valid certification as stated in SB418 for the number of days identified in the certification.

Payspan

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

eServices

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

- Submit claims
- Check real-time claim status
- Print explanation of benefit (EOB) information
- Check member eligibility
- Check initial encounters used
- Request authorizations

- Check the status of authorizations, including units used
- Update practice and clinician information
- View or print provider documents such as manuals, forms, or bulletins
- Generate and print reports
- eServices transactions take less time to complete than paper submissions, enabling providers to improve productivity. Fax transmission problems, mail delays, and most errors are eliminated, and as a result, rework by provider administrative staff is nearly eliminated.

Links to information and documents important to providers are located on the eServices page of our website. https://www.beaconhealthoptions.com/providers/beacon/eservices-edi/

CONTACT INFORMATION

Email Contacts

- TexasProviderRelations@beaconhealthoptions.com
- e-supportservices@beaconhealthoptions.com

Telephone

- **Claims Hotline:** **800-247-9311**
  Hours of operation are 8 a.m. to 6 p.m., EST, Monday through Friday.
- Provider Relations: **800-397-1630**
  Hours of operation are 8 a.m. to 8 p.m., EST, Monday through Friday
- TTY **711**

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.

HOW THE PROGRAM WORKS

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

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.

BEACON 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.

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 reports such recoupments and adjustments on the EOB with Beacon's record identification number (REC.ID) and the provider's patient account number.

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. Refer to authorization notification for correct date ranges.
- 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 Xl3, 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.

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 claim submissions; this includes HIPAA-compliant revenue, CPT, HCPCS and ICD codes. Providers should refer to their exhibit A for a complete listing of contracted, reimbursable procedure codes.
- Beacon accepts only ICD diagnosis codes listing approved by CMS and HIPAA. In order to be considered for payment by Beacon, all claims must have a Primary ICD diagnosis. 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 following table lists HIPAA-compliant discharge status codes.

DISCHARGE STATUS CODES

CODE	DESCRIPTION
01	Discharged to Home/Self-Care
02	Discharged/Transferred to Another Acute Hospital
03	Discharged/Transferred to Skilled Nursing Facility
04	Discharged/Transferred to Intermediate Care Facility
05	Discharged/Transferred to a Another Facility
06	Discharged/Transferred to Home/Home Health Agency
07	Left Against Medical Advice or Discontinued Care
08	Discharged/Transferred Home/IV Therapy
09	Admitted as Inpatient to this Hospital
20	Expired
30	Still a Patient

BILL TYPE CODES

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

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

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. The table below lists HIPAA-compliant modifiers accepted by Beacon. **Clinician level modifiers are required on claims.**

*** Please see your Exhibit A for modifiers that are specific to your agreement.

HIPAA MODIFIER	MODIFIER DESCRIPTION
AH	Clinical psychologist
AJ	Clinical social worker / Licensed professional counselor
HA	Child/Adolescent program
HQ	Group setting
SA	Nurse practitioner
TF	Intermediate level of care
TG	Complex/high level of care
U3	Psychology intern
U6	Psychiatrist
U7	APRN and PA's
U8	Identifies service provided by an LMFT
U9	Identifies service provided by a PLP
UB	Identifies service provided by a pre-doctoral psychology intern or post-doctoral psychology fellow
UC	Identifies service provided by an LPA
U1	Take home dose for Methadone treatment
UA	Facility administered Methadone treatment
95	Delivered by synchronous audiovisual technology
FQ	Delivered by synchronous telephone (audio-only) technology
HE	Mental Health Program

HIPAA MODIFIER	MODIFIER DESCRIPTION
HF	Substance Use program

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 with a copy of the primary insurance's explanation of benefits report and received by Beacon within 95 days of the date on the EOB.
- Beacon reserves the right of recovery for all claims in which a primary payment was made prior to receiving COB information that deems Beacon the secondary payer. Beacon applies all recoupments and adjustments to future claims processed, and reports such recoupments and adjustments on the EOB.

Chapter 8

Communicating with Beacon

Transactions and Communications with Beacon

Beacon's website, www.beaconhealthoptions.com, contains answers to frequently asked questions, Beacon's 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.

Electronic Media

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

eSERVICES

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 claims 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 TexasProviderRelations@beaconhealthoptions.com

ELECTRONIC TRANSACTIONS AVAILABILITY

EDI AND ESERVICES 866-247-9311

https://www.beaconhealthoptions.com/providers/beacon/eservices-edi/

If you have a technical question about electronic transactions, please contact the EDI Operations team:

EDI.Operations@beaconhealthoptions.com

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 claims 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.

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

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
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
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.*

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.

8.5. STAR/CHIP Special Access Requirements

INTERPRETATION/TRANSLATION SERVICES

Beacon is committed to ensuring that staff are educated about, aware of, and sensitive to the linguistic needs and cultural needs of members. In order to meet this need, Beacon provides or coordinates the following:

- Beacon Customer Service is staffed with Spanish and English bilingual personnel, trained professional language interpreters.
- Behavioral education materials are provided in Spanish and/or English at the appropriate 4th to 6th grade reading level.

CULTURAL DIVERSITY

Beacon employs staff members who are sensitive to the needs of the cultural diversity of PCHP members. In order to meet the needs of these members, Beacon is staffed with Spanish and English bilingual personnel as described above and provides educational materials in Spanish and/or English at the appropriate reading level as described above.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

Service management is available to Children with Special Needs, which include but are not limited to:

- The discussion of covered services available to the child with the child's family
- Out-of-network services that may be available in the event that services are not available from an in-network provider;
- Care coordination as well as suggestions concerning the availability of community resources/ referrals
- Case management services that will assess the needs of the child and develop an individual plan to meet the needs of the child as well as periodic reassessments.

OTHER BENEFIT INFORMATION

- Benefits do not include payment for healthcare services that are not medically necessary.
- Neither Beacon nor PCHP 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 enrollee's care.
- Authorization is required for all services except emergency services.

PARKLAND COMMUNITY HEALTH PLAN MEMBER IDENTIFICATION CARDS

Plan members are issued one card, the plan membership 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.

A PCHP member card contains the following information:

- Member's name
- Plan identification number

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.

Chapter 9

Case Management and Utilization Management

Case Management

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

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

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

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

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

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

ICM and care coordination are voluntary programs, and member consent is required for participation. For further information on how to refer a member to case management services, please contact Beacon at 800-945-4644.

Utilization Management

Utilization management (UM) is designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures or settings. UM may include, but is not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, discharge planning and retrospective review.

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

- All Utilization Management decisions are based on a combination of InterQual medical necessity criteria, the Texas Administrative Code criteria for Substance Use Disorder care and the clinical expertise the staff bring to the position.
- Financial incentives based on an individual UM clinician's number of adverse determinations/adverse actions or denials of payment are prohibited
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization

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

Medical Necessity and Level of Care Criteria (LOCC)

All requests for authorization are reviewed by Beacon clinicians based on Beacon's medical necessity criteria including InterQual for Behavioral Health and clinical best practices.

Beacon's Level of Care Criteria (LOCC) is the basis for all medical necessity determinations; Beacon-specific LOCC for the plan and for each level of care is also available on Beacon's web page under provider resources. In addition, providers can also contact us to request a printed copy of Beacon's LOCC.

In 2019, Beacon adopted InterQual Medical Necessity Criteria for Behavioral Health.

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

Click the link for InterQual Medical Necessity criteria below:

- https://www.beaconhealthoptions.com/providers/beacon/handbook/clinical-criteria/

9.5. Utilization Management Terms and Definitions

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

TERM	DEFINITION
Adverse Determination	A decision to deny, terminate, or modify (an approval of fewer days, units or another level of care other than was requested, which the practitioner does not agree with) an admission, continued inpatient stay, or the availability of any other behavioral health care service, such as outpatient services, based upon the following: a. Failure to meet the requirements for coverage based on medical necessity b. Appropriateness of health care setting and level-of-care effectiveness c. Health plan benefits
Adverse Action	The following actions or inactions by Beacon or the provider organization: 1. Beacon's denial, in whole, or in part, of payment for a service that fails to provide the covered services in a timely manner and in accordance with the time standards established by contract, or in-line with national time standards. 2. Beacon's denial or limited authorization of a requested service, including the determination that a requested service is not a covered service 3. Beacon's reduction, suspension, or termination of a previous authorization for a service 4. Beacon's denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including but not limited to, denials based on the following: a. failure to follow prior authorization procedures b. failure to follow referral rules c. failure to file a timely claim 5. Beacon's failure to act within the timeframes for making authorization decisions 6. Beacon's failure to act within the timeframes for making appeal decisions
Non-Urgent Concurrent Review & Decision	Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments. A non-urgent concurrent decision may authorize or modify requested treatment over a period of time or a number of days or treatments, or deny requested treatment, in a non-acute treatment setting.

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

Authorization Procedures and Requirements

This section describes the processes for obtaining authorization for inpatient, diversionary, and outpatient levels of care, and for Beacon's medical necessity determinations and notifications. In all cases, the treating provider, whether admitting facility or an outpatient practitioner is responsible for following the procedures and requirements presented, in order to ensure payment for properly submitted claims.

Administrative denials may be rendered when applicable authorization procedures, including timeframes, are not followed.

MEMBER ELIGIBILITY VERIFICATION

The first step in seeking authorization is to determine the member's eligibility. Since member eligibility changes occur frequently, providers are advised to verify a plan member's eligibility upon admission to, or initiation of treatment, as well as on each subsequent day or date of service to facilitate reimbursement for services.

EMERGENCY SERVICES

Definition

Emergency services are those physician and outpatient hospital services, procedures, and treatments, including psychiatric stabilization and medical withdrawal management from drugs or alcohol, needed to evaluate or stabilize an emergency medical condition. The definition of an emergency medical condition is as follows:

Covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the Contract and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post-Stabilization Care Services.

Emergency Screening and Evaluation

Plan members must be screened for an emergency medical condition by a qualified behavioral health professional from the hospital emergency room, or by an emergency service program (ESP). This process allows members access to emergency services as quickly as possible and at the closest facility, or by the closest crisis team.

After the emergency evaluation is completed, the facility or program clinician should call Beacon to complete a clinical review, if admission to a level of care that requires pre-certification is needed.

The facility/program clinician is responsible for locating an In-Network bed, but may request Beacon's assistance. Beacon may contact an out-of-network facility in cases where there is not a timely or appropriate placement available within the network. In cases where there is no in-network bed available Beacon will consider using an out-of-network psychiatric facility, as available, Beacon will authorize boarding the member on a medical unit, if neither in-network or out-of-network options exist and until an appropriate placement becomes available.

BEACON CLINICIAN AVAILABILITY

Beacon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures. Beacon clinicians are available 24 hours a day, seven days a week, to take emergency calls from members, their guardians, and providers. Beacon will respond to a call within 1 hour of the call being received by Beacon's customer service staff. Communication of an authorization for medically necessary treatment and the reference number for that authorization will be communicated back to the requesting facility/provider by the Beacon UR clinician within twenty-four (24) hours.

DISAGREEMENT BETWEEN BEACON AND ATTENDING PHYSICIAN

For acute services, in the event that the Beacon physician advisor and the emergency service physician do not agree on the service that the member requires, the emergency service physician's judgment shall prevail, and treatment shall be considered appropriate for an emergency medical condition, if such treatment is consistent with generally accepted principles of professional medical practice and is a covered benefit under the member's program of medical assistance or medical benefits. All Beacon

clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures.

AUTHORIZATION PROCEDURES AND REQUIREMENTS

	INPATIENT AND DIVERSIONARY SERVICES
Initial Assessment	Beacon requires a face-to-face evaluation for all members who require admission to acute services. To the maximum extent feasible, all members must be screened by a qualified behavioral health professional or at the nearest emergency room prior to admission to: ▪ Inpatient mental health ▪ Partial hospitalization ▪ Intensive outpatient program (IOP) ▪ Inpatient substance abuse rehabilitation ▪ Inpatient Withdrawal Management (medically managed and medically monitored) ▪ Ambulatory Withdrawal Management
Pre-Service	See Information Due at Time of Review
Services Requiring Authorization	The following services require Beacon's prior authorization: ▪ Inpatient services ▪ Diversionary services ▪ Extended outpatient sessions past 30 Initial Episodes ▪ Psychological and neuropsychological testing ▪ Out-of-network services Inpatient services do not require pre-service authorization; however, facilities must notify and request authorization from Beacon of the emergency treatment and/or admission within 24 hours. Out-of-network service is not a covered benefit. It may be authorized in some circumstances where needed care is not available within the network or available in a timely manner. Providers must request approval from Beacon prior to transferring members. The member must meet Beacon's admission criteria for the receiving facility prior to transfer. Without pre-service authorization for the receiving facility, elapsed days will not be reimbursed or considered for appeal.
Other Services Requiring Pre-Service Approval	▪ Psychological testing ▪ Ambulatory Withdrawal Management ▪ Continued/extended outpatient visits after member has exhausted his or her initial visits

	INPATIENT AND DIVERSIONARY SERVICES
	▪ Inpatient and outpatient services with out-of-network providers. Note that out-of-network care is not a covered benefit, but may be approved in certain circumstances.

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 ▪ DSM diagnosis: All five axes are appropriate; Axis I and Axis V are required. (A provisional diagnosis is acceptable). ▪ Description of precipitating event and current symptoms requiring inpatient psychiatric care ▪ Medication history ▪ Substance use disorder history ▪ Prior hospitalizations and psychiatric treatment ▪ Member's and family's general medical and social history ▪ Recommended treatment plan relating to admitting symptoms and the	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
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.

UM REVIEW REQUIREMENTS – PSYCHOLOGICAL TESTING AND OUTPATIENT SERVICES AFTER 30 INITIAL EPISODES

Psychological and Neuropsychological Testing

Psychological and Neuropsychological testing requires approval from the Beacon Utilization Management team. Providers should complete the Beacon Psych and Neuro Psych Request form and submit via fax or web-based portal.

Outpatient Services after 30 Initial Episodes

Outpatient Services past the 30 Initial Episodes of treatment require additional authorization. Providers should complete the Beacon Outpatient Review Form and submit via fax or web-based portal.

Members are allowed a fixed number of 30 initial therapy sessions without prior authorization. These sessions, called initial encounters or IEs, must be provided by contracted in-network providers, and are subject to meeting medical necessity criteria.

To ensure payment for services, providers are strongly encouraged to ask new patients if they have been treated by other therapists. Via eServices, providers can look up the number of IEs that have been billed to Beacon Health Strategies; however, the member may have used additional visits that have not been billed. If the member has used some IEs elsewhere, the new provider is encouraged to obtain authorization before beginning treatment.

The following services do count against the member's IEs:

1. Outpatient mental health;
2. Outpatient substance abuse services; and
3. Combined psychopharmacology and therapy visits.

The following services do not require authorization and do not count against the member's IEs:

4. Medication management sessions; and
5. Group therapy sessions.

RETURN OF INADEQUATE OR INCOMPLETE TREATMENT REQUESTS

All requests must be original and specific to the dates of service requested, and tailored to the member's individual needs. 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) that must be taken by the provider to resubmit the request.

NOTICE OF INPATIENT/DIVERSIONARY APPROVAL OR DENIAL

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

If the clinical information available does not support the requested level of care, the UR clinician discusses alternative levels of care that match the member's presenting clinical symptomatology, with the requestor. If an alternative setting is agreed to by the requestor, the revised request is approved. If agreement cannot be reached between the Beacon UR clinician and the requestor, the UR clinician consults with a Beacon psychiatrist or physician advisor. The requesting provider is offered the opportunity for a peer-to-peer conversation with the reviewing physician prior to the issuance of an adverse determination or action. The provider is given at least 24 hours to respond to the offer of a peer-to-peer. All denial decisions are made by a Beacon physician or psychologist advisor. The UR clinician and/or Beacon physician advisor offers the treating provider the right to appeal.

All member notifications are provided in English and Spanish and include instructions on the following: how to access interpreter services; how to proceed if the notice requires translation or a copy in an alternate format; and toll-free telephone numbers for TDD/TTY capability, in established prevalent languages, (Babel Card).

TERMINATION OF OUTPATIENT CARE

Beacon requires that all outpatient providers set specific termination goals and discharge criteria for members. Providers are encouraged to use the Level of Care Criteria LOCC (accessible through Beacon's webpage or through eServices) to determine whether the service meets medical necessity for continuing outpatient care.

UR Decision and Notification Time Frames

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

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

MEDICAID STAR			
TYPE OF REQUEST	**TYPE OF INFORMATION**	**URGENT/EXPEDITED**	**NON-URGENT/ STANDARD**
Pre-Service	Decision Time	1 hour	24 hours
	Verbal Notification	1 hour	24 hours
	Written Notification	3 working day	3 working days
Concurrent	Decision Time	24 hours	24 hours
	Verbal Notification	24 hours	24 hours
	Written Notification	3 working days	3 working days
Post-Service	Decision Time	N/A	30 calendar days
	Verbal Notification	N/A	30 calendar days
	Written Notification	N/A	30 calendar days

CHIP			
TYPE OF REQUEST	**TYPE OF INFORMATION**	**URGENT/EXPEDITED**	**NON-URGENT/ STANDARD**
Pre-Service	Decision Time	1 hour	24 hours
	Verbal Notification	1 hour	24 hours
	Written Notification	3 working day	3 working days
Concurrent	Decision Time	24 hours	24 hours
	Verbal Notification	24 hours	24 hours
	Written Notification	3 working days	3 working days
Post-Service	Decision Time	N/A	30 calendar days
	Verbal Notification	N/A	30 calendar days
	Written Notification	N/A	30 calendar days

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

Clinical Appeal Processes

OVERVIEW

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. Appeals may be filed verbally, in person, or in writing.

Appeal policies are made available to members and/or their appeal representatives as enclosures in all denial letters, and upon request.

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

PEER REVIEW

A peer review conversation may be requested at any time by the treating provider, and may occur prior to or after an adverse action/adverse determination. Beacon UR clinicians and physician advisors are available daily to discuss denial cases by phone at **800-945-4644**.

URGENCY OF APPEAL PROCESSING

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

APPEAL PROCESS DETAIL

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

- Table 1: Standard Clinical Appeals
- Table 2: Expedited Clinical Appeals

Each table illustrates:

- How to initiate an appeal
- Resolution and notification timeframes for expedited and standard clinical appeals, at the internal first level and external review levels

TABLE 1: STANDARD CLINICAL APPEALS	
INTERNAL APPEAL REVIEWS	**EXTERNAL APPEAL REVIEWS**
Standard Appeals for Medicaid (STAR) Members Members, authorized member representatives, physicians or providers have up to 60 calendar days after receiving notice of an adverse action in which to file an **appeal**. The member, or representative must send a written signed appeal request to initiate a **standard appeal**. Beacon provides an appeal form with the initial action letter. Within five working days, an appeal acknowledgement letter will be sent to the member and provider. A Beacon physician advisor, who has not been involved in initial decision, reviews all available information. Decision is made within 30 calendar days of initial request. Throughout the course of an appeal, Medicaid members shall continue to receive services without liability for services previously authorized by Beacon, if the following conditions are met: ▪ The member or his representative files the appeal within the required timeframe. ▪ The appeal involves the termination, suspension, or reduction of previously authorized services and they are currently being provided. ▪ The services were ordered by an authorized provider. ▪ The period of the original authorization has not expired. ▪ The member requests an extension of the benefits. ▪ The member may be held liable for payment of continuing services if the appeal is not deemed in their favor. **Standard Appeals for CHIP Members** A member, a person acting on behalf of a member, the member's physician or provider may	**External Reviews for Medicaid (STAR) Members** Medicaid members have the right to file a FAIR HEARING request with the Texas HHSC upon receipt of an adverse action issued by Beacon. The member may represent themselves at the fair hearing, or name someone else to be their representative. The request must be filed within 120 calendar days from the date on the adverse action letter sent by Beacon. The member must call or write Beacon to request a fair hearing. HHSC will give a final decision within 90 days from the date of the request for the hearing. Members are notified that they can continue receiving services that are the subject of the appeal, as long as the service was previously authorized by Beacon, they submit their request for a Fair Hearing to the HHSC within 10 calendar days of receiving the appeal decision, and they request the fair hearing before the known date of the intended denial. **External Reviews for CHIP Members** If Beacon denies the appeal, the member, someone acting on their behalf, or their provider has the right to request a review by an Independent Review Organization (RO). The IRO does not have an affiliation with your health plan, your health care providers, or Beacon Health Options. You can ask for an IRO review from MAXIMUS by filing the "HHS-Administered Federal External Review Request Form". The member, member's parent or legal guardian must sign the consent to release medical information to the IRO. The completed and signed IRO request form can be faxed to 1-888-866-6190. If you need help requesting an IRO, call 1-888-866-6205 Monday-Friday from 8:00 am- 5pm EST. There is no cost to you for an IRO.

TABLE 1: STANDARD CLINICAL APPEALS	
INTERNAL APPEAL REVIEWS	**EXTERNAL APPEAL REVIEWS**
appeal an adverse determination orally or in writing. Within 5 working days, an appeal acknowledgement letter will be sent to the member and provider. A Beacon physician advisor, who has not been involved in initial decision, reviews all available information. Decision is made within 30 calendar days of initial request. If the appeal review results in a denial, CHIP members are informed of their right to an independent review through the Texas Department of Insurance.	The covered person must sign the consent form, unless they have a legal guardian, personal representative, are incapacitated, or have otherwise delegated authority to complete the form. If the covered person cannot sign this form, the authorized representative must give written proof of his or her authority to sign for the member. The decision is made by MAXIMUS within 30 calendar days of the request. Throughout the course of an appeal, the member shall continue to receive services without liability for services previously authorized by Beacon, until he/she is notified of the appeal determination. In order for services to continue without liability, the appeal request must be submitted within 10 days of the Adverse Action. Beacon will cover the cost of the independent review. Beacon will comply with the IRO's determination.
Contact Information Appeal requests can be made by calling Beacon's Appeals Coordinator at **1-800-945-4644** or by writing the Appeals Coordinator at the following address: Beacon Health Options PO Box 1856 Hicksville, NY 11802	**Contact Information** HHS Federal External Review Request MAXIMUS Federal Services 3750 Monroe Avenue, Suite 705 Pittsford, NY 14534

TABLE 2: EXPEDITED CLINICAL APPEALS	
INTERNAL EXPEDITED REVIEW	**EXTERNAL EXPEDITED REVIEW**
Expedited Appeals for Medicaid (STAR) Members The request for an expedited appeal may be received orally or in writing, as soon as is practical. A Beacon physician advisor, who has not been involved in initial decision, reviews all available	**External Expedited Reviews for Medicaid (STAR) Members** Medicaid members have the right to file a **Fair Hearing** request with Texas HHSC upon receipt of an adverse action issued by Beacon. The member may represent themselves at the fair hearing, or name someone else to be their

TABLE 2: EXPEDITED CLINICAL APPEALS	
INTERNAL EXPEDITED REVIEW	**EXTERNAL EXPEDITED REVIEW**
information and attempts to speak with the member's attending physician. Decision is made within one working day of initial request for expedited appeals. Throughout the course of an appeal, the member shall continue to receive services without liability if all the following conditions are met: ▪ The member or his/her representative files the appeal timely ▪ The appeal involves the termination, suspension or reduction of a previously authorized course of treatment ▪ The services were ordered by an authorized provider ▪ The period of the original authorization has not expired and the member requests an extension of the benefits. The member may be held liable for payment of continuing services if the appeal is not deemed in their favor. Medicaid members are notified that they have the right to access the State Fair Hearing process at any time during the appeal process. However, if the member is requesting an expedited State Fair Hearing, the member must complete the internal appeal process. **Expedited Appeals for CHIP Members** A member, a person acting on behalf of a member, the member's physician or provider may appeal an adverse determination orally or in writing. A Beacon physician advisor, who has not been involved in initial decision, reviews all available information and attempts to speak with the member's attending physician. Decision is made within one working day of initial request for expedited appeals. If the appeal review results in a denial, CHIP members are informed of their right to an	representative. The request must be filed within 120 calendar days from the date on the adverse action letter sent by Beacon. The member must call or write Beacon to request a fair hearing. HHSC will give a final decision within 90 days from the date of the request for the hearing. Members have the right to request an expedited Fair Hearing if the member meets the definition of urgent care. Members must exhaust the expedited internal appeal process before making a request for an expedited Fair Hearing. Members are notified that they can continue receiving services that are the subject of the appeal, as long as the service was previously authorized by Beacon, they submit their request for a Fair Hearing to the HHSC within 10 calendar days of receiving the appeal decision and they request the fair hearing before the known end date of the intended denial. **External Reviews for CHIP Members** Independent reviews are available to eligible CHIP members. The member/ authorized representative or provider must complete the internal appeal process before requesting an independent review unless the appeal involves a life-threatening condition, in which case the member, authorized representative, or provider is entitled to an immediate expedited appeal to an Independent Review Organization (IRO). The member/authorized representative or provider must make requests for a review by an Independent Review Organization within a reasonable timeframe. Decision is made within 8 calendar days of initial expedited request. The IRO will notify the parties involved of the IRO determination. Throughout the course of an appeal, the member shall continue to receive services without liability for services previously authorized by Beacon, until he/she is notified of the appeal determination. In order for services to continue without liability, the

TABLE 2: EXPEDITED CLINICAL APPEALS	
INTERNAL EXPEDITED REVIEW	**EXTERNAL EXPEDITED REVIEW**
independent review through the Texas Department of Insurance at the time of telephone notification of the appeal determination.	appeal request must be submitted within 10 days of the adverse action. Beacon will cover the cost of the independent review. Beacon will comply with the IRO's determination.
Contact Information Appeal requests can be made by calling Beacon's Appeals Coordinator at **1-800-945-4644** or by writing the Appeals Coordinator at the following address: Beacon Health Options PO Box 1856 Hicksville, NY 11802	**Contact Information** HHS Federal External Review Request MAXIMUS Federal Services 3750 Monroe Avenue, Suite 705 Pittsford, NY 14534

Member Appeal Processes

CAN I ASK FOR A STATE FAIR HEARING?

If a STAR member of the health plan disagrees with the health plan's decision, the member has the right to ask for a fair hearing. The member may name someone to represent him or her by writing a letter to the health plan telling them the name of the person the member wants to represent. A provider/practitioner may be the member's representative. The member or member representative must ask for the fair hearing within 120 days of the date on the health plan's letter that tells of the decision the member is challenging. If the member does not ask for the fair hearing within 120 days, the member may lose his/her right to a fair hearing. To ask for a fair hearing, the member or member representative should fill out the "Filing for a Fair Hearing" form included in the adverse determination letter:

Beacon Health Options
P.O. Box 1856
Hicksville, NY 11802-1856

If the member asks for a fair hearing within 10 days from the time he or she gets the hearing notice from the health plan, the member has the right to keep getting any service the health plan denied, and at least until the final hearing decision is made. If the member does not request a fair hearing within 10 days from the time the member gets the hearing notice, the service the health plan denied will be stopped. If the member asks for a fair hearing, the member will get a packet of information letting him/her know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, the member or the member's representative can tell why he/she needed the service the health plan denied.

HHSC will give the member a final decision within 90 days from the date the member asked for the hearing.

CHIP COMPLAINT APPEALS TO THE STATE – TEXAS DEPARTMENT OF INSURANCE

CHIP members may appeal to the Texas Department of Insurance if not satisfied with the resolution of a complaint or complaint appeal. Members can contact:

Texas Department of Insurance Consumer Protection
Mail Code 111-1A P.O. Box 149591
Austin, Texas 78714-9591
Phone: 800.252.3439

NOTICE OF ACTION (ADVERSE DETERMINATION)

At times Beacon will not authorize a service requested by a provider/practitioner. When Beacon determines that a specific service does not meet criteria, Beacon completes and sends a written notice of action that includes:

- The reason(s) for the denial in clearly understandable language
- A reference to the criteria, guideline, benefit provision, or protocol used in the decision, communicated in an easy-to-understand summary
- Information on how the provider/practitioner may contact clinical personnel to discuss decisions and proposed actions.
- Instructions for requesting an appeal, including the right to submit written comments or documents with the appeal request; the member's right to appoint a representative to assist them with the appeal, and the timeframe for making the appeal decision
- The member's right to request review by an Independent Review Organization (CHIP) or State Fair Hearing (STAR) and instructions for submitting this request
- For all urgent pre-certification and concurrent review clinical adverse actions, instructions for requesting an expedited appeal

APPEAL OF ADVERSE DETERMINATION/ADVERSE ACTION

A member or provider/practitioner has the right to appeal if Beacon denies or limits a request for a covered service, which includes an option for the request of an appeal for denial of payment for services in whole or in part. Beacon's Appeals Coordinators are available to assist a member in understanding and using the Beacon appeal process.

Denials for non-covered benefits cannot be appealed. STAR members have the option of requesting a State Fair Hearing at any time during or after the appeal process. STAR members have 60 days from the date of the adverse action denial letter to appeal the denial or limitation. CHIP members may file an appeal at any time after receiving the notification of adverse determination. For Standard Appeals, Beacon will acknowledge the appeal within five days of receipt, and complete the appeal process within 30 days. For Expedited Appeals, Beacon will complete the appeal process within one working day. Written appeals should be sent to:

Beacon Health Options
PO Box 1856
Hicksville, NY 11802

In addition, a STAR Member may be granted an additional 14 days to have the appeal resolved if more information is needed to benefit the member that will take additional time or if the member requests such

extension. Beacon will provide written notice of the reason for delay if the member has not requested the delay.

CONTINUATION OF SERVICES DURING THE APPEAL PROCESS (STAR MEMBERS)

If a STAR member is currently receiving a service that is being denied or limited, the appeal must be filed within 10 days of the adverse action letter or the date that services will be discontinued or limited, to facilitate review for continuation of the receipt of the services currently being provided.

Beacon will continue to provide benefits that are currently being provided while the appeal is being reviewed, if all of the following conditions are met:

1. The appeal is sent in the required timeframe.
2. The appeal is for a service that has been previously approved and is currently being provided.
3. The appeal is for a service ordered by a Beacon approved provider/practitioner.
4. The period of the original authorization has not expired
5. The member requests an extension of the benefits.

EXPEDITED ADVERSE DETERMINATION\ADVERSE ACTION APPEALS

Members and authorized representatives also have the right to request that Beacon expedite an appeal if the timeframe of a standard review would seriously jeopardize the individual's health or life. Expedited appeals are not offered retrospectively. For an expedited appeal in which the member is currently inpatient in a hospital, a healthcare worker or hospital representative may act as the member's authorized representative without a signed written consent from the member. Expedited appeals can be submitted orally or in writing.

To submit an expedited appeal in writing, please fax the expedited appeal to 781.994.7636. To initiate your expedited appeal by phone, please call Beacon at 1-800-945-4644.

Expedited appeals will be resolved within one business day and the provider/practitioner will be notified telephonically. Written notification is sent out within two business days of providing or attempting to provide oral notification. If Beacon determines that the appeal does not qualify to be expedited, the member will be notified immediately, and the resolution will be made within 30 calendar days. The Beacon Appeals Coordinator can assist the member with their expedited appeal. The member may also have their network provider/practitioner, a friend, a relative, legal counsel or another spokesperson assist them.

EXTERNAL REVIEW

Medicaid (STAR)

Medicaid members have the right to file a fair hearing request with the Texas HHSC upon receipt of an adverse action issued by Beacon. A Fair Hearing can be requested by calling **1-800-945-4644** or writing to:

Beacon Health Options
PO Box 1856
Hicksville, NY 11802-1856

The member may represent themselves at the fair hearing, or name someone else to be their representative. The request must be filed within 120 calendar days from the date on the adverse action letter sent by Beacon. The member must call or write Beacon to request a fair hearing. HHSC will give a final decision within 90 days from the date of the request for the hearing.

Members have the right to request an expedited Fair Hearing if the member meets the definition of urgent care. Members must exhaust the expedited internal appeal process before making a request for an expedited Fair Hearing.

Members are notified that they can continue receiving services that are the subject of the appeal, as long as the service was previously authorized by Beacon, they submit their request for a Fair Hearing to the HHSC within 10 calendar days of receiving the appeal decision, and they request the fair hearing before the known date of the intended denial.

CHIP Members

External reviews for CHIP Members If Beacon denies the appeal, the member, someone acting on their behalf, or their provider has the right to request a review by an Independent Review Organization (RO). The IRO does not have an affiliation with your health plan, your health care providers, or Beacon Health Options.

You can ask for an IRO review from MAXIMUS by filing the “HHS-Administered Federal External Review Request Form”. The member, member’s parent or legal guardian must sign the consent to release medical information to the IRO. The completed and signed IRO request form can be faxed to 1-888-866-6190. If you need help requesting an IRO, call 1-888-866-6205 Monday-Friday from 8:00 am- 5pm EST. There is no cost to you for an IRO.

The covered person must sign the consent form, unless they have a legal guardian, personal representative, are incapacitated, or have otherwise delegated authority to complete the form. If the covered person cannot sign this form, the authorized representative must give written proof of his or her authority to sign for the member. The decision is made by MAXIMUS within 30 calendar days of the request.

Throughout the course of an appeal, the member shall continue to receive services without liability for services previously authorized by Beacon, until he/she is notified of the appeal determination. In order for services to continue without liability, the appeal request must be submitted within 10 days of the Adverse Action.

COMPLAINT SPECIALIST REVIEW

At the request of the complainant, Beacon shall provide, in lieu of a Complaint Appeal Panel, a review by a specialist of the same or similar specialty as the physician or provider who would typically manage the medical condition, procedure or treatment and who has not previously reviewed the case. The physician or provider reviewing the appeal may interview the patient or the patient’s designated representative and shall decide on the appeal. Initial notice of the decision may be delivered orally if followed by written notice not later than three days after the date of the decision.

The complaint appeals process must be completed not later than 30 calendar days after receipt of the written request for appeal.

Complainants are informed of their right to contact the Texas Department of Insurance (TDI) in the event they are not satisfied with the outcome of Beacon’s complaint resolution.

- Call toll-free: 800.252.3439
- Fax toll-free: 888.780.8099

Online complaint form - https://www.tdi.texas.gov/forms/consumer/cp012complform.pdf