



BEACON HEALTH  
STRATEGIES, LLC

# Behavioral Health Policy and Procedure Manual for Providers

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

[WWW.BEACONHEALTHSTRATEGIES.COM](http://WWW.BEACONHEALTHSTRATEGIES.COM)

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**The following information is available via the health plan-specific Contact Information sheet available on Beacon's web site at [www.beaconhealthstrategies.com](http://www.beaconhealthstrategies.com)**

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

**Information specific to Exchange, FIDA, QHP and HARP product lines are available in the Product Addendum located on Beacon's web site – [www.beaconhealthstrategies.com](http://www.beaconhealthstrategies.com)**

## Chapter 1: Introduction

### Introduction to Beacon Health Strategies LLC

Beacon Health Strategies LLC (Beacon) is a limited liability, managed behavioral health care company. Established in 1996, Beacon's mission is to partner with health plans and contracted providers to improve the delivery of behavioral healthcare for the members we serve.

Through these partnerships,, Beacon provides care management services to members served by its health plan clients. Most often co-located at the physical location of our plan partners, Beacon's "in-sourced" approach deploys utilization review clinicians, case managers and provider network professionals into each local market where Beacon conducts business. Working closely with our plan partners, this approach facilitates better coordination of care for members with physical, behavioral and social conditions and is designed to support a "medical home" model. Quantifiable results prove that this approach improves the lives of individuals and their families through improved integration of behavioral health with medical care.

### About this Provider Manual

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

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

The Manual is posted on Beacon's website, [www.beaconhealthstrategies.com](http://www.beaconhealthstrategies.com), and on Beacon's **eServices** provider portal; only the version on **eServices** includes Beacon's LOC criteria. Providers may request a printed copy of the Manual by calling their Beacon facility contract manager.

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

## **Quality Improvement Efforts Focus on Integrated Care**

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

## **Behavioral Health Services**

### **Definition of Behavioral Health**

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

### **Accessible Intervention and Treatment**

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

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

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

## **Outpatient Benefits**

Outpatient behavioral health treatment is an essential component of a comprehensive healthcare delivery system. Plan members may access outpatient mental health and substance use services by

self-referring to a network provider, by calling Beacon, or by referral through acute or emergency room encounters. Members may also access outpatient care by referral from their primary care practitioners (PCP); however, a PCP referral is not required for behavioral health services.

## **Inpatient Benefits**

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

## **Primary Care Provider Requirements for Behavioral Health**

Primary care providers (PCPs) may be able to provide behavioral health services within the scope of their practice. However, PCPs should submit claims to their medical payor and not to Beacon.

## **Chapter 2: Network Operations**

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

## **Contracting and Maintaining Network Participation**

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

## **Provider Credentialing and Recredentialing**

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

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

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

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

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

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

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

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

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

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

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

## **Recredentialing**

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

- Licensure
- Clinical privileges
- Board certification
- Sanctions/restrictions – Beacon shall query the National Practitioner Data Bank and obtain updated sanction or restriction information from licensing agencies, Medicare, and Medicaid.
- Beacon does not perform site visits on practitioners or groups for recredentialing. Site visits, medical record audits, including evaluation of the quality of encounter notes, are performed randomly by the Clinical Department for quality of care and compliance review. These site visits are not performed by the Network Management Department, except for those facilities that are not accredited at the time of recredentialing.

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

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

## **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 AND eligible for licensure to practice independently in the state in which he/she works
- Supervised in the provision of services by a licensed independent clinical social worker, a licensed psychologist, a licensed master's-level clinical nurse specialist, or licensed psychiatrist meeting the contractor's credentialing requirements;
- Is covered by the hospital or mental health/substance abuse agency's professional liability coverage at a minimum of \$1,000,000/\$3,000,000
- Absence of Medicare/Medicaid sanctions

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

To request credentialing information and application(s), please email [provider.relations@beaconhs.com](mailto:provider.relations@beaconhs.com).

### Credentialing Process Overview

<b>Individual Practitioner Credentialing</b>	<b>Organizational Credentialing</b>
<p>Beacon individually credentials the following categories of clinicians in private or solo or practice settings:</p> <ul style="list-style-type: none"> <li>• Licensed Psychiatrist</li> <li>• Physician certified in addiction medicine</li> <li>• Licensed Psychologist</li> <li>• Licensed Independent Clinical Social Worker</li> <li>• Licensed Independent Counselor</li> <li>• Master's-Level Clinical Nurse Specialists/Psychiatric Nurses</li> <li>• Licensed Mental Health Counselors</li> <li>• Licensed Marriage and Family Therapists</li> <li>• Other behavioral healthcare specialists who are master's level or above and who are independently licensed, certified, or registered by the state in which they practice</li> </ul>	<p>Beacon credentials and recredentials facilities and licensed outpatient agencies as organizations. Facilities that must be credentialed by Beacon as organizations include:</p> <ul style="list-style-type: none"> <li>• Licensed outpatient clinics and agencies, including hospital-based clinics</li> <li>• Freestanding inpatient mental health facilities – freestanding and within general hospital</li> <li>• Inpatient mental health units at general hospitals</li> <li>• Inpatient detoxification facilities</li> <li>• Other diversionary mental health and substance use disorder services including:               <ol style="list-style-type: none"> <li>1) Partial hospitalization</li> <li>2) Day treatment</li> <li>3) Intensive outpatient</li> <li>4) Residential</li> </ol> </li> </ul>

	5) Substance use rehabilitation
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## Waiver Request Process

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

## Chapter 3: Quality Management and Improvement Programs

### QM & I Program Overview

#### Program Description

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

#### Program Principles

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

#### Program Goals and Objectives

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

#### Provider Role

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

To participate in Beacon's Provider Advisory Council, email [provider.relations@beaconhs.com](mailto:provider.relations@beaconhs.com). Members who wish to participate in the Member Advisory Council should contact the Member Services Department.

## 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 member PCPs, other behavioral health providers, government and community agencies
- Tracking of adverse incidents, complaints, grievances and appeals
- Other quality improvement activities

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

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

## Treatment Records

### Treatment Record Reviews

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

- use of screening tools for diagnostic assessment of substance use, adolescent depression and ADHD;
- continuity and coordination with primary care providers and other treaters;
- explanation of member rights and responsibilities;

- inclusion of all applicable required medical record elements as listed below; and
- allergies and adverse reactions, medications, and physical exam.

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

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

## **Treatment Record Standards**

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

### **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 indicating review of patient's rights and responsibilities

### **Medication Information**

Treatment records contain medication logs clearly documenting the following:

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

### **Medical and Psychiatric History**

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, and 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 the members aged 6-12 were assessed for ADHD:

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

### **Diagnostic Information**

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

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

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

### **Treatment Planning**

The treatment record contains clear documentation of the following:

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

### **Treatment Documentation**

The treatment record contains clear documentation of the following:

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

### **Coordination and Continuity of Care**

The treatment record contains clear documentation of the following:

- Documentation of communication and coordination among behavioral health providers, primary care physicians, ancillary providers, and healthcare facilities. (See Behavioral Health – PCP Communication Protocol, and download *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 [provider.relations@beaconhs.com](mailto:provider.relations@beaconhs.com).

## Outcomes Measurement

Beacon and the health plan strongly encourage and support providers in the use of outcomes 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 PCPs, Other Treaters

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

- notice of commencement of outpatient treatment within 4 visits or 2 weeks, whichever occurs first;
- updates at least quarterly during the course of treatment;
- notice of initiation and any subsequent modification of psychotropic medications; and
- notice of treatment termination within 2 weeks.

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

- presenting problem/reason for admission;
- date of admission;
- admitting diagnosis;
- preliminary treatment plan;
- currently prescribed medications;
- proposed discharge plan; and
- behavioral health provider contact name and telephone number.

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

- status of immunizations;
- date of last visit;
- dates and reasons for any and all hospitalizations;
- ongoing medical illness;
- current medications;
- adverse medication reactions, including sensitivity and allergies;
- History of psychopharmacological trials; and
- Any other medically relevant information.

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

## **Communication between Inpatient/Diversionsary Providers and PCPs, Other Outpatient Treaters**

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

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

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

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

## **Transitioning Members from one Behavioral Health Provider to Another**

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

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

## **Reportable Incidents and Events**

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

### **Adverse Incidents**

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

## Sentinel Events

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

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

## Other Reportable Incidents

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

1. Non-medicolegal deaths
2. Suicide attempt at a behavioral health facility not requiring medical admission
3. Any absence without authorization from a facility involving a member who does not meet the criteria for a sentinel event as described above
4. Any physical assault or alleged physical assault by or against a member that does not meet the criteria of a sentinel event
5. Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization.
  - A serious injury is an injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted.

6. Any unscheduled event that results in the temporary evacuation of a program or facility, such as a small fire that requires fire department response
7. Member fall unrelated to a physical altercation on a behavioral health unit
8. A medical event resulting in admission to a medical unit or facility
9. Any possession or use of contraband to include illegal or dangerous substances or tools (i.e., alcohol/drugs, weapons, or other non-permitted substances or tools)
10. Self-injurious behavior exhibited by a member while at a behavioral health facility.
11. Illegal behavior exhibited by a member while at a behavioral health facility defined as illegal by state, federal or local law (i.e., selling illegal substances, prostitution, public nudity).

## **Reporting Method**

- Beacon's Clinical Department is available 24 hours a day.
- Providers must call, regardless of the hour, to report such incidents.
- Providers should direct all such reports to their Beacon clinical manager or UR clinician by phone.
- In addition, providers are required to fax a copy of the *Adverse Incident Report Form* (for adverse and other reportable incidents and sentinel events) to Beacon's Ombudsperson at 781-994-7500. All adverse incidents are forwarded to the health plan for notification as well.
- Incident and event reports should not be emailed unless the provider is using a secure messaging system.

## **Provider Responsibilities**

### **Members Discharged from Inpatient Psychiatric Facilities**

Beacon requires that all members receiving inpatient psychiatric services must be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. Beacon Health Strategies providers will follow up with Medicaid members and attempt to reschedule missed appointments.

Providers should be prepared to present:

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

### **Primary Care Providers**

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

The individual provider is ultimately responsible for accuracy and valid reporting of all claims submitted for payment. A provider utilizing the services of a billing agency must ensure through legal contract (a copy of which must be made available to Beacon upon request) the responsibility of a

billing service to report claim information as directed by the provider in compliance with all policies stated by Beacon.

## **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 [provider.relations@beaconhs.com](mailto:provider.relations@beaconhs.com) of any change of address, telephone number, group affiliation, etc.

## **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.

*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

## **Accessibility Standards**

### Appointment Standards and After-Hours Accessibility

<b>Type of Appointment/ Service</b>	<b>Appointment Access Time Frames and Expectations:</b>
<b>General Appointment Standards</b>	
Routine/Non-Urgent Services	Within 14 calendar days
Urgent Care	Within 24 hours
Emergency Services	Immediately, 24 hours per day, 7 days per week
<b>Aftercare Appointment Standards</b>	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
Psychopharmacology services/Medication Management	Within 14 calendar days
<b>Service Availability</b>	<b>Hours of operation</b>
On-call	<ul style="list-style-type: none"><li>• 24-hour on-call services for all members in treatment</li><li>• Ensure that all members in treatment are aware of how to contact the treating or covering provider after hours and during provider vacations</li></ul>

Crisis Intervention	<ul style="list-style-type: none"> <li>• Services must be available 24 hours per day, 7 days per week</li> <li>• Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours.</li> <li>• 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.</li> </ul>
Outpatient Services	<ul style="list-style-type: none"> <li>• Outpatient providers should have services available Monday through Friday, from 8 a.m. to 5 p.m., CST at a minimum.</li> <li>• Evening and/or weekend hours should also be available at least 2 days per week.</li> </ul>
Interpreter Services	<ul style="list-style-type: none"> <li>• Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency.</li> </ul>

***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 Prescription Supply

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

The 72-hour emergency supply should be dispensed any time a PA 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 PA, 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.

## Chapter 4: Provider and Member Complaint and Appeals Process

### Complaints/Grievances

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

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

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

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

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

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

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

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

### Appeals of Complaint/Grievance Resolutions

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

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

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

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

## **Request for Reconsideration of Adverse Determination**

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

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

## **Clinical Appeals 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. Both clinical and administrative denials may be appealed. Appeals may be filed either verbally, in person, or in writing.

Appeal policies are made available to members and/or their appeal representatives upon request. Appeal rights are included in all action/adverse determination notifications.

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

### **Peer Review**

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

### **Urgency of Appeal Processing**

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

### **Appeals Process Detail**

This section contains detailed information about the appeal process for [health plan] members, in two tables: Table 4-1: Expedited Clinical Appeals; Table 4-2: Standard Clinical Appeals

Each table illustrates:

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

**Table 4-1: Expedited Clinical Appeals**

<b>Expedited Clinical Appeals</b>		
<b>Level 1 Appeal</b>	<b>Level 2 Appeal</b>	<b>External Review</b>
<p>Members, their legal guardian, or their authorized representative have up to 30-60 calendar days for Medicaid; 180 calendar days for commercial; 60 calendar days for Medicare/Duals after receiving notice of an adverse action in which to file an appeal.</p> <p>If the member designates an authorized representative to act on his or her behalf, Beacon will attempt to obtain a signed and dated <i>Authorization of Representative Form</i>. Both verbal and written communication can take place with a provider who initiated the expedited appeal or with the individual who the member verbally designated as his or her representative.</p> <p>A Beacon PA, who has not been involved in the initial decision, reviews all available information and attempts to speak with the member's attending physician.</p> <p>A decision is made within 24-72 hours, depending on line of business and state regulations of initial request. Written notification of the decision is sent to the provider and the member within 1-2 business days after the appeal decision.</p> <p>Throughout the course of an appeal the member shall continue to receive services without liability for services previously</p>	n/a	<p><b>External reviews for Medicaid Members:</b></p> <p>Members or their representatives may request an expedited State Fair Hearing with the state office associated with the member's Medicaid plan. <b>Please refer to the health plan-specific Contact Information sheet</b> for the address and phone number of the State Fair Hearing office.</p> <p>For assistance in filing a request for a State Fair Hearing with the state office associated with the member's Medicaid plan on your behalf, you may contact Beacon's Member Services Department through the plan's dedicated phone line. <b>Please refer to the health-plan specific Contact Information sheet.</b></p>

<p>authorized by Beacon, as long as all of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• The appeal was filed in a timely fashion</li> <li>• The appeal involved the termination, suspension, or reduction of a previously authorized course of treatment</li> <li>• The services were ordered by an authorized provider</li> <li>• The original period covered by the authorization has not expired</li> <li>• The member requested an extension of the benefits</li> </ul>		<p>Please note at this fair hearing, members may represent him/herself or appoint someone to represent him/her. <b>Please refer to the health plan-specific Product Addendum for the number of business days a decision will be made after Beacon receives the request for the State Fair Hearing.</b></p> <p><b>External Reviews for Commercial Members:</b></p> <p>Members or their representatives may request an expedited external review by an Independent Review Organization (IRO). The member, representative or provider must complete Beacon's internal appeal process before requesting an IRO unless the appeal involves a life-threatening condition.</p>
<p><i>Contact Information:</i></p> <p>Appeal requests can be made by calling Beacon's Appeals Coordinator. Please refer to the health plan-specific addendum for contact information</p>		<p><i>Contact Information:</i></p> <p><u>For Medicaid members:</u></p> <p><b>Please refer to the health plan-specific Contact Information sheet for the address and phone number of the State Fair Hearing office.</b></p>

	<p><u>For Commercial Members:</u></p> <p>Please contact the state's Independent Review Organization. <b>Please refer to the health plan-specific Contact Information</b> sheet for the address and phone number of the Independent Review Organization.</p>
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**Please note that providers may act as a member's Authorized Representative.**

**Table 4-2: Standard Clinical Appeals**

Standard Clinical Appeals		
Level 1 Appeal	Level 2 Appeal	External Review
<p>Members, their legal guardian, or their Authorized Representative have up to 30-60 calendar days for Medicaid; 180 calendar days for Commercial; 60 calendar days for Medicare/Duals after receiving notice of an adverse action in which to file an appeal.</p> <p>If the member designates an Authorized Representative to act on his or her behalf, Beacon will attempt to obtain a signed and dated <i>Authorization of Representative Form</i>.</p> <p>Both verbal and written communication can take place with a provider who initiated the appeal or with the individual who the member verbally designated as his or her</p>	<p>N/A</p>	<p><b>External Reviews for Medicaid Members</b></p> <p>Members or their representatives may request an expedited state fair hearing with the state. <b>Please refer to the health plan-specific Contact Information</b> sheet.</p> <p>For assistance in filing a request for a state fair hearing with the state on your behalf, you may contact Beacon's Member Services. Please refer to the health plan specific addendum for contact information. You may also request assistance by sending a written request to Beacon's Appeals Coordinator. <b>Please refer to the health plan specific Contact Information</b> sheet for the phone number of the Appeals Coordinator.</p>

<p>representative.</p> <p>A Beacon PA, who has not been involved in the initial decision, reviews all available information.</p> <p>A decision is made within 30 calendar days of initial request, (depending on line of business and state regulations) for standard appeals.</p> <p>If the appeal requires review of medical records, the member's or AMR's signature is required on an <i>Authorization to Release Medical Information Form</i> authorizing the release of medical and treatment information relevant to the appeal.</p> <p>If the medical record with <i>Authorization to Release Medical Information Form</i> is not received prior to the deadline for resolving the appeal, a resolution will be rendered based on the information available.</p> <p>The provider must submit the medical chart for review. If the chart is not received, a decision is based on available information.</p>		<p>Please note at this fair hearing, members may represent themselves or appoint someone to represent them. A decision will be made within a certain number of business days of the date the Department received the request for the state fair hearing. <b>Please refer to the health plan-specific Contract Information sheet for the number of business days associated with State Fair Hearings.</b></p> <p><b>External Reviews for Commercial Members</b></p> <p>Members or their representatives may request an external review by an Independent Review Organization. The member, representative or provider must complete Beacon's internal appeal process before requesting an IRO.</p>
<p><i>Contact Info:</i></p> <p>Appeal requests can be made by calling Beacon's Appeals Coordinator. Please refer to the health plan specific addendum for contact information.</p>		<p><i>Contact Info:</i></p> <p><b>For Medicaid Members</b></p> <p>Please contact your state's State Fair Hearings office. <b>Please refer to the health plan specific Contact Information sheet for the address and phone number of the State Fair Hearings office..</b></p>

		<p><b>For Commercial Members</b></p> <p>Please contact the state's Independent Review Organization. Please refer to the health plan-specific Contact Information sheet for the address and phone number of the Independent Review Organization.</p>
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**Please note that providers may act as a member's Authorized Representative.**

## Chapter 5: Member Eligibility

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

### Disenrollment

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

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

Upon receipt of such request, staff may:

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

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

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

### Member Rights and Responsibilities

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

## Fraud Reporting

### Reporting waste, abuse or fraud by a provider, client or member

#### MEDICAID MANAGED CARE

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

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

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

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

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

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

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

## Chapter 6: Encounter Data, Billing and Claims

### General Claims Policies

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

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

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

#### Definition of "Clean Claim"

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

#### Time Limits for Filing Claims

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

- Outpatient claims: Please refer to the health plan-specific Contact Information sheet for the filing limit for your health plan.
- Inpatient claims: Please refer to the health plan-specific Contact Information for the filing limit for your plan.

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the filing limit will deny. Please refer to the health plan-specific Contact Information sheet for the filing limit associated with your plan.

### Electronic Billing

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

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

- Electronic Data Interchange (EDI) supports electronic submission of claim batches in HIPAA-compliant 837P format for professional services and 837I format for institutional services.

Providers may submit claims using EDI/837 format directly to Beacon or through a billing intermediary. If using Emdeon as the billing intermediary, two identification numbers must be included in the 837 file for adjudication:

- Beacon Health Strategies payor ID is 43324; and

- **Your Health Plan's EDI Code. Please refer to the health plan-specific Contact Information sheet for your PlanID**

- **eServices** enables providers to submit inpatient and outpatient claims without completing a CMS 1500 or UB04 claim form. Because much of the required information is available in Beacon's database, most claim submissions take less than one minute and contain few, if any errors. Please call Beacon's Provider Relations for additional information on **eServices**.

### Additional Information available online:

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

## Claims Transaction Overview

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

**Table 6-1: Claims Transaction Overview Table (continued on the next page)**

Transaction	eServices			Applicable When:	Time Frame for Receipt by Beacon	Other Information
	EDI		IVR			
Member Eligibility Verification	Y	Y	Y	<ul style="list-style-type: none"> <li>• Completing any claim transaction; and</li> <li>• Submitting clinical authorization requests</li> </ul>	N/A	N/A

<b>Submit Standard Claim</b>	Y	Y	N	Submitting a claim for authorized, covered services, within the timely filing limit	Within the plan's filing limit from the date of service. Please refer to the health plan-specific Contact Information sheet for the filing limit.	N/A
<b>Resubmission of Denied Claim</b>	Y	Y	N	Previous claim was denied for any reason except timely filing	Within the plan's filing limit from the date on the EOB. Please refer to the health plan-specific Contact Information sheet for the filing limit.	<ul style="list-style-type: none"> <li>• Claims denied for late filing may be resubmitted as reconsiderations.</li> <li>• Rec ID is required to indicate that claim is a resubmission.</li> </ul>

<p>Please refer to the health plan-specific addendum for your plan's filing limit) <b>Waiver* (Request for waiver of timely filing limit)</b></p>	<p>N</p>	<p>N</p>	<p>N</p>	<p>A claim being submitted for the <i>first time</i> will be received by Beacon after the original plan filing limit (please refer to the health plan- specific addendum for your plan's filing limit , <i>and</i> must include evidence that one of the following conditions is met:</p> <ul style="list-style-type: none"> <li>• provider is eligible for reimbursement retroactively; or</li> <li>• member was enrolled in health plan retroactively; or</li> <li>• services were authorized retro-actively; or</li> <li>• third party coverage is available and was billed first. (A copy of the other insurance explanation of benefits (EOB) or payment is required.) You still have to be within the filing limit when submitting an EOB for coordination of benefits.</li> </ul>	<p>Within the filing limit)from the qualifying event. <b>Please refer to the health plan-specific Contact Information sheet for your plan's filing limit.</b></p>	<ul style="list-style-type: none"> <li>• Waiver requests will be considered only for these 4 circumstances. A waiver request that presents a reason not listed here, will result in a claim denial on a future EOB.</li> <li>• A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as a reconsideration request.</li> <li>• Beacon's waiver determination is reflected on a future EOB with a message of "Waiver Approved" or "Waiver Denied": if waiver of the filing limit is approved, the claim appears adjudicated; if the request is denied, the denial reason appears.</li> </ul>
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<b>Request for Reconsideration of Timely Filing Limit*</b>	N	Y	N	Claim falls outside of all time frames and requirements for resubmission, waiver and adjustment	Within the filing limit from the date of payment or nonpayment. Please refer to the health plan-specific Contact Information sheet for the plan's filing limit.	Future EOB shows "Reconsideration Approved" or "Reconsideration Denied" with denial reason
<b>Request to Void Payment</b>	N	N	N	<ul style="list-style-type: none"> <li>• Claim was paid to provider in error; and</li> <li>• Provider needs to return the entire paid amount to Beacon</li> </ul>	N/A	<b>Do NOT send a refund check to Beacon.</b>
<b>Request for Adjustment</b>	Y	Y	N	<ul style="list-style-type: none"> <li>• The amount paid to provider on a claim was incorrect</li> <li>• Adjustment may be requested to correct:             <ul style="list-style-type: none"> <li>- underpayment (positive request); or</li> <li>- overpayment (negative request)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Positive request must be received by Beacon within the plan's filing limit) from the date of original payment. Please refer to the health plan-specific Contact Information sheet for the plan's filing limit.</li> <li>• No filing limit applies to negative requests</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Do NOT send a refund check to Beacon.</b></li> <li>• <b>A Rec ID is required to indicate that claim is an adjustment.</b></li> <li>• Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount, and if money is owed to provider, repayment of the claim at the correct amount.</li> </ul>

						<ul style="list-style-type: none"> <li>• If an adjustment appears on an EOB and is not correct, another adjustment request may be submitted based on the previous incorrect adjustment.</li> <li>• Claims that have been denied cannot be adjusted, but may be resubmitted.</li> </ul>
<b>Obtain Claim Status</b>	N	Y	Y	Available 24/7 for all claims transactions submitted by provider	N/A	Claim status is posted within 48 hours after receipt by Beacon.
<b>View/Print Remittance Advice (RA)</b>	N	N	N	Available 24/7 for all claims transactions received by Beacon	N/A	Printable RA is posted within 48 hours after receipt by Beacon.

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

Beacon Discourages Paper Transactions  
 BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS EARLIER IN THIS CHAPTER.  
 Paper submissions have more fields to enter, a higher error rate/lower approval rate, and slower payment.

**Paper Claims Transactions**

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

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

## Where to Send Claims

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

Providers should submit Emergency Services claims related to behavioral health for processing and reimbursement consideration. **Please refer to the health plan-specific Contact Information sheet for the Beacon claims address associated with your plan:**

## Professional Services: Instructions for Completing the CMS 1500 Form

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

**Table 6-2: CMS 1500 Form Overview Table (continued on the next page)**

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

11c	No	Insurance Plan Name or Program Name (if applicable)
11d	No	Is there another health benefit plan?
12	Yes	Member's or Authorized Person's Signature and Date on File
13	No	Member's or Authorized Person's Signature
14	No	Date of Current Illness
15	No	Date of Same or Similar Illness
16	No	Date Client Unable to Work in Current Occupation
17	No	Name of Referring Physician or Other Source (if applicable)
17 B	No	NPI of Referring Physician
18	No	Hospitalization Dates Related to Current Services (if applicable)
19	No	Additional Claim Information (Designated by NUCC), if applicable.
20	No	Outside Lab?
21	Yes	Diagnosis or Nature of Illness or Injury. Enter the applicable ICD indicator according to the following: 9 – ICD-9-CM diagnosis or 0 – ICD-10-CM diagnosis
22	Yes	Medicaid Resubmission Code or Former Control Number (record ID if applicable)
23	Yes	Prior Authorization Number (if applicable)
24a	Yes	Date of Service
24b	Yes	Place of Service Code (HIPAA compliant)
24d	Yes	Procedure Code (HIPAA-compliant between 295 and 319) and modifier, when applicable (See Table 7.4 for acceptable modifiers)
24e	Yes	Diagnosis Code - 1, 2, 3 or 4
24f	Yes	Charges
24g	Yes	Days or Units
24h	No	EPSDT
24i	No	ID Qualifier
24 j	Yes	Rendering Provider Name and Rendering Provider NPI
25	Yes	Federal Tax ID Number
26	No	Provider's Member Account Number
27	No	Accept Assignment (check box)
28	Yes	Total Charges
29	Yes	Amount Paid by Other Insurance (if applicable)
30	Yes	Balance Due
31	Yes	Signature of Physician/Practitioner
32	Yes	Name and Address of Facility where services were rendered (Site ID). If missing, a claim specialist will choose the site shown as 'primary' in Beacon's database.
32 a	No	NPI of Servicing Facility

33	Yes	Provider Name
33 a	Yes	Billing Provider NPI
33 b	No	Pay to Provider Beacon ID Number

## Institutional Services: Instructions for Completing the UB04 Form

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.

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

**Table 6-3: UB-04 Form Overview Table (continued on the next page)**

Block #	Required?	Description
1	Yes	Provider Name, Address, Telephone #
2	No	Untitled
3	No	Provider's Member Account Number
4	Yes	Type of Bill (See Table 7-3 for 3-digit codes)
5	Yes	Federal Tax ID Number
6	Yes	Statement Covers Period (include date of discharge)
7	Yes	Covered Days (do not include date of discharge)
8	Yes	Member Name
9	Yes	Member Address
10	Yes	Member Birth Date
11	Yes	Member Sex
12	Yes	Admission Date
13	Yes	Admission Hour
14	Yes	Admission Type
15	Yes	Admission Source
16	Yes	Discharge Hour
17	Yes	Discharge Status (See Table 7-2: Discharge Status Codes)
18 -28	No	Condition Codes
29	No	ACDT States
30	No	Unassigned

31-34	No	Occurrence Code and Date
35-36	No	Occurrence Span
37	No	REC.ID for Resubmission
38	No	Untitled
39-41	No	Value CD/AMT
42	Yes	Revenue Code (if applicable)
43	Yes	Revenue Description
44	Yes	Procedure Code (CPT) (Modifier may be placed here beside the HCPCS code. See Table 7-4 for acceptable modifiers.)
45	Yes	Service Date
46	Yes	Units of Service
47	Yes	Total Charges
48	No	Non-Covered Charges
49	Yes	Modifier (if applicable; see Table 7-4 for acceptable modifiers)
50	Yes	Payer Name
51	Yes	Beacon Provider Id Number
52	Yes	Release of Information Authorization Indicator
53	Yes	Assignment of Benefits Authorization Indicator
54	Yes	Prior Payments (if applicable)
55	No	Estimated Amount Due
56	Yes	Facility NPI
57	No	Other ID
58	No	Insured's Name
59	No	Member's Relationship to Insured
60	Yes	Member's Identification Number
61	No	Group Name
62	No	Insurance Group Number
63	Yes	Prior Authorization Number (if applicable)
64	No	RecID Number for Resubmitting a Claim
65	No	Employer Name
66	No	Employer Location
67	Yes	Principal Diagnosis Code
68	No	A-Q Other Diagnosis
69	Yes	Admit Diagnosis
70	No	Patient Reason Diagnosis
71	No	PPS Code
72	No	ECl
73	No	Unassigned

74	No	Principal Procedure
75	No	Unassigned
76	Yes	Attending Physician NPI/TPI, First and Last Name and NPI
77	No	Operating Physician NPI/TPI
78 -79	No	Other NPI
80	No	Remarks
81	No	Code-Code

## Paper Resubmission

- See Table 6-1 for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.
- If the resubmitted claim is received by Beacon more than allowed by the plan's filing limit (please refer to the health plan-specific addendum for the plan's filing limit) from the date of service, the REC.ID from the denied claim line is required and may be provided in either of the following ways:
  - Enter the REC.ID in box 64 on the UB04 claim form or in box 19 on the CMS 1500 form.
  - Submit the corrected claim with a copy of the EOB for the corresponding date of service.
- *The REC.ID corresponds with a single claim line on the Beacon EOB. Therefore, if a claim has multiple lines, there will be multiple REC.ID numbers on the Beacon EOB.*
- The entire claim that includes the denied claim line(s) may be resubmitted regardless of the number of claim lines; Beacon does not require one line per claim form for resubmission. When resubmitting a multiple-line claim, it is best to attach a copy of the corresponding EOB.
- Resubmitted claims cannot contain original (new) claim lines along with resubmitted claim lines.
- *Resubmissions must be received by Beacon within the plan's filing limit from the date on the EOB. Please refer to the health plan-specific Contact Information sheet for the plan's filing limit.*

## Paper Submission of the plan's filing limit Waiver *Please refer to the health plan-specific Contact Information sheet for the plans filing limit.*

- See Table 6-1 for an explanation of waivers, when a waiver request is applicable, and procedural guidelines.
- Watch for notice of waiver requests becoming available on **eServices**.
- Download the plan filing limit *Waiver Form*.
- Complete the plan filing limit *Form* for each claim that includes the denied claim(s), per the instructions below.

- Attach any supporting documentation.
- Prepare the claim as an original submission with all required elements.
- Send the form, all supporting documentation, claim and brief cover letter to: the Beacon claims address associated with the health plan. **Please refer to the health plan-specific Contact Information sheet for the address.**

## Completion of the Waiver Request Form

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

1. **Provider Name**  
Enter the name of the provider who provided the service(s).
2. **Provider ID Number**  
Enter the provider ID Number of the provider who provided the service(s).
3. **Member Name**  
Enter the member's name.
4. **Health Plan Member ID Number**  
Enter the member ID Number associated with the member's health plan. Please refer to the health plan-specific addendum for the plan's filing limit.
5. **Contact Person**  
Enter the name of the person whom Beacon should contact if there are any questions regarding this request.
6. **Telephone Number**  
Enter the telephone number of the contact person.
7. **Reason for Waiver**  
Place an "X" on all the line(s) that describe why the waiver is requested.
8. **Provider Signature**  
A plan filing limit waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept "Signature on file". **Please refer to the health plan-specific Contact Information sheet for the plan's filing limit.**
9. **Date**  
Indicate the date that the form was signed.

## Paper Request for Adjustment or Void

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.

- See Table 6-1 for an explanation of adjustments and voids, when these requests are applicable, and procedural guidelines.
  - *Do not send a refund check to Beacon Health Strategies.* A provider who has been incorrectly paid by Beacon must request an adjustment or void.
  - Prepare a new claim as you would like your final payment to be, with all required elements
  - Place the Rec.ID in box 19 of the CMS 1500 claim form, or box 64 of the UB04 form;
- or
- Download and complete the *Adjustment/Void Request Form* per the instructions below.
  - Attach a copy of the original claim.
  - Attach a copy of the EOB on which the claim was paid in error or paid an incorrect amount.

Send the form, documentation and claim to the address listed in the health plan-specific Contact Information sheet.

## How to Complete 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 Health Strategies Record ID Number**  
Enter the record ID number as listed on the EOB.

6. **Beacon Health Strategies 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 the plan/ state-required notice filing limit in advance written notice to all in-network providers of such a change. Please refer to the health plan specific addendum for the plan/state required notice filing limit.

### **Catastrophic Event**

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

### **Claims Inquiries and Resources**

Additional information is available through the following resources:

#### **Online**

- Beacon Health Strategies Claims Page
- Read About **eServices**
- **eServices** User Manual
- Read About EDI
- EDI Transactions - 837 Companion Guide
- EDI Transactions - 835 Companion Guide
- EDI Transactions - 270-271 Companion Guide

#### **Email Contact**

- [Provider.relations@beaconhs.com](mailto:Provider.relations@beaconhs.com)
- [EDI.Operations@beaconhs.com](mailto:EDI.Operations@beaconhs.com)

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

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

## Provider Education and Outreach

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

Beacon's goal in this outreach program is to assist providers in as many ways as possible to receive payment in full, based upon contracted rates, for all services delivered to members.

## Administrative Appeals Process

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

### How the Program Works

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

## Coordination of Benefits (COB)

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

- When it is determined that Beacon is the secondary payer, claims must be submitted on paper with a copy of the primary insurance's explanation of benefits report and received by

Beacon within the plan's filing limit of the date on the EOB. Please refer to the health plan-specific addendum for the plan's filing limit.

- Beacon reserves the right of recovery for all claims in which a primary payment was made prior to receiving COB information that deems Beacon the secondary payer. Beacon applies all recoupments and adjustments to future claims processed, and reports such recoupments and adjustments on the EOB.

## Claims for Inpatient Services

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

## Recoupments and Adjustments by Beacon Health Strategies

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

### Limited Use of Information

All information supplied by Beacon Health Strategies 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.

## Coding

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

- Providers are required to submit HIPAA-compliant coding on all claims submissions; this includes HIPAA-compliant revenue, CPT, HCPCS and ICD-9 codes. Providers should refer to their exhibit A for a complete listing of contracted, reimbursable procedure codes.

- Beacon accepts only ICD-9 diagnosis codes listing approved by CMS and HIPAA. In order to be considered for payment by Beacon, all claims must have a Primary ICD-9 diagnosis in the range of 295-298.9, 300.00-316. 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. Table 6-5 lists HIPAA-compliant discharge status codes.

**Table 6-5: Discharge Status Codes**

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

**Table 6-6: 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. Please see your specific contract for the list of contracted modifiers.

## **Beacon Health Strategies Right to Reject Claims**

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

## Chapter 7: Communicating with Beacon Health Strategies

### Transactions and Communications with Beacon Health Strategies

Beacon Health Strategies' website, [www.beaconhealthstrategies.com](http://www.beaconhealthstrategies.com), contains answers to frequently asked questions, Beacon clinical practice guidelines, clinical articles, links to numerous clinical resources and important news for providers. As described below, **eServices** and EDI are also accessed through the website.

#### Electronic Media

To streamline providers' business interactions with Beacon, we offer three provider tools: **eServices**, Interactive Voice Recognition (IVR) and email.

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

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

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

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

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

*The account administrator should be an individual in a management role, with appropriate authority to manage other users in the practice or organization. The provider may reassign the account administrator at any time by emailing [provider.relations@beaconhs.com](mailto:provider.relations@beaconhs.com).*

#### Interactive Voice Recognition (IVR)

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

In order to maintain compliance with HIPAA and all other federal and state confidentiality/privacy requirements, providers must have their practice or organizational tax identification number (TIN),

national provider identifier (NPI), as well as the member's full name, Plan ID and date of birth, when verifying eligibility through **eServices** and through Beacon's IVR.

**Electronic Transactions Availability (when Beacon is claims payor)**

Transaction/Capability	Available 24/7 on:		
	eServices at <a href="http://www.beaconhealthstrategies.com">www.beaconhealthstrategies.com</a>	IVR 888.210.2018	EDI at <a href="http://www.beaconhealthstrategies.com">www.beaconhealthstrategies.com</a>
Verify member eligibility, benefits and copayment	Yes	Yes	Yes (HIPAA 270/271)
Check number of visits available	Yes	Yes	Yes (HIPAA 270/271)
Submit outpatient authorization requests	Yes	No	
View authorization status	Yes	Yes	
Update practice information	Yes	No	
Submit claims	Yes	No	Yes (HIPAA 837)
Upload EDI claims to Beacon and view EDI upload history	Yes	No	Yes (HIPAA 837)
View claims status	Yes	No	Yes (HIPAA 835)
Print claims reports and graphs	Yes	No	
Download electronic remittance advice	Yes	No	Yes (HIPAA 835)
EDI acknowledgment & submission reports	Yes	No	Yes (HIPAA 835)
Pend authorization requests for internal	Yes	No	
Access Beacon's level-of-care criteria & provider manual	Yes	No	

**Email**

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

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

## Communication of Member and Provider Information

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

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

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

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

### Required Notifications

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

Type of Information	Method of Notification	
	eServices	Email
<b>General Practice Info</b>		
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 service 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
<b>Appointment Access</b>		
Change in licensure or accreditation of provider or any of its professional staff	Yes (license)	Yes
Change in hours of operation	Yes	Yes

## Beacon Health Strategies' 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. [View Locate-a-Provider.](#)

## Other Benefits Information

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

## Your Health Plan Member Identification Cards

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

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

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

## Member Eligibility Verification Tools

Online	Electronic Data Interchange (EDI)	Via Telephone
Beacon's  <b>eServices</b>	<ul style="list-style-type: none"> <li>Providers with EDI capability can use the 270/271 EDI transaction with Beacon. To set up an EDI connection, view the companion guide, then contact <a href="mailto:edi.operations@beaconhs.com">edi.operations@beaconhs.com</a>.</li> </ul>	<ul style="list-style-type: none"> <li>888.210.2018 Beacon's integrated voice recognition (IVR)</li> </ul>

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

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

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

## Chapter 8: Case Management and Utilization Management

### 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, PCPs, state agencies, members and their families.

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

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

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

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

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

## **Utilization Management**

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

- all UM decisions are based on medical necessity;
- financial incentives based on an individual UM clinician's number of adverse determinations/adverse actions or denials of payment are prohibited; and
- UM decision-makers do not receive financial incentives for decisions that result in underutilization.

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

## **Medical Necessity Level-of-Care (LOC) Criteria**

Beacon shall perform utilization review (UR) for the determination of clinical appropriateness, level of care (LOC) and/or medical necessity to authorize payment for behavioral health services in the areas of mental health and substance use disorders. Beacon defines medically necessary services as healthcare and services that:

1. Are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap
2. Have no comparable medical service or site of service available or suitable for the member requesting the service that is more conservative and less costly

3. Are of a quality that meets generally accepted standards of health care
4. Are reasonably expected to benefit the member

Beacon's application of LOC criteria and authorization procedures represent a set of formal techniques designed to monitor the use of, and/or evaluate the medical necessity, appropriateness, efficacy, and efficiency of, behavioral health care services.

Beacon's LOC criteria were developed from the comparison of national, scientific and evidenced-based criteria sets, including but not limited to, those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). Beacon's LOC criteria are reviewed annually, or more frequently, as necessary by the LOC Criteria Committee (which contains licensed behavioral health practitioners) and updated as needed when new treatment applications and technologies are adopted as generally accepted professional medical practice. The criteria sets are reviewed by Beacon's physician advisors (PAs), all of whom are practicing psychiatrists. New treatment applications and technologies are reviewed by the Clinical Research and Innovative Programming (CRIP) Committee, and then presented to a Provider Advisory Council for further review and recommendations. Changes recommended as a result of practitioner review are forwarded to the vice president of Medical Affairs and the LOC Committee, which makes the final determination regarding the content of the LOC criteria. After review and approval of any new or changed LOC criteria, they are updated on Beacon's participating provider webpage, as appropriate.

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

- Online, via **eServices** at [www.beaconhealthstrategies.com](http://www.beaconhealthstrategies.com)
- Telephonically – Callers are assisted by Member Services to have LOC criteria sent either electronically or by hard copy.

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

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

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

Beacon does not require a primary care physician (PCP) referral to obtain authorization for behavioral health (BH) services. A member may initiate outpatient BH services for a predetermined number of visits, without prior authorization from Beacon, as determined by his/her HP/MCO benefit package. Authorization is required for ongoing outpatient services after members exceed the predetermined number of visits allowed by their health plan.

Beacon will cover emergency services for all members whether the emergency services are provided by an affiliated or non-affiliated provider. Beacon does not impose any requirements for prior approval of emergency services.

Unless otherwise specified, all admissions to inpatient mental health and substance use disorder facilities and any diversionary services require prior authorization. The decision to provide treatment or service to a member is the responsibility of the attending provider and the member (his or her patient). If the requesting provider does not provide the necessary information for Beacon to make a medical necessity determination, Beacon will make a determination based on the information received within the specified time frames, which may result in an adverse determination/action.

Adverse determinations (denials) are never decided on the basis of pre-review or initial screening and are always made by a Beacon physician/psychologist advisor (PA). All adverse determinations are rendered by board-certified psychiatrists or a psychologist of the same or similar specialty as the services being denied. All Beacon PAs hold current and valid, unrestricted licenses. Treating providers may request reconsideration of an adverse determination from a clinical peer reviewer, which will be completed within one business day of the request. Unless excluded by state regulation, psychologist advisors may deny outpatient services, including psychological testing, except when the requesting provider is a physician or a nurse prescriber; in those cases, a physician advisor must review and make a determination.

Court-ordered treatment benefits vary by state. Please contact Beacon's Member

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

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

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

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

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

consent from a member to release his/her record is preferred.

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

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

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

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

## **Utilization Management Terms and Definitions**

### **Utilization Management**

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

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

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

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

### **Adverse Action/Determination**

The following actions or inactions by the organization:

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

### **Emergency Services**

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

### **Member**

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

### **Non-urgent (standard) concurrent review decisions**

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

### **Non-urgent (standard) pre-service decisions**

Any case or service that must be approved in advance of a member obtaining care or

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

### **Peer review conversation**

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

### **Post-service review and decisions**

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

### **Urgent care requests**

Any request for medical care or treatment concerning application of the time periods for making non-urgent care decisions:

- 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 cannot be adequately managed without the care or treatment that is requested.

### **Urgent (expedited) concurrent review decisions**

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

### **Urgent (expedited) pre-service decisions**

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

## UM Review Requirements – Inpatient and Diversionary

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

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

### 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/Diversiory 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 required time frames.

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 PA. All denial decisions are made by Beacon PAs. The UR clinician and/or Beacon PA offer the treating provider the opportunity to seek reconsideration.

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

### **Outpatient Initial Encounters (IEs)**

Some plans allowed a fixed number of initial therapy sessions without prior authorization (will vary by plan and member benefit; please refer to member's plan benefit). Providers may search the number of IEs billed to Beacon via **eServices**. Please be aware the member may have used additional visits that have not been billed or through another provider that are not viewable in **eServices**. If the member has exhausted his/her IEs (or is close to the limit), the new provider must obtain authorization before beginning treatment.

*Please see plan benefits to determine what services count against the member's IEs.*

### **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 LOCC (accessible through **eServices**) to determine whether the service meets medical necessity for continuing outpatient care.

## Decision and Notification Time Frames

Beacon is required by states, federal government, NCQA and URAC to render utilization review decisions in a timely manner to accommodate the clinical urgency of a situation. The maximum time frames on a case-by-case basis in accordance with state, federal government, NCQA or URAC requirements that have been established for each line of business. In all cases, Beacon has adopted the strictest time frame for all UM decisions in order to comply with the various requirements. All time frames begin at the time of Beacon's receipt of a request.

Providers must submit their appeal concerning administrative operations to the Beacon appeals coordinator no later than 60 days from the date of their receipt of the administrative denial decision. The appeals coordinator instructs the provider to submit in writing the nature of the administrative appeal and documentation to support an overturn of Beacon's initial decision.

The following information describes the process for first- and second-level administrative appeals:

- First-level administrative appeals should be submitted in writing to the appeals coordinator at Beacon. Provide any supporting documents that may be useful in making a decision. *(Do not submit medical records or any clinical information.)* An administrative appeals committee reviews the appeal, and a decision is made within 20 business days of date of receipt of the appeal. A written notification is sent within three business days of the appeal determination.
- Second-level administrative appeals should be submitted in writing to the appeals coordinator at Beacon. A decision is made by the president of Beacon within 20 business days of receipt of appeal information, and notification of the decision is sent within three business days of the appeal determination.