Giving Value Back to the Provider 2020

Agenda

1	Fraud, Waste, and Abuse: An Introduction to Special Investigations Unit and Payment Integrity	2	Company Overview
3	Operational Areas	4	Project, Programs and Initiatives
5	Electronic Resources Overview of ProviderConnect and eServices	6	Communication and Contact Information
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Chapter

01

Fraud, Waste and Abuse

“We help people live their lives to the fullest potential.”

Our Commitment

beacon
health options

Introduction to Special Investigation Unit and Payment Integrity

Objectives

- Describe Special Investigations Unit (SIU) and its purpose
- Describe Payment Integrity and its purpose
- Review Relevant Laws and Requirements
- Overview of Audits and Enforcement Entities
- Preparing for an Audit
- Documentation Requirements

Medicare Annual Fraud, Waste, and Abuse Training

- The Centers of Medicare and Medicaid Services (CMS) require Medicare providers to complete Fraud, Waste, and Abuse and General Compliance Annual Training.
- Disclaimer: While this presentation is beneficial to help understand fraud, waste, and abuse, it does NOT meet the requirements for the Fraud, Waste, and Abuse and General Compliance Annual Training for Medicare providers
- For more information, please see:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf

Key Terms

- **Fraud** – Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit.
  - Many payment errors are billing mistakes and are not the result of someone such as a physician, provider, or pharmacy trying to take advantage of the Medicaid or Medicare program
  - Fraud occurs when someone intentionally falsifies information or deceives the Medicaid or Medicare program

Key Terms

- **Waste** – Thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of healthcare resources, including incurring costs because of inefficient or ineffective practices, systems, or controls
- **Abuse** – Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to health programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards
- **Compliance Program** – Systematic procedures instituted to ensure contractual and regulatory requirements are being met

Key Terms

- **Compliance Risk Assessment** – Process of assessing a company's risk related to its compliance with contractual and regulatory requirements
- **Compliance Work Plan** – Prioritization of activities and resources based on the Compliance Risk Assessment findings
- **Program Integrity** – Steps and activities included in the compliance program & plan specific to fraud, waste, and abuse

Purpose of Special Investigations Unit

- **Special Investigations Unit (SIU)** – Beacon's SIU reviews and monitors claims and billing practices of providers by conducting audits to ensure compliance with Federal and State documentation and billing requirements, as well as to monitor providers for fraud, waste, and abuse (FWA)
  - An anti-fraud program that detects, investigates, and resolves potential FWA is required per Federal/State regulations and Beacon's contracts with our clients
  - If fraud is suspected or confirmed during the audit, SIU will follow regulatory and contractual requirements, which may include notifying our clients or law enforcement

Introduction and Purpose of Payment Integrity

- **Payment Integrity** – Beacon Health Options Payment Integrity department works to achieve the functions set out by Beacon's Payment Integrity Center of Excellence. The Payment Integrity Center of Excellence maintains objectives in ensuring claims accuracy, payment accuracy and administration, compliance, coordination of benefits and subrogation, and process improvements.
  - Broad functions of Payment Integrity include improper payments from system errors, coding and billing compliance, coordination of benefits (COB), retrospectively termed-member eligibility, provider negative balances, investigative analysis, and identification of potential fraud, waste, and abuse issues.
  - Payment Integrity works closely with SIU in reporting potential or suspected fraud, waste, and abuse scenarios.

Relevant Laws and Requirements

Fraud, Waste, and Abuse (FWA) Laws and Requirements

- Balanced Budget Act (BBA)
  - Amended Social Security Act (SSA) re: Healthcare Crimes
  - Must exclude from Medicare and state healthcare programs those convicted of health care offenses
  - Can impose civil monetary penalties for anyone who arranges or contracts with excluded parties
- Federal False Claims Act (FCA)
  - Liable for a civil penalty of not less than $5,500 & no more than $11,000, plus 3x amount of damages for those who submit, or cause another to submit, false claims
- Deficit Reduction Act (DRA)
  - Requires communication of policies and procedures to employees re: FCA, whistleblower rights, and fraud, waste, and abuse prevention, if receiving more than $5M in Medicaid

FWA Laws and Requirements

- Laws and regulations formalized and emphasized the prevention, detection, and resolution of fraud, waste, and abuse, as well as the recovery of overpayments
- Fraud Enforcement and Recovery Act of 2009 (FERA)
- Patient Protection and Affordable Care Act (PPACA – Healthcare Reform Act)
- Per Federal regulations, providers excluded from one line of business with Beacon, will not be able to participate in any Beacon network or lines of business
- Beacon is required to check Federal exclusion lists regularly to make sure no excluded providers are in network

Other Relevant Laws and Requirements

- Recoupment laws
  - Federal, State, Commercial
    - May differ from state to state
- Professional Licensure Standards

Some examples:

—National Association of Social Workers (NASW)

https://www.socialworkers.org/LinkClick.aspx?fileticket=6rzm0hojQqA%3d&portalid=0

—American Psychological Association (APA) Record Keeping Guidelines

http://www.apa.org/practice/guidelines/record-keeping.aspx

Other Relevant Laws and Requirements

- State Requirements:
  - Some examples - *(seek information from your specific state agencies)
  - New York State:

Title: Section 85.29- Maintenance of Medical Records

https://regs.health.ny.gov/content/section-8529-maintenance-medical-records

  - New York State Medicaid Program:

Record-Keeping Requirements

https://www.emedny.org/ProviderManuals/AllProviders/PDFS/archive/Infor_mation_for_All_Providers-General_Policy-2004-1.pdf

Elements of an Effective Compliance Program

- Elements of an effective Compliance Program as Adopted by OIG & CMS (based on Federal Sentencing Guidelines)
  1. Compliance Officer and Compliance Committee
  2. Effective lines of communication between the Compliance Officer, Board, Executive Management, & staff (incl. an anonymous reporting function)
  3. Written policies and procedures
  4. Effective training
  5. Internal monitoring and auditing
  6. Mechanisms for responding to detected problems
  7. Disciplinary enforcement

Elements of an Effective Compliance Program

8. Compliance Programs Must be Effective
   - Must show that compliance plans are more than a piece of paper
   - Must be able to show an effective program that signifies a proactive approach to the identification of fraud, waste, and abuse
   - How much fraud, waste, and abuse have you identified?
   - How much fraud, waste, and abuse have you prevented?

Audit Types and Enforcement Entities

Audit Types

- Compliance Audit
  - Evaluates strength and thoroughness of compliance preparations
- Special Investigations Unit (SIU) Audit
  - Evaluates strength and thoroughness of efforts to prevent, detect, and correct Fraud, Waste, and Abuse
- Pre-Payment Audit – Evaluates the validity of a claim submission prior to adjudication
- Post-Payment Audit / Retrospective Audit / Investigative Audit – Evaluates the validity of a claim submission after adjudication and payment is made

Enforcement Entities: Federal Level Activities – CMS

- Medicaid Integrity Program (MIP)
- Medicaid Integrity Group (MIG)
- Medicaid Integrity Contractors (MIC)
- Medicare Zone Integrity Contractors (ZPIC)
- Medicare Recovery Audit Contractors (RAC)
- Payment Suspension:
  - Switch from “pay and chase” to fraud prevention.
  - Requires provider payment suspension based on a credible allegation of fraud
  - Good cause exception must be met if payments aren’t suspended
    - http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/xml/CFR-2011-title42-vol4-sec455-23.xml

CMS Required Medicare Advantage and Part D Training

- CMS issued a regulation called “Reducing the Burden of the Compliance Program Training Requirements”
- The purpose was to reduce the burden on first tier, down stream, and related entities (FDRs) by requiring CMS Compliance and Fraud, Waste, and Abuse training
- Regulation went into effect on 1/1/16
- If you are a provider receiving funding under Medicare Advantage (Part C) or Pharmacy (Part D) you will need to review this information
- For more information, please see:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf

Other Enforcement Entities

- U.S. Department of Health & Human Services, Office of Inspector General (OIG)
- U.S. Department of Justice (DOJ)
- Office of the State Attorney General (AG) – Medicaid Fraud Control Unit (MFCU)
- Federal Bureau of Investigation (FBI)
- Department of Insurance (DOI)

ALWAYS BE PREPARED FOR AN AUDIT

How To Ensure You're Prepared

- Use the eight elements of an effective compliance program as a guide in the development of a compliance program
- Delegate a knowledgeable point person for compliance oversight and monitoring
- Know your contractual and regulatory requirements regarding billing and coding compliance, and fraud, waste, and abuse
  - Educate staff on how daily activities prevent, detect, and address improper billing and coding, and fraud, waste, and abuse
- OIG Compliance Resource Links:
  - https://oig.hhs.gov/compliance/101/index.asp

Establish an Environment of Awareness

- Provide clinically necessary care through services within the scope of the practitioners' licensure
- Routinely monitor treatment records for required standardized documentation elements
- Monitor and adhere to claims submission standards
- Correct identified errors
- Hold staff accountable for errors
- Cooperate with all audits, surveys, inspections, etc.
- Cooperate with efforts to recover overpayments

Establish an Environment of Awareness

- Maintain documentation of all P&Ps, activities, audits, investigations, etc.
- Verify member eligibility
- Ensure staff know how to report fraud, waste, and abuse
- Communicate internally and externally
- Set-up a suggestion box for anonymous concerns and suggestions for improvement
- Post fraud, waste, and abuse tips
- Send out weekly tips on how to prevent fraud

Conduct Self-Assessments

- Detail all documentation, billing, and contract requirements
- Assess and prioritize gaps in compliance and develop action plans to remedy - Document all efforts
- Identify employees who've lost credentials
- Keep current with medical record documentation standards and requirements
- Assess to ensure accurate billing, coding, and documenting for services rendered is maintained

Conduct Self-Assessments

- Maintain routine validation of member eligibility
- Appropriate, periodic and “as necessary” training of staff
- Evaluate effectiveness of current processes
- Maintain ability for anonymous reporting internal fraud, waste, and/or abuse concerns

Train Staff to Recognize Fraud, Waste, and Abuse

- Common Fraud Schemes:
  - Billing for “Phantom Patients”
  - Billing for Services Not Provided
  - Billing for More Hours than In a Day
  - Using False Credentials
  - Double-Billing
  - Misrepresenting diagnosis, type/place of service, or who rendered service
  - Billing for non-covered services
  - Upcoding
  - Failure to collect co-insurance or deductibles
  - Inappropriate documentation
  - Lack of computer integrity
  - Failure to resolve overpayments
  - Delays in discharge to run up bill
  - Kickbacks

Train Staff to Recognize Fraud, Waste, and Abuse

- Common Member Fraud Schemes:
  - Forgery
  - Impersonation
  - Co-Payment Evasion
  - Providing False Information
  - Sharing or theft of Medicaid benefits

Basic Documentation Requirements

If it's Not Documented – It Didn't Happen

Purposes for Documentation

- Provides evidence services were provided
- Required to record pertinent facts, findings, and observations about an individual's medical history, treatment, and outcomes
- Facilitates communication and continuity of care among counselors and other health care professionals involved in the member's care
- Facilitates accurate and timely claims review and payment
- Supports utilization review and quality of care evaluations
- Enables collection of data useful for research and education

Beacon's Provider Handbook and Contract

- The provider handbook is an extension of the provider contract and includes guidelines on doing business with Beacon, including policies and procedures for individual providers, affiliates, group practices, programs, and facilities
- Together, the provider agreement, addenda, and handbook outline the requirements and procedures applicable to participating providers in the Beacon network(s)
- Except to the extent a given section or provision in the handbook is included to address a regulatory, accreditation or government program requirement or specific benefit plan requirement, in the event of a conflict between a member's benefit plan, the provider agreement and the handbook, such conflict will be resolved by giving precedence in the following order: (1) the member's benefit plan, (2) the provider contract, and (3) the handbook

Additional Documentation Standards

- State regulations and/or disciplinary standards may also have an impact on documentation standards
- Be sure to check your state regulations and licensing standards for any additional requirements

Code of Conduct

- The Beacon Code of Conduct was created pursuant to State and Federal requirements
- Providers should read the code of conduct and comply with the parts that are applicable to their line of business

Beacon's Approach to FWA and Payment Integrity

- Prevention
  - Being an Industry Partner
  - Training and Education
  - Provider Support
  - Contractual Provisions
  - Provider Profiling and Credentialing
  - Ethics Hotline
  - Claims Edits
  - Prior Authorizations
  - Member Handbook

Beacon's Approach to FWA and Payment Integrity

- Audit and Detection
  - Internal/External Leads
  - Audits
  - Post-Processing Review of Claims
  - Data Mining and Trend Analysis
  - Special Reviews
- Investigation and Resolution
  - Investigation and Disciplinary Processes
  - Reporting Requirements

Basic Documentation Needs

- All billable activities should have a documented start and stop time and/or duration time, as well as appropriate detail of service(s) rendered
- Documentation must support service codes used in claims
- Detailed progress notes for members
- Documentation must support number of units billed
- Full signatures with credentials and dates on all documentation
- Covered vs. non-covered services
  - Services provided/documented meet service definition for code billed
  - Progress notes are legible and amendments clearly marked

Documentation – Additional Tips

- Treatment plans should be reviewed and signed by clinician and patient and should be updated when necessary
- Activity and encounter logs should not be pre-signed
- Progress notes must be written after the group/individual session and completed before billing
- All entries should be in blue or black ink for handwritten notes, not pencil; no white-out
- Keep records secure and collected in one location for each member

Beacon's SIU Audit Process

- Lead received
- Lead reviewed and charts may be requested
- Providers required to supply copies of the charts requested within specified timeframes
- Charts will be reviewed by Beacon's staff
- After completion of the review, results letter will be sent to the provider

Beacon's Payment Integrity Audit Process

- Payment Integrity conducts retrospective reviews of claims and provider records to ensure billing, claims, and payment accuracy.
  - Beacon will review provider claims and records through progressive samples:
  - Beacon will start with an initial sample of claims
  - If significant documentation or billing errors are identified in the initial sample, Beacon will progress to an expanded sample of claims based on the size of population.
  - If there are significant billing errors, Beacon will progress to an on-site audit or self-audit of focused population.

Common Patient Record Errors Identified

- Patient record not submitted for audit
- Evaluation does not meet the documentation requirements
- Assessment does not meet the documentation requirement
- No consent to treatment form
- No release of information
- Patient name or identifier is not on all pages of patient record
- No documentation on the weekends for residential services

Common Treatment Plan Errors Identified

- Treatment plan is not submitted for the audit
- Treatment plan is invalid for date of service
- Treatment plan is not signed and dated by the patient, guardian, or agent
- Treatment plan is not signed and dated by the clinician
- Treatment plan does not have the required clinical elements
- Treatment plan review was not completed
- Treatment plan is illegible

Common Progress Note Errors Identified

- Progress note is not submitted for the audit or is for the wrong date of service
- Progress note is illegible
- Progress note is duplicative or similar to another progress note
- Progress note references that no services were rendered
- Progress note does not have a narrative to describe services
- Progress note does not have the required clinical requirements
- Progress note does meet the service code billed on claim
- Progress note does not include the start and stop times
- Progress note is overlapping another service or patient

Beacon's FWA Contact and Reporting Info

- Beacon's Safe to Say Compliance & Ethics Hotline

  - 888-293-3027

- Report concerns to your organization’s compliance office, Beacon directly, or via Beacon’s Ethics Hotline
  - Remember: you may report anonymously and retaliation is prohibited when you report a concern in good faith
  - Reporting all instances of suspected fraud, waste, and/or abuse is an expectation and responsibility for everyone
- If available, report to your state’s Medicaid Fraud and Abuse Control Unit (MFCU)

Laws Regulating FWA and Payment Integrity

- False Claims Act (FCA), 31 U.S.C. §§ 3729-3733
- Stark Law, Social Security Act, § 1877
- Anti-Kickback Statute, 41 U.S.C
- HIPAA, 45 CFR, Title II, § 201-250
- Deficit Reduction Act (DRA), Public Law No. 109-171, § 6032
- Care Programs, 42 U.S.C. § 1128B, 1320a-7b
- False Claims Whistleblower Employee Protection Act, 31 U.S.C. § 3730(h)
- Administrative Remedies for False Claims and Statements, 31 U.S.C. Chapter 8, § 3801

FWA and Payment Integrity Links

- Code of Federal Regulation:
  - TITLE 42-Public Health, Chapter IV-CMS, DHHS, SUBCHAPTER C-Medical Assistance Programs, Part 455-Program Integrity: Medicaid.
  - www.gpoaccess.gov/cfr/index.html
- Office of Inspector General (OIG):
  - www.oig.hhs.gov/fraud.asp
- *Center for Medicare and Medicaid Services (CMS):
  - www.cms.gov/MedicaidIntegrityProgram/
- National Association of Medicaid Fraud Control Units (NAMFCU):
  - www.namfcu.net/

Chapter

02

Company Overview

“We help people live their lives to the fullest potential.”

Our Commitment

Our mission drives our commitment to clients, members, and providers

We help people live their lives to the **fullest potential.**

Beacon offers expert guidance to solve behavioral health issues from the common to the complex

Beacon's Value Proposition

Clinical Innovation

Ensures access to high quality care and improves health outcomes

Beacon is singularly focused on behavioral health care, serving the full spectrum with specialization in high acuity populations

Broad Access to Quality Care

Elevates behavioral health care through national network of over 115,000 providers

We offer a multi-modal approach, with ability to guarantee access; Beacon Care Services delivers quality care in highest need communities

Value Driven

Offers proven clinical, administrative, and financial value across the delivery system

Beacon integrates behavioral and medical health services with a full range of clinical and operational capabilities to manage risk for specialty populations

Beacon At A Glance

Company Overview

- Beacon ensures access to high quality care and improves health outcomes for **~40M members nationwide**
- Four major product offerings:
  - Beacon Behavioral
  - Beacon Total Health
  - Beacon Wellbeing
  - Beacon Care Services

Beacon by the Numbers

~280 clients

Behavioral health specialty network of more than **115,000 providers across 50 states**

Nation's largest virtual care network with more than **1,000 state-licensed, board-certified therapists** nationwide

More than 4,700 employees, including ~1,000 licensed clinicians and 350+ clinicians co-located with clients

Chapter

03

Operational Areas

“We help people live their lives to the fullest potential.”

Our Commitment

Operational Areas: Network Strategy

- Provider Relations
  - Ensures members' behavioral health care needs are met through a geographically and clinically robust network of providers
  - Ensures maintenance of network composition by engaging in assertive retention strategies
  - Engages in timely and appropriate recruitment
  - Engages in professional, consistent, and educative communications with provider community and staff
- Contracting and Provider Quality Managers (PQMs)
  - Regionally-based Contracting Directors and Provider Quality Managers support facility and large group providers based on contract and location assignment

Operational Areas: Network Operations

- Practitioner Credentialing and Recredentialing
  - Completion of Credentialing and Contracting Materials is required for network consideration
    - Providers must participate with CAQH® (Council for Affordable Quality Healthcare)
    - Once credentialed, review and reattest to CAQH quarterly
  - For more information about CAQH:
    - Visit our Credentialing section under Administrative Forms
    - Visit the CAQH website at http://www.caqh.org

Operational Areas: Network Operations (cont'd.)

- Practitioner Recredentialing
  - Verify credentialing information every three years (or more frequently per state requirements)
  - Provide required supporting documentation such as current license, certification, and malpractice information
  - Beacon will send reminders at minimum:
    - If your CAQH Proview application is expired or missing information
    - If you are not currently registered with CAQH
    - Failure to provide required information within the recredentialing timeframe will result in disenrollment from the network

Operational Areas: Quality Management

- Medical Director oversees Quality Management Program
- Key Quality Indicators include but are not limited to:
  - Quality improvement activities/projects addressing HEDIS performance improvement
  - Quality analytics and reporting
  - Member satisfaction survey measures
  - Access/availability of services – geographic access, appointment availability, etc.
  - Complaints/Grievances – tracking, trending and reporting
  - Patient safety – adverse incidents and quality of care
  - Coordination of care/care integration
  - Accreditation (at select locations) by URAC & NCQA

Operational Areas: Quality Management

- Ongoing Quality Improvement Activities (QIAs)
  - Clinical QIAs
    - Improving Ambulatory Follow-Up following inpatient admission for mental health treatment
    - Improving initiation, engagement, and treatment for alcohol and substance use
    - Assuring accurate risk tracking – referral for urgent and emergent treatment
  - Service QIAs
    - Member satisfaction by improving customer service response
    - Provider satisfaction with utilization management

Operational Areas: Customer Service

1	Responds to routine claims, benefits, and eligibility questions via telephone, correspondence, and web inquiries
2	Responds to authorization and referral requests
3	Facilitates the resolution of complex claims issues
4	Responds to all administrative complaints and appeals via dedicated appeal and complaint departments
5	Provides education and assistance with processes and available resources

Operational Areas: Customer Service (cont'd)

- Committed to providing members and providers with the most accurate and informed benefit, eligibility, claims, and certification information in the most effective, efficient, and compassionate manner
- Puts member and provider needs and concerns first and is committed to resolving inquiries promptly without the need to make a re-contact
- Member and provider satisfaction is the heart of our Customer Service philosophy; we value questions and concerns raised by both members and providers

Operational Areas: Care Management and Referral Assistance

- Licensed care management staff is available 24/7 for referral and utilization management
  - Member referral process:
    - Emergencies are followed until disposition
    - Urgent referrals are offered appointments within 48 hours and are called to ensure appointment is kept
    - Providers should contact Beacon for referral assistance if needed
    - Providers should contact Beacon anytime (24/7) if members require higher level of care or increased visit frequency
    - Care management staff will assist with referral to inpatient or specialty programs
    - Self-referral: members can submit a request for care management

Operational Areas: Utilization Management

- Inpatient
  - Complete requests through our provider portal or telephonically by calling the number on the member's identification card
  - Some clients still require pre-authorization for higher levels of care – notification requirements may also vary
  - Beacon staff are available 24/7
- Outpatient
  - Since pass-through or registration no longer applies to outpatient services impacted by federal parity, authorization cannot be required
    - NOTE: Not all clients are subject to federal parity

Operational Areas: Utilization Management (cont'd)

- Outpatient care management will be conducted primarily through front-end claims or claims extracts, and will emphasize three areas:
  - Complex diagnosis
  - Intensive Care Management
  - Predictive Modeling
- Always verify benefits and authorization requirements for each member through our provider portal or by calling the number on the member's identification card

Care Coordination

- Facilitate the exchange of member information with PCPs to coordinate care
- Alleviate barriers by having the member complete an authorization to release information form and ensure smooth coordination of care
- Access Beacon's Authorization for Coordination of Behavioral Health care forms available on Beacon's website:
  - PCP Toolkit:
    - Behavioral Health and Primary Care Physician to share confidential information
    - Provider to Release Confidential Information to Beacon Health Options
    - Authorization to Release Confidential Information
  - Also located on our Administrative Forms page:
    - Authorization to Release Confidential Information (Spanish)

- All providers involved in medical and/or behavioral health care, including Primary Care Physician (PCP) treatment of a member, should coordinate the delivery of care
- All care coordination should be documented in the member treatment record
- Beacon's PCP Toolkit includes forms and helpful resources

Clinical Resources for Providers

- Clinical information on beaconhealthoptions.com
  - Beacon's Expertise page
  - Medical Necessity Criteria
  - Clinical Practice Guidelines
  - Stamp Out Stigma
  - Achieve Solutions®
  - Medication-Assisted Treatment (MAT) options
  - Project ECHO

Additional Clinical Resources for Providers

- Intensive Case Management Services
- Health Alert
  - Available through our provider portal
- Pharmacy program analyzes pharmacy data and uses automated rules engine to screen for:
    - Sub-optimal therapy
    - Under-use
    - Early discontinuation
    - Automatic notification to providers

Chapter

04

Projects, Programs and Initiatives

“We help people live their lives to the fullest potential.”

Our Commitment

Demographics and Appointment Availability

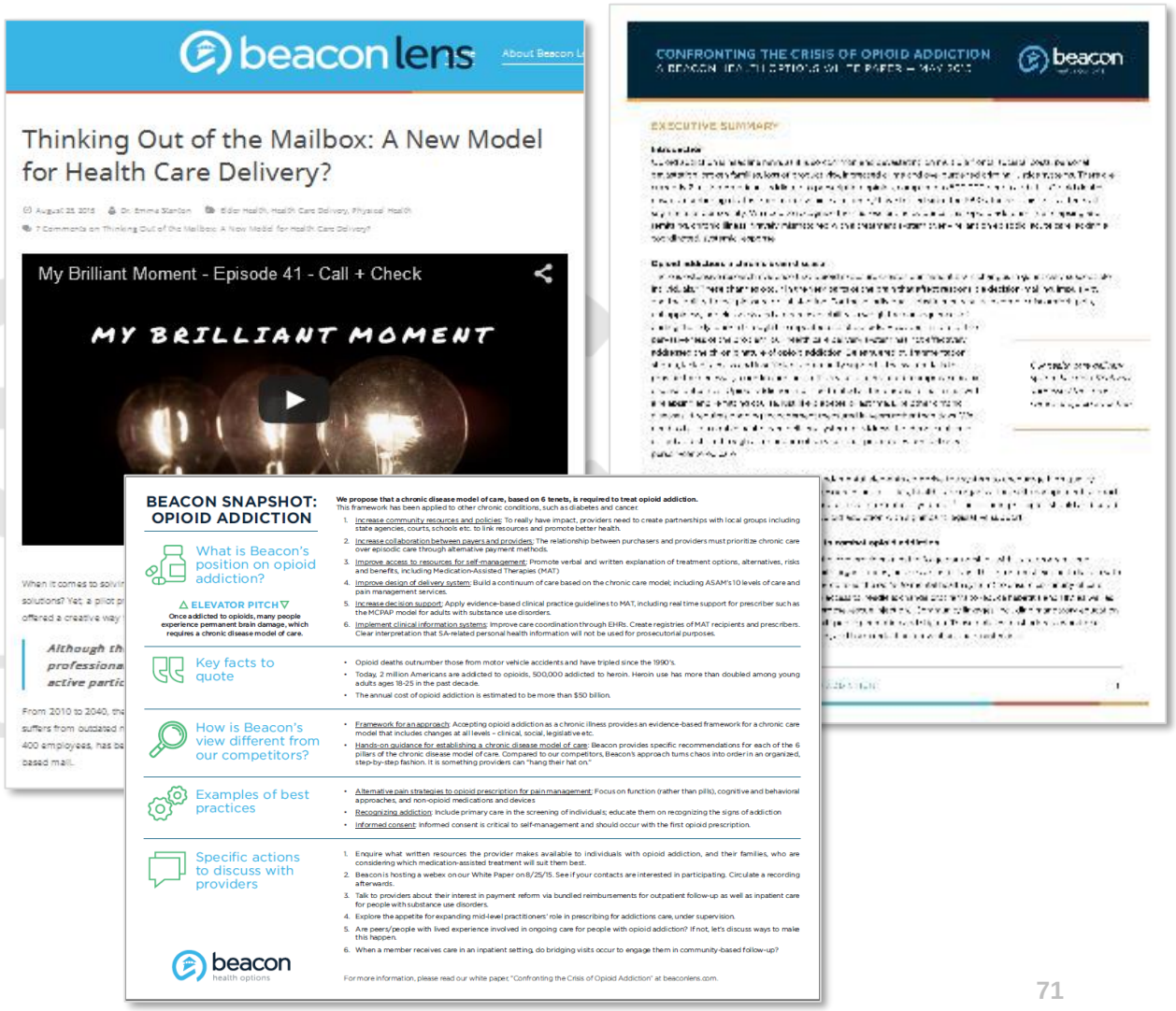
- In order to be compliant with CMS, state, and client requirements, we must ensure that all provider information is accurate for our network
- Various outreach methods include:
  - CAQH and Atlas Systems
  - Webinars
  - Video tutorials
  - Appointment availability surveys
  - Monthly provider newsletter articles
  - Periodic credentialing outreach
  - Quarterly demographic information review reminders

Claims Improvement: Tips for Success

- Ensure that correct information is included on all claims
- Submit claims electronically whenever possible
- If using a paper form, complete a valid CMS-1500 or UB-04 claim form as invalid or incomplete forms will be rejected
- Verify mailing address prior to sending paper correspondence
- Resources:
  - Providers: Claims Tips Sheets located under Administrative Forms
  - Members: Tips and sample claim forms located MemberConnect Forms
  - Claims Process Improvement Program, located under Important Tools
  - Direct claim submission: Required fields designated with an asterisk (*)
  - Batch claim submission: Follow Implementation and Companion Guides

Beacon Thought Leadership Activities

- Beacon Lens
- Beacon Expertise (website)
- White Papers
- Clinical Topics
- Beacon Expert Panels
- Academic Affiliations
- Stamp out Stigma

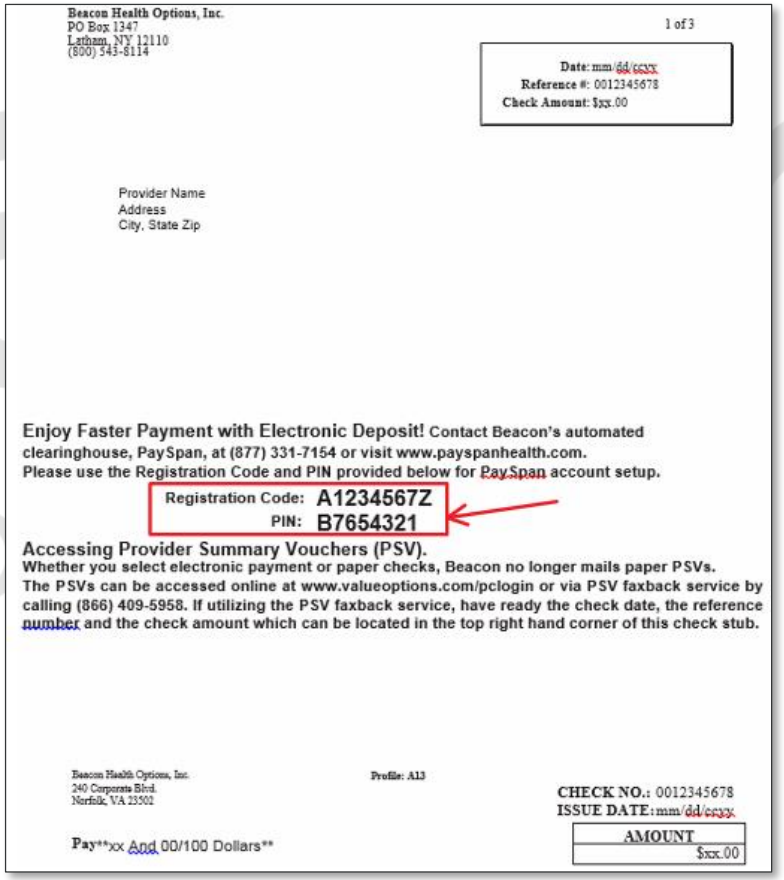


E-Commerce Initiative

- Providers in the Beacon network are strongly encouraged to electronically conduct all available routine transactions, including:
  - Submission of claims
  - Submission of authorization requests
  - Verification of eligibility inquiries
  - Electronic funds transfer through Payspan
  - Credentialing and demographic data maintenance through CAQH

PaySpan Required for EFT

- Providers must use PaySpan EFT for electronic payments and to view summary vouchers
- Benefits:
  - Receive payments automatically to bank account of choice
  - Email notifications immediately upon payment
  - View remittance advices online and download an 835 file to use for auto-posting purposes.
- To register, visit PayspanHealth.com or call 877-331-7154



Beacon Health Options, Inc.
PO Box 1347
Latham, NY 12110
(800) 543-8114

1 of 3

Date: mm/dd/ccyy
Reference #: 0012345678
Check Amount: $xx.00

Provider Name
Address
City, State Zip

Enjoy Faster Payment with Electronic Deposit! Contact Beacon's automated clearinghouse, PaySpan, at (877) 331-7154 or visit www.payspanhealth.com.
Please use the Registration Code and PIN provided below for PaySpan account setup.

Registration Code: A1234567Z
PIN: B7654321

Accessing Provider Summary Vouchers (PSV).
Whether you select electronic payment or paper checks, Beacon no longer mails paper PSVs.
The PSVs can be accessed online at www.valueoptions.com/pclogin or via PSV faxback service by calling (866) 409-5958. If utilizing the PSV faxback service, have ready the check date, the reference number and the check amount which can be located in the top right hand corner of this check stub.

Beacon Health Options, Inc.
240 Corporate Blvd.
Norfolk, VA 23502

Profile: A13

CHECK NO.: 0012345678
ISSUE DATE: mm/dd/ccyy

Pay**xx And 00/100 Dollars**

AMOUNT
$xx.00

Chapter

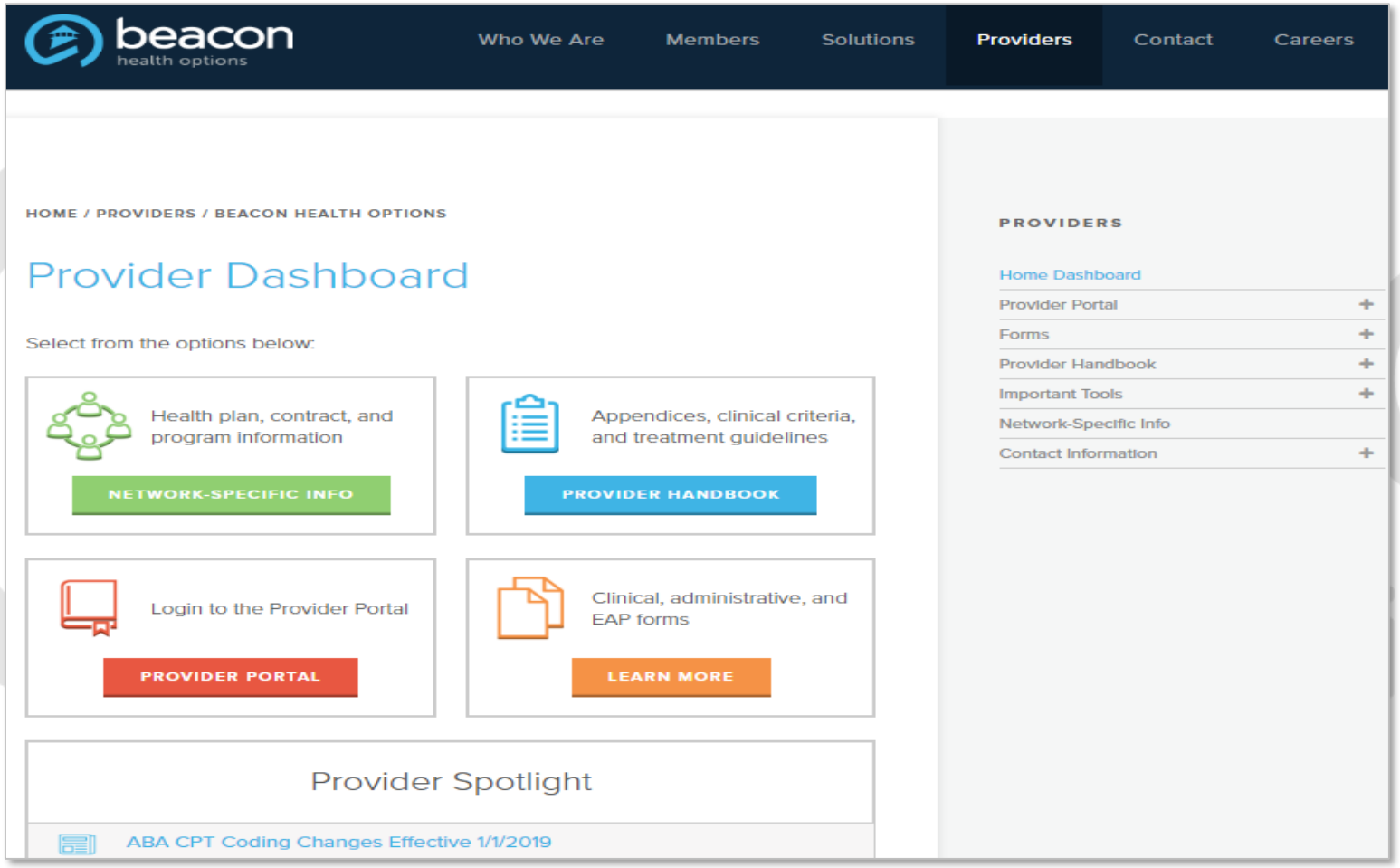
05

“We help people live their lives to the fullest potential.”

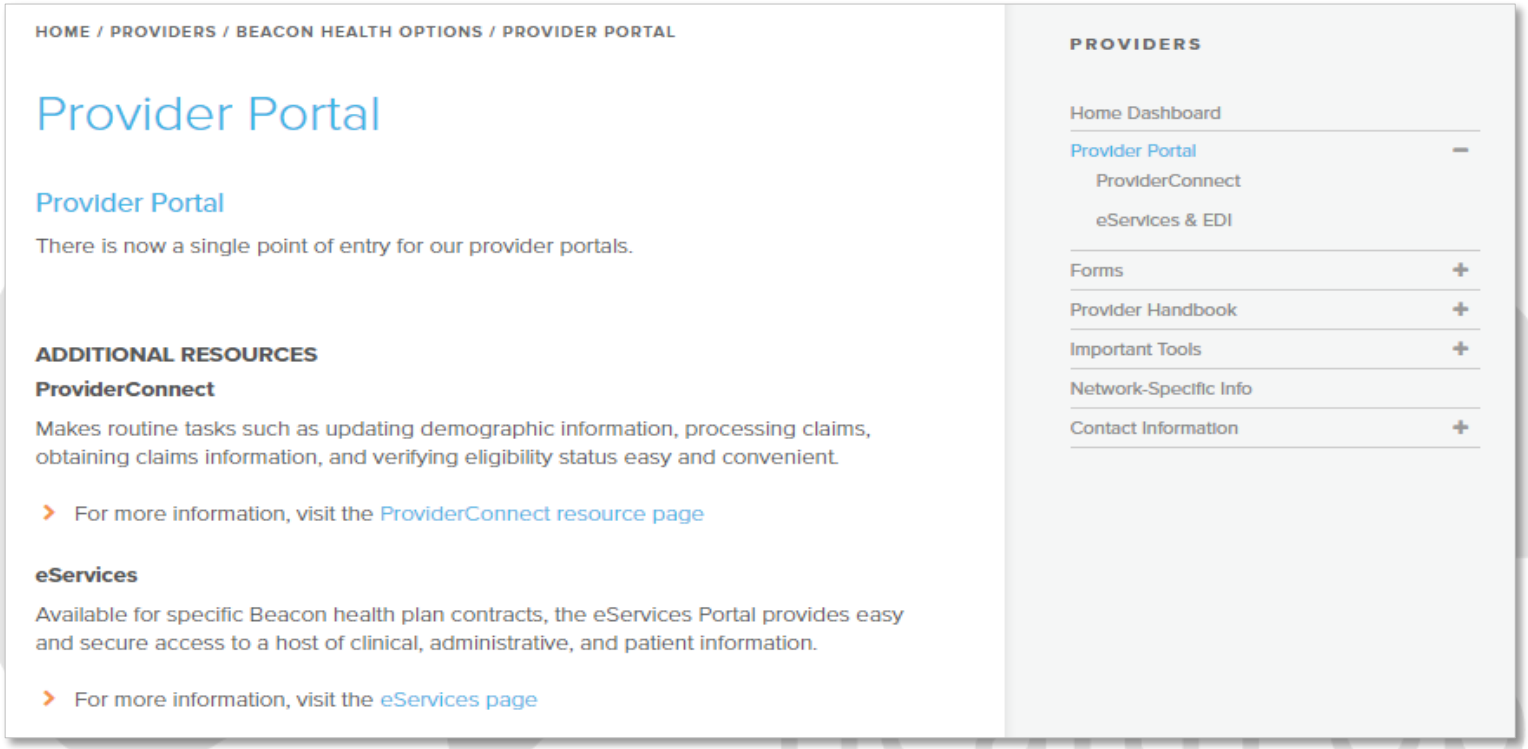
Our Commitment

Electronic Resources: Overview of ProviderConnect and eServices

Electronic Resources

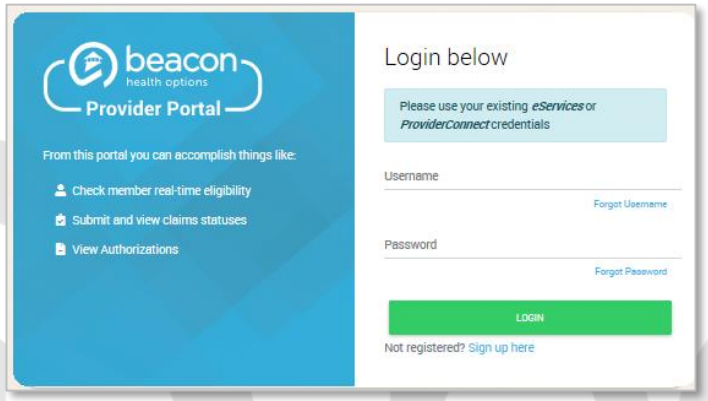


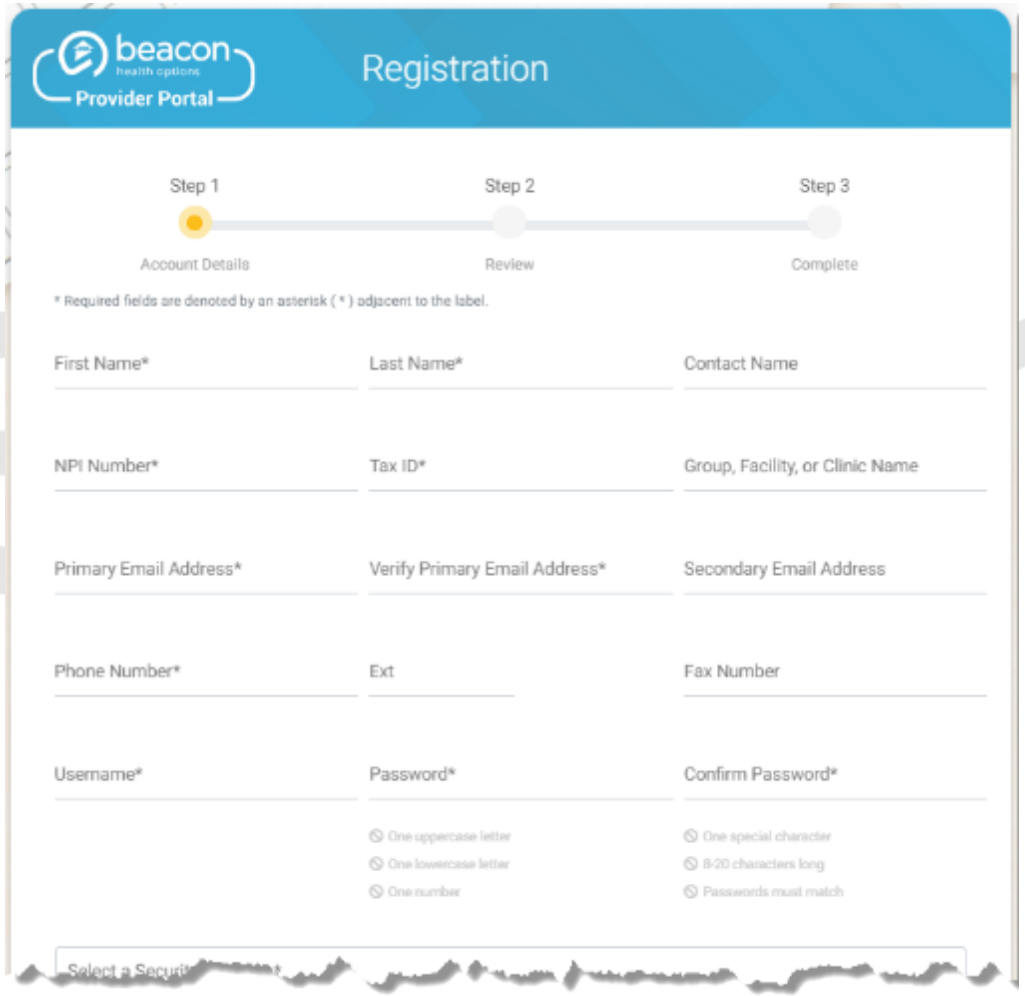
Electronic Resources: Provider Portals



- As we improve the provider experience, we are creating a unified provider portal
- Resources are located under Provider Portal

Other Features





- Existing User?

  Login with your existing eServices or ProviderConnect credentials

- New User?

  Click Sign Up Here to register online!

Overview of ProviderConnect

Services

• Verify member benefits and eligibility	• View and print forms
• Request and view authorizations	• Download and print authorization letters
• Submit claims and view status	• Access Provider Summary Vouchers
• Request payment for EAP services	• Submit EAP case activity forms (CAF)
• Update demographic information	• Submit credentialing applications
• Submit customer service inquiries	• ProviderConnect message center
• Practices can appoint an administrator, or Super User, to maintain and manage larger ProviderConnect accounts	

Claim Submission

- Accepts claims files from any Practice Management System outputting HIPAA formatted 837p or 837i batch files, and from EDI claims submission vendors
- Offers Direct Claims Submission on website for providers who do not have own software or who wish to submit certain claims outside their batch files
  - These claims are processed immediately and you are provided the claim number
  - You may submit batch claims files or Direct Claims interchangeably
- No charge for electronic claims submission
- Access to support:
  - https://www.beaconhealthoptions.com/providers/beacon/providerconnect
  - EDI Helpdesk: 888-247-9311 between 8 a.m.-6 p.m. ET

ProviderConnect Resources

- ProviderConnect Helpful Resources and Demo
- How-to video tutorials
- Training
  - Webinars scheduled monthly or training as needed
    - Topics include: Authorizations, Claim Submission, Tips and Tricks
  - Additional webinars may also be offered for particular contracts, so visit your appropriate Network Specific pages

Overview of eServices

eServices

What is eServices?

This is an additional provider portal used for specific Beacon health plan business. It is also a free platform offered to all contracted and in-network providers. The goal of using eServices is to make clinical, administrative, and claims transactions **easy** to do. By utilizing eServices you will be able to perform the following:

- Submit claims and outpatient services requests (when needed)
- Verify member eligibility
- Confirm outpatient services status
- Check claim status
- Update and edit provider site information
- View claims performance information
- Access to provider manuals, forms, bulletins and mailings
- View or print frequently asked questions (FAQs)

eServices Resources

- Training
  - Webinars scheduled monthly or training as needed
  - Additional webinars may also be offered for particular contracts, and email invitations are sent when those are available

Chapter

06

Communicating with Beacon Health Options

“We help people live their lives to the fullest potential.”

Our Commitment

Communication Channels

- Email Alerts and Bulletins
- Webinars
- Video Tutorials
- Monthly Valued Provider eNewsletter
- Provider Pulse^{SM} Messages
- Fax Communications
- Provider Mailings

Contact Information

	Beacon Health Strategies	Beacon Health Options
Website and EDI	**EDI Helpdesk** Monday through Friday, 8 a.m.-6 p.m. ET Phone: 888-247-9311 e-supportservices@beaconhealthoptions.com	
PaySpan	**Payspan Registration Provider Support** Monday through Friday, 8 a.m. – 8 p.m. ET Phone: 877-331-7154 providersupport@payspanhealth.com	Unable to locate your registration code? Email: corporatefinance@beaconhealthoptions.com Reply will be received within three business days
Credentialing and Contracting	**National Provider Services Line** Monday through Friday, 8 a.m.-8 p.m. ET Phone: 800-397-1630 Regional Provider Relations Team	

Thank You

Contact Us

Questions