Behavioral Health Policy and Procedure Manual for Providers serving Fallon Community Health Plan members.

This document contains chapters 1-7 of Beacon’s Behavioral Health Policy and Procedure Manual for providers serving Fallon Community Health Plan members. Note that links within the manual will be activated in a revised version to be posted soon, however, all referenced materials are available on this website. Chapters 8-12, which contain all level-of-care service descriptions and criteria will be posted on eServices; to obtain a copy, please email provider.relations@beaconhs.com or call 888.421.8861.
Chapter 1: Introduction

Beacon / Fallon Community Health Plan Partnership
About this Provider Manual
Introduction to Fallon Community Health Plan
Introduction to Beacon Health Strategies, LLC
Beacon / Fallon Community Health Plan Behavioral Health Program
Commonwealth of Massachusetts: Children’s Behavioral Health Initiative
Additional Information

Chapter 2: Provider Participation in Beacon’s Behavioral Health Services Network

Network Operations
Contracting and Maintaining Network Participation
Electronic Transactions and Communication with Beacon
Appointment Access Standards
Service Availability and Hours of Operation
Required Notification of Practice Changes and Limitations in Appointment Access
Beacon’s Provider Database
Adding Sites, Services and Programs
Provider Credentialing & Recredentialing
Prohibition on Billing Members
Additional Regulations

Chapter 3: Members, Benefits and Member-Related Policies

Mental Health and Substance Abuse Benefits
Member Rights & Responsibilities
Non-Discrimination Policy and Regulations
Confidentiality of Member Information
Fallon Community Health Plan Member Eligibility
Chapter 4: Quality Management and Improvement Program
  QM & I Program Overview
  Treatment Records
  Performance Standards and Measures
  Practice Guidelines
  Outcome Measurement
  Continuity and Coordination of Care
  Reportable Incidents and Events
  Fraud and Abuse
  Complaints
  Grievances and Appeal of Grievance Resolution

Chapter 5: Utilization Management and Case Management
  Utilization Management
  Case Management

Chapter 6: Clinical Reconsideration and Appeals
  Request for Reconsideration of Adverse Determination
  Clinical Appeal Processes

Chapter 7: Billing Transactions
  General Claim Policies
  Electronic Submission of Claims
  Reconsideration of Timely Filing Requests
  Coding
Chapter 1
INTRODUCTION

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About this Provider Manual
Introduction to Fallon Community Health Plan
Introduction to Beacon Health Strategies, LLC
Beacon / Fallon Community Health Plan
Behavioral Health Program
Commonwealth of Massachusetts:
Children’s Behavioral Health Initiative
Additional Information
Beacon/FCHP Partnership

The Fallon Community Health Plan (Fallon Community Health Plan or health plan) has contracted with Beacon Health Strategies, LLC (Beacon) to manage the delivery of mental health and substance abuse services for all Fallon Community Health Plan members covered by the following products: Commercial, Medicaid, Medicare, and the Commonwealth Health Insurance Plan. The health plan delegates these areas of responsibility to Beacon:

• Claims processing and claims payment
• Member rights and responsibilities
• Member connections
• Provider contracting and credentialing
• Selected quality management and improvement activities
• Service authorization
• Utilization management/case management

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 with Beacon Health Strategies.

The Manual serves as an administrative guide outlining Beacon’s policies and procedures governing network participation, service provision, claims submission, and quality management and improvement program in Chapters 1-4. Detailed information regarding clinical processes, including authorizations, utilization review, case management, reconsiderations and appeals are found in Chapters 5 and 6. Chapter 7 covers billing transactions and Beacon’s level-of-care criteria are presented in Chapters 8-12, accessible only through eServices or by calling Beacon. Additional information is provided in the following appendices:

Appendix A: Links to Clinical and Quality Forms
Appendix B: MassHealth Covered Services

The Manual is posted on Beacon’s website, www.beaconhealthstrategies.com and on Beacon’s eServices; only the version on eServices includes Beacon’s level-of-care criteria. Providers may request a printed copy of the Manual by calling Beacon at 888.421.8861.

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

Introduction to Fallon Community Health Plan

Fallon Community Health Plan is a not-for-profit HMO providing health insurance products and related services to Commercial, Commonwealth Care, Medicare, and MassHealth (Medicaid) members. Founded in 1977, the plan contracts with providers and hospital systems throughout Massachusetts to deliver care to more than 200,000 members.
Introduction to Beacon Health Strategies, LLC

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

Beacon / Fallon Community Health Plan Behavioral Health Program

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

Commonwealth of Massachusetts: Children’s Behavioral Health Initiative

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

- Improved education and outreach to MassHealth members, providers, members of the public, and private and state agency staff who come into contact with MassHealth members for early periodic screening, diagnosis and treatment (EPSDT) services;
- Implementation of standardized behavioral health screening as a part of EPSDT “well-child” visit;
- Improved and standardized behavioral-health assessments for eligible members who use behavioral-health services;
- The development of an information-technology system known as the virtual gateway, to track assessments, treatment planning and treatment delivery; and
- A requirement to seek federal approval to cover several new or improved community-based services

Beacon and Fallon Community Health Plan are full and active participants in CBHI. All behavioral health services created under CBHI are contracted with Beacon and available to serve Fallon Community Health Plan MassHealth members under age 21; some CBHI services are available to all Medicaid youth.

For more information on the court order, and the elements of the state’s remedy plan please visit the Children’s Behavioral Health Initiative website at www.mass.gov/masshealth/childbehavioral-health.gov, and Beacon’s CBHI webpage.
Additional Information

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

1. Return to the **PROVIDER TOOLS** page of this website, for detailed information about working with Beacon, frequently asked questions, clinical articles and practice guidelines, and links to additional resources.

2. Call **IVR, 888.210.2018**, to check member eligibility, number of visits available and applicable copayments, confirm authorization, get claim status.

3. Log on to **eServices** to check member eligibility and number of visits available, submit claims and authorization requests, view claims and authorization status, view/print claim reports, update practice information, and use other electronic tools for communication and transactions with Beacon.

4. Email **provider.relations@beaconhs.com**

5. Click **here** for other Beacon contact information or call 888.421.8861.

6. For benefit and other administrative information pertaining to medical/surgical care, visit **www.fchp.org** or call Fallon Community Health Plan at **800.868.5200**.
Chapter 2
PROVIDER PARTICIPATION IN BEACON’S BEHAVIORAL HEALTH SERVICES NETWORK

Network Operations
Contracting and Maintaining Network Participation
Electronic Transactions and Communication with Beacon
Appointment Access Standards
Service Availability and Hours of Operation
Required Notification of Practice Changes and Limitations in Appointment Access
Beacon’s Provider Database
Adding Sites, Services and Programs
Provider Credentialing & Recredentialing
Prohibition on Billing Members
Additional Regulations
Network Operations

Beacon’s Network Operations Department, with Provider Relations, is responsible for procurement and administrative management of Beacon’s behavioral health provider network. Beacon’s Network staff performs all contracting, credentialing and provider relations functions. Representatives are easily reached by emailing provider.relations@beaconhs.com, or by phone between 8:30 AM and 6:00 PM Monday through Thursday, and 8:30 AM to 5:00 on Fridays. Contact Beacon.

Contracting and Maintaining Network Participation

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

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

Electronic Transactions and Communication with Beacon

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

Electronic Tools

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

• Interactive voice recognition (IVR) is available for selected transactions by telephone at 888.210.2018;
• eServices, Beacon’s secure web portal for providers, can be used to complete almost all transactions and is accessible through www.beaconhealthstrategies.com; and
• Electronic Data Interchange (EDI) is available for claim submission and eligibility verification directly by provider or via an intermediary.

These tools are described in the following sections.

Interactive Voice Recognition (IVR): 888.210.2018

Interactive voice recognition (IVR) is available to providers as an alternative to eServices. It provides accurate, up-to-date information by telephone, enabling providers to:

• Verify member eligibility, benefits and copayment
• Check number of visits available
• Check claim status
• Confirm an authorization

IVR is free, easy to use, available 24/7, and requires only a telephone. To access IVR, call toll-free 888.210.2018.
eServices

Beacon’s secure web portal supports all provider transactions, while saving providers’ time, postage expense and billing fees and reducing paper waste. eServices is completely free to contracted providers and no software is needed. Use eServices to:

• Verify member eligibility & benefits;
• View authorization status;
• Update practice information;
• Check number of visits available;
• Submit claims;
• Upload EDI claims to Beacon;
• View claims status and print EOBs;
• Print claims reports and graphs;
• Download electronic remittance advice;
• EDI acknowledgment & submission reports;
• Submit authorization requests;
• Pend authorization requests for internal approval;
• View EDI upload history; and
• Access Beacon’s level-of-care criteria & provider manual.

Providers can access eServices 24/7. Many fields are automatically populated to minimize errors and improve claim approval rates on first submission. Claim status is available within 2 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.
Electronic Data Interchange (EDI)

Beacon accepts standard HIPAA 837 professional and institutional health care claim transactions and provides 835 remittance advice response transactions. Beacon also offers member eligibility verification through the 270 and 271 transactions.

Providers can submit EDI claims directly to Beacon, or through a billing intermediary. For information about testing and set-up for EDI, download Beacon’s 837 & 835 companion guides.

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

Email

Beacon encourages providers to communicate with Beacon by email addressed to provider.relations@beaconhs.com 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 Information

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

<table>
<thead>
<tr>
<th>Type of care</th>
<th>Appointment must be offered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine/Non-Urgent Services</td>
<td>Within 14 calendar days</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Immediately, 24 hours per day, 7 days per week</td>
</tr>
<tr>
<td>ESP Services</td>
<td>Immediately, 24 hours per day, 7 days per week</td>
</tr>
</tbody>
</table>

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

Appointment Access Standards

The Massachusetts Division of Insurance (DOI), MassHealth, and the Commonwealth Connector monitor accessibility of appointments within our network, based on the following standards:
Inpatient and 24-hour diversionary service must schedule an aftercare follow-up prior to a member’s discharge; the appointment date must be within the following timeframes:

<table>
<thead>
<tr>
<th>Type of care</th>
<th>Appointment must be offered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-24 Hour Diversionary</td>
<td>Within 2 calendar days</td>
</tr>
<tr>
<td>Psychopharmacology services / Medication Management</td>
<td>Within 14 calendar days</td>
</tr>
<tr>
<td>All other outpatient services</td>
<td>Within 7 calendar days</td>
</tr>
<tr>
<td>Intensive Care Coordination (ICC)</td>
<td>Within 3 calendar days</td>
</tr>
</tbody>
</table>

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.

Service Availability and Hours of Operation

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

Crisis intervention services must be available 24 hours per day, 7 days per week. Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours. After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team or hospital emergency room.

In addition, outpatient providers should have services available Monday through Friday from 9 a.m. to 5 p.m. at a minimum; evening and/or weekend hours should also be available at least two days per week.

Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency.
Required Notification of Practice Changes and Limitations in Appointment Access

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

Providers are encouraged to check the database regularly, to ensure that 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 in eService:

• Changes or limitations in appointment access for the practice or any clinician, including but not limited to:
  - Change in hours of operation
  - Is no longer accepting new patients;
  - Is available during limited hours or only in certain settings;
  - Has any other restrictions on treating members; or
  - Is temporarily or permanently unable to meet Beacon standards for appointment access;

• Change in address or telephone number of any service;

• Addition or departure of any professional staff;

• Change in linguistic capability, specialty or program;

• Discontinuation of any covered service listed in Exhibit A of provider’s PSA; and

• Change in licensure or accreditation of provider or any of its professional staff.

Notice of the practice changes and access limitations listed above, can also be submitted to Beacon by emailing provider.relations@beaconhs.com.

The following additional examples also require notification but cannot be communicated via eServices. Please email provider.relations@beaconhs.com or call the Provider Relations Department – click here for phone numbers:

• Change in designated account administrator for the provider’s eServices accounts; and

• Merger, change in ownership, or change of tax identification number (As specified in the PSA, Beacon is not required to accept assignment of the PSA to another entity;

Note that eServices capabilities are expected to expand over time, so that these and other changes may become available for updating in eServices.
Beacon’s Provider Database

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

- Quarterly reporting to the health plan for mandatory MassHealth reporting requirements;
- Periodic reporting to the health plan for updating printed provider directories;
- Identifying and referring members to providers who are appropriate and available services to meet their individual needs and preferences;
- Network monitoring to ensure member access to a full continuum of services across the entire geographic service area; and
- 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.

Adding Sites, Services and Programs

The provider services agreement (PSA) is specific to the sites and services for which the provider originally contracted with Beacon. A separate fee schedule is included in the PSA for each contracted site.

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

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

Beacon conducts a rigorous credentialing process for network providers based on CMS (Centers for Medicare & Medicaid Services) and NCQA (National Committee for Quality Assurance) guidelines. All providers must be approved for credentialing by Beacon in order to participate in Beacon’s behavioral health services network, and must comply with credentialing standards by submitting requested information within the specified timeframe.

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

Individual Practitioner Credentialing

Beacon individually credentials the following categories of clinicians in private solo or group practice settings:

- Psychiatrist;
- Physician certified in Addiction Medicine;
- Psychologist;
- Licensed Clinical Social Workers;
- Master’s Level Clinical Nurse Specialists/Psychiatric Nurses;
- Licensed Mental Health Counselors;
- Licensed Marriage and Family Therapists;
- Licensed Chemical Dependency Professional;
- Advanced Chemical Dependency;
- Certified Alcohol Counselors;
- Certified Alcohol and Substance/Drug Abuse Counselors;
- Certified Alcoholism/Drug Abuse Counselors; and
- Other behavioral healthcare specialists who are Master’s level or above and who are licensed, certified, or registered by the state in which they practice.

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

Once the practitioner has been approved for credentialing and contracted, Beacon will notify the practitioner or the practice’s credentialing contact of the date on which he or she may begin to serve members of specified health plans.
Organizational Credentialing

Beacon credentials and recredentials facilities and licensed outpatient agencies as organizations. Facilities that Beacon must credential as organizations include:

- licensed outpatient clinics and agencies, including hospital-based clinics;
- freestanding inpatient mental health facilities – freestanding and within general hospital;
- inpatient mental health units at general hospitals;
- inpatient detoxification facilities;
- CBHI programs:
  - Therapeutic Mentoring Services
  - In-Home Therapy Services
  - In-Home Behavioral Services
  - Family Support and Training (Family Partners)
  - Intensive Care Coordination (ICC); and
- other diversionary mental health and substance abuse services, including:
  - Partial hospitalization
  - Day treatment
  - Intensive outpatient
  - Residential
  - Substance use rehabilitation.

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 the facility’s credentialing or recredentialing. If the facility is not accredited by one of these accrediting bodies, Beacon conducts a site visit prior to rendering a credentialing decision.

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

Behavioral health program eligibility criteria include the following:

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

In addition to the criteria noted, clinicians – including private and facility-based practitioners - who provide behavioral health assessment and treatment to MassHealth members under age 21 must be trained and certified in the use of CANS. Re-certification will be required every two years. If you have questions, email mass.cans@umassmed.edu or call the University of Massachusetts CANS Training Program at 508-857-1116.

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

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

Recredentialing

All practitioners and organizational providers are reviewed for re-credentialing within 36 months of their last credentialing approval date. They must continue to meet Beacon’s established credentialing criteria and quality of care standards for continued participation in Beacon’s behavioral health provider network. Failure to comply with recredentialing requirements, including timelines, may result in removal from the network.

Prohibition on Billing Members

Health plan members may not be billed for any covered service or any balance after reimbursement by Beacon except for any applicable copayment.

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

MassHealth Members: Providers may not charge members for any service: (a) that is not a medically necessary MCO or Non-MCO Covered Service; (b) for which other MCO covered services or non-MCO covered service may be available to meet the member’s needs; or (c) where the Provider did not explain items (a) and (b) and (c), that the Enrollee will be liable to pay the Provider for the provision of any such services. The Provider shall be required to document compliance with this provision.

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

Additional Regulations

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

According to 211 CMR 52.12(12), “[n]othing in 211 CMR 52.12 shall be construed to restrict or limit the rights of health benefit plans to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers.”
Chapter 3
MEMBERS, BENEFITS AND MEMBER-RELATED POLICIES

Mental Health and Substance Abuse Benefits
Member Rights & Responsibilities
Non-Discrimination Policy and Regulations
Confidentiality of Member Information
Fallon Community Health Plan Member Eligibility
Mental Health and Substance Abuse Benefits

Fallon Community Health Plan offers benefit programs for Commercial, MassHealth, Medicare, and Commonwealth Care enrollees. Under each of these plans, the following levels of care are covered, provided that services are medically necessary and delivered by contracted network providers:

- Inpatient Detoxification
- Substance Abuse Rehabilitation
- Inpatient Mental Health
- Traditional Outpatient (OP) Mental Health Treatment
- Traditional Outpatient (OP) Substance Abuse Treatment
- Crisis Stabilization Bed
- Partial Hospital Program (PHP)
- Intensive Outpatient Program (IOP)
- Ambulatory Detoxification
- Community Support
- Emergency Services
- Psychological and Neuropsychological Testing
- CBHI Services (MassHealth enrollees)
- Autism Services

Outpatient Benefits

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

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

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

Commercial and Medicare Members
• 8 IEs per member per calendar year; and
• Standard co-pays may apply for therapy and medication visits which are listed on member’s identification card.

MassHealth Members
• 12 IEs per member per calendar year; and
• Co-pays do not apply.

Commonwealth Care Members
• IEs are administered on a fiscal year, from July 1 to June 30
• 8 IEs per member per calendar year; and
• Standard co-pays may apply for therapy and medication visits which are listed on member’s identification card.
• Copayments are subject to change each benefit year; and
• Member copayments can be verified on eServices or by calling Beacon’s automated IVR system at 888.210.2018. (See Chapter 2; for more information)

Commercial, MassHealth, Medicare and Commonwealth Care Members
• Both outpatient mental health and substance abuse services count against the member’s IEs;
• Medication management sessions (CPT Code 90862) require no authorization and do not count toward member’s IEs. However, combined psychopharmacology and therapy visits (CPT Codes 90805 and 90807) do count against the member’s IEs; and
• Group therapy sessions (CPT Code 90853) do not require authorization and do not count towards member’s IEs.

Additional Benefit Information
• Benefits do not include payment for health care services that are not medically necessary.
• Neither Beacon nor the health plan are responsible for the costs of investigational drugs or devices or the costs of non-healthcare services such as the costs of managing research or the costs of collecting data that is useful for the research project but not necessary for the enrollee’s care.
• Authorization is required for all services except emergency services. See Chapter 5 for authorization procedures.
Member Rights & Responsibilities

Member Rights

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

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

Right to Receive Information

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

Right to Respect and Privacy

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

Right to Confidentiality

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

Right to Participate in the Treatment Process

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

Right to Treatment and Informed Consent

Members have the right to give or refuse consent for treatment and for communication to PCPs and other behavioral health providers.

Right to Clinical/Treatment Information

Members and their legal guardian have the right to, upon submission of a written request, review the member’s medical records. Members and their legal guardian may discuss the information with the designated responsible party at the provider site.
Right to Appeal Decisions Made by Beacon

Members and their legal guardian have the right to appeal Beacon’s decision not to authorize care at the requested level-of-care, or Beacon’s denial of continued stay at a particular level-of-care according to the clinical appeals procedures described in Chapter 6. Members and their legal guardians may also request the mental health or substance abuse health care provider to appeal on their behalf according to the same procedures.

Right to Submit a Complaint or Concern to Beacon

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

- The quality of care delivered to the member by a Beacon contracted provider.
- The Beacon utilization review process.
- The Beacon network of services.
- The procedure for filing a complaint or grievance as described in Chapter 4.

Right to Contact Beacon Ombudsperson

Members have the right to contact Beacon’s Office of Ombudsperson to obtain a copy of Beacon’s Member Rights and Responsibilities statement. The Beacon Ombudsperson may be contacted at 888.421.8861 or by TTY at 866.727.9441.

Right to Make Recommendations About Member Rights And Responsibilities

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

Member Responsibilities

Members of the health plan agree to do the following:

- Choose a primary care practitioner (PCP) and site for the coordination of all medical care. Members may change PCPs at any time by contacting their health plan;
- Carry the health plan identification card and show the card whenever treatment is sought;
- In an emergency, seek care at the nearest medical facility and call their PCP within 48 hours. The back of the health plan identification card highlights the emergency procedures
- Provide clinical information needed for treatment to their behavioral health care provider.
- To the extent possible, understand their behavioral health problems and participate in the process of developing mutually agreed upon treatment goals.
- Follow the treatment plans and instructions for care as mutually developed and agreed upon with their practitioners.
Posting Member Rights and Responsibilities

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

• Department of Public Health (DPH) licensed facilities—Network facilities whose licenses are issued by DPH are required to post DPH’s statement of human rights within the facility prominently, consistent with the primary language of the facility’s membership.

• All other network facilities—Facilities not licensed by DPH must visibly post a statement approved by their Board of Directors incorporating DPH’s statement of human rights. All hospitals that provide behavioral health inpatient services must have a human rights protocol that is consistent with DMH requirements (104 CMR 27.00) including a human rights officer and human rights committee.

Informing Members of their Rights and Responsibilities

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

• Distribute and review a written copy of Member Rights and Responsibilities at the initiation of every new treatment episode and include in the member’s medical record signed documentation of this review.

• Inform members that Beacon does not restrict the ability of contracted providers to communicate openly with health plan members regarding all treatment options available to them including medication treatment regardless of benefit coverage limitations.

• Inform members that Beacon does not offer any financial incentives to its contracted provider community for limiting, denying, or not delivering medically necessary treatment to health plan members.

• Inform members that clinicians working at Beacon do not receive any financial incentives to limit or deny any medically necessary care.
Non-Discrimination Policy and Regulations

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

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

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

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

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

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

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

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

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

Member Consent

At every intake and admission to treatment, provider should explain the purpose and benefits of communication to the member’s PCP and other relevant providers. (See Chapter 4.) The behavioral health clinician should then ask the member to sign a statement authorizing the clinician to share clinical status information with the PCP and for the PCP to respond with additional member status information. A sample form is available here (See Provider Tools web page) or providers may use their own form; the form must allow the member to limit the scope of information communicated.

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

Confidentiality of Members’ HIV-Related Information

Beacon works in collaboration with the health plan to provide comprehensive health services to members with health conditions that are serious, complex, and involve both medical and behavioral health factors. Beacon coordinates care with health plan medical and disease management programs and accepts referrals for behavioral health case management from health plan. Information regarding HIV infection, treatment protocols and standards, qualifications of HIV/AIDS treatment specialists, and HIV/AIDS services and resources, medications, counseling and testing is available directly from health plan. Beacon will assist behavioral health providers or members interested in obtaining any of this information by referring them to health plan’s case management department. Beacon limits access to all health related information, including HIV-related information and medical records, to staff trained in confidentiality and the proper management of patient information. Beacon’s case management protocols require Beacon to provide any Plan member with assessment and referral to an appropriate treatment source. It is Beacon’s policy to follow Federal and Commonwealth Information laws and guidelines concerning the confidentiality of HIV-related information.
Fallon Community Health Plan Member Eligibility

Fallon Community Health Plan Member Cards

Fallon Community Health Plan members are issued a health plan membership card. The membership 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 health plan. For this reason providers are strongly encouraged to check member eligibility frequently.

A Fallon Community Health Plan member card contains the following information:

- Member’s name
- Health plan identification number
- Primary care provider
- Co-pay amount (if applicable)
- Plan Type

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

Member Eligibility Verification

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

The following resources are available to assist in eligibility verification:

- **Online**
  - Beacon’s eServices (see Chapter 2 for more information); and
  - MassHealth Eligibility Verification System (EVS) for both MassHealth and Commonwealth Care members. Providers will need a user name and password – go to www.mass.gov/masshealth/newmmis to register

- **Electronic Data Interchange (EDI)**

  Providers with EDI capability can utilize the 270/271 EDI transaction with Beacon. To set up an EDI connection, view the companion guide then contact edi.operations@beaconhs.com.

- **Via telephone:**
  - 888.210.2018 - Beacon’s integrated voice recognition (IVR); and
  - 800.554.0042 - MassHealth automated voice response (AVR)
  - 888.421.8861 - Beacon Member Services
  - 800.868.5200 - Fallon Member Services
In order to maintain compliance with HIPAA and all other federal and state confidentiality/privacy requirements, providers must have their practice or organizational tax identification number (TIN), National Provider Identifier (NPI), as well as member’s full name, health plan ID and date of birth, when verifying eligibility through eServices and through Beacon’s IVR.

The Beacon Clinical Department may also assist the provider in verifying the member’s enrollment in Fallon Community 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 4
QUALITY MANAGEMENT AND IMPROVEMENT PROGRAM

QM & I Program Overview
Treatment Records
Performance Standards and Measures
Practice Guidelines
Outcome Measurement
Continuity and Coordination of Care
Reportable Incidents and Events
Fraud and Abuse
Complaints
Grievances and Appeal of Grievance Resolution
QM & I Program Overview

Fallon Community Health Plan (FCHP) retains responsibility for the majority of quality management functions for the FCHP Behavioral Health Program. Those quality management functions which Beacon Health Strategies (Beacon) is delegated include monitoring and analyzing provider access and availability, and adopting and disseminating clinical practice guidelines to practitioners. In addition, the Beacon Quality Management and Improvement (QM&I) Department partners with FCHP, it’s Members and Providers to identify opportunities for improvement.

Beacon administers a quality management and improvement (QM&I) program whose goal is to continually monitor and improve the quality and effectiveness of behavioral health services delivered to members. Beacon’s QM&I Program integrates the principles of continuous quality improvement (CQI) throughout our organization and the provider network. These principles direct us to:

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

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

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

Provider Role

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

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

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

On a quarterly basis, Beacon’s QM & I Department aggregates and trends all data collected and presents the results to the Quality Improvement Committee for review. The QIC may recommend initiatives at individual provider sites and throughout the Beacon’s 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, re-credentialing and network (re)procurement activities and decisions.

Treatment Records

Treatment Record Reviews

Beacon reviews member charts and utilizes 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
- 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; physical exam.
Beacon may conduct chart reviews on-site at a provider facility, or may ask a provider to copy and send specified sections of a member’s medical record to Beacon. Any questions that a provider may have regarding Beacon’s access to health plan member information should be directed to Beacon’s privacy officer, donna.zeh@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. (See Confidentiality of Member Information, Chapter 3)

**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 number on every page;
- Member’s address;
- Employer or school;
- Home and work telephone number;
- Marital/legal status;
- Appropriate consent forms; and
- Guardianship information, if applicable.

**Informed Member Consent for Treatment**

The treatment record contains signed consents for the following:

- Implementation of the proposed treatment plan;
- Any prescribed medications;
- Consent forms related to interagency communications;
- Individual consent forms for release of information to the member’s PCP and other behavioral health providers, if applicable; each release of information to a new party (other than Beacon or the health plan) requires its own signed consent form;
- Consent to release information to the payer or MCO (In doing so, the provider is communicating to the member that treatment progress and attendance will be shared with the payer.);
- For adolescents, ages 12–17, the treatment record contains consent to discuss substance abuse issues with their parents;
- For Mass Health members under age 21, member or guardian consent to enter information gathered using the CANS Tool and the provider’s determination as to whether the assessed member is or is not suffering from a Serious Emotional Disturbance (SED), into the IT system; and
- 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; and
• 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; and
• Previous consultation and evaluation reports.

Substance Abuse Information

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

• Cigarettes;
• Alcohol; and
• Illicit, prescribed, and over-the-counter drugs.
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; and
- A complete mental status evaluation is included in the treatment record, which documents the member’s:
  - Affect;
  - Speech;
  - Mood;
  - Thought control, including memory;
  - Judgment;
  - Insight;
  - Attention/concentration;
  - Impulse control;
  - Initial diagnostic evaluation and DSM-IV diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information; and
  - Diagnoses updated at least quarterly basis.

Treatment Planning

The treatment record contains clear documentation of the following:

- Evidence of the use of an Outcomes tool as required;
- 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 utilized and their consistency with stated treatment goals and objectives;
- Member, family and/or guardian’s involvement (as appropriate) in treatment planning, treatment plan meetings and discharge planning; and
- 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 their 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; and
- 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 between behavioral health providers, primary care physicians, ancillary providers, and health care facilities. (See Behavioral Health - PCP Communication Protocol later in this chapter, and download Behavioral Health – PCP Communication Form); and
- Dates of follow-up appointments, discharge plans and referrals to new providers.

Additional Information for Outpatient Treatment Records

All of the above noted elements are required for the outpatient medical record, with the addition of the following:

- Telephone intake/request for treatment;
- Face sheet;
- Termination and/or transfer summary, if applicable; and
- The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan, and updates) include the following treating clinician information:
  - Clinician’s name
  - Professional degree
  - Licensure
  - NPI or Beacon Identification number, if applicable
  - Clinician signatures with dates.

Additional Information for Inpatient and Diversionary Levels of Care

All of the above noted elements are required for inpatient medical records, with the addition of the following:

- Referral information (ESP evaluation);
- Admission history and physical condition;
- Admission evaluations;
- Medication records;
- Consultations;
- Laboratory and X-ray reports; and
- Discharge summary and Discharge Review Form.
Additional Documentation Requirements for Records Pertaining to Inpatient Services for MassHealth Members

All records pertaining to inpatient services for MassHealth members must include the following:

• Member’s name
• Name of attending physician
• Name of the member’s physician
• Date of admission, date of application for, and authorization of, MassHealth benefits if application is made after admission;
• Care plan
• Initial and subsequent continued stay review dates
• Verification that attending physician believes continued stay is necessary including:
  - Reason for continued stay
  - Care plan for continued stay
• Other supporting material believed appropriate to be included in the record by the contractor’s utilization management staff

Additional Information for Children and Adolescents

For MassHealth members under age 21, documentation that a Child Adolescent Needs and Strengths (CANS) tool has been completed in an outpatient, inpatient or community based acute treatment (CBAT) setting is required (See Outcome Measures, next section). A complete developmental history must include the following developmental information:

• Physical, including immunizations;
• Psychological;
• Social;
• Intellectual;
• Academic; and
• 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:

• 7-and 30-day ambulatory care rates: inpatient facilities are responsible for scheduling a follow-up outpatient appointment within 7 days of every member discharge;
• 14-day medication monitoring;
• Communication with PCPs and other providers treating shared members; and
• Availability of routine, urgent and emergent appointments (See Chapter 2).
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.

Outcome Measurement

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

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

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

The Child and Adolescent Needs and Strengths Tool (CANS)

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

Behavioral health clinicians must be trained and certified in the use of CANS and re-certification is required every two years. Questions about CANS training and certification should be directed to the CANS training group at mass.cans@umassmed.edu or 508-857-1116.

There are two forms of the Massachusetts CANS:

• “CANS Birth through Four” is used until a child’s fifth birthday; and
• “CANS Five through Twenty” is used from the child’s fifth birthday until the adolescent’s 21st birthday.
The state requirement to use CANS extends to all Beacon-contracted providers who provide behavioral health assessment and treatment to MassHealth members under age 21, for outpatient therapy, in-home therapy, in-home behavioral services, and intensive care coordination. Outpatient providers are required to use the CANS as part of an initial behavioral health assessment and must update it at least every 90 days. When a member is treated by more than one behavioral health provider, each provider is required to use the CANS. Inpatient providers are required to use CANS as part of the discharge planning process for 24-hour care, including:

- Psychiatric inpatient hospitalization; and
- Community-based acute treatment.

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

Providers must obtain member consent to enter the information gathered using the CANS Tool and the provider’s determination as to whether the assessed member is or is not suffering from a Serious Emotional Disturbance (SED), into the IT system. If consent is not obtained, providers are still required to enter the SED determination.

Continuity and Coordination of Care

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

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

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

Educate Members and Obtain Member Consent

Providers are expected to educate members about the benefits of care coordination and encourage them to grant consent for their clinical and environmental information to be shared among treaters. Notification requirements in this section can be fulfilled only with the member’s consent. See Chapter 3, Members and Member-Related Policies for information about member consent.
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 and the Behavioral Health - PCP Communication Form available for initial communication and subsequent updates, in Appendix B, or their own form that includes the following information:

• Presenting problem/reason for admission;
• Date of admission;
• Admitting diagnosis;
• Preliminary treatment plan;
• Currently prescribed medications;
• Proposed discharge plan;
• Behavioral health provider contact name and telephone number;
• Request for PCP response by fax or mail within three (3) 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.

Transitioning Members from one Behavioral Health Provider to Another

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

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

With the member’s informed consent, acute care facilities should contact the PCP by phone and/or by fax, within 24 hours of a member’s admission to treatment. Inpatient and diversionary providers must also alert the PCP 24 hours prior to a pending discharge, and must fax or mail the following member information to the PCP within 3 days post-discharge:

- Date of Discharge;
- Diagnosis;
- Medications;
- Discharge plan; and
- 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.

Reportable Incidents and Events

Beacon requires that all providers report adverse incidents, other reportable incidents and sentinel events involving health plan members to Beacon on the same day as the incident or event occurs, by phone and by fax. Data regarding critical incidents is analyzed and trended on a quarterly basis for the purpose of identifying opportunities for quality improvement.

Providers should direct all such reports to their Beacon clinical manager or UR clinician by phone. Beacon’s Clinical Department is available 24 hours a day, and providers must call, regardless of the hour, to report such incidents. Providers should be prepared to present all relevant information related to the nature of the incident, the parties involved (names and telephone numbers) and the member’s current condition.

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 quality manager at 781.994.7642.

Incident and event reports should not be emailed unless the provider is using a secure messaging system.

Download Adverse Incident Report Form

Click here for phone numbers
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.

Adverse Incidents include the following:

• All medicolegal or non-medicolegal deaths;

• Any absence without authorization (AWA) involving a member who is under the age of 18 or was admitted or committed pursuant to M.G.L. c. 123 §7–8, 10–12 and is at high risk to harm self or others;

• Any AWA involving a member who does not meet the criteria above;

• Any injury while in a 24-hour program that could or did result in transportation to an acute care hospital for medical treatment or hospitalization;

• Any sexual assault or alleged sexual assault;

• Any physical assault or alleged physical assault by a staff person or another patient against a member;

• Any medication error or suicide attempt that requires medical attention beyond general first aid procedures;

• Any unscheduled event that results in the temporary evacuation of a program or facility (e.g. fire resulting in response by fire department);

• Any violation or alleged violation of DMH Restraint and Seclusion Regulation;

• Serious threat of harm to Executive Office of Health and Human Services (EOHHS) personnel;

• Death of a member in the care or custody of EOHHS; and

• Serious threat of damage to EOHHS facility.

Sentinel Events

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

Inpatient and acute service providers are required to report sentinel events to their assigned Beacon UR clinician on the same day that the incident occurs. Beacon’s Clinical Department is available 24 hours a day and providers must call, regardless of the hour, to report such incidents. Providers should be prepared to present all relevant information related to the nature of the incident, the parties involved (names and telephone numbers) and the member’s current condition.
Sentinel Events include the following:

- All medico-legal deaths;

- Any medico-legal death is any death required to be reported to the Medical Examiner or in which the Medical Examiner takes jurisdiction;

- Any absence without authorization (AWA) involving a patient involuntarily admitted or committed and/or who is at high risk of harm to self or others;

- Any serious injury resulting in hospitalization for medical treatment;

- A serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is subsequently medically admitted;

- Any sexual assault or alleged sexual assault;

- Any medication error or suicide attempt that requires medical attention beyond general first aid procedures;

- Any physical assault or alleged physical assault by a staff person against a member; and

- Any unscheduled event that results in the evacuation of a program or facility whereby regular operations will not be in effect by the end of the business day and may result in the need for finding alternative placement options for member.

Other Reportable Incidents

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

Providers are required to report all “other reportable incidents” to their Beacon UR clinician or clinical manager for health plan on the same day that the incident occurs. Providers may access Beacon’s Clinical Department 24 hours a day, and must notify Beacon after-hours when necessary to remain in compliance with this requirement.

Other Reportable Incidents include:

- Any non-medico-legal death;

- Any absence without authorization from a facility involving a member who does not meet the criteria for a sentinel event as described above;

- Any physical assault or alleged physical assault by or against a member that does not meet the criteria of a sentinel event;

- Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization;

- A serious injury, defined as any injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted; and

- Any unscheduled event that results in the temporary evacuation of a program or facility such as a small fire that requires fire department response. Data regarding critical incidents is gathered in the aggregate and trended on a quarterly basis for the purpose of identifying opportunities for quality improvement.
Fraud and Abuse

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

- **Fraud** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

- **Abuse** involves provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

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

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

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

Federal False Claims Act

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

**Summary of Provisions:** The FCA imposes civil liability on any person who knowingly:

1. Presents (or causes to be presented) to the federal government a false or fraudulent claim for payment or approval;

2. Uses (or causes to be used) a false record or statement to get a claim paid by the federal government;

3. Conspires with others to get a false or fraudulent claim paid by the federal government; and

4. Uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the federal government.

**Penalties:** The FCA imposes civil penalties and is not a criminal statute.

Persons (including organizations and entities such as hospitals) may be fined a civil penalty of not less than $5,500 nor more than $11,000, plus triple damages, except that double damages may be ordered if the person committing the violation furnished all known information within (30) days. The amount of damages in health care terms includes the amount paid for each false claim that is filed.
Qui Tam (Whistleblower) Provisions:

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

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

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

Non-retaliation and Anti-discrimination:

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

Reduced Penalties:

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

If any member or provider becomes aware of any potential fraud by a member or provider, please contact us at 781.994.7500 or 888.421.8861 and ask to speak to the Compliance Officer.

Complaints

Providers with complaints or concerns should contact Beacon at 888.421.8861 (TTY 866.727.9441) and ask to speak with the clinical manager for the health plan. All provider complaints are thoroughly researched by Beacon and resolutions proposed within 20 business days.

If a health 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, they should be directed to call Beacon’s ombudsperson at 888.421.8861 or (TTY at 866.727.9441).
Grievances and Appeal of Grievance Resolution

The FCHP Member Relations Department reviews and resolves all FCHP Member grievances related to behavioral health services. The telephone number for the FCHP Member Relations Department is 800.868.5200. Beacon reviews and resolves all Provider grievances related to behavioral health services. The telephone number for Beacon’s Member Services Department is 888.421.8861. FCHP and Beacon review and provide a timely response and resolution of all grievances that are submitted by members, authorized member representative (AMR), and/or providers. Every grievance is thoroughly investigated, and receives fair consideration and timely determination.

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

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

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

For both urgent and non-urgent grievances, the resolution letter informs the member or member’s representative to contact Beacon’s Ombudsperson in the event that they are 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 in Chapter 6, Utilization Management.*
Chapter 5
UTILITY MANAGEMENT AND CASE MANAGEMENT

Utilization Management
Case Management
Utilization Management

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

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

• All UM decisions are based upon Beacon’s level-of-care criteria (medical necessity);
• Financial incentives based on an individual UM clinician’s number of adverse determinations or denials of payment are prohibited; and
• Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Note that the information in this chapter, including definitions, procedures, and determination and notification timeframes may vary for different lines of business (Commercial, Medicaid, Commonwealth Care), based on differing regulatory requirements. Such differences are indicated where applicable.

Medical Necessity

All requests for authorization are reviewed by Beacon clinicians based on the information provided, according to the following definition of medical necessity:

Medically necessary services are health care 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) for which there is 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; and (4) that are reasonably expected to benefit the person. This definition applies to all levels of care and all instances of Beacon’s utilization review.

Level-of-Care Criteria

Beacon’s level-of-care criteria (LOCC), are the basis for all medical necessity determinations; Chapters 7-12 of this manual, accessible through eServices, present Beacon’s specific LOCC for Fallon Community Health Plan for each level of care. Providers can also Contact Us to request a printed copy of Beacon’s LOCC.

Beacon’s LOCC were developed from the comparison of national, scientific and evidence-based criteria sets, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). They are reviewed and updated annually or more often as needed to incorporate new treatment applications and technologies that are adopted as generally accepted professional medical practice. Beacon’s Research and Development Committee reviews all new treatment applications and technologies and then presents the information to the Provider Advisory Council for review and recommendations.

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

The definitions below describe utilization review including the types of the authorization requests and UM determinations, as 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 Determination: Commercial and Commonwealth Care Members

A decision to deny, terminate or modify (an approval of fewer days, units or another level-of-care other than was requested, which the practitioner does not agree with) an admission, continued inpatient stay, or the availability of any other behavioral health care service, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level-of-care effectiveness, or health plan benefits.

Adverse Action: MassHealth (Medicaid) Members

The following actions or inactions by Beacon or the provider organization:

- Beacon’s denial, in whole or in part, of payment for a service failure to provide covered services in a timely manner in accordance with the waiting time standards;
- Beacon’s denial or limited authorization of a requested service, including the determination that a requested service is not a covered service;
- Beacon’s reduction, suspension, or termination of a previous authorization for a service;
- Beacon’s denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including but not limited to denials based on the following:
  - Failure to follow prior authorization procedures
  - Failure to follow referral rules
  - Failure to file a timely claim
- Beacon’s failure to act within the timeframes for making authorization decisions
- Beacon’s failure to act within the timeframes for making appeal decisions

Non-Urgent Concurrent Review and Decision

Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments. A non-urgent concurrent decision may authorize or modify requested treatment over a period of time or a number of days or treatments, or deny requested treatment, in a non-acute treatment setting.

Non-Urgent Pre-Service Review and Decision

Any case or service that must be approved before the member obtains care or services. A non-urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment, in non-acute treatment setting.
Post-Service Review and Decision (formerly called “Retrospective Decision”)

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

Urgent Care Request and Decision

Any request for care or treatment for which application of the normal time period for a non-urgent care decision:

- Could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, based on a prudent layperson’s judgment; or
- In the opinion of a practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is requested.

Urgent Concurrent Review Decision

Any review for a requested extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments in an acute treatment setting, when a member’s condition meets the definition of urgent care, above.

Urgent Pre-Service Decision

Formerly known as a precertification decision, any case or service that must be approved before a member obtains care or services in an inpatient setting, for a member whose condition meets the definition of urgent care above. An urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment in an acute treatment setting.
Services Requiring Authorization

For Commercial, MassHealth, Medicare and Commonwealth Care members, the following services require Beacon’s prior authorization:

- Inpatient services
- Diversionary services
- Extended outpatient sessions
- Day treatment
- Psychological and neuro-psychological testing
- Out-of-network services
- CBHI Services

1. Emergency services do not require pre-service authorization, however facilities must notify Beacon of the emergency treatment and/or admission within 24 hours. (See Emergency Services, later in this chapter)

2. Outpatient psychopharmacology visits (90862) never require authorization. However, the initial evaluation by a psychopharmacologist (medication management) may require authorization if the member has used up his or her initial visit allowance. Extended visits for outpatient psychopharmacology with therapy (90805, 90807) do require authorization.

3. Group therapy (90853) never requires authorization.

4. Out-of-network service is not a covered benefit. It may be authorized in some circumstances where needed care is not available within the network.

Authorization Procedures and Requirements

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

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

Member Eligibility Verification

The first step in seeking authorization is to determine the member’s eligibility. Since member eligibility changes occur frequently, providers are advised to verify a health plan member’s eligibility upon admission to, or initiation of treatment, as well as on each subsequent day or date of service to facilitate reimbursement for services. Instructions for verifying member eligibility are presented in Chapter 3.

Member eligibility can change, and possession of a health plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check Beacon’s eServices or by calling IVR at 888.210.2018.
Emergency Services

Definition

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

“...a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person’s bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.”

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

Emergency Screening and Evaluation

Mass Health and the Commonwealth Connector mandate that Emergency Service Providers (ESPs) perform an emergency screening for all MassHealth and Commonwealth Care enrollees requiring inpatient admission. If there are extenuating circumstances, and the ESP cannot evaluate the member in a timely manner (within one hour from telephone notification or member’s arrival to the site), Beacon will allow a qualified clinician from a hospital emergency room or other evaluation site to provide the emergency evaluation for MassHealth and Commonwealth Care members. This process allows members to access emergency services as quickly as possible and at the closest facility or by the closest crisis team. All ESPs are contracted providers for Beacon.

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

The ESP is responsible for locating a bed, but may request Beacon’s assistance. Beacon may contact an out-of-network facility in cases where there is not a timely or appropriate placement available within the network. In cases where there is no in-network or out-of-network psychiatric facility available, Beacon will authorize boarding the member on a medical unit until an appropriate placement becomes available.

Beacon Clinician Availability

All Beacon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures. Beacon clinicians are available 24 hours a day, seven days a week, to take emergency calls from members, their guardians, and providers. If Beacon does not respond to the call within 30 minutes, authorization for medically necessary treatment can be assumed and the reference number will be communicated to the requesting facility/provider by the Beacon UR clinician within four hours.
Disagreement between Beacon and Attending Physician

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

Inpatient and Diversionary Services

Initial Assessment

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

- Inpatient mental health;
- Partial hospitalization;
- Intensive outpatient program (IOP);
- Inpatient substance abuse rehabilitation;
- Inpatient detoxification (medically managed and medically monitored);
- Crisis Stabilization Bed; and
- Ambulatory Detoxification.

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

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

- Member’s health plan Identification number;
- Member’s name, gender, date of birth, and city or town of residence;
- Admitting facility name and date of admission;
- DSM-IV diagnosis: All five axes are appropriate, Axis I and Axis V are required. (A provisional diagnosis is acceptable);
- Description of precipitating event and current symptoms requiring inpatient psychiatric care;
- Medication history;
- Substance abuse history;
- Prior hospitalizations and psychiatric treatment;
- Member’s and family’s general medical and social history; and
- Recommended treatment plan relating to admitting symptoms and the member’s anticipated response to treatment.

Member eligibility can change, and possession of a health plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check Beacon’s eServices or by calling IVR at 888.210.2018. See additional information in Chapter 3.

Continued Stay (Concurrent) Review

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

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

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

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

Members must be notified of all pre-service and concurrent denial decisions. Members are notified by courier of all acute pre-service and concurrent denial decisions. For members in inpatient settings, the denial letter is delivered by courier to the member on the day the adverse determination is made, prior to discharge. The service is continued without liability to the member until the member has been notified of the adverse determination.

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

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

Notice of inpatient authorization is mailed to the admitting facility.

Transfer between Facilities

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

Other Services Requiring Pre-Service Approval

- Electro-convulsive therapy during an inpatient stay and in outpatient settings; Download Form
- Psychological testing – Download Form
- Home-based therapy appointment – Download Form
- Ambulatory detoxification – Call Beacon.
- Continued/extended outpatient visits after member has exhausted his or her initial visits – see next section and eServices
- Inpatient and outpatient services with out-of-network providers. Note that out-of-network care is not a covered benefit, but may be approved in certain circumstances – Call Beacon.
Outpatient Services

Outpatient behavioral health treatment is an essential component of a comprehensive health care delivery system. All health plan members are covered for outpatient mental health and substance abuse services, provided that the authorization procedures described in this chapter are followed.

See Chapter 3 for more information about outpatient benefits including copayments and initial encounters (IEs) available to members without authorization. Member benefits can also be found on eServices with other eligibility information.

Authorization Not Required for Initial Encounters (IEs)

As presented in Chapter 3, MassHealth members are allowed 12 initial encounters (IEs) per calendar year without authorization. Commercial and Medicare members are allowed 8 IEs per calendar year. Similarly, Commonwealth Care members are allowed 8 IEs for each fiscal year beginning July 1 and ending June 30 of the following year.

Other Exemptions from Authorization:

- Group therapy (CPT code 90853) does not require authorization and does not count towards the member’s IEs.
- Psychopharmacology (CPT Code 90862) does not require authorization and does not count toward the member’s IEs. Note however that combined psychopharmacology and therapy visits (CPT codes 90805 and 90807) do count towards the member’s IEs. Additionally, the psychopharmacologist’s initial evaluation (CPT code 90801) may need authorization if the member has used all IEs.

Extended Outpatient Authorization:

If a provider wishes to begin or continue treatment after a member has exhausted his or her IEs, or to continue treatment beyond completion of an existing outpatient authorization, he or she must submit an Electronic Outpatient Review Form (eORF) via Beacon’s eServices. The extended authorization request should be submitted approximately 2 weeks before the additional visits are scheduled.

Termination of Outpatient Care

Beacon requires that all outpatient providers set specific termination goals and discharge criteria for members. Providers are encouraged to use the level-of-care criteria documented in Chapters 8-14 (accessible through eServices) to determine if the service meets medical necessity for continuing outpatient care.

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 reserve the right to reject or return authorization requests that are incomplete, lacking in specificity, or incorrectly filled out. Beacon will provide an explanation of action(s) which must be taken by the provider to resubmit the request.
Notice of Outpatient Authorization Determination

Beacon’s outpatient authorization decisions are posted on eServices, whether approved, modified or denied, within the decision timeframe specified below. Providers receive an email message, alerting them that a determination has been made.

Beacon also faxes an authorization letter to the provider if requested. However, Beacon strongly encourages providers to opt out of receiving paper notices and to rely on eServices instead; log on to eServices to opt out of receiving paper notices.

Both electronic and paper notices specify the number of units (sessions) approved, the timeframe within which the authorized visits may be used, and an explanation of any modifications made by Beacon.

Outpatient Denials

Denials for extended outpatient services may be appealed by the member or provider and are subject to the reconsideration process outlined in Chapter 6.

Post-Service Review

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

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

Decision and Notification Timeframes

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

The timeframes below present Beacon’s internal timeframes for rendering a UM determination, and notifying members of such determination. All timeframes begin at the time of Beacon’s receipt of the request. Please note, the maximum timeframes may vary from those on the table below 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.
Decision and Notification Time frames: MassHealth

<table>
<thead>
<tr>
<th>Request</th>
<th>Type of Decision</th>
<th>Decision Timeframe</th>
<th>Verbal Notification</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Service</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Auth for Inpatient Behavioral Health Emergencies</td>
<td>Expedited</td>
<td>Within 30 minutes</td>
<td>Within 30 minutes</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Initial Auth for Non Emergent Inpatient Behavioral Health Services</td>
<td>Expedited</td>
<td>Within 2 hours</td>
<td>Within 2 hours</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Initial Auth for Other Urgent Behavioral Health Services</td>
<td>Urgent</td>
<td>Within 72 hours</td>
<td>Within 72 hours</td>
<td>Within 72 hours</td>
</tr>
<tr>
<td>Initial Auth for Non Urgent Behavioral Health Services</td>
<td>Standard</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
</tr>
<tr>
<td><strong>Concurrent Review</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continued Auth for Inpatient and Other Urgent Behavioral Health Services</td>
<td>Urgent/ Expedited</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Continued Auth for Non-Urgent Behavioral Health Services</td>
<td>Non-Urgent/ Standard</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
</tr>
<tr>
<td><strong>Post-Service</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorization for Behavioral Health Services Already Rendered</td>
<td>Non-Urgent/ Standard</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
</tr>
</tbody>
</table>

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

When the specified time frames for standard and expedited prior authorization requests expire before Beacon makes a decision, an adverse action notice will go out to the member on the date the timeframe expires.
### Decision and Notification Time frames: Commercial / Commonwealth Care

<table>
<thead>
<tr>
<th>Request</th>
<th>Type of Decision</th>
<th>Determination Approval</th>
<th>Verbal Notification</th>
<th>Written Notification</th>
<th>Determination Denial</th>
<th>Verbal Notification</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Service</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent</td>
<td>Within 2 Business Days</td>
<td>Within 24 Hours</td>
<td>Within 2 Business Days</td>
<td>Within 24 Hours</td>
<td>Within 2 Business Days</td>
<td>Within 24 Hours</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Non-Urgent/Standard</td>
<td>Within 2 Business Days</td>
<td>Within 24 Hours</td>
<td>Within 2 Business Days</td>
<td>Within 24 Hours</td>
<td>Within 24 Hours</td>
<td>Within 24 hours</td>
<td></td>
</tr>
<tr>
<td><strong>Concurrent Review</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent/Expedited</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 Hours</td>
<td>Within 24 Hours</td>
<td>Within 24 hours</td>
<td></td>
</tr>
<tr>
<td>Non-Urgent/Standard</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 Hours</td>
<td>Within 24 Hours</td>
<td>Within 24 hours</td>
<td></td>
</tr>
<tr>
<td><strong>Post-Service</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Urgent/Standard</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
<td></td>
</tr>
</tbody>
</table>

### Case Management

Beacon’s Intensive Clinical Management Program (ICM), a component of Beacon’s Case Management Program (CM), through collaboration with members and their treatment providers, PCPs, Fallon Community Health Plan medical case managers, and state agencies (DMH and DCF) is designed to ensure the coordination of care, including individualized assessment, case management planning, discharge planning and mobilization of resources to facilitate an effective outcome for members whose clinical profile or usage of service indicates that they are at high risk for readmission into 24-hour psychiatric or addiction treatment settings. The primary goal of the program is stabilization and maintenance of members in their communities through the provision of community based support services. These community-based providers can provide short-term service designed to respond with maximum flexibility to the needs of the individual member. The intensity and amount of support provided is customized to meet the individual needs of members and will vary according to the member’s needs over time.

When clinical staff or providers identify members who demonstrate medical co-morbidity (i.e., pregnant women), a high utilization of services, and an overall clinical profile which indicates that they are at high-risk for admission or readmission into a 24-hour mental health or substance abuse treatment setting, they may be referred to Beacon’s Case Management Program. The ICM program utilizes specialty community support providers that offer outreach programs uniquely designed for adults with severe and persistent mental illness, dually diagnosed adults, pregnant women with mental health or substance use disorders, hospitalized children and members with AIDS.
Criteria for ICM includes but is not limited to the following:

• Member has a prior history of acute psychiatric, or substance abuse admissions authorized by Beacon; with a readmission within a 60 day period;

• First inpatient hospitalization following a particularly high risk 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 abuse issues could result in exacerbation of fragile medical status;

• Adolescent or adult that is currently pregnant, or within a 90 day post partum 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 that requires support to link family, providers and state agencies which places the member at risk of requiring acute behavioral health services;

• Multiple family members that are receiving acute behavioral health and/or substance abuse treatment services at the same time; and

• 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.

ICM and Care Coordination are voluntary programs and member consent is required for participation. For further information on how to refer a member to case management services, please contact Beacon Health Strategies at 888.421.8861.
Chapter 6
CLINICAL RECONSIDERATION AND APPEALS

Request for Reconsideration of Adverse Determination
Clinical Appeal Processes
CHAPTER 6: CLINICAL RECONSIDERATION AND APPEALS

Request for Reconsideration of Adverse Determination

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

A peer review conversation may be requested at any time by the treating provider, and may occur prior to or after an adverse determination, upon request for a reconsideration. Beacon UR clinicians and physician advisors (PAs) are available daily to discuss adverse determinations by phone at 888.421.8861.

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

Clinical Appeal Processes

Overview

A 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. While Beacon processes provider administrative appeals, and Fallon processes appeals filed by, or on behalf of, a member regarding a clinical medical necessity determination, all appeal requests may be initiated by contacting Beacon’s Appeals Coordinator at 1.888.421.8861.

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

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

Peer Review

For all acute and diversionary levels of care, adverse determinations are rendered by board eligible or board certified psychiatrists of the same or similar specialty as the services being denied.

A peer review conversation may also be requested at any time by the Treating Provider, and it may occur prior to an adverse determination or after, upon request for a reconsideration.

Urgency of Appeal Processing

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

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

Appeal Process Detail

This section contains detailed information about the appeal process for Commercial, including Commonwealth Care and Mass Health members, in two tables:

Table 1: Expedited Clinical Appeals

Table 2: Standard Clinical Appeals

Each table illustrates:

• How to initiate an appeal;
• AMR requirements; and
• Resolution and notification timeframes for expedited and standard clinical appeals, at the first, second, and external review levels.
### Chapter 6: Clinical Reconsideration and Appeals

#### Table 1

**Expedited Clinical Appeals**

<table>
<thead>
<tr>
<th>MassHealth</th>
<th>Level 1 Appeal</th>
<th>Level 2 Appeal</th>
<th>External Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members, their legal guardian, or their appeal representative (AMR) have up to 30 calendar days after receiving notice of an adverse action in which to file an appeal.</td>
<td></td>
<td>N/A</td>
<td>Members, their legal guardian, or AMRs who remain aggrieved by an expedited internal appeal decision, have the option to request, an external review from the Executive Office of Health and Human Services, Office of Medicaid’s Board of Hearings (BOH). Beacon will provide the BOH with all documentation relating to the expedited internal appeal.</td>
</tr>
<tr>
<td>If the member designates an AMR to act on their behalf, Beacon will attempt to obtain a signed and dated Designation of Appeal Representative Form. Every attempt will be made to have this form completed prior to the deadline for resolving the appeal. All expedited internal appeals will be processed by Beacon even if we have not received the Designation of Appeal Representative Form.</td>
<td></td>
<td></td>
<td>Members or their AMR must make this request to BOH within 20 days after the expedited internal appeal decision, but within 10 days if they wish to receive continuing services without liability. Members or their AMR must complete the Request for Fair Hearing form, included with the expedited internal appeal decision notification, and submit to BOH.</td>
</tr>
<tr>
<td>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 their AMR.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Fallon Physician Advisor, who has not been involved in initial decision, reviews all available information and attempts to speak with the member’s attending physician.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision is made within 72 hours of initial request.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Throughout the course of an appeal the member shall continue to receive services without liability for services previously authorized by Beacon, until he/she is notified of the appeal determination.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members must submit appeal request within 10 days of the Adverse Action in order to continue services without liability.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Contact Information:**

Appeal requests can be made by calling Beacon’s Appeals Coordinator at 888.421.8861.

**Contact Information:**

Members or their AMR should contact the Beacon Appeals Coordinator for assistance in making the request to BOH at 888.421.8861.

Board of Hearings, Office of Medicaid
100 Hancock Street, 6th Floor
Quincy, MA 02171
1-800-655-0338 or 617-847-1200

Please note that providers may act as a member’s appeal representative.
### Table 1
#### Expedited Clinical Appeals

<table>
<thead>
<tr>
<th>Commercial / Commonwealth Care (continued from previous page)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1 Appeal</strong></td>
</tr>
<tr>
<td>Members, their legal guardian, or AMR have up to 180 days to file an appeal after notification of Beacon’s adverse determination.</td>
</tr>
<tr>
<td>The provider may act as the member’s appeal representative (AMR) without completing the Designation of Appeal Representative Form. The provider can file an expedited appeal on behalf of the member regardless of the services. A Fallon Physician Advisor, who has not been involved in initial decision, reviews all available information and attempts to speak with member’s attending physician. Decision is made within 48 hours of initial request. Throughout the course of an appeal for services previously authorized by Beacon, the member shall continue to receive services without liability until notification of the appeal resolution, provided the appeal is filed on a timely basis.</td>
</tr>
</tbody>
</table>

**Contact Information:**

Appeal requests can be made by calling Beacon’s Appeals Coordinator at 888.421.8861.

**Contact Information:**

Members or their AMR should contact the Beacon Appeals Coordinator for assistance in making the request to OPP at 888.421.8861, Members or their AMR may also contact OPP directly. Office of Patient Protection 1-800-436-7757 or www.state.ma.us/dph/opp to obtain the forms and additional instructions for the external review. (there is a fee of $25)

*Please note that providers may act as a member’s appeal representative.*
Table 2
Standard Clinical Appeals

<table>
<thead>
<tr>
<th>MassHealth</th>
<th>Level 1 Appeal</th>
<th>Level 2 Appeal</th>
<th>External Review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Members, their legal guardian, or their appeal representative (AMR) have up to 30 calendar days after receiving notice of an adverse action in which to file an appeal.</td>
<td>In the event that Beacon’s standard first level appeal decision upholds the initial determination, the member has the right to initiate a second level appeal with Beacon or waive their right to a second level appeal and file an appeal with the Executive Office of Health and Human Services, Office of Medicaid’s Board of Hearings (BOH).</td>
<td>MassHealth members or their AMR should contact Beacon’s Appeals Coordinator for help in making a request for external appeal with BOH. Beacon will provide BOH with all documentation relating to the standard first and/or second level appeal. MassHealth members or their AMR must submit requests to BOH within 30 days from Beacon’s standard first or second level appeal decision notification, but within 10 days if they wish to receive continuing services without liability. Language re: members may be held liable to pay back MH for continuing services if the appeal is not resolved in their favor. MassHealth members or their AMR must complete the Request for Fair Hearing form included with all levels of appeal decisions, and submit to BOH. External Review Agency will review case if the member is not satisfied with the second level hearing.</td>
</tr>
<tr>
<td></td>
<td>When the member is designating an appeal representative to appeal on their behalf, the member must complete and return a signed and dated Designation of Appeal Representative Form prior to the deadline for resolving the appeal (20 calendar days). Failure to do so prior to the appeal due date will result in dismissal of the appeal, however verbal and written communication can only occur with the member or their legal guardian until such time as the form is received.</td>
<td>When the member is designating an appeal representative to appeal on their behalf, the member must complete and return a signed and dated Designation of Appeal Representative Form prior to the deadline for resolving the appeal (20 calendar days). Failure to do so will result in the dismissal of the appeal and notice of dismissal to the member only.</td>
<td>MassHealth members or their AMR should contact Beacon’s Appeals Coordinator for help in making a request for external appeal with BOH. Beacon will provide BOH with all documentation relating to the standard first and/or second level appeal. MassHealth members or their AMR must submit requests to BOH within 30 days from Beacon’s standard first or second level appeal decision notification, but within 10 days if they wish to receive continuing services without liability. Language re: members may be held liable to pay back MH for continuing services if the appeal is not resolved in their favor. MassHealth members or their AMR must complete the Request for Fair Hearing form included with all levels of appeal decisions, and submit to BOH. External Review Agency will review case if the member is not satisfied with the second level hearing.</td>
</tr>
<tr>
<td></td>
<td>If an individual other than the member or their legal guardian requests the standard first level appeal, the member must complete and return the Designation of Appeal Representative Form prior to the deadline for resolving the appeal. Failure to do so will result in the dismissal of the appeal and notice of dismissal to the member only.</td>
<td>If an individual other than the member or their legal guardian requests the standard first level appeal, the member must complete and return the Designation of Appeal Representative Form prior to the deadline for resolving the appeal. Failure to do so will result in the dismissal of the appeal and notice of dismissal to the member only.</td>
<td>MassHealth members or their AMR should contact Beacon’s Appeals Coordinator for help in making a request for external appeal with BOH. Beacon will provide BOH with all documentation relating to the standard first and/or second level appeal. MassHealth members or their AMR must submit requests to BOH within 30 days from Beacon’s standard first or second level appeal decision notification, but within 10 days if they wish to receive continuing services without liability. Language re: members may be held liable to pay back MH for continuing services if the appeal is not resolved in their favor. MassHealth members or their AMR must complete the Request for Fair Hearing form included with all levels of appeal decisions, and submit to BOH. External Review Agency will review case if the member is not satisfied with the second level hearing.</td>
</tr>
<tr>
<td></td>
<td>A Fallon physician advisor, not involved in the initial decision, will review available information and attempt to contact the member’s attending physician/provider. Resolution and notification will be provided within 20 calendar days of the appeal request.</td>
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</tr>
<tr>
<td></td>
<td>If the appeal requires review of medical records (post service situations), the member’s or AMR’s signature is required on an Authorization to Release Medical Information Form authorizing the release of medical and treatment information relevant to the appeal.</td>
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<td>If the medical record with Authorization to Release Medical Information Form is not received prior to the deadline for resolving the appeal, a resolution will be rendered based on the information available.</td>
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</tr>
<tr>
<td></td>
<td>Throughout the course of an appeal the member may continue to receive services without liability for services previously authorized by Beacon, until he/she is notified of the appeal determination.</td>
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Please note that providers may act as a member’s appeal representative.
**Table 2**  
**Standard Clinical Appeals**

<table>
<thead>
<tr>
<th>MassHealth (continued from previous page)</th>
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<tbody>
<tr>
<td><strong>Level 1 Appeal</strong></td>
</tr>
<tr>
<td>The member may be held liable for payment of continuing services if the appeal is not deemed in their favor.</td>
</tr>
<tr>
<td>MassHealth members must submit appeal request within ten days of the Adverse Action in order to continue services without liability.</td>
</tr>
<tr>
<td>Provider must submit medical chart for review. If chart is not received within 20 days of initial letter, a reminder letter is sent, giving additional 15 days. If chart is not received, decision is made, based on available information.</td>
</tr>
<tr>
<td>Provider must submit medical chart for review. If chart is not received within 20 days of initial letter, a reminder letter is sent, giving additional 15 days. If chart is not received, decision is made, based on available information.</td>
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**Contact Info:**

Appeal requests can be made by calling Beacon’s Appeals Coordinator at 888.421.8861 or in writing to Appeals Coordinator

Beacon Health Strategies  
500 Unicorn Park Drive  
Suite 401  
Woburn, MA 01801

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or

Board of Hearings,  
Office of Medicaid  
100 Hancock Street, 6th Floor  
Quincy, MA 02171  
1-800-655-0338 or  
617-847-1200

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<th>External Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial members, their legal guardian, or AMR have up to 180 days to file an appeal after notification of Beacon’s adverse determination.</td>
<td>N/A</td>
<td>In the event that Beacon’s Standard First Level Appeal decision upholds the adverse determination, the member may request an external review with the Department of Public Health, Office of Patient Protection (OPP).</td>
</tr>
<tr>
<td>A Fallon physician advisor, not involved in the initial decision, will review available information and attempt to contact the member’s attending physician /provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resolution and notification will be provided within 20 calendar days of the appeal request.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the appeal requires review of medical records (post service situations), the member’s or AMR’s signature is required on an Authorization to Release Medical Information Form authorizing the release of medical and treatment information relevant to the appeal.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the medical record with Authorization to Release Medical Information Form is not received prior to the deadline for resolving the appeal, a resolution will be rendered based on the information available.</td>
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</tr>
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<td>Throughout the course of an appeal for services previously authorized by Beacon, the member shall continue to receive services without liability until notification of the appeal resolution, provided the appeal is filed on a timely basis.</td>
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<td></td>
</tr>
<tr>
<td><strong>Contact Info:</strong></td>
<td><strong>Contact Info:</strong></td>
<td><strong>Contact Info:</strong></td>
</tr>
<tr>
<td>Appeal requests can be made by calling Beacon’s Appeals Coordinator at 888.421.8861 or in writing to Appeals Coordinator</td>
<td>N/A</td>
<td>Members or their AMR should contact the Beacon Appeals Coordinator for assistance in making the request to OPP at 1-800-462-5449, however members or their AMRs may contact OPP directly.</td>
</tr>
<tr>
<td>Beacon Health Strategies</td>
<td></td>
<td>Office of Patient Protection 1-800-436-7757 or <a href="http://www.state.ma.us/dph/opp">www.state.ma.us/dph/opp</a> to obtain the forms and additional instructions for the external review. (there is a fee of $25 which is paid by Beacon Health Strategies)</td>
</tr>
<tr>
<td>500 Unicorn Park Drive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suite 401</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Woburn, MA 01801</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note that providers may act as a member’s appeal representative.
Administrative Appeal 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.)

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

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

• **First Level** administrative appeals for both Commercial (including Commonwealth Care), Medicaid, and Medicare members should be submitted in writing to the Appeals Coordinator at Beacon. Provide any supporting documents that may be useful in making a decision. (Do not submit Medical Records or any clinical information.) An administrative appeals committee reviews the appeal and a decision is made within 20 business days of date of receipt of appeal. A written notification is sent within three business days of the appeal determination.

• **Second Level** administrative appeals for both Commercial (including Commonwealth Care), Medicaid, and Medicare members should be submitted in writing to the Chief Operations Officer at Beacon. A decision is made within 20 business days of receipt of appeal information and notification of decision is sent within three business days of appeal determination.
Chapter 7
BILLING TRANSACTIONS

General Claim Policies
Electronic Submission of Claims
Reconsideration of Timely Filing Requests
Coding
This chapter presents all information needed to submit claims to Beacon. Beacon strongly encourages providers to rely on electronic submission, either through EDI or eServices in order to achieve the highest success rate of first-submission claims.

**General Claim Policies**

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

- The required edits, minimum submission standards, signature certification form, authorizing agreement and certification form, data specifications as outlined in this P&P Manual must be fulfilled and maintained by all providers and billing agencies submitting EMC to Beacon.

- 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.

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

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

- Providers are not permitted to bill health plan members under any circumstances for covered services rendered, excluding co-payments when appropriate. See Chapter 3, Prohibition on Billing Members for more information.

**Time Limit for Filing Claims**

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

- Within 60 days of the dates of service on outpatient claims

- Within 60 days of the date of discharge on inpatient claims, or

- Within 60 days from the last date on an interim bill on an inpatient claim

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the 60-day filing limit will deny unless submitted with a valid and approved Waiver Request Form (see 60-Day Waiver Policy later in this chapter.

All clean claims will be adjudicated within thirty (30) days from the date that Beacon Health Strategies receives the claim.
Definition: Clean Claims

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 or is missing any required substantiating documentation of particular circumstance requiring special treatment that prevents timely payments from being made on the claim.

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

Electronic Submission of Claims

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

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

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

Electronic Data Interchange (EDI)

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

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

- Beacon’s payer ID is 43324; and
- Beacon’s FCHP ID is 005.

Beacon requires testing for all submitters, including providers and/or their billing intermediaries, prior to submission of 837P and 837I transactions. After testing is successfully completed, providers and/or their billing intermediaries submit 837 claim transaction files by direct internet connection via Beacon’s secure EDI Gateway which is a secure web server.

To use Beacon’s EDI Gateway, submitters need an Internet connection and a browser that supports 128-bit encryption, such as Internet Explorer 5.5 or higher. A Login ID, Password & URL for the EDI Gateway will be provided during the testing and certification process.

When the claims in the 837 file are adjudicated, the explanation of benefits (EOB) remittance report can be downloaded from the EDI gateway in the HIPAA 835 transaction format. Claim status and EOB reports are also available through eServices; claim status is also accessible telephonically through Beacon’s IVR (See Chapter 2).
Providers interested in submitting EDI claims using the HIPAA-compliant 837 transaction, should **download and review the 837 companion guide**, then email Beacon at **EDI.Operations@beaconhs.com** for setup and testing.

Additional EDI Resources:

- Read *About EDI*
- Read/Download EDI Companion Guides

### Submitting Claims on eServices

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

- Chapter 2 of this Manual
- More About eServices
- eServices User Manual

### Paper Claims

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

Mail paper claims to:
Beacon Health Strategies
Claims Department
500 Unicorn Park Drive, Suite 401
Woburn, MA  01801-3393

Claim status and EOB information are available in **eServices** regardless of how a claim was submitted. Claim status is also available through **IVR**.
### Professional Services: Instructions for Completing the CMS 1500 Form

<table>
<thead>
<tr>
<th>H. block #</th>
<th>I. required?</th>
<th>J. description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
<td>Check Applicable Program</td>
</tr>
<tr>
<td>1a</td>
<td>Yes</td>
<td>Member’s Touchstone ID Number</td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
<td>Member’s Name</td>
</tr>
<tr>
<td>3</td>
<td>Yes</td>
<td>Member’s Birth date and Sex</td>
</tr>
<tr>
<td>4</td>
<td>Yes</td>
<td>Insured’s Name</td>
</tr>
<tr>
<td>5</td>
<td>Yes</td>
<td>Member’s Address</td>
</tr>
<tr>
<td>6</td>
<td>No</td>
<td>Member’s Relationship to Insured</td>
</tr>
<tr>
<td>7</td>
<td>No</td>
<td>Insured’s Address</td>
</tr>
<tr>
<td>8</td>
<td>Yes</td>
<td>Member’s Status</td>
</tr>
<tr>
<td>9</td>
<td>Yes</td>
<td>Other Insured’s Name (If Applicable)</td>
</tr>
<tr>
<td>9a</td>
<td>Yes</td>
<td>Other Insured’s Policy or Group Number</td>
</tr>
<tr>
<td>9b</td>
<td>Yes</td>
<td>Other Insured’s Date of Birth and Sex</td>
</tr>
<tr>
<td>9c</td>
<td>Yes</td>
<td>Employer’s Name or School Name</td>
</tr>
<tr>
<td>9d</td>
<td>Yes</td>
<td>Insurance Plan Name or Program Name</td>
</tr>
<tr>
<td>10a-c</td>
<td>Yes</td>
<td>Member’s Condition Related to Employment</td>
</tr>
<tr>
<td>11</td>
<td>No</td>
<td>Member’s Policy, Group or FICA Number (If Applicable)</td>
</tr>
<tr>
<td>11a</td>
<td>No</td>
<td>Member’s Date of Birth (MM, DD, YY) and Sex (check box)</td>
</tr>
<tr>
<td>11b</td>
<td>No</td>
<td>Employer’s Name or School Name (If Applicable)</td>
</tr>
<tr>
<td>11c</td>
<td>No</td>
<td>Insurance Plan Name or Program Name (If Applicable)</td>
</tr>
<tr>
<td>11d</td>
<td>No</td>
<td>Is there another health benefit plan?</td>
</tr>
<tr>
<td>12</td>
<td>Yes</td>
<td>Member’s or Authorized Person’s Signature and Date On File</td>
</tr>
<tr>
<td>13</td>
<td>No</td>
<td>Member’s or Authorized Person’s Signature</td>
</tr>
<tr>
<td>14</td>
<td>No</td>
<td>Date of Current Illness</td>
</tr>
<tr>
<td>15</td>
<td>No</td>
<td>Date of Same or Similar Illness</td>
</tr>
<tr>
<td>16</td>
<td>No</td>
<td>Date Client Unable to Work in Current Occupation</td>
</tr>
<tr>
<td>17</td>
<td>No</td>
<td>Name of Referring Physician or Other Source (If Applicable)</td>
</tr>
<tr>
<td>17B</td>
<td>No</td>
<td>NPI of referring Physician</td>
</tr>
<tr>
<td>18</td>
<td>No</td>
<td>Hospitalization Dates Related to Current Services (If Applicable)</td>
</tr>
<tr>
<td>19</td>
<td>Yes</td>
<td>Former Control Number (Record ID If Applicable)</td>
</tr>
<tr>
<td>20</td>
<td>No</td>
<td>Outside Lab</td>
</tr>
<tr>
<td>21</td>
<td>Yes</td>
<td>Diagnosis or Nature of Illness or Injury</td>
</tr>
<tr>
<td>22</td>
<td>No</td>
<td>Medicaid Resubmission Code</td>
</tr>
<tr>
<td>23</td>
<td>Yes</td>
<td>Prior Authorization Number (If Applicable)</td>
</tr>
<tr>
<td>24a</td>
<td>Yes</td>
<td>Date of Service</td>
</tr>
<tr>
<td>24b</td>
<td>Yes</td>
<td>Place of Service code (HIPAA Compliant)</td>
</tr>
</tbody>
</table>


**Professional Services: Instructions for Completing the CMS 1500 Form (continued)**

<table>
<thead>
<tr>
<th>H. block #</th>
<th>I. required?</th>
<th>J. description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24d</td>
<td>Yes</td>
<td>Procedure Code (HIPAA Compliant) and Modifier when applicable</td>
</tr>
<tr>
<td>24e</td>
<td>Yes</td>
<td>Diagnosis Code- 1,2,3 or 4</td>
</tr>
<tr>
<td>24f</td>
<td>Yes</td>
<td>Charges</td>
</tr>
<tr>
<td>24g</td>
<td>Yes</td>
<td>Days or Units</td>
</tr>
<tr>
<td>24h</td>
<td>No</td>
<td>EPSDT</td>
</tr>
<tr>
<td>24i</td>
<td>No</td>
<td>ID Qualifier</td>
</tr>
<tr>
<td>24 j</td>
<td>Yes</td>
<td>Rendering Provider Name and Rendering Provider NPI</td>
</tr>
<tr>
<td>25</td>
<td>Yes</td>
<td>Federal Tax ID Number</td>
</tr>
<tr>
<td>26</td>
<td>No</td>
<td>Provider’s Member Account Number</td>
</tr>
<tr>
<td>27</td>
<td>No</td>
<td>Accept Assignment (check box)</td>
</tr>
<tr>
<td>28</td>
<td>Yes</td>
<td>Total Charges</td>
</tr>
<tr>
<td>29</td>
<td>Yes</td>
<td>Amount Paid by Other Insurance (If Applicable)</td>
</tr>
<tr>
<td>30</td>
<td>Yes</td>
<td>Balance Due</td>
</tr>
<tr>
<td>31</td>
<td>Yes</td>
<td>Signature of Physician/Practitioner nx NPI</td>
</tr>
<tr>
<td>32</td>
<td>Yes</td>
<td>Name and Address of Facility where services were rendered (Site ID)</td>
</tr>
<tr>
<td>32 a</td>
<td>No</td>
<td>NPI of Servicing Facility</td>
</tr>
<tr>
<td>33</td>
<td>Yes</td>
<td>Provider Name</td>
</tr>
<tr>
<td>33 a</td>
<td>Yes</td>
<td>Billing Provider NPI</td>
</tr>
<tr>
<td>33 b</td>
<td>No</td>
<td>Pay to Provider Beacon ID Number</td>
</tr>
</tbody>
</table>

*Please Note: Beacon requires the Physician/Practitioner’s name and NPI number in box 24j.*

All providers are required to record the name, site ID and address of the facility where services were rendered in Box 32 on the CMS 1500 claim form. If the facility name, site ID or address is not identified, a Beacon Claim Specialist will choose the ‘primary’ site as the default.
Instructions for Completing the UB 04 Form

<table>
<thead>
<tr>
<th>K. block #</th>
<th>L. required?</th>
<th>M. description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>Provider Name, Address, Telephone #</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>Untitled</td>
</tr>
<tr>
<td>3</td>
<td>No</td>
<td>Provider’s Member Account Number</td>
</tr>
<tr>
<td>4</td>
<td>Yes</td>
<td>Type of Bill (See Bill Type Codes below)</td>
</tr>
<tr>
<td>5</td>
<td>Yes</td>
<td>Federal Tax ID Number</td>
</tr>
<tr>
<td>6</td>
<td>Yes</td>
<td>Statement Covers Period (Include date of Discharge)</td>
</tr>
<tr>
<td>7</td>
<td>Yes</td>
<td>Covered Days (Do not include date of Discharge)</td>
</tr>
<tr>
<td>8</td>
<td>Yes</td>
<td>Member Name</td>
</tr>
<tr>
<td>9</td>
<td>Yes</td>
<td>Member Address</td>
</tr>
<tr>
<td>10</td>
<td>Yes</td>
<td>Member Birth Date</td>
</tr>
<tr>
<td>11</td>
<td>Yes</td>
<td>Member Sex</td>
</tr>
<tr>
<td>12</td>
<td>Yes</td>
<td>Admission Date</td>
</tr>
<tr>
<td>13</td>
<td>Yes</td>
<td>Admission Hour</td>
</tr>
<tr>
<td>14</td>
<td>Yes</td>
<td>Admission Type</td>
</tr>
<tr>
<td>15</td>
<td>Yes</td>
<td>Admission Source</td>
</tr>
<tr>
<td>16</td>
<td>Yes</td>
<td>Discharge Hour</td>
</tr>
<tr>
<td>17</td>
<td>Yes</td>
<td>Discharge Status (See Discharge Status Codes below)</td>
</tr>
<tr>
<td>18-28</td>
<td>No</td>
<td>Condition Codes</td>
</tr>
<tr>
<td>29</td>
<td>No</td>
<td>ACDT States</td>
</tr>
<tr>
<td>30</td>
<td>No</td>
<td>Unassigned</td>
</tr>
<tr>
<td>31-34</td>
<td>No</td>
<td>Occurrence Code And Date</td>
</tr>
<tr>
<td>35-36</td>
<td>No</td>
<td>Occurrence Span</td>
</tr>
<tr>
<td>37</td>
<td>No</td>
<td>REC.ID For Resubmission</td>
</tr>
<tr>
<td>38</td>
<td>No</td>
<td>Untitled</td>
</tr>
<tr>
<td>39-41</td>
<td>No</td>
<td>Value CD/AMT</td>
</tr>
<tr>
<td>42</td>
<td>Yes</td>
<td>Revenue Code (If Applicable)</td>
</tr>
<tr>
<td>43</td>
<td>Yes</td>
<td>Revenue Description</td>
</tr>
<tr>
<td>44</td>
<td>Yes</td>
<td>Procedure Code (CPT)</td>
</tr>
<tr>
<td>45</td>
<td>Yes</td>
<td>Service Date</td>
</tr>
<tr>
<td>46</td>
<td>Yes</td>
<td>Units Of Service</td>
</tr>
<tr>
<td>47</td>
<td>Yes</td>
<td>Total Charges</td>
</tr>
<tr>
<td>48</td>
<td>No</td>
<td>Non-Covered Charges</td>
</tr>
<tr>
<td>49</td>
<td>Yes</td>
<td>Modifier (If Applicable)</td>
</tr>
<tr>
<td>50</td>
<td>Yes</td>
<td>Payer Name</td>
</tr>
<tr>
<td>51</td>
<td>Yes</td>
<td>Beacon Provider Id Number</td>
</tr>
</tbody>
</table>
Instructions for Completing the UB 04 Form (continued)

<table>
<thead>
<tr>
<th>K. block #</th>
<th>L. required?</th>
<th>M. description</th>
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</thead>
<tbody>
<tr>
<td>52</td>
<td>Yes</td>
<td>Release Of Information Authorization Indicator</td>
</tr>
<tr>
<td>53</td>
<td>Yes</td>
<td>Assignment Of Benefits Authorization Indicator</td>
</tr>
<tr>
<td>54</td>
<td>Yes</td>
<td>Prior Payments (If Applicable)</td>
</tr>
<tr>
<td>55</td>
<td>No</td>
<td>Estimated Amount Due</td>
</tr>
<tr>
<td>56</td>
<td>Yes</td>
<td>Facility NPI</td>
</tr>
<tr>
<td>57</td>
<td>No</td>
<td>Other ID</td>
</tr>
<tr>
<td>58</td>
<td>No</td>
<td>Insured’s Name</td>
</tr>
<tr>
<td>59</td>
<td>No</td>
<td>Member’s Relationship To Insured</td>
</tr>
<tr>
<td>60</td>
<td>Yes</td>
<td>Member’s Identification Number</td>
</tr>
<tr>
<td>61</td>
<td>No</td>
<td>Group Name</td>
</tr>
<tr>
<td>62</td>
<td>No</td>
<td>Insurance Group Number</td>
</tr>
<tr>
<td>63</td>
<td>Yes</td>
<td>Prior Authorization Number (If Applicable)</td>
</tr>
<tr>
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<td>No</td>
<td>Document Control Number</td>
</tr>
<tr>
<td>65</td>
<td>No</td>
<td>Employer Name</td>
</tr>
<tr>
<td>66</td>
<td>No</td>
<td>Employer Location</td>
</tr>
<tr>
<td>67</td>
<td>Yes</td>
<td>Principal Diagnosis Code</td>
</tr>
<tr>
<td>68</td>
<td>No</td>
<td>A-Q Other Diagnosis</td>
</tr>
<tr>
<td>69</td>
<td>Yes</td>
<td>Admit Diagnosis</td>
</tr>
<tr>
<td>70</td>
<td>No</td>
<td>Patient Reason Diagnosis</td>
</tr>
<tr>
<td>71</td>
<td>No</td>
<td>PPS Code</td>
</tr>
<tr>
<td>72</td>
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<td>ECI</td>
</tr>
<tr>
<td>73</td>
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<td>Unassigned</td>
</tr>
<tr>
<td>74</td>
<td>No</td>
<td>Principle Procedure</td>
</tr>
<tr>
<td>75</td>
<td>No</td>
<td>Unassigned</td>
</tr>
<tr>
<td>76</td>
<td>Yes</td>
<td>Attending Physician NPI, First And Last Name and NPI</td>
</tr>
<tr>
<td>77</td>
<td>No</td>
<td>Operating Physician NPI</td>
</tr>
<tr>
<td>78 -79</td>
<td>No</td>
<td>Other NPI</td>
</tr>
<tr>
<td>80</td>
<td>No</td>
<td>Remarks</td>
</tr>
<tr>
<td>81</td>
<td>No</td>
<td>Code-Code</td>
</tr>
</tbody>
</table>

Please Note: Beacon requires the Attending NPI in box 76.
Bill Type Codes

All inpatient UB04 claims must include the 3-digit bill type codes in **Box 4**, according to the following table:

<table>
<thead>
<tr>
<th>Type of Facility – 1st Digit</th>
<th>Bill Classifications – 2nd digit</th>
<th>Frequency – 3rd digit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hospital</td>
<td>1. Inpatient</td>
<td>1. Admission through Discharge Claim</td>
</tr>
<tr>
<td>1. Skilled Nursing Facility</td>
<td>2. Inpatient Professional Component</td>
<td>2. Interim – First Claim</td>
</tr>
<tr>
<td>5. Christian Science</td>
<td>5. Intermediate Care – Level I</td>
<td>5. Late Charge Only</td>
</tr>
<tr>
<td>Extended Care Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Clinic</td>
<td>7. Intermediate Care – Level III</td>
<td></td>
</tr>
<tr>
<td>8. Special Facility</td>
<td>8. Swing Beds</td>
<td></td>
</tr>
<tr>
<td>9. Reserved</td>
<td>9. Reserved</td>
<td></td>
</tr>
</tbody>
</table>

Discharge Status Codes

All inpatient UB04 claims must include one of the following discharge status codes in **Box 17**:  
01 – Discharged to Home / Self Care  
02 – Discharged/Transferred to Another Acute Hospital  
03 – Discharged/Transferred to Skilled Nursing Facility  
04 – Discharged/Transferred to Intermediate Care Facility  
05 – Discharged/Transferred to Another Facility  
06 – Discharged/Transferred to Home / Home Health Agency  
07 – Left Against Medical Advice or Discontinued Care  
08 – Discharged/Transferred Home / IV Therapy  
09 – Admitted as Inpatient to this Hospital  
20 – Expired  
30 – Still a Patient

*Note that Beacon’s contracted reimbursement for inpatient procedures reflect all-inclusive per diem rates.*
Interim Billing & Date Ranges

Beacon accepts interim billing on inpatient claims.

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

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

Resubmission Policy & Procedures

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

If the original denied claim to be resubmitted was received by Beacon within 60 days from the date of service:

- The corrected claim may be resubmitted as an original.
- A corrected and legible photocopy is also acceptable.

If the original denied claim to be resubmitted was received by Beacon more than 60 days from the date of service, the following procedures apply:

*Note: The REC.ID corresponds with a single claim line on the Beacon EOB. Therefore, if a claim has multiple lines there will be multiple REC.ID numbers on the Beacon EOB.*

Electronic Resubmission

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

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

Paper Resubmission

The entire claim 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 claim lines along with resubmitted claim lines.

Beacon requires that the corrected claim (or a corrected and legible photocopy) be resubmitted in one of the following ways:

- Submit the corrected claim with a copy of the EOB for the corresponding date of service; or
- Enter the REC.ID in box 64 on the UB04 claim form, or in box 19 on the CMS 1500 form.
Resubmission Timeframe

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

60-Day Waiver Policy

Providers may request a waiver of the 60-day filing limit, when a claim being submitted for the first time will be received by Beacon after the original 60-day filing limit. To be approved, a waiver request must include evidence demonstrating that one or more of the following conditions has been met:

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

These conditions are the only valid reasons for submission of a 60-day waiver request. A 60-Day Waiver Request Form that presents reasons not listed above, will result in a claim denial on a future EOB. Claims that are outside of 60 days but do not meet the above criteria should be submitted as a reconsideration request.

Procedure for Requesting a 60-Day Waiver

To request a 60-day waiver:

- Complete a 60-Day Waiver Form per the instructions below;
- Attach any supporting documentation;
- Prepare the claim as an original submission with all required elements;
- Send the form, documentation and claim to:

  Beacon Health Strategies
  Claims Department / 60-Day Waivers
  500 Unicorn Park Drive, Suite 401
  Woburn, MA  01801-3393

Completion of the 60-Day Waiver Request Form

Providers are required to complete one 60-Day Waiver Request Form per claim, as accurately and legibly as possible, including:

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 Fallon Community Health Plan member ID Number.

5. **Contact Person**
   Enter the name of the person whom Beacon should contact if there are any questions regarding this request.

6. **Telephone Number**
   Enter the telephone number of the contact person.

7. **Reason for Waiver**
   Place an “X” on all the line(s) that describe why the waiver is requested.

8. **Provider Signature**
   A 60-day waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept “Signature on file”.

9. **Date**
   Indicate the date that the form was signed.

**Beacon’s Waiver Decision**

Beacon’s determination regarding the 60-day waiver request is reflected on a future EOB: If the request is approved for waiver of the 60-day filing limit, the claim appears adjudicated; if the waiver request is denied, the reason for denial appears. (See appendix for denial codes.) Note that approval of a 60-day waiver request only means that the timely filing requirement has been overridden - approval does not guarantee payment of the associated claim. Each claim will pay or deny based upon normal adjudication logic.

Contact Beacon’s Claims Department with any questions.

**Recoupments and Adjustments by Beacon**

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

**Provider Request for Adjustment or Void**

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

- **Adjustment** requests are filed to increase or decrease the original amount paid on a claim. Claims that have been denied cannot be adjusted but may be resubmitted. Adjustment requests can be filed electronically.

- **Void** requests are filed to refund the entire original payment on a claim, to Beacon. Void requests can only be sent via the paper adjustment process.

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

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

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

If an EOB shows that Beacon overpaid the provider on a single claim, the provider must submit an adjustment request to Beacon. The provider should **not** send a refund check. Beacon will investigate the need for an adjustment and if a reduction in payment is warranted, Beacon will reduce the next payment to the provider and this adjustment will be reflected in the provider’s next EOB. If money is owed to Beacon, the 60 day filing limitation is not applicable.

*Do NOT send a refund check to Beacon.*

Electronic Adjustment Requests

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

**EDI:** Follow the instructions in the **EDI companion guide** for correct placement of REC.ID number.

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

Paper Adjustment Requests

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

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

• Complete the **Adjustment/Void Request Form** per the instructions below;

• Attach copy of the EOB on which the claim was paid an incorrect amount;

• Prepare the claim based on your requested final payment, with all required elements; place the REC.ID in box 19 of the CMS 1500 claim form, or box 64 of the UB04 form

• Send the form, documentation and claim to:

Beacon Health Strategies
Claims Department - 60-Day Waivers
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393
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. *A copy of the original claim must be attached to the request.*

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. **Health Plan Member Identification Number**
   Enter the Fallon Community Health Plan member ID Number as it appears on the EOB. If a payment was made for the wrong member, the claim must be **voided** and a new claim must be submitted.

5. **Beacon Record ID number**
   Enter the record ID number as listed on the EOB.

6. **Beacon Paid Date**
   Enter the date the check was cut as listed on the EOB.

7. **Check Appropriate Line**
   Place an “X” on the line that best describes the type of adjustment/void being requested.

8. **Check All that Apply**
   Place an “X” on the line(s) which 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.

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

Beacon Health Strategies  
Claims Department – Adjustment Void / Request  
500 Unicorn Park Drive, Suite 401  
Woburn, MA 01801-3393
Reconsideration of Timely Filing Requests

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

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

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

Coding

Providers are required to submit HIPAA-compliant coding on all electronic and paper claim submissions; this includes HIPAA-compliant revenue, CPT, HCPCS and ICD-9 codes. Claims submitted without HIPAA-compliant coding will be denied for payment. Providers should refer to their exhibit A for a complete listing of contracted, reimbursable procedure codes.

Modifiers

Modifiers are used to make up specific code sets that are applied to identify services for correct payment.

On the CMS 1500 claim form place the modifier code in Box 24d. On the UB04 claim form place the modifier code in Box 49 or beside the HCPCS code in Box 44. The modifier reflects the discipline and licensure status of the treating practitioner. Please refer to the following list of modifiers as a guide for billing; your exhibit A will define what services require modifiers:

<table>
<thead>
<tr>
<th>HIPAA Modifier</th>
<th>Modifier Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AH</td>
<td>Clinical Psychologist</td>
</tr>
<tr>
<td>AJ</td>
<td>Clinical Social Worker</td>
</tr>
<tr>
<td>HA</td>
<td>Child/Adolescent program</td>
</tr>
<tr>
<td>HB</td>
<td>Adult program, non-geriatric</td>
</tr>
<tr>
<td>HC</td>
<td>Adult program, geriatric</td>
</tr>
<tr>
<td>HD</td>
<td>Pregnant/parenting women’s program</td>
</tr>
<tr>
<td>HE</td>
<td>Mental health program</td>
</tr>
<tr>
<td>HF</td>
<td>Substance abuse program</td>
</tr>
<tr>
<td>HG</td>
<td>Opioid addiction treatment program</td>
</tr>
<tr>
<td>HH</td>
<td>Integrated mental health/substance abuse program</td>
</tr>
<tr>
<td>HI</td>
<td>Integrated mental health and mental retardation/developmental disabilities program</td>
</tr>
<tr>
<td>HJ</td>
<td>Employee assistance program</td>
</tr>
</tbody>
</table>
Medication Management

All providers must use CPT code 90862 when billing for a medication management session. In addition, one of the following modifiers is required to indicate the licensure level of the practitioner who provided the service:

- For licensed physician, use modifier U6
- For licensed RNCS, use modifier SA
Diagnosis Codes

Beacon accepts only ICD-9 diagnosis codes listing approved by CMS and HIPAA. Providers must record the appropriate primary diagnosis code in Box 21 on the CMS 1500 claim form and in Box 67 on the UB04 claim form. In order to be considered for payment all claims must have a Primary ICD-9 diagnosis in the range of 290 to 319. All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.

Coordination of Benefits

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

- When it is determined that Beacon Health Strategies is the secondary payer, claims must be submitted with a copy of the primary insurance’s explanation of benefits report and received by Beacon within 60 days of the date on the EOB.
- Beacon Health Strategies reserves to 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 Health Strategies has TPL and COB specialists to address any specific questions regarding these types of claims.

Providers should use the TPL Indicator Form to notify EOHHS of the potential existence of other health insurance coverage and to include a copy of the Enrollee’s health insurance card with the TPL Indicator Form whenever possible.

The TPL Indicator Form can be found on the Beacon Health Strategies web site at www.beacon-healthstrategies.com, and see your ‘provider tools page’ or Click here to print this form directly.

Provider Education and Outreach

Summary

In an effort to help providers that may be experiencing claims payment issues, Beacon runs quarterly reports identifying those providers than 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 Beacons documented guidelines.

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

How the Program Works

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

1. **eServices**  
   Providers can check claim status 24/7 via eServices, regardless of how claims were submitted.

   Our Interactive Voice Response System is available 24 hours a day. You will need your tax ID, member ID and date of birth, the date of service.

3. **Claims Hotline: 888.249.0478**  
   Hours of operation are 8:30 a.m. to 5:30 p.m. Monday through Thursday.  
   9:00 a.m. to 5:00 p.m. Friday.