# ProviderConnect User Guide

This document is confidential and proprietary to Beacon Health Options.

# Revision History

Click on the link for the revision that you want. Although every effort is made to keep the links current, users should consult the Table of Contents if a particular link does not work. Note that the revision history encompasses a maximum of three years.

| Last Revised Date | Revised By | Revisions |
|---|---|---|
| 01/17 | L. Finta | Updates from 12/16/16 release:<br>• New Warn and Restrict Access to ProviderConnect When Attestation Is Due chapter added<br>• New *Invalidate a Service Location* section added to Chapter 23, Update Demographic Information |
| 06/17 | L. Finta | Updates from 6/23/17 release:<br>• New ABA Availability Survey link added to the Navigation Bar<br>• New PCP fields added to the IP/HLOC Inpatient Treatment Report (ITR2) form<br>• New PCP fields added to the Notification form |
| 06/17 | L. Finta | Login instructions updated |
| 09/17 | L. Finta | Updates from 9/22/17 release – Enter an ABA Authorization Request chapter modified |
| 03/18 | L. Finta | Updates from 3/2/18 off-cycle release – New Primary Care Provider tab added to Chapter 7, Access Member Information |
| 12/18 | L. Finta | Updated Log in to ProviderConnect instructions (includes Forgot Username & Forgot Password) Updated New User Registration Information |
| 04/19 | L. Finta | Updates from 3/22/19 release:<br>• ProviderConnect Navigation chapter updated<br>• New Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge chapter added |
| 06/19 | L. Finta | Updates from 6/21/19 release – Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge chapter modified; Figure 75 in chapter 16 replaced |
| 3/20 | L. Laurino | Updates from 12/13/19 release – Replaced Figure 30 in Chapter 8 to include new verbiage and ORP Supervising First/Last Name |

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# 1 Introduction

## ProviderConnect Overview

ProviderConnect is an easy-to-use online application that providers can use to complete everyday service requests. Providers have the ability to access information 24 hours a day/7 days a week.

Providers can use ProviderConnect to:
- Obtain information about member eligibility and benefit status
- Enter authorization/notification requests
- Search claims and authorizations
- View and print correspondence
- Access and update practice profiles
- Submit EDI claims and inquiries to the Beacon Customer Service Department
- Send messages to and receive messages from Beacon
- Send messages to and receive messages from members
- Attach documents

In addition, ProviderConnect contains links to other resources such as:
- Compliance
- Provider Handbook
- Forms
- Network Specific Information

## User Guide Overview

After reading this guide, users will be able to:
- Understand the basic navigational system flow
- Access and register a provider
- Search member information
- Search claims
- Enter an authorization/notification request
- Enter a claim
- Update a provider profile
- Verify eligibility and benefit status
- Submit an EDI claim
- Obtain applicable forms

## Contact Information

If you have any questions or need further clarification about the subject matter, please contact National IT Training at ITtrainingrequests@beaconhealthoptions.com or visit the Learning and Development page on Navigator.

## Before You Begin

Before using this guide please take note of the following:

- A **Note** graphic showing in the margin signifies a freestanding user note.

- Important things to remember are indicated with a 🖐 symbol.

- Hyperlinks look like this: Sample Link

- **Things like button, field, checkbox, icon, and tab names look like this.**

- Screen captures are examples only.

- The workflows presented here represent one possible scenario. Workflows may vary in practice depending on a particular user's circumstances.

# 2 Accessing ProviderConnect

## Log in to ProviderConnect

To log in to ProviderConnect:
1. Access the following URL: www.beaconhealthoptions.com

The Beacon Health Options home page displays.

2. Click the Beacon Health Options Providers link on the **Providers** tab.

The Provider Dashboard displays.

3. Click on the Provider Portal link.
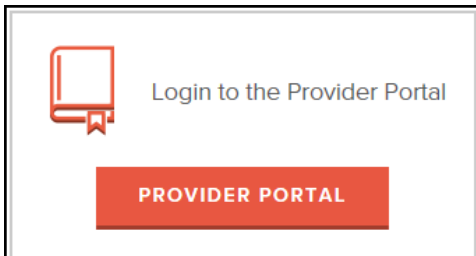


The following screen displays.
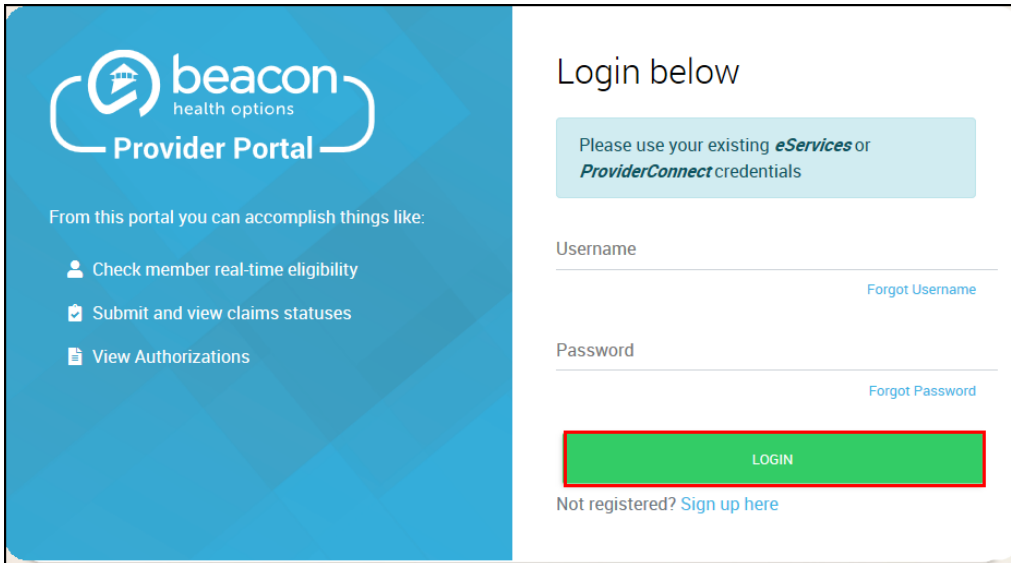
Figure 1: Provider Portal Login Screen

4. Enter your username and password.
5. Click **Login**.
6. Carefully read the Use Agreement and click **Continue**.
7. Select from the list of available plans if applicable and click **Go**.
8. Carefully read the ProviderConnect Use Agreement and select **I Agree**.

| Note | *ProviderConnect allows submitters belonging to providers with the same NPI# to use a single login to access multiple accounts.* |
|------|---|

⚠ Refer to the [Warn and Restrict Access to ProviderConnect When Attestation Is Due](#) chapter for important information.

## Forgot Username

Click on the Forgot Username link if you have forgotten your user name. The following screen displays.
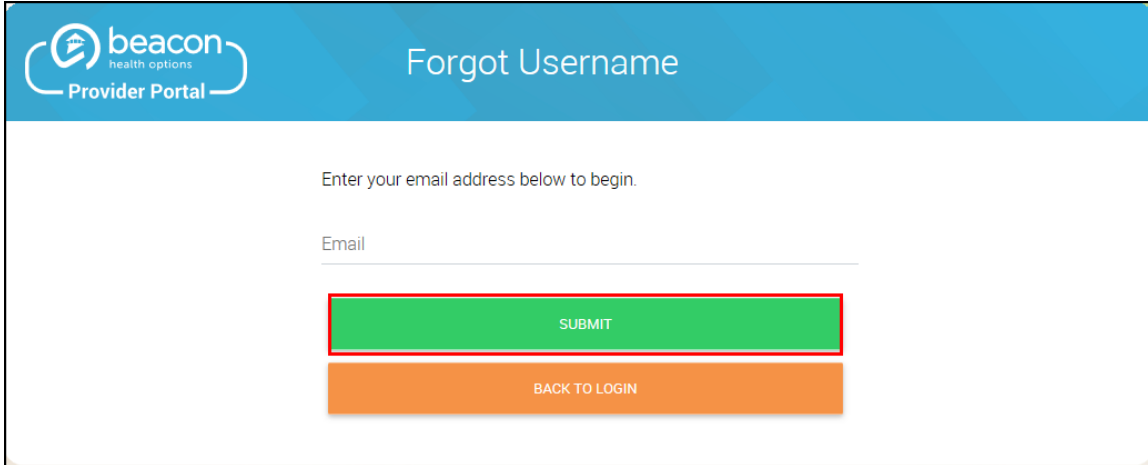


Figure 2: Forgot Username?

Enter your e-mail address and click **Submit**. You will receive an e-mail message containing your user name at the e-mail address on record.

## Forgot Password

Click on the Forgot Password link if you have forgotten your password. The following screen displays.
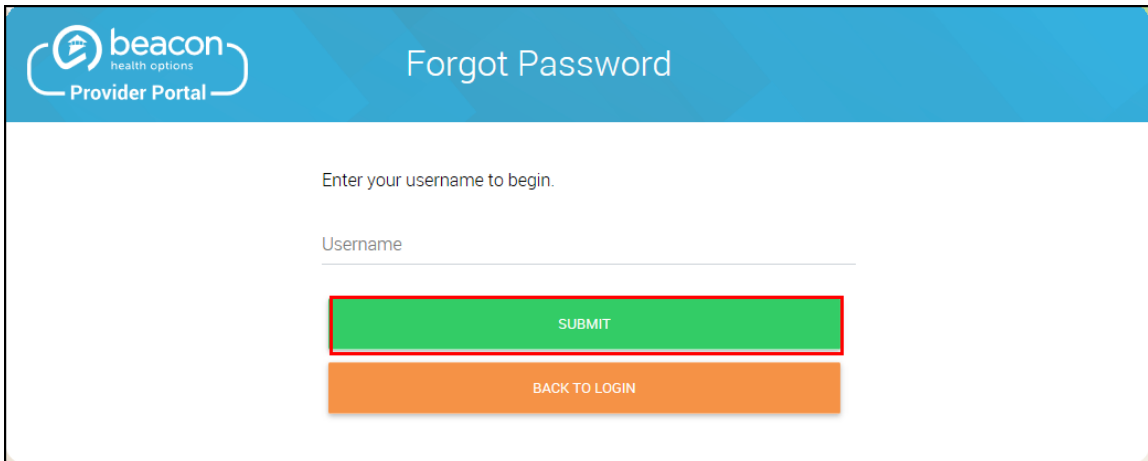


Figure 3: Forgot Password?

Enter your username and click **Submit**. You will receive an e-mail message containing password reset instructions at the e-mail address on record.

# New User Registration

New users must register in order to access ProviderConnect. To register, click on Sign up here.
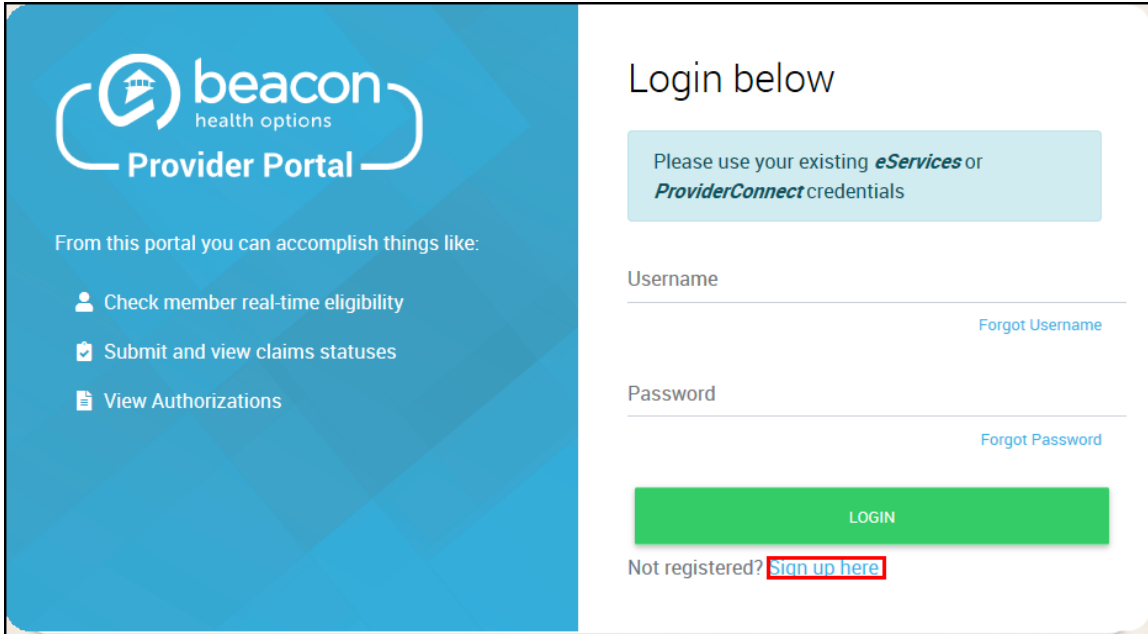


Figure 4: New User Registration

Complete the following information on the Registration page.

*An asterisk (\*) indicates a required field.*

1. Enter the provider's first and last names in the **First Name** and **Last Name** fields.
2. Enter a contact name in the **Contact Name** field.
3. Enter the provider number in the **NPI Number** field.
4. Enter the provider's nine-digit Federal ID or Social Security Number in the **Tax ID** field.
5. Enter the provider's group, facility, or clinic name if applicable.
6. Enter the provider's primary e-mail address in the **Primary Email Address** field.
   *Note: E-mail addresses must be formatted as name@company.com.*
7. Enter the same e-mail address in the **Verify Primary Email Address** field.
8. Enter the provider's secondary e-mail address in the **Secondary Email Address** field.
   *Note: E-mail addresses must be formatted as name@company.com.*
9. Enter a ten-digit phone number in the **Phone Number** field, omitting dashes.
10. Enter an extension in the **Ext** field.
11. Enter a ten-digit fax number in the **Fax Number** field, omitting dashes.
12. Enter a user name in the **Username** field.

13. Enter a password in the **Password** field. (See: Password Change Rules)

*Note: Passwords cannot contain spaces and are case-sensitive.*

- Passwords must contain at least:
  - One uppercase letter (A-Z),
  - One lowercase letter (a-z),
  - One number (0-9), and
  - One of the following special characters:

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- Passwords must be between 8 and 20 characters in length.

14. Enter the same password in the **Confirm Password** field.
15. Select a security question.

16. Enter the answer to the security question.
17. Confirm the answer to the security question.
18. Click **Next**.
19. Review the registration details and click **Complete Registration**.

The Additional Information page displays.

20. Select the **Would you like to be able to Submit Claims?** checkbox if applicable. (See: Account Request Form)
21. Select the **Message Center?** checkbox if you want to be able to send and receive messages. (See: Your Message Center)
22. Click **Continue**.

The Use Agreement page displays.

23. Check the box to confirm that you have read and agree to the Use Agreement and click **Continue**.

# Password Change Rules

Users are required to change their passwords every 90 days. A Password Expired page is available that allows a user to change an expired password. The **Submit** and **Cancel** buttons on this page allow the user to either create a new password or cancel the password change.

When a user attempts to update an expired password, the system prohibits "recent" password reuse by not allowing the last 10 passwords to be reused. If a user enters a password that is one of the last 10 passwords used (includes password case-sensitivity), an appropriate error message displays.

## Account Request Form

Upon clicking **Would you like to be able to Submit Claims?** and clicking **Continue**, the Use Agreement page displays. Upon agreeing, the Account Request Form displays. The following fields display on this form.

*A red asterisk (\*) indicates a required field.*

- Provider Name (pre-populated)
- NPI Number (pre-populated)
- Tax ID (pre-populated)
- Provider Group, Facility or Clinic Name (pre-populated if entered)
- Online Provider Services Options
  - Electronic Batch Claims Submission (837 HIPAA format)
  - Military OneSource Case Activity Form
  - Direct Claims Submission

- Provider has retained a 3rd party Billing Agent or Clearinghouse to submit claims on their behalf. (Yes/No)

### Claim Operation Center

The user is required to select a Claim Operation Center and one of the following options.

- Yes (Medicaid)
- No (Commercial Only)
- Both (Medicaid and Commercial)

The user also needs to enter the e-mail address where he/she would like to receive batch submission file feedback if applicable and the provider contact name.

## Attestation Page

Upon clicking **Next**, the Attestation page displays pre-populated with the information from the Account Request Form. The user must attest to one of the following:

- I am a provider.
  *-or-*
- I am office staff of a provider, and am authorized to sign on their behalf.

The following options are available.

- Electronically sign the attestation
- Manually sign and fax the attestation

### Electronically Sign the Attestation

To electronically sign the attestation, click on <u>Click here to sign this document electronically</u>. The <u>Welcome to the Claims e-Signature Process</u> page displays.

### Manually Sign and Fax the Attestation

To manually sign and fax the attestation, select the **Check here if you intend to fax the Attestation form** checkbox. (After indicating their intention to fax the form, users should print the document *prior to saving.*)

*Note*

This action enables the **Continue to ProviderConnect** button.

### Welcome to the Claims e-Signature Process

Once on the Welcome to the Claims e-Signature Process page, the user should review the steps to apply an electronic signature and then:

1. Enter his or her full name.
2. Click **Submit**.

The US Federal Consumer Disclosure – E-Sign Act page displays.

3. Carefully read the information on this page.
4. Click on <u>Yes</u> to signify consent to complete and sign the document electronically. The Signer Information page displays.
5. Enter the user's name to apply to the attestation document.
   *Note: Users should enter their name as they would normally write it when signing a paper document, using upper and lower case letters as appropriate.*
6. Click the **Submit** button to display the e-Claims Agreement Terms.
   *Note: The applicant's name and application date pre-populate.*
7. Click in the highlighted **Click Here to Sign** area to electronically sign the document. A Thank You page displays stating that the document has been successfully signed and the user role changed to general claims user.
8. Follow the instructions to download a copy of the document and save it to a local or network drive.

9. Click **Continue to ProviderConnect** to continue to the ProviderConnect home page.

## Access Information without Logging On

A number of features are available to providers on the ProviderConnect page (https://www.beaconhealthoptions.com/providers/beacon/providerconnect/) without them having to log in. Examples include:

- Forms – Administrative, Clinical, and EAP forms specific to Beacon Health Options
- Provider Handbook – Beacon's policies and procedures
- Important Tools
- Network-Specific Information – Program-specific handbooks, forms, etc., unique to a particular network
- Contact Information
- Compliance – Federal and state-specific program requirements for maintaining HIPAA-compliant claims submission
- EDI (Electronic Data Interchange) Claims Link for Windows®

# 3 Warn and Restrict Access to ProviderConnect When Attestation Is Due

As part of the user login, the system checks to see whether ProviderConnect is permitted to make a call to a special NetworkConnect service that identifies providers who are due for demographic attestation. If the system determines that ProviderConnect should call the service, the call is initiated by passing information like the submitter ID and provider ID. (This occurs during provider login and when switching accounts.)

ProviderConnect reads the response from the service to determine whether to display a warning message to the provider.
- If the response indicates the provider is not yet due for attestation, the provider is not warned nor restricted.
- If the response indicates the provider should be warned, ProviderConnect displays a warning message on the Use Agreement page.
- If the response indicates the provider's account should be locked, ProviderConnect displays a warning message on the Use Agreement page and restricts the provider to all but the Update Demographic Information feature.

*If the service fails to respond, ProviderConnect logs the provider in without checking his/her attestation status.*

## Display Warning Message

The following message displays on the Use Agreement page following the Message from Webpage and Message Center pop-ups if the response from the service indicates the provider needs to be warned: "Please review your demographic information and provide attestation in the Provider Demographics page. Your demographic information attestation is due by MM-DD-YYYY for Provider ID XXXXXX. Please verify your information by this date to continue using ProviderConnect. You will have restricted access to ProviderConnect, if you do not attest by this date."

- *MM-DD-YYYY is replaced with the actual due date.*
- *Provider ID XXXXXX is replaced with the actual provider ID.*

## Update Provider Demographics / Continue with ProviderConnect

The following buttons display on the warning message pop-up.

- **Update Provider Demographics** – Redirects the user to the Provider Demographics page.
- **Continue with ProviderConnect** – Redirects the user to the ProviderConnect home page.

## Restrict User Access

The above warning message also displays for those providers whose accounts should be locked according to the response received from the service. In addition, the following message displays on the ProviderConnect home page: "Your access is restricted because Provider ID XXXXXX is due for attestation and you will not be able to use all functionalities available in ProviderConnect. Please click on "Update Demographic Information" link to review and provide attestation. Access to ProviderConnect will be restored once you provide your attestation."

| Note | *Provider ID XXXXXX is replaced with the actual provider ID.* |
|------|--------------------------------------------------------------|

# 4 ProviderConnect Navigation

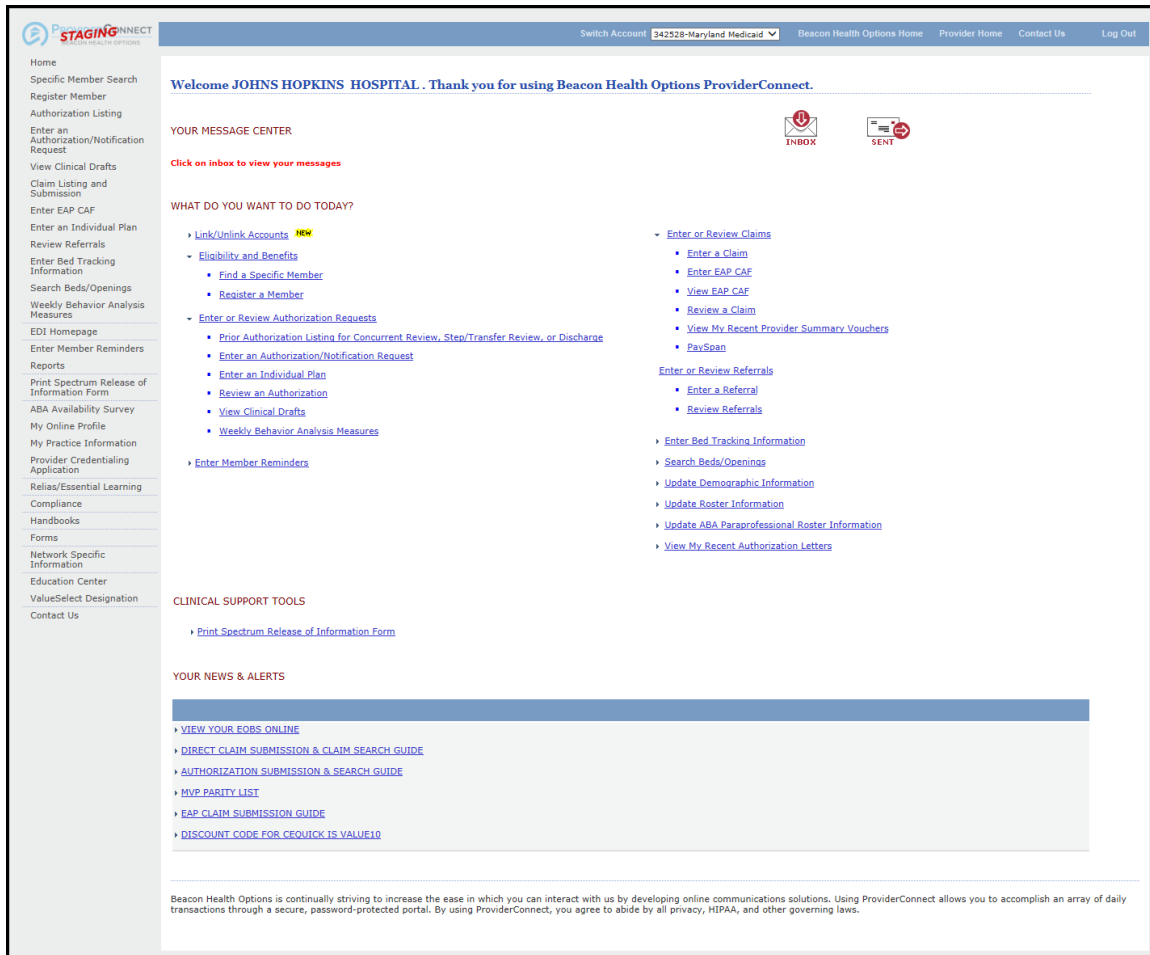Users have the ability to navigate ProviderConnect via the main menu or the navigation bar.



Figure 5: ProviderConnect Home Page Example

# Main Menu

A user can access a specific section by clicking the appropriate link on the ProviderConnect main menu. The main menu contains the following options.

- Link/Unlink Accounts – Works in conjunction with the **Switch Account** field. The **Switch Account** field displays all the submitters linked to the logged in ID. (This field defaults to the logged in account regardless of whether or not the submitter has any linked accounts.) The Link/Unlink Accounts feature allows the user to link or unlink accounts as needed.
- Eligibility and Benefits
  - Find a Specific Member
  - Register a Member
- Enter or Review Claims
  - Enter EAP CAF
  - Enter a Claim
  - Review a Claim
  - View My Recent Provider Summary Vouchers
  - PaySpan – Allows providers to directly access the PaySpan website to retrieve Explanation of Benefits (EOBs) and receive any payments that were submitted electronically.

    *Note: The provider must have the appropriate role.*
- Enter or Review Authorization Requests
  - Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge
  - Enter an Authorization/Notification Request
  - Enter an Individual Plan
  - Review an Authorization
  - View Clinical Drafts
  - Weekly ABA Measures
- Enter or Review Referrals
  - Enter a Referral
  - Review Referrals
- Enter Member Reminders
- Enter Case Management Referral
- Enter Bed Tracking Information
- Search Beds/Openings
- Update Demographic Information
- Update Roster Information
- Update ABA Paraprofessional Roster Information
- View My Recent Authorization Letters
- Print Spectrum Release of Information Form

# Navigation Bar

A user can access a specific section by clicking the appropriate link on the navigation bar. The options are alphabetized here for ease of use.

- Authorization Listing
- ABA Availability Survey

  *Note: Provider must have the appropriate user security role along with an active contract that has been set up to use this survey. If not, an error message displays.*

- Claim Listing and Submission
- Complete Provider Forms
- Compliance
- Contact Us
- EDI Homepage
- Education Center
- Enter a Comprehensive Service Plan
- Enter a Referral
- Enter a Special Program Application
- Enter a Treatment Plan
- Enter an Authorization/Notification Request
- Enter an Individual Plan
- Enter Bed Tracking Information
- Enter Case Management Referral
- Enter EAP CAF
- Enter Member Reminders
- Forms
- Handbooks
- Home
- Manage Users (Restricted to users with "super user" status)
- My Online Profile
- My Practice Information
- Network Specific Information
- On Track Outcomes
- Performance Report
- Print Spectrum Release of Information Form
- Provider Data Sheet (Facility Data Sheet)
- Provider Data Verification (Available only for DMH providers)
- Register Member
- Reports
- Request for Care
- Review Referrals
- Search Beds/Openings
- Special Application

- Specific Member Search
- ValueSelect Designation
- View Clinical Drafts
- View EOBs
- Weekly ABA Measures

## Clinical Support Tools

- View My Outcomes with On Track

## News & Alerts

A *News & Alerts* section is also located on the home page. This section displays information disseminated by Beacon Health Options. Providers can view this information by clicking on the links.

## Your Message Center

A *Your Message Center* is available that provides a secure message center to ensure confidentiality and to comply with HIPAA requirements. Providers can send messages to and receive messages from Beacon. Providers can also send messages to and receive messages from members. (Refer to the [Secure Provider/Member Communications](#) chapter for more information.)

To view the Inbox, click the **Inbox** icon. The Message Center – Inbox page displays.
- If there are no messages in the provider's Inbox, the following message displays: "*Your Inbox is empty.*"
- If there are messages in the provider's Inbox, the following message displays: "*Click on Inbox to view your messages.*"

*All messages in the provider's Inbox, including messages from Beacon, are available for viewing until the provider deletes them.*

To view Sent items, click the **Sent** icon. The Message Center – Sent page displays.

*All messages in the provider's Sent Messages, including inquiries and replies sent to Beacon, are available for viewing until the provider deletes them.*

# 5 Secure Provider/Member Communications

ProviderConnect offers providers a secure method of electronic communication between themselves and the member. This chapter focuses on that functionality.

## Enable/Disable Communication with All Members

Providers have the ability to either enable or disable communication with all members. A **Use ProviderConnect Message Center to communicate with members? (Yes/No)** field is available in the online profile for that purpose. (Refer to the My Online Profile chapter for more information.)

- **Yes** – Enables Message Center communication functionality between the provider and all members that the provider has not expressly excluded.
- **No** – Disables Message Center communication functionality between the provider and all members.

## Enable/Disable Communication with Individual Members

Providers have the ability to either enable or disable communication with individual members.

- **Enable Communication** – Communication with an individual member is automatically enabled when the provider opts in to the communication functionality *if* the member in question has also opted in to the communication functionality and has not disabled communication with that provider.
- **Disable Communication** –
  - If the provider has opted in to the communication functionality and communication with a member is enabled, the Message Details page displays a **Disable Communication** button that allows the provider to disable communication with that one member. (To disable communication with all members the provider would need to update his/her online profile.)

    *If the provider has disabled communication with a member after receiving a message from that member, the Message Details page displays an **Enable Communication** button if the provider has opted in to the communication functionality.*

    If the provider has opted in to the communication functionality and communication with a member is enabled, the Member Demographics page displays a **Disable Member Communication** button. This button functions in the same manner as the **Disable Communication** button.

    *If the provider has disabled communication with a member, the Member Demographics page displays an **Enable Member Communication** button.*

## Send Messages to Members

Providers have the ability to send messages to members via the Member Demographics page. A provider may initiate communication with a member upon executing a successful search for that member. (The member in question must have opted in to the communication functionality.)

A read-only **Member Participates in Message Center Communication with Providers? (Yes/No)** field displays on the Member Demographics page.
- Displays as **Yes** if –
  - The member is an active MemberConnect user, and
  - The member has opted in to the communication functionality, and
  - The member has not disabled communication with that provider.
- Displays as **No** if –
  - The member is not an active MemberConnect user, or
  - The member has opted out of the communication functionality, or
  - The member has disabled communication with that provider.

A **Send Message to Member** button also displays on this page if all the following conditions have been met.
- The provider has the appropriate role assignment, and
- The provider has opted in to the communication function, and
- The provider has not disabled communication with that member, and
- The member has not disabled communication with that provider.

Upon clicking Send Message to Member, the system displays the Send Message to Member page.

## Receive Messages from Members

Providers have the ability to receive messages from members. A provider can receive messages from a member if both the following conditions have been met.
- The provider has opted in to the communication functionality, and
- The provider has not disabled communication with that member.

## Reply to Messages from Members

Providers have the ability to reply to messages received from members. The Message Details page for member messages contains a message reply section that is similar to the message reply section for Beacon Health Options messages.

## View Messages Exchanged with Members

Providers have the ability to view messages sent to members. The system automatically displays all messages and message replies sent to a member in the provider's Message Center Sent Messages. Upon selecting a specific message, a Sent Message Details page displays.

Providers can also view messages received from members. The system automatically displays all messages received from a member in the provider's Message Center Inbox. Upon selecting a specific message, a Message Details page displays.

## Print Messages Exchanged with Members

Providers have the ability to print messages and message replies sent to members. The Sent Message Details page contains a **Print** button for that purpose.

Providers can also print messages received from members. The Message Details page contains a **Print** button for that purpose.

## Receive New Messages Notifications

Providers have the ability to be automatically alerted when new messages arrive in their Message Center Inbox. The system automatically sends an e-mail notification to the provider whenever a new system-generated or member message arrives in his/her Inbox if the provider has enabled the e-mail notification functionality.

## Send New Messages Notifications

The system automatically sends an e-mail notification to the member whenever a new system-generated or provider message is sent to his/her Inbox if the member has answered **Yes** to the **Receive Email Notification Of New Message Center Messages?** question in the MemberConnect online profile.

# 6 EDI Homepage

The EDI Homepage allows users to access the EDI Transactions page. A user can submit batch files; search files; view previous claims; and view, download, and delete files from within this section.

*Beacon can also accommodate batch claims processed via a clearinghouse. If you currently use a clearinghouse, please provide them with Beacon's payer ID: FHC & Affiliates.*

## Submit a Batch File

To submit a batch file, click the EDI Homepage link on the navigation bar. The EDI Transactions page displays.



**EDI Transactions**

**Batch Submission.** To submit files, select the "Submit Batch File" button below.

**Search Files.** To find and review the status of submitted files, select the "Search Files" button below.

Submit Batch File     Search Files

*Note: In order to activate your Provider account, please complete the Account Request Form and return it to ValueOptions.
**Signature must be on file.

**Previous Claims File Batch Submissions**

| Submission # | Result | Date Received | Form # |
|---|---|---|---|
| 0119126370 | Failed Validation | Mon Sep 12 09:53:57 EDT 2011 | 837i |
| 0119126369 | Failed Validation | Mon Sep 12 09:53:54 EDT 2011 | 837i |
| 0119126368 | Failed Validation | Mon Sep 12 09:53:52 EDT 2011 | 837i |
| 0119126367 | Failed Validation | Mon Sep 12 09:53:46 EDT 2011 | 837i |
| 0119126366 | Failed Validation | Mon Sep 12 09:53:44 EDT 2011 | 837i |
| 0119126365 | Failed Validation | Mon Sep 12 09:53:33 EDT 2011 | 837i |

Figure 6: EDI Transactions

Click the Submit Batch File link on the navigation bar or click the **Submit Batch File** button on the EDI Transactions page.

The Submit Batch File –Step 1 of 4 page displays.

# Complete Four Pages

The following four pages must be completed in order to submit a batch file.

On the Submit Batch File –Step 1 of 4 page, select the required form from the **Form Type** drop-down and click **Next**.
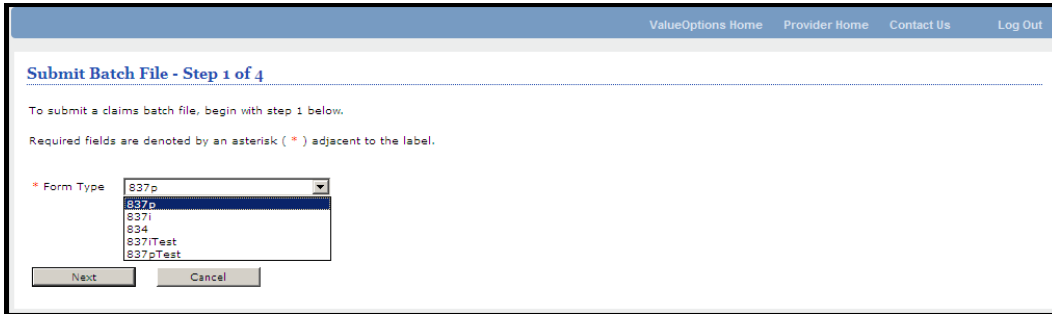


Figure 7: Step 1 of 4

On the Submit Batch File – Step 2 of 4 page:
1. Enter the number of claims in the file in the **How many claims are in this file** field.
2. Enter the total dollar amount of all the claims submitted in the **What is the total dollar amount** field and click **Next**.
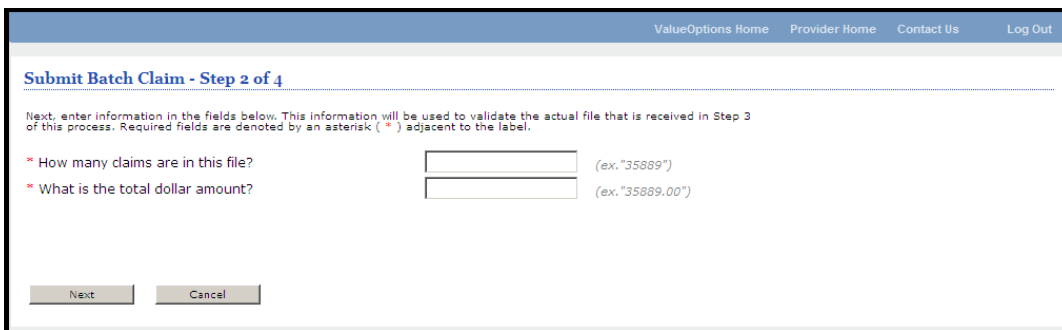


Figure 8: Step 2 of 4

On the Submit Batch File – Step 3 of 4 page:
1.  Click **Browse**.
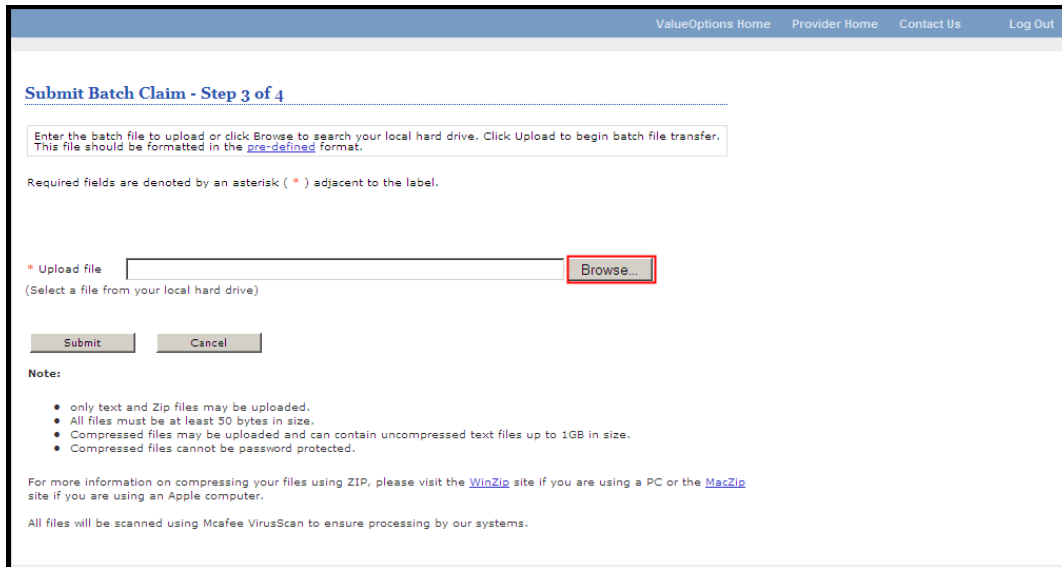


Figure 9: Step 3 of 4

2.  Search for the batch file.
3.  Select the batch file.
4.  Click **Open**.
5.  Click **Upload**. The batch file transfer begins.

| Note | *Some restrictions apply to the files, such as they must be only text or zip files, must be at least 50 bytes in size, and cannot be password-protected.* |
|------|---|

The Submit Batch File – Step 4 of 4 page displays when the upload is completed. The following information displays on this page.
-   A confirmation that the file was successfully uploaded.
-   A statement that the submission number will be sent to the registered e-mail address.
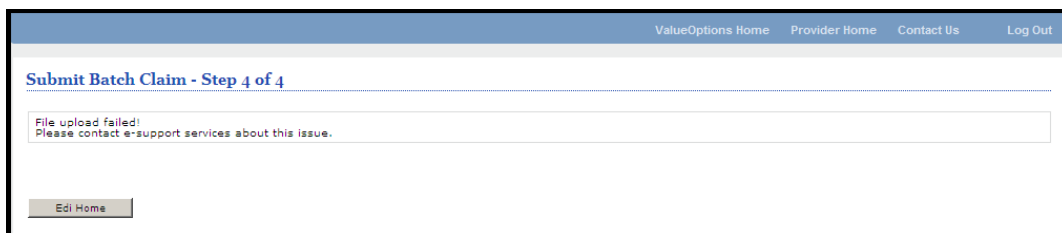


Figure 10: Step 4 of 4

## Search Files
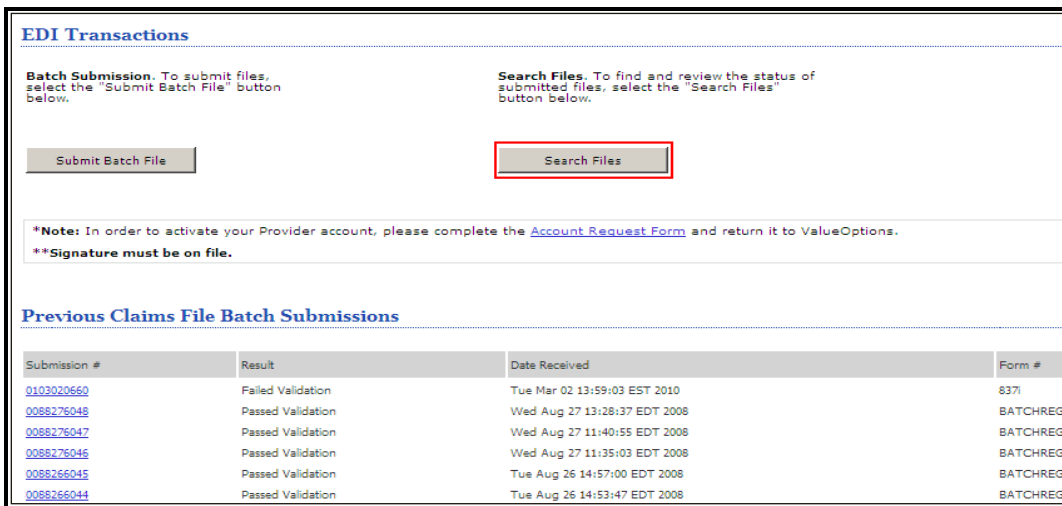
The Search File option on the EDI Transactions page allows users to find and review the status of submitted files.

To search for a file:
1. Click the EDI Homepage link on the navigation bar.

The EDI Transactions page displays.

2. Click the Search Files link on the navigation bar or click the **Search Files** button on the EDI Transactions page.



Figure 11: Search Files on EDI Transactions

3. Enter information in the fields on the Search File Submissions page.
4. Click **Search**.



Figure 12: Search File Submissions

The Batch Claim Submissions Search Results page displays.

5. Click on the Tracking # for the file.


Figure 13: Tracking Number Link

The Submission Detail page displays. This page contains the following information.
- Submission Number
- Form Type
- Upload and Process Date and Time
- Entry Location
- File Status
- Information on the Original File

**Submission Detail**

Submission Information - Current as of 03/08/2010 (08:10:15 AM) EST

| | |
|---|---|
| Submission Number | 0088215966 |
| Form Type | 837p |
| Upload Date & Time | 08/21/2008 10:50:21 AM EST |
| Process Date & Time | 08/21/2008 10:50:27 AM EST |
| Entry Location | eProvider Website |
| File Status | Failed |

ORIGINAL FILE

| | | |
|---|---|---|
| File Name | 88191308.txt | This file is over 90 days old and has been archived. Please contact e-Support Services with questions or concerns. |
| File Size | 1199 Byte(s) | |
| Verification Object | ETSHIPAA837pF1 | |
| Export File Name | | |
| Queue Position | 0 of 193 | |

| Resubmission Date/Time | Resubmitted By |
|---|---|
| 0 resubmissions found. | |

| Error Line # | Description |
|---|---|
| 1 | Invalid data. The Authorization Information field (#2) does not match your ValueOptions EDI Submitter ID setting. |
| | Additional Information: No additional information is available. Please contact eSupport Services at 888-247-9311 with any further questions. |
| 1 | Invalid data. The Security Information field (#4) does not match your ValueOptions EDI Password setting. |
| | Additional Information: No additional information is available. Please contact eSupport Services at 888-247-9311 with any further questions. |
| 10 | Invalid data. The NPI ID_Code must be 10 numeric characters. 1000007 is invalid. |
| | Additional Information: Error occured in the Billing Provider Information for <2010AA, ANTHONY>. |
| 14 | Provider Secondary Identification is not allowed because the National Provider Identifier has been mandated as the only valid provider identifier for HIPAA transactions. |
| | Additional Information: Error occured in the Billing Provider Information for <2010AA, ANTHONY>. |
| 15 | Provider Secondary Identification is not allowed because the National Provider Identifier has been mandated as the only valid provider identifier for HIPAA transactions. |
| | Additional Information: Error occured in the Billing Provider Information for <2010AA, ANTHONY>. |
| 25 | Invalid data. The NPI ID_Code must be 10 numeric characters. 1000021 is invalid. |
| | Additional Information: Error occured in the Rendering Provider for Patient <2010BA, ANDREA APOLLO>. |
| 27 | Provider Secondary Identification is not allowed because the National Provider Identifier has been mandated as the only valid provider identifier for HIPAA transactions. |
| | Additional Information: Error occured in the Rendering Provider for Patient <2010BA, ANDREA APOLLO>. |
| 28 | Invalid data. The NPI ID_Code must be 10 numeric characters. 1438902 is invalid. |
| | Additional Information: Error occured in the Rendering Provider for Patient <2010BA, ANDREA APOLLO>. |
| 28 | Missing data. The Service_Provider_ID field is required. |
| | Additional Information: Error occured in the Rendering Provider for Patient <2010BA, ANDREA APOLLO>. |

9 errors found.

| Question | Answer |
|---|---|
| [submitterid] | [submitterid] |
| [test] | [test] |
| [password] | [password] |
| How many claims are in this file? | 1 |
| What is the total dollar amount? | 101.00 |

| Backend Information | Value |
|---|---|
| Backend Code: | PFLO |
| Backend Description: | HIPAA 837p Development FLO Files |

Figure 14: Submission Details

# View Previous Claims File Batch Submissions

The EDI Transactions page also contains a *Previous Claims File Batch Submissions* section. The six most recent submissions can be viewed in this section. A file search must be conducted to view all the submissions for an account.



Figure 15: Previous Claims File Batch Submissions

## View Incoming Files

The EDI Transactions page also contains an *Incoming Files* section. All the files that have been sent from Beacon can be viewed in this section.



Figure 16: Incoming Files

1. Click on the File Name.

The View Incoming Files page displays.

2. Click on the File Name to access the Download File page.
   *Note: A file can be deleted from this page by clicking on the **Select Files** column and clicking **Delete**.*
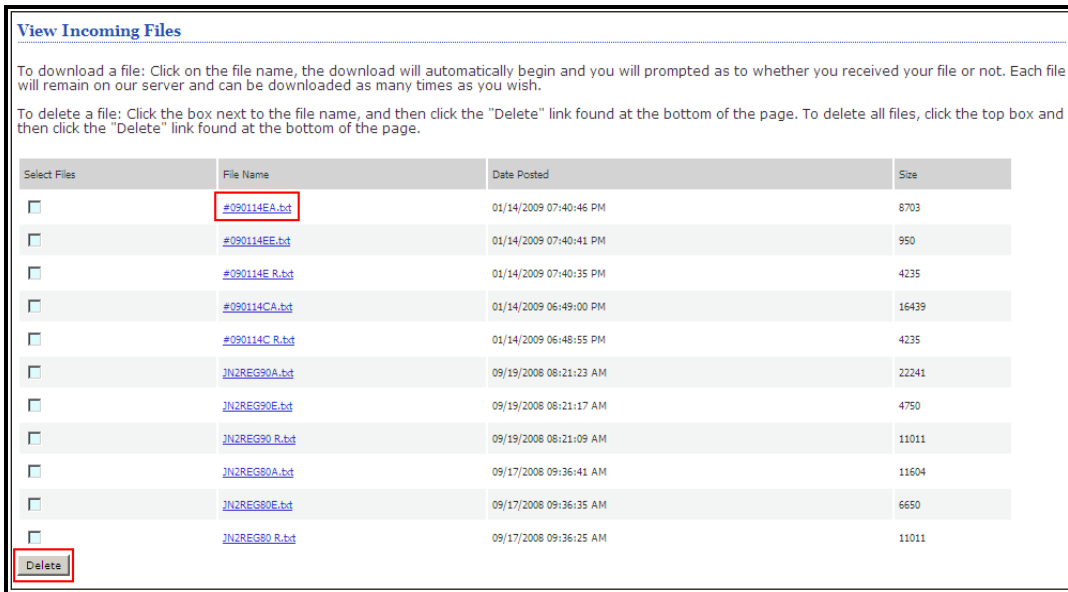
Figure 17: View Incoming Files

The Download File page displays.

> 3. Click **Yes** if the download was completed successfully.
> 4. Click **No** if the download was not completed successfully.
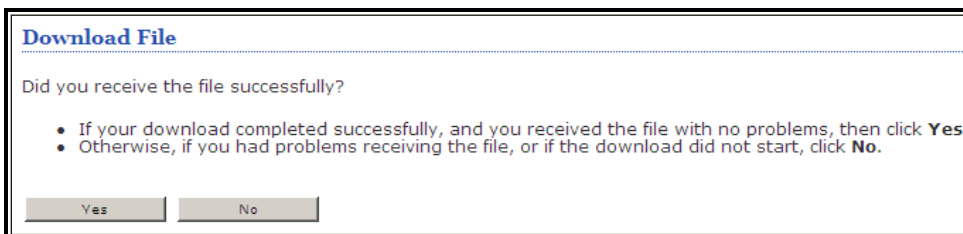


Figure 18: Download a File

If the download was unsuccessful, a page containing instructions displays.
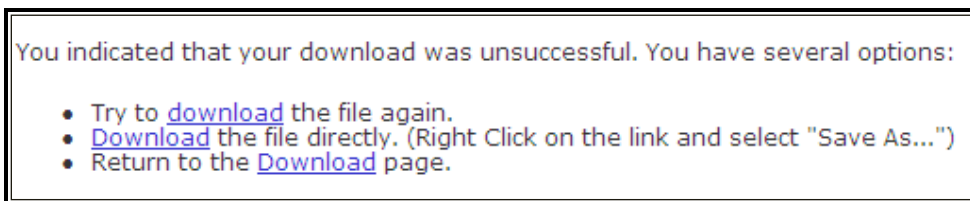


Figure 19: Download Unsuccessful

# 7 Access Member Information

A user can search for and access information for a member via the *Specific Member Search* section of ProviderConnect.

## Member Search
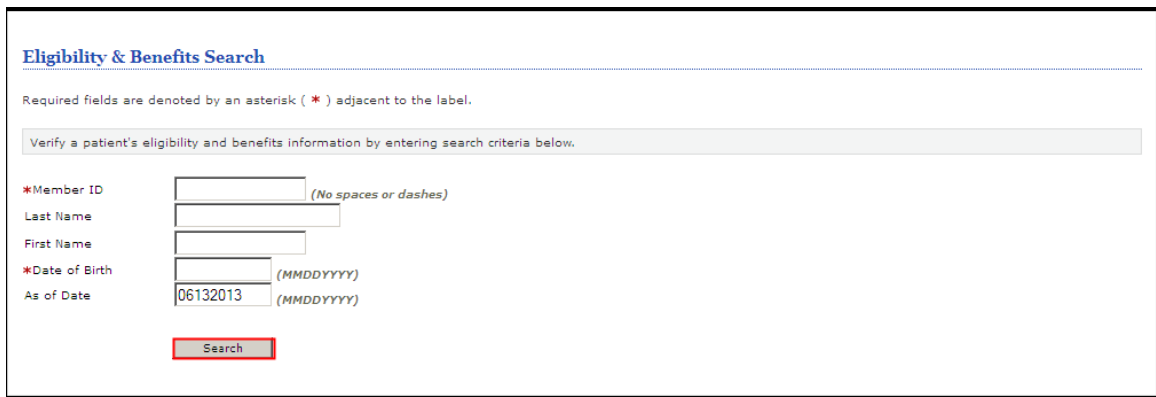
To search for a member, either click Specific Member Search on the navigation bar or Find a Specific Member on the ProviderConnect main menu. The Eligibility & Benefits Search page displays.

To retrieve member information:
1. Enter the member ID in the **Member ID** field.
2. Enter a date in the **Date of Birth** field.
   *Note: Enter information in MMDDYYYY format only.*
3. Enter the member's first and last names to narrow the search. (This step is optional.)
4. Click **Search**.

---

**Eligibility & Benefits Search**

Required fields are denoted by an asterisk ( ✱ ) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

✱Member ID    [_____]   *(No spaces or dashes)*
Last Name    [_____]
First Name    [_____]
✱Date of Birth    [_____]   *(MMDDYYYY)*
As of Date    [06132013]   *(MMDDYYYY)*

[ Search ]

---

Figure 20: Search Member Eligibility & Benefits
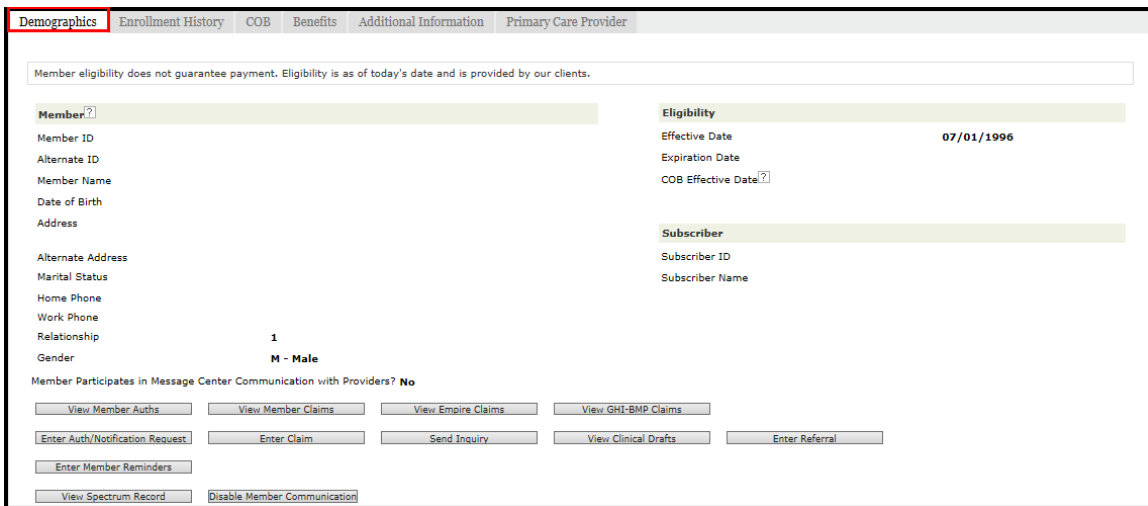
Whenever a provider is using an alternate ID to look up a member, he/she should always start with Specific Member Search or Find a Specific Member. (Because alternate IDs are shared among family members, this allows the provider to enter a date of birth and locate the correct member.)

Once the search has been completed, the member's information displays in a section that contains the following tabs.

- Demographics – Displays all of the member's demographic information
- Enrollment History – Displays all of the member's enrollments
- COB – Displays information about the member's other insurance policies
- Benefits – Displays the member's benefit information
- Additional Information – Displays the claims mailing address(es), member information, and eligibility data
- Primary Care Provider – Displays detailed information about the member's primary care provider or providers

## Demographics Tab

The Demographics tab displays member-specific information such as member ID, name, date of birth, eligibility, and so forth. Claims and authorization/notification requests are displayed for a member ID number that is associated with the provider number entered in the search. If providers have multiple numbers, some of the authorization/notification requests and claims that are linked to different numbers may not display in the search results.



Figure 21: Demographics Tab

# Enrollment History Tab

Member enrollment and eligibility information are located on the Enrollment History tab.

The following information can be found in the *Member Detail* section of this page.
- Subscriber ID
- Group #
- Fund
- Expiration Date
- Member ID
- Group Name
- Benefit Package
- Date Changed
- Member Name
- Account #
- Effective Date

On the bottom of the page are tabs used to either retrieve member information or to enter/request member information.
- View Member Auths – Displays all the authorizations for the member
- View Member Claims – Displays information about the member's claims
- View Empire Claims – Displays Empire Claims
  *Note: Applicable only to the Empire Client.*
- View GHI-BMP Claims – Displays GHI-BMP Claims
- Enter Auth/Notification Request – Authorization/notification requests can be submitted electronically
- Enter Claim – Claims can be submitted for a member electronically
- Send Inquiry – Inquiries can be submitted to the Beacon Customer Service Center electronically
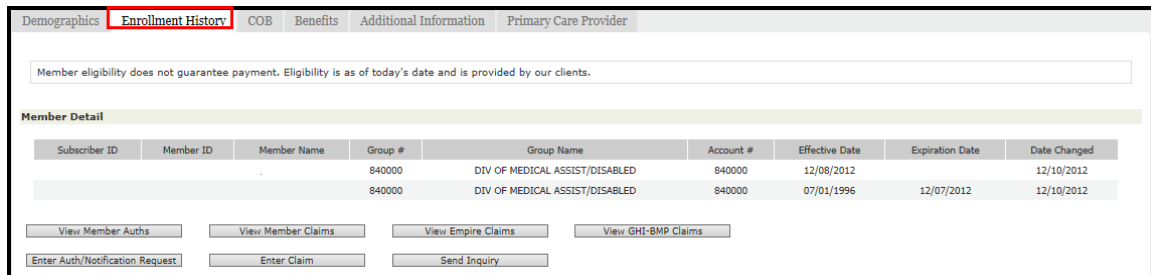
Note *The same buttons are located on the next four member tabs as well.*



| Demographics | Enrollment History | COB | Benefits | Additional Information | Primary Care Provider |

Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

**Member Detail**
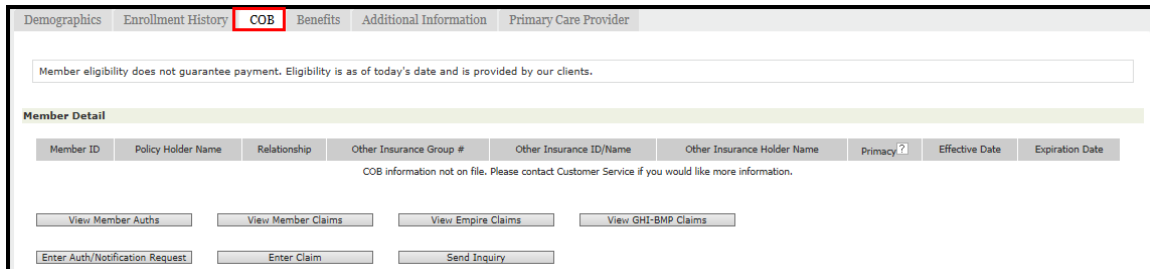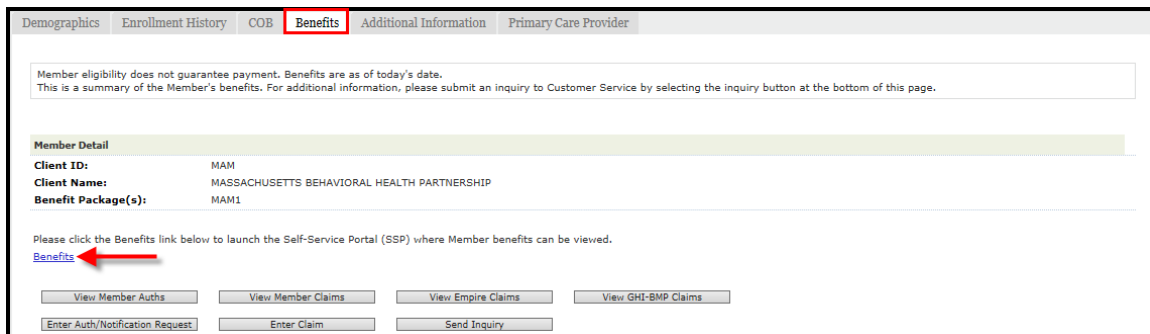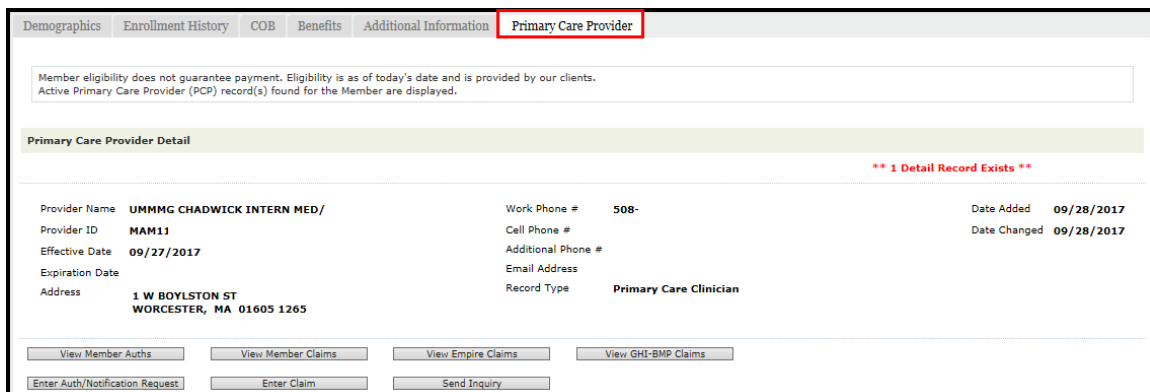
| Subscriber ID | Member ID | Member Name | Group # | Group Name | Account # | Effective Date | Expiration Date | Date Changed |
|---|---|---|---|---|---|---|---|---|
| | | . | 840000 | DIV OF MEDICAL ASSIST/DISABLED | 840000 | 12/08/2012 | | 12/10/2012 |
| | | | 840000 | DIV OF MEDICAL ASSIST/DISABLED | 840000 | 07/01/1996 | 12/07/2012 | 12/10/2012 |

| View Member Auths | View Member Claims | View Empire Claims | View GHI-BMP Claims |
| Enter Auth/Notification Request | Enter Claim | Send Inquiry | |

Figure 22: Enrollment History Tab

# COB Tab

If applicable, additional insurance information for a specific member displays on the Coordination of Benefits (COB) tab. Some of the same buttons on the bottom of the Demographics page also display on the bottom of the COB page.



Figure 23: COB Tab

# Benefits Tab

 Upon clicking the Benefits link, the user is redirected to the Self-Service Portal (SSP) application where he/she can view detailed benefit information for the member.



Figure 24: Benefits Tab

## Additional Information Tab

The Additional Information tab displays the claims mailing address(es), member information, and eligibility data.



Figure 25: Additional Information Tab

## Primary Care Provider Tab

The Primary Care Provider tab displays detailed information about the member's primary care provider or providers.



Figure 26: Primary Care Provider Tab

# 8 View Member Authorizations & Claims Information

As previously mentioned, there are a number of buttons on the Member tabs. These buttons are:

- View Member Auths
- View Member Claims
- View Empire Claims

  *Note: Applicable only to the Empire Client.*

- View GHI-BMP Claims
- Enter Auth/Notification Request
- Enter Claim
- Send Inquiry
- View Clinical Drafts
- Enter Member Reminders
- View Member Registrations
- View Spectrum Record

# View Member Authorizations

To view member authorizations:
1. Click the **View Member Auths** button. The following fields display with some of the information already populated.
    - Provider ID
    - Auth #
    - Service From/Through
2. Click **Search**.

The Authorization Search Results page displays. This page contains information about member-specific authorizations. Clicking the links on this page enables providers to view authorization letters, authorization summary, and authorization details information.

# View an Authorization Letter

To view an authorization letter:
1. Click the **View Letter** icon on the Authorization Search Results page.
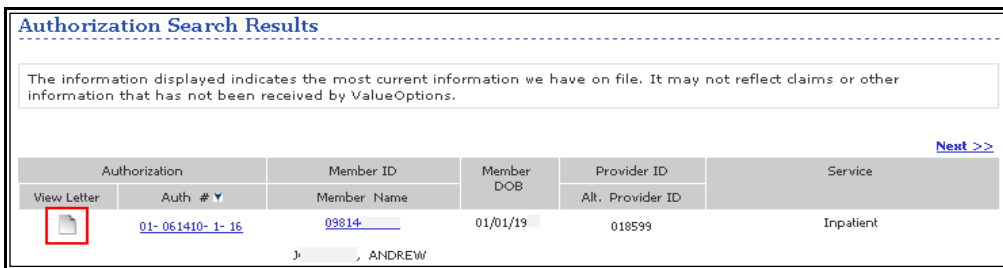


Figure 27: View Letter Icon

2. Click on the View link to display the authorization letter.

The Authorization Letter displays.
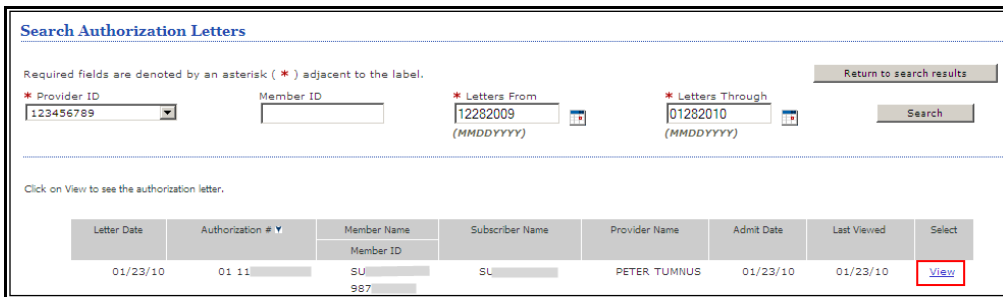


Figure 28: View Letter Link

# View Member Claims

A user can search for information about a specific member claim.

1. Click **View Member Claims**.

> *Note: This button also appears on the Enrollment History, COB, Benefits, Additional Information, and Primary Care Provider pages.*

The following fields display with some of the information already populated.

- Provider ID
- Claim #
- Service From/Through

2. Click **Search**.

The Member Claims Results displays.

3. Select a provider ID from the **Provider ID** drop-down if necessary.
4. Enter the claim number in the **Claim ID** field.
5. Enter the service start date in the **Service From** field.
6. Enter the service end date in the **Service Through** field.
7. Click **Search**.

The Claims Search Results page displays all the claims that meet the selected criteria.

- Claim Number
- Member Name and ID Number
- Provider ID Number
- Vendor Name and ID Number
- Dates of Service
- Claim Status
- Charge Amount ($)

To review the information about a specific claim, click on the Claim #.

# View Empire Claims

A user can search for information on an Empire claim for a member by clicking the **View Empire Claims** button.

| Note | *Applicable only to the Empire Client.* |

To view information about Empire claims:
1. Click the **View Empire Claims** button on the Enrollment History tab.

   *Note: This button also appears on the COB, Benefits, Additional Information, and Primary Care Provider pages.*
2. Follow the directions for entering claim information in the View Member Claims section of this user guide.

The Empire Claims Search Results page displays all the claims that meet the selected criteria.
- Claim Number
- Member Name and ID Number
- Provider ID Number
- Vendor Name and ID Number
- Dates of Service
- Claim Status
- Charge Amount ($)
- Paid Amount ($)

To review the information about a specific claim, click on the Claim #.

# View GHI-BMP Claims

A user can search for information on a GHI-BMP claim for a member by clicking the **View GHI-BMP Claims** button. To view information on GHI-BMP claims:
1. Click the **View GHI-BMP Claims** button on the Demographics tab.

   *Note: This button also appears on the Enrollment History, COB, Benefits, Additional Information, and Primary Care Provider pages.*
2. Follow the directions for entering claim information in the View Member Claims section of this user guide.

The GHI-BMP Claims Search Results page displays all the claims that meet the selected criteria. The following information displays on this page.
- Claim Number
- Member Name and ID Number
- Provider ID Number
- Vendor Name and ID Number
- Dates of Service

- Charge Amount ($)
- Paid Amount ($)

To review the information about a specific claim, click on the Claim #.

## Enter Member Reminders

A user can enter member reminder information, allowing appointment and medication reminders to be displayed.

1. Click the **Enter Member Reminders** button on the Demographics tab.

The Enter Member Reminders page displays the member ID and member name, with links pertaining to setting up appointment and medication reminders.

*Clicking on the Member ID redirects you to the Member Demographics page.*

2. Click on each link and enter the necessary information for setting up reminders.

## View Member Registrations

A user can enter/view member registration information. This allows demographic information to be captured and saved for a specific member.

1. Click the **View Member Registrations** button on the Demographics tab.
2. Enter the member information.

## Enter an Authorization Request

Refer to the [Enter an Authorization Request (RFS)](#) chapter for detailed information about how to enter authorization requests (requests for services).

# Enter a Claim

A user can enter and submit a claim for a member electronically.

1. Click the **Enter Claim** button.

> *Note: This button also appears on the Enrollment History, COB, Benefits, Additional Information, and Primary Care Provider pages.*

The Provider page displays.
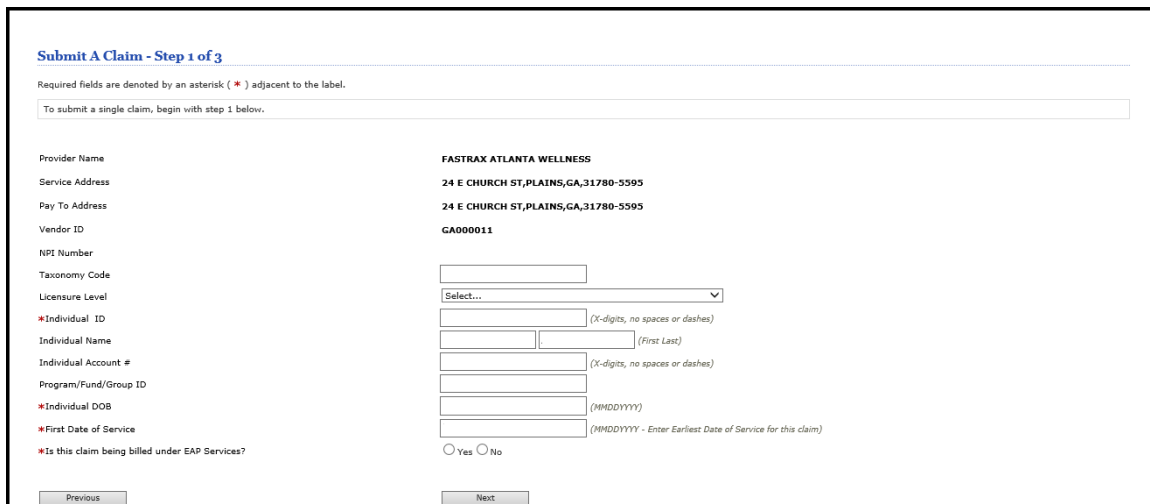
2. Select an option from the **Select Service Address** list and click **Next**.

The Submit A Claim – Step 1 of 3 page displays. (Note that the Member ID and Member DOB fields pre-populate.)

3. Select a different **NPI Number** if necessary. (Defaults to the first number in the list if there are multiple NPI numbers. Otherwise, displays just the one number.)
4. Enter a **Taxonomy Code**.
5. Enter the earliest date of service for the claim in the **First Date of Service** field.
6. Select either **Yes** or **No** in the **Is this claim being billed under EAP Services?** field and click **Next**.

Note    *The **Next** button is disabled if the claim cannot be processed.*



Figure 29: Submit a Claim – Step 1 of 3

The Submit A Claim (Step 2 of 3) page displays. Complete any applicable fields and click **Next**.

Figure 30: Submit a Claim – Step 2 of 3

The Submit A Claim (Step 3 of 3) page displays. Complete the *Service Line Entry* section.

1. Enter dates in the **Service From** and **Service Through** fields.
2. Enter a code in the **Service Code** field.
3. Enter codes, if needed, in the **Modifier Code 1, 2, 3,** and **4** fields.
4. Enter a dollar amount in the **Charge Amount ($)** field.
5. Enter a code (from 00-99) in the **Place of Service** field.
6. Enter a number (up to three digits) in the **Units** field.
7. Enter a code (e.g., 765.04) in the **Diagnosis Code 1** field.
8. Enter codes, if needed, in the **Diagnosis Code 2, 3, 4, 5, 6, 7,** and **8** fields.
9. Enter codes, if needed, in the **Primary Payer**, **Secondary Payer,** and **Tertiary Payer** fields.
10. Complete the **National Drug Code** (**NDC**) fields if applicable. (Note that these fields may not apply to all users!)
    - NDC Number (Allows 48 characters maximum. Must be all numerals.)
    - NDC Units (Allows 19 characters maximum; up to 17 digits, a decimal point, and 1 decimal place. For example: 12345678901234567**.**0)
    - Type of Units
      - UN – Unit
      - ML – Milliliter
      - ME – Milligram
      - GR – Gram
      - F2 – International Unit

    > *Note: The National Drug Code is a unique product identifier used in the United States for drugs that are intended for human use.*

11. Complete the **Association Qualifier** field if applicable. (Note that this field may not apply to all users, but is <u>required</u> if an association number is entered.)
12. Complete the **Association Number** field if applicable. (Note that this field may not apply to all users, but is <u>required</u> if an association qualifier is entered.)
13. Click the **Add Service Line** button. (The Claim Detail: Ready to Submit page displays.)



Figure 31: Submit a Claim – Step 3 of 3

Click **Submit** to submit the entire claim.

To remove a service line:
1. Select the **Click to Remove** option button.
2. Click **Remove**.
3. Click **Previous** to return to the preceding provider and member entry page.

After the claim has been submitted, the Submit A Claim page displays. This page shows the submission results and the claim information.

Clicking on the Claim # directs the user to the Claim Summary page.

## Send an Inquiry

A user can submit an inquiry about a member to the Beacon Customer Service Center electronically.

1. Click **Send Inquiry**.
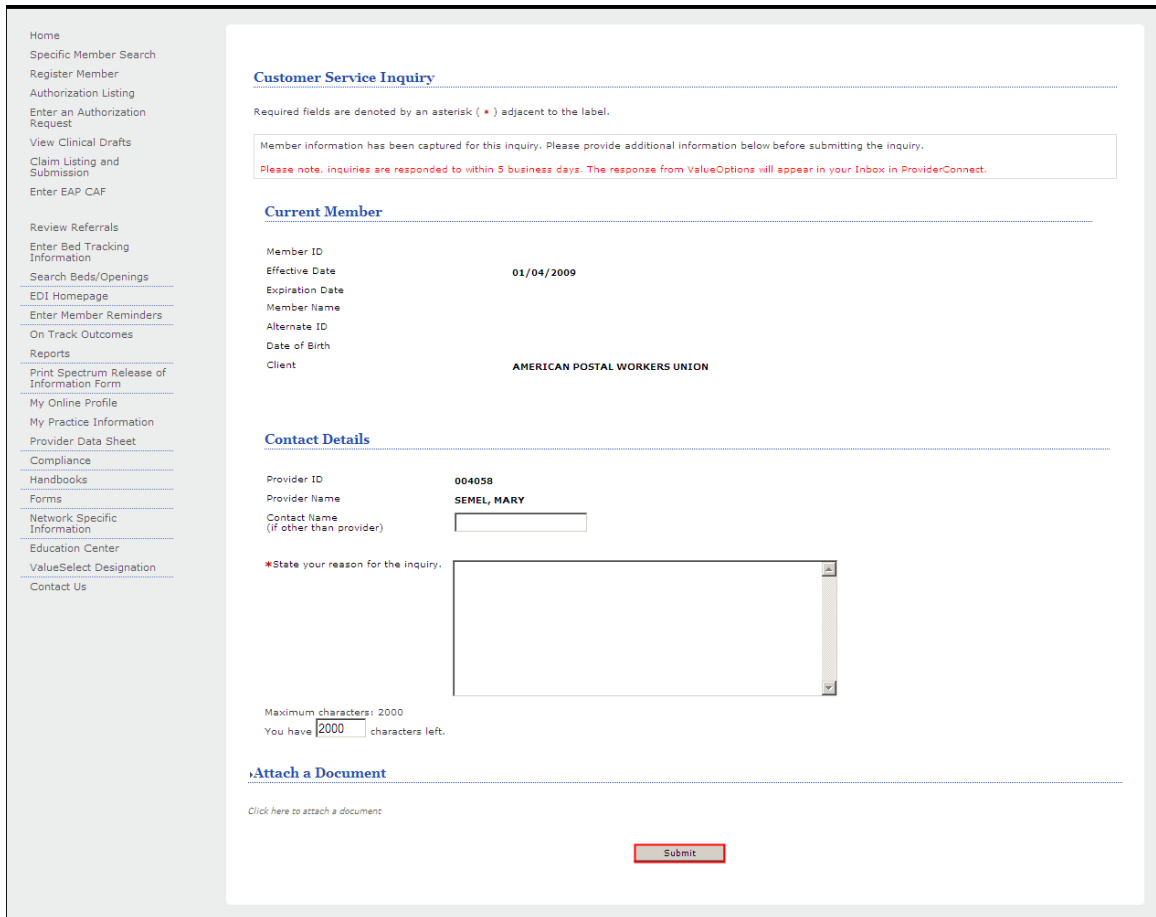
*Note: This button also appears on the Enrollment History, COB, Benefits, Additional Information, and Primary Care Provider pages.*

The Customer Service Inquiry page displays.

2. Review the information in the Current Member section for accuracy.
3. Enter a name in the **Contact Name** field if necessary.
4. Enter the reason for the inquiry in the **State your reason for the inquiry** text box.

*Note: This text box accepts up to 2,000 characters.*

5. Attach a document if applicable.
6. Click **Submit**.



Figure 32: Customer Service Inquiry

The inquiry will be sent to the Beacon Customer Service Center, and a confirmation of the submission and an inquiry number will be displayed.

# 9 Authorization Listing

In this section of ProviderConnect, a user can search for information on provider-specific authorizations (e.g., authorization letters, associated claims).

*To research a specific member's authorizations, select **Specific Member Search** on the navigation bar instead of selecting **Authorization Listing**.*
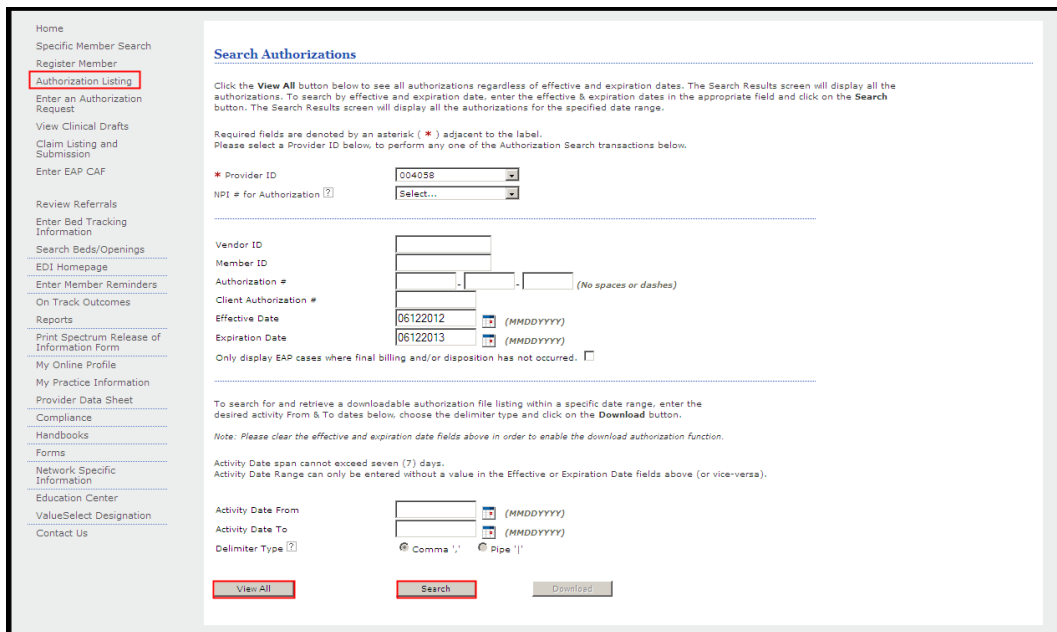
Upon clicking either Authorization Listing or Review an Authorization, the Search Authorizations page displays. Click **View All** to see all the authorizations for the provider. (The Search Results page displays all the authorizations.)

*Results can be sorted by member ID, member name, or authorization number.*

*-or-*

1. Enter a number in the **Authorization #** field.
2. Enter a date range in the **Effective Date** and **Expiration Date** fields.
3. Click **Search**. (The Search Results page displays the specified authorization.)



Figure 33: Search Authorizations

Refer to the Review an Authorization - EAP CAF chapter for detailed information about the *Search Results* section (including the Auth Summary, Auth Details, and Associated Claims tabs).

# 10 Enter an Authorization Request (RFS)

The *Enter an Authorization Request* function enables providers to electronically submit requests for services (RFS) for outpatient, inpatient, and medication management services. (This process is based on the member's contract.)

ProviderConnect sends automatic e-mail reminders to providers who have both saved drafts in RFS as well as saved a re-credentialing application draft. The e-mail reminder is sent 5 days after the last time the re-credentialing application draft was saved and 25 days after the RFS was saved.

An e-mail will be sent to each ProviderConnect user on the 6th day (after 5 days) after the last change date on an existing Provider Data Sheet (PDS) draft. An Authorization Request Draft Reminder e-mail will be sent to each ProviderConnect user (that is, the user who initially saved the draft) on the 26th day (after 25 days) after the initial save date on an existing Authorization (RFS) draft.

Draft reminder e-mails are not sent if a user does not have an e-mail address on file in the user's ProviderConnect account/profile record. Also, ProviderConnect sends reminder e-mails for only those RFS drafts that are in a "Saved" status, not in an "Expired" or a "Deleted" status.

Additionally, clinicians have the ability to electronically send a message to a provider's inbox with a request for any missing clinical information. The message, which is in the form of a web response, displays to the provider with a read-only history of the authorization request that was submitted by the provider and allows the provider an opportunity to respond back with the missing information within a defined turnaround time. The provider's feedback will be clinical information and will display in the CareConnect review. Providers can attach clinical documents and enter notes. Be aware however, that messages not responded to within the allotted time frame will be disabled.

Upon clicking Enter an Authorization/Notification Request, the Disclaimer page displays.
1. Review the disclaimer.
2. Click **Next**.
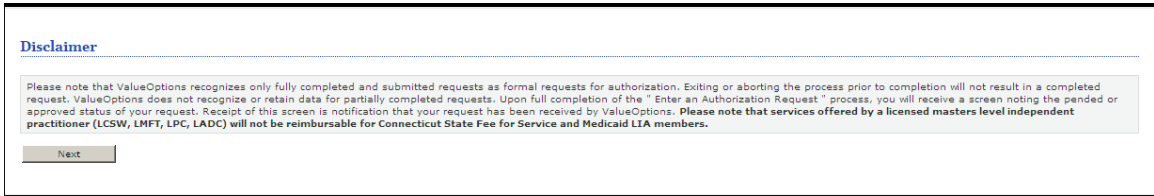
Figure 34: Disclaimer

# Search a Member

The Search a Member page displays.
1. Enter the member ID in the **Member ID** field.
2. Enter a date in the **Date of Birth** field.
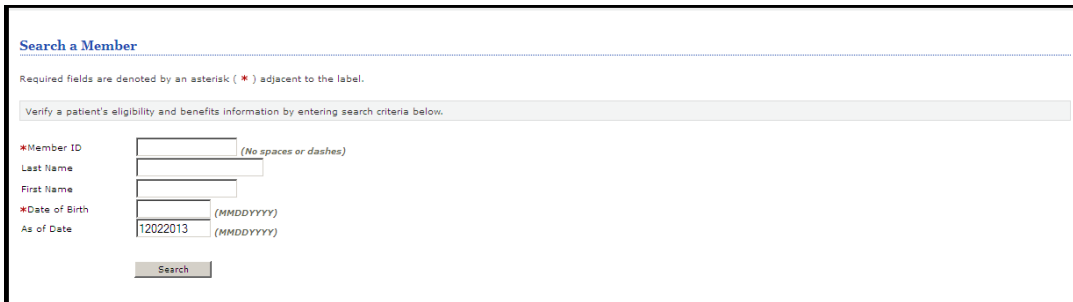


Figure 35: Search a Member

3. Enter the member's first and last names to narrow the search. (This step is optional.)
4. Click **Search**.

# Review Demographics

The Demographics page displays.
1. Review the member's information.
2. Click **Next**.

# Capture Provider

The Provider page displays.
1. Select the service address.
2. Click **Next**.

## Enter Requested Services

The Requested Services Header page displays next. The level of service selected on this page determines which additional fields display and which pages need to be completed.
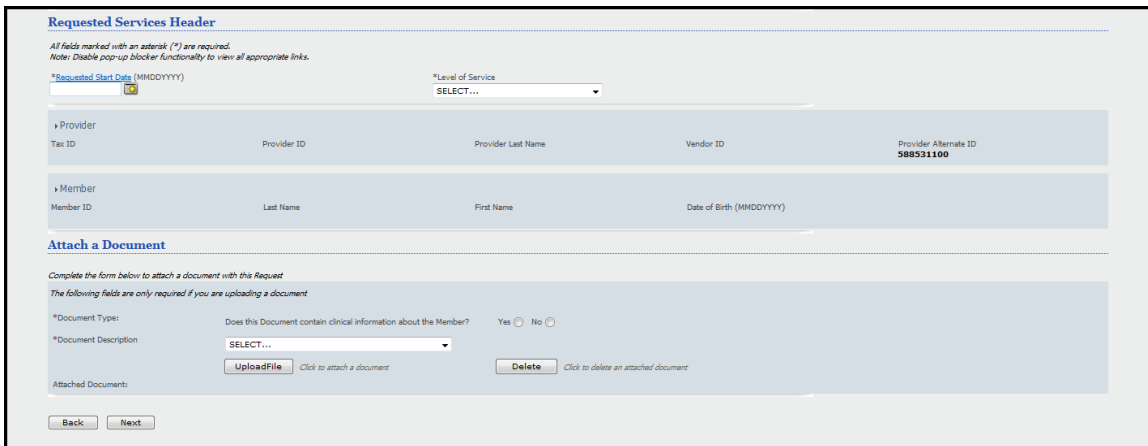
The three options for the level of service are:
- Outpatient
- Inpatient/HLOC/Specialty
- Medication Management

The steps for each level of service are covered in the following sections.

> **Note** *Instructions are provided for all the fields on a particular page. Only the fields with asterisks (\*) are required, however.*



Figure 36: Requested Services Header

## Outpatient Level of Service

Pages for either an ORF1 or an ORF2 display for the outpatient level of service depending on pre-established authorization parameters. In either case, you must enter a date in the **Requested Start Date** field.

### Outpatient ORF1

If the outpatient request generates the equivalent of an ORF1 form, the following pages display.
- Type of Services
- Current Risks
- Requested Services
- Results
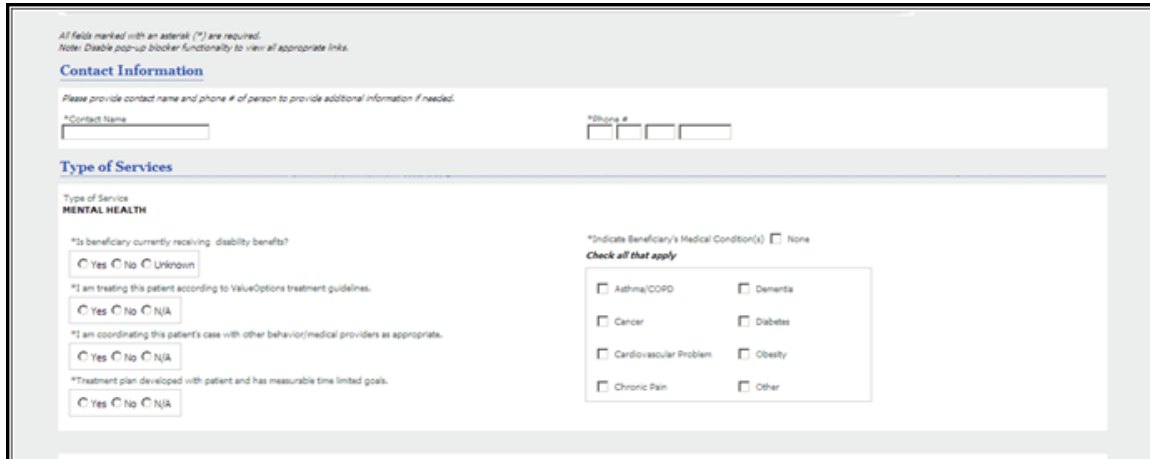
These pages need to be completed sequentially.

> **Note** *Only the fields with asterisks (\*) are required.*

## *Type of Services*

The Type of Services page is completed first.
1.  Enter a **Contact Name** and **Phone Number**.
2.  Answer the **Type of Services** questions.



Figure 37: Type of Services

3.  Enter the member's diagnosis information. (Refer to the Diagnosis section under Outpatient ORF2 authorization requests.)

Figure 38: Diagnosis

## *Current Risks*

The Current Risks page displays next.
1. Enter a rating in the **Member's Risk to Self** field.
2. Enter a rating in the **Member's Risk to Others** field.



Figure 39: Current Risks

*Click the links to display the rating information windows.*

In the Current Impairments section:
1. Rate the severity of each of the listed impairments.
2. Click **Next**.

Figure 40: Current Impairments

3.  Either **Accept** or **Reject** the number of visits.

## *Requested Services*

The Requested Services page displays next.
1. Select an option from the **Place of Service** drop-down.
2. Click **Add/Modify Service Classes** and select the appropriate service class from the list. (Up to 20 service classes can be selected.)

The number of visits/units auto-populate. If more than one service is requested:
1. Enter information on additional lines.
2. Enter the number of visits in the **Visits/Units** field.
3. Go back and modify the **Visits/Units** field in the previous line so that the **Total Visits/Units** amount does not exceed the allowed amount.
4. Click **Submit**.

Clicking **Next** on the Requested Services page redirects the user to the Determination Status page. (If needed, refer to the Decrease Approved Visits section at the end of this chapter for detailed information about how to decrease the number of approved visits.)

# Outpatient ORF2

If the outpatient request generates the equivalent of an ORF2 form, the following several pages display. (The Requested Services page may or may not display depending on pre-established parameters.)
- Type of Services
- Current Risks
- Diagnosis
- Treatment History
- Treatment Plan
- Psychotropic Medications
- Requested Services
- Results

## *Type of Services*

The Type of Services page is completed first.
1. Enter the **Contact Name** and **Phone Number** of the person to be contacted if additional information is needed.
2. Enter a name, if applicable, in the **Member's Guardian** field.
3. Select an option in the **Is member currently receiving disability benefits?** field and click **Next**.

## *Current Risks*

The Current Risks page displays next.
1. Enter a rating in the **Member's Risk to Self** field.
2. Enter a rating in the **Member's Risk to Others** field.

---

*Click the links to display the rating information windows.*

---



Figure 41: Current Risks

In the Current Impairments section:
1. Rate the severity of each of the listed impairments.
2. Click **Next**.



Figure 42: Current Impairments

## *Diagnosis*

The Diagnosis page displays next and contains the following sections for capturing diagnosis information.

- Behavioral Diagnoses
- Primary Medical Diagnoses
- Social Elements Impacting Diagnosis
- Functional Assessment

### *Behavioral Diagnoses*

The *Behavioral Diagnoses* section contains five rows for capturing diagnoses. Each row contains the following fields.

- Diagnostic Category
- Diagnosis Code
- Description

The system uses the value entered in the **Diagnostic Category** field to determine the values of the other two fields. If multiple options are available for the remaining fields, the user can select from among a list of possible choices. If only one option is available for the remaining fields, the system auto-populates those values.

Note | *Entering either a diagnosis code or description automatically populates the other two fields if only one description exists for that particular code or vice versa.*

This section functions as follows:

- Users may enter up to five diagnoses, **but only the principal (primary) diagnosis is required**.
- All the fields are required as all three fields are needed to obtain a complete behavioral diagnosis.
- The user must enter at least three characters of the diagnosis code in order to initiate the automatic search. (That is, the automatic search begins when the fourth character is entered.)
- Upon a user entering a partial or complete diagnosis description and then tabbing or clicking out of the field, the system begins an automatic search to complete the other two fields if there is only a single match

### *Primary Medical Diagnoses*

The *Primary Medical Diagnoses* section contains three rows for capturing diagnoses. Each row contains the following fields.

- Diagnostic Category
- Diagnosis Code
- Description

The system uses the value entered in the **Diagnostic Category** field to determine the values of the other two fields. If multiple options are available for the remaining fields, the user can select from among a list of possible choices. If only one option is available for the remaining fields, the system auto-populates those values.

> **Note** *Entering either a diagnosis code or description automatically populates the other two fields if only one description exists for that particular code or vice versa.*

This section functions as follows:
- Users may enter up to three diagnoses, **but only the principal (primary) diagnosis is required**.
- The diagnosis code and description are optional.
- The user must enter at least two characters of the diagnosis code in order to initiate the automatic search. (That is, the automatic search begins when the third character is entered.)
- Upon a user entering a partial or complete diagnosis description and then tabbing or clicking out of the field, the system begins an automatic search to complete the other two fields if there is only a single match.

### Social Elements Impacting Diagnosis

The *Social Elements Impacting Diagnosis* section contains the following checkboxes. (Users may select multiple checkboxes, but are required to select at least one.)
- None
- Educational problems
- Financial problems
- Housing Problems (Not Homelessness)
- Homelessness
- Occupational problems
- Problems with Primary support group
- Problems with access to health care services
- Problems related to interaction w/legal system/crime
- Problems related to the social environment
- Other psychosocial and environmental problems**\***
- Unknown

\*Selecting **Other psychosocial and environmental problems** activates a 250-character text box. (This field is required.)

### Functional Assessment

The *Functional Assessment* section contains the following fields.
- Assessment Measure
- Secondary Assessment Measure

The following options are available in both drop-downs.
- CDC HRQOL
- FAST
- GAF
- Other*
- OMFAQ
- SF12
- SF36
- WHO DAS

*Selecting **Other** from either drop-down activates a 25-character text box. (This field is required.)

The system also displays an **Assessment Score** field next to each assessment measure. These fields accept a maximum of 25 alphanumeric characters and are required for each assessment measure selected.

## *Treatment History*

The Treatment History page displays next.
1. Complete the Psychiatric Treatment in the Past 12 Months section.
2. Complete the Substance Abuse Treatment in the Past 12 Months section.
3. Complete the Medical Treatment in the Past 12 Months section.
4. Click **Next**.

Figure 43: Treatment History

> **Note**
>
> *If any of the blue highlighted options are selected, additional fields display that must be completed.*

## *Treatment Plan*
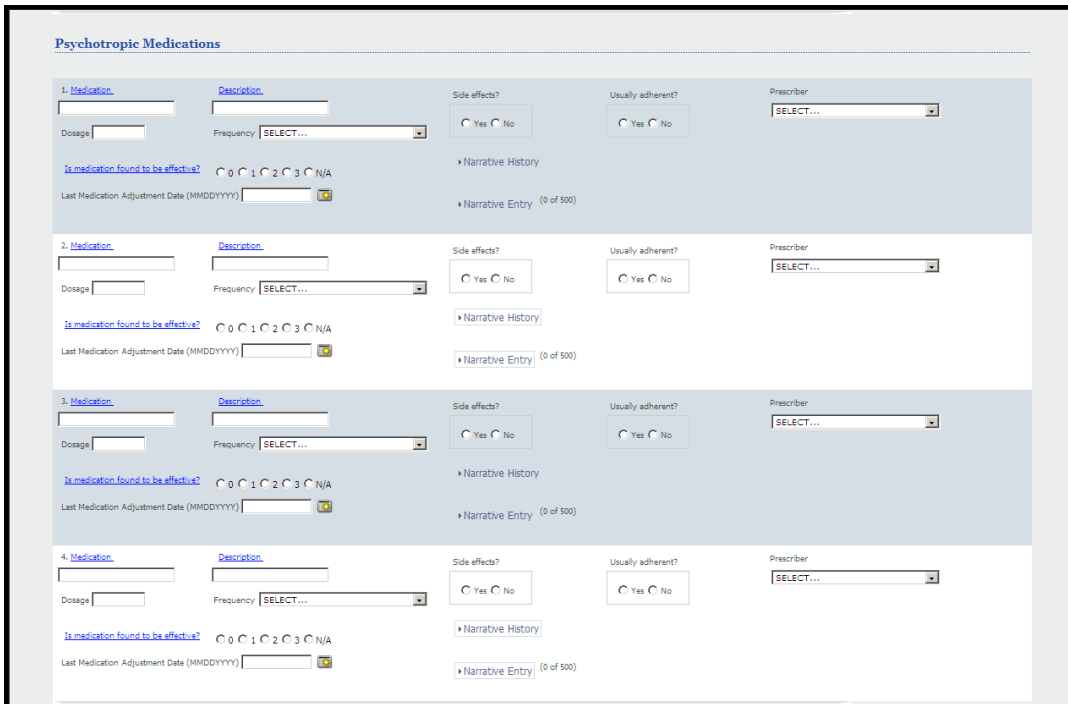
Information can be entered on the Treatment Plan page if applicable.
1. Complete all the fields that apply.
2. Complete the required questions **I am treating this member according to Beacon Health Options treatment guidelines** and **Treatment plan developed with member and has measureable time limited goals**.
3. Click **Next**.

## Psychotropic Medications

Information must now be entered on the Psychotropic Medications page.

1. Enter the medication's name in the **Medication** field or click on the link to select a medication.
2. Enter the amount in the **Dosage** field.
3. Select an option from the **Frequency** drop-down.
4. Select either **Yes** or **No** in the **Side Effects** field.
5. Select either **Yes** or **No** in the **Usually adherent** field.
6. Select an option from the **Prescriber** drop-down.
7. Repeat steps 1 through 6 for each additional medication and click **Next**.



Figure 44: Psychotropic Medications

*Click on the Medication link to display the Select Medication Code window.*

## *Requested Services*

The Requested Services tab may display next.
1. Select an option from the **Place of Service** drop-down.
2. Click **Add/Modify Service Classes** and select the appropriate service class from the list.

    *Note: Up to 20 service classes can be selected.*

3. Click **Submit**.

The number of visits/units auto-populate. If more than one service is requested:
1. Enter information on additional lines.
2. Enter the number of visits in the **Visits/Units** field.
3. Go back and modify the **Visits/Units** field in the previous line so that the **Total Visits/Units** amount does not exceed the allowed amount.
4. Click **Submit.**

Clicking **Next** on the Requested Services page redirects the user to the Determination Status page. (If needed, refer to the Decrease Approved Visits section at the end of this chapter for detailed information about how to decrease the number of approved visits.)

# Inpatient/HLOC/Specialty Level of Service – ITR Form

For an Inpatient/HLOC/Specialty Level of Service using the Inpatient Treatment Report (ITR) form:
1. Enter a date in the **Requested Start Date** field.
2. Select **Inpatient/HLOC/Specialty** from the **Level of Service** drop-down.
3. Select an option from the **Type of Service** drop-down.
4. Select an option from the **Level of Care** drop-down.
5. Select an option from the **Type of Care** drop-down.
6. Enter a date in the **Admit Date** field.
7. Enter a time in the **Admit Time** field.
8. Select either **Yes** or **No** in the **Has the member already been admitted to the facility?** field.

    *Note:*
    - *This question displays only if the level of service is Inpatient/HLOC/Specialty.*
    - *This question is required if the level of service is Inpatient/HLOC/Specialty and any combination of type of service, level of care, and type of care is selected.*

9. Attach any applicable documents and click **Next**.

Figure 45: Requested Services Header

A page containing several tabs displays.

**Note:** *Only the fields with asterisks (*) are required.*

## Level of Care

The Level of Care page is completed first.

1. Verify the level of care and type of service.
2. Enter the treatment in the **Treatment Unit/Program** field.
3. Enter a name in the **Member's Guardian** field.
4. Select an option from the **Member's Current Location** drop-down.
5. Select an option from the **Primary Referral Source** drop-down.
6. Enter an aftercare follow-up phone number.
   *-or-*
   Select **N/A** and enter a reason.


Figure 46: Level of Care – Preliminary Information

7. Enter at least one contact name and phone number and click **Next**.
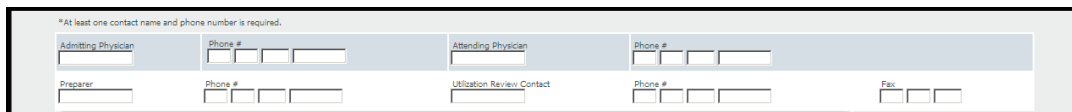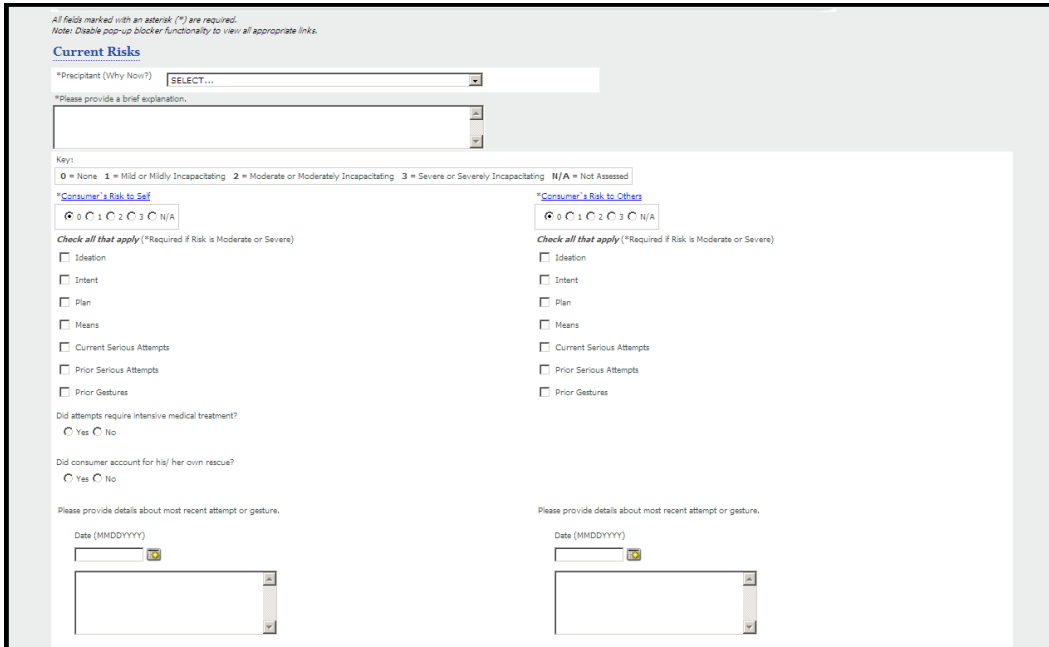

Figure 47: Level of Care – Contact Information

## *Current Risks*

The Currents Risks page displays next.

1. Select an option from the **Precipitant (Why Now?)** drop-down and enter a brief explanation.
2. Complete the Member's Risk to Self section.
3. Complete the Member's Risk to Others section.
4. Click **Next**.



Figure 48: Current Risks

## *Current Impairments*

The Current Impairments page displays next.
1. Rate the severity of each of the listed impairments.
2. Click **Next**.
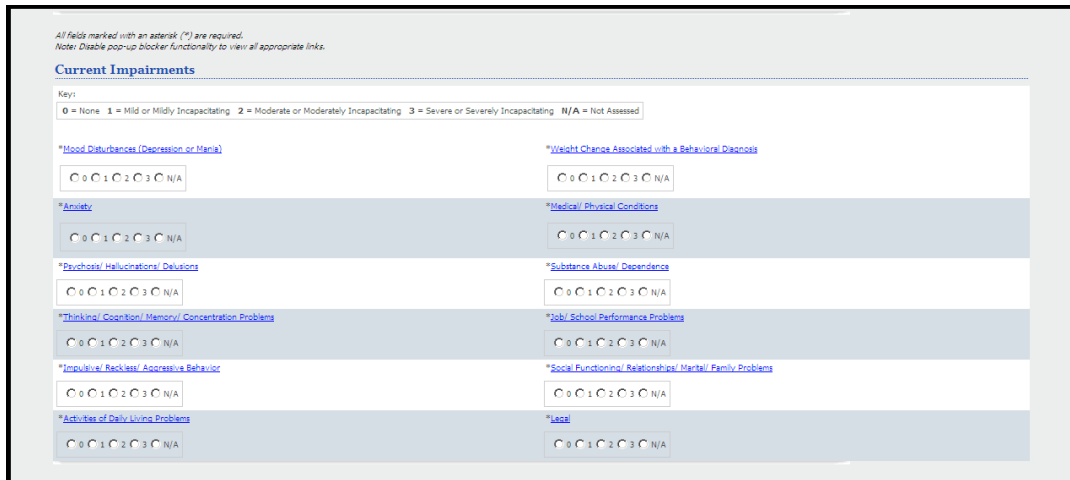

Figure 49: Current Impairments

## *Diagnosis*

The Diagnosis page displays next and contains the following sections for capturing diagnosis information.
- [Behavioral Diagnoses](#)
- [Primary Medical Diagnoses](#)
- [Social Elements Impacting Diagnosis](#)
- [Functional Assessment](#)

## *Behavioral Diagnoses*

The *Behavioral Diagnoses* section contains five rows for capturing diagnoses. Each row contains the following fields.
- Diagnostic Category
- Diagnosis Code
- Description

The system uses the value entered in the **Diagnostic Category** field to determine the values of the other two fields. If multiple options are available for the remaining fields, the user can select from among a list of possible choices. If only one option is available for the remaining fields, the system auto-populates those values.

> *Entering either a diagnosis code or description automatically populates the other two fields if only one description exists for that particular code or vice versa.*

This section functions as follows:
- Users may enter up to five diagnoses, **but only the principal (primary) diagnosis is required**.
- All the fields are required as all three fields are needed to obtain a complete behavioral diagnosis.
- The user must enter at least three characters of the diagnosis code in order to initiate the automatic search. (That is, the automatic search begins when the fourth character is entered.)
- Upon a user entering a partial or complete diagnosis description and then tabbing or clicking out of the field, the system begins an automatic search to complete the other two fields if there is only a single match

### Primary Medical Diagnoses

The *Primary Medical Diagnoses* section contains three rows for capturing diagnoses. Each row contains the following fields.
- Diagnostic Category
- Diagnosis Code
- Description

The system uses the value entered in the **Diagnostic Category** field to determine the values of the other two fields. If multiple options are available for the remaining fields, the user can select from among a list of possible choices. If only one option is available for the remaining fields, the system auto-populates those values.

Note

*Entering either a diagnosis code or description automatically populates the other two fields if only one description exists for that particular code or vice versa.*

This section functions as follows:
- Users may enter up to three diagnoses, **but only the principal (primary) diagnosis is required**.
- The diagnosis code and description are optional.
- The user must enter at least two characters of the diagnosis code in order to initiate the automatic search. (That is, the automatic search begins when the third character is entered.)
- Upon a user entering a partial or complete diagnosis description and then tabbing or clicking out of the field, the system begins an automatic search to complete the other two fields if there is only a single match.

### Social Elements Impacting Diagnosis

The *Social Elements Impacting Diagnosis* section contains the following checkboxes. (Users may select multiple checkboxes, but are required to select at least one.)
- None
- Educational problems
- Financial problems
- Housing Problems (Not Homelessness)

- Homelessness
- Occupational problems
- Problems with Primary support group
- Problems with access to health care services
- Problems related to interaction w/legal system/crime
- Problems related to the social environment
- Other psychosocial and environmental problems**\***
- Medical disabilities that impact diagnosis or must be accommodated for in treatment
- Unknown

\*Selecting **Other psychosocial and environmental problems** activates a 250-character text box. (This field is required.)

### Functional Assessment

The *Functional Assessment* section contains the following fields.
- Assessment Measure
- Secondary Assessment Measure

The following options are available in both drop-downs.
- CDC HRQOL
- FAST
- GAF
- Other\*
- OMFAQ
- SF12
- SF36
- WHO DAS

\*Selecting **Other** from either drop-down activates a 25-character text box. (This field is required.)

The system also displays an **Assessment Score** field next to each assessment measure. These fields accept a maximum of 25 alphanumeric characters and are required for each assessment measure selected.

### Treatment History

The Treatment History page displays next.
1. Complete the Psychiatric Treatment in the Past 12 Months section.
2. Complete the Substance Abuse Treatment in the Past 12 Months section.
3. Complete the Medical Treatment in the Past 12 Months section if needed.
4. Click **Next**.

Figure 50: Treatment History
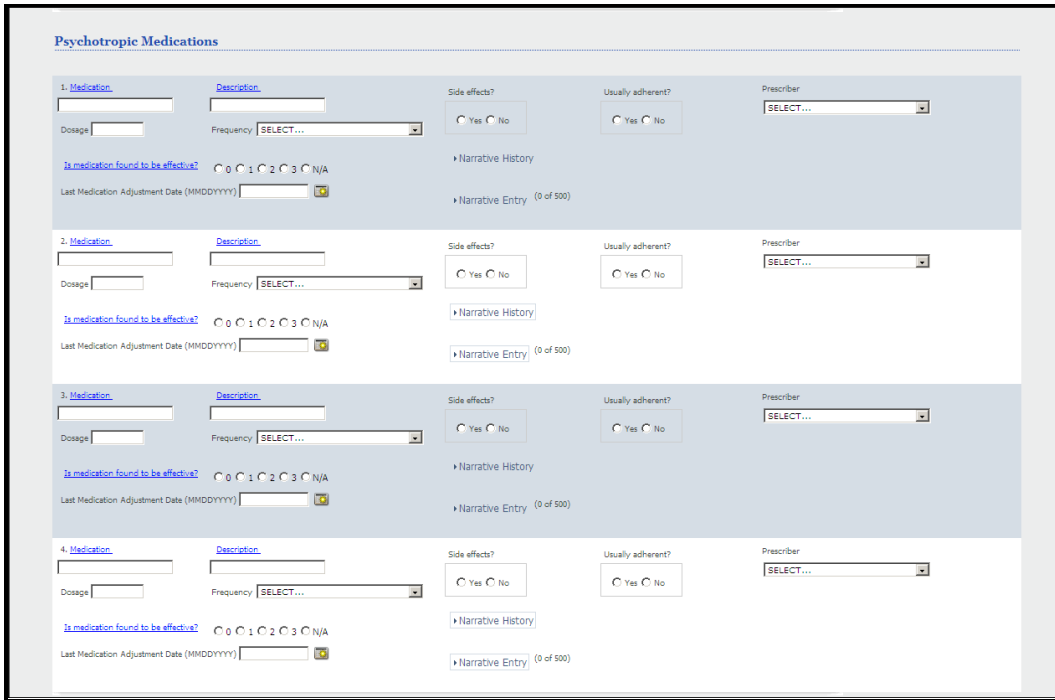
## *Psychotropic Medications*

The Psychotropic Medications page displays next.

1. Enter the medication's name in the **Medication** field or click on the link to select a medication.
2. Enter the amount in the **Dosage** field.
3. Select an option from the **Frequency** drop-down.
4. Select either **Yes** or **No** in the **Side Effects** field.
5. Select either **Yes** or **No** in the **Usually Adherent** field.
6. Select an option from the **Prescriber** drop-down.
7. Repeat steps 1 through 6 for each additional medication and click **Next**.



Figure 51: Psychotropic Medications

## *Substance Abuse*

The Substance Abuse page displays next.

1. Check all **Substance Abuse** types that apply.



Figure 52: Substance Abuse Types

For each substance you selected:

- Select an option from the **Total Years of Use** drop-down.
- Select an option from the **Length of Current Use** drop-down.
- Enter an amount in the **Amount of Use** field.
- Select an option from the **Frequency of Use** drop-down.
- Enter a date in the **Date Last Used** field.

2. Select all **Withdrawal Symptoms** that the member is experiencing.

   *Note: This field is required if the type of service is **Detoxification**.*

3. Complete the Vitals section (i.e., Blood Pressure, Temperature, Pulse, Respiration, and Blood Alcohol).
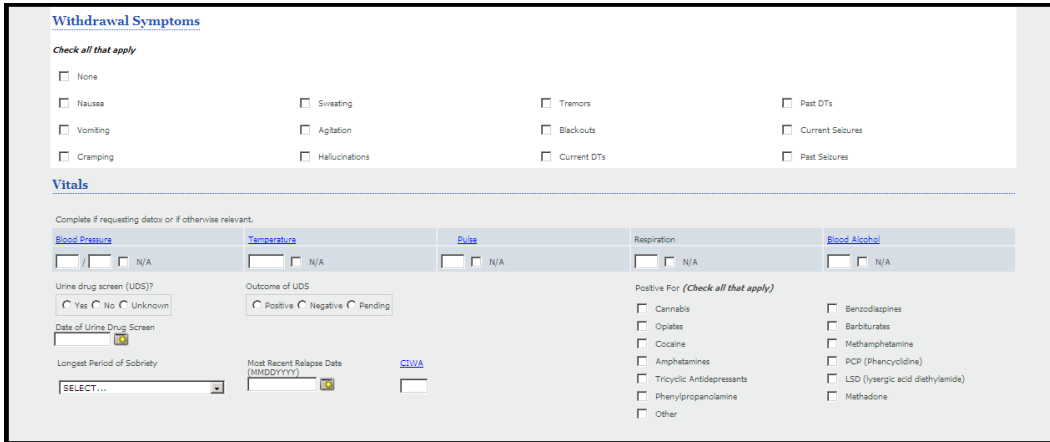
Figure 53: Withdrawal Symptoms and Vitals

The ASAM/Other Patient Placement Criteria section must be completed next.

1. Select **Low, Medium**, or **High** for the **Dimension 1**, **Dimension 2**, and **Dimension 3** fields if the type of service is **Detoxification**.
2. Select **Low**, **Medium**, or **High** for the **Dimension 1** through **Dimension 6** fields if the type of service is **Substance Abuse** and click **Next**.


Figure 54: ASAM/Other Placement Criteria

## Treatment Plan

The Treatment Plan page displays next.

1. Enter the **Date of Plan**.
2. Select either **Yes** or **No** in the **Member/Guardian Involved in Treatment Plan** field.
3. Expand the **PCP for Select Medicaid Accounts** section if applicable.
4. Enter **Long Term Goals**.
5. Enter information in the **Symptom/Observation** text box and all applicable text boxes in that section. (Sections repeat for multiple symptoms to be entered.)

Figure 55: Treatment Plan

## *Treatment Request*

The Treatment Request page displays next.

1. Select either **Yes** or **No** in the **Certificate of Need Required** field.
2. Select either **Yes** or **No** in the **Is Family/Couples Therapy Indicated** field.
3. Expand the **Medical Implications** section if applicable.
4. Check all boxes that apply for the **Treatment Request Information** fields.
5. Enter the length in the **Specify Length** field if the Fixed Length Program option is selected.
6. Enter a number (of visits per week or days per month) if the Frequency of Program option is selected.
7. Select an option from the **Primary Reason for Continued Stay** drop-down.
8. Select an option from the **Primary Barrier to Discharge** drop-down.

Figure 56: Treatment Request

9. Check all applicable **Baseline Functioning** behaviors. Describe the behavior in the text box if **Other** is checked.
10. Enter a date in the **Expected Discharge Date** field.
11. Enter a date in the **Estimated Return to Work Date** field.
    *-or-*
    Select **N/A** if the information is not available.
12. Select an option from the **Planned Discharge Level of Care** drop-down.
13. Select an option from the **Planned Discharge Residence** drop-down.
14. Click **Submit**.



Figure 57: Baseline Functioning

The Determination Status page displays next.

# Inpatient/HLOC/Specialty Level of Service – ITR2 Form

The IP/HLOC Inpatient Treatment Report (ITR2) form is designed to encourage more provider use of ProviderConnect.
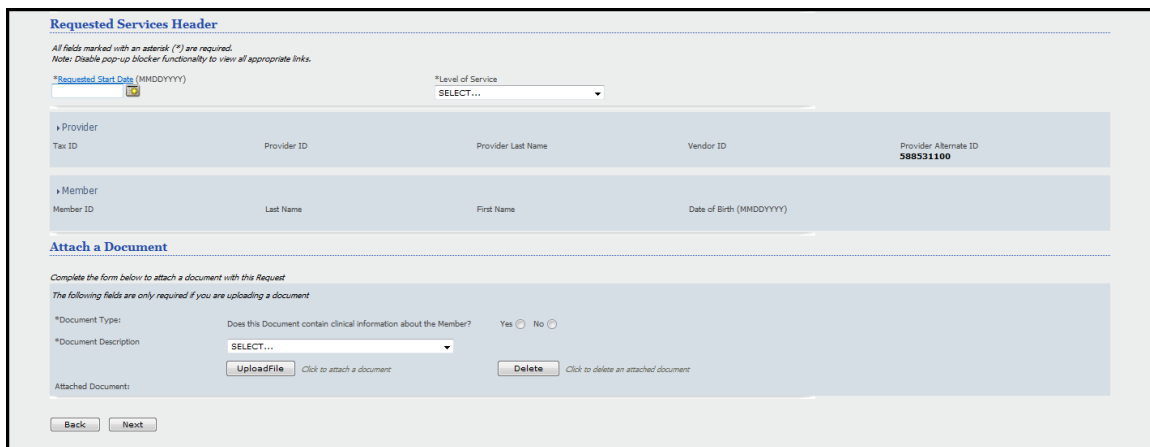
For an Inpatient/HLOC/Specialty Level of Service using the Inpatient Treatment Report (ITR2) form:

1. Enter a date in the **Requested Start Date** field.
2. Select **Inpatient/HLOC/Specialty** from the **Level of Service** drop-down.
3. Select an option from the **Type of Service** drop-down.
4. Select an option from the **Level of Care** drop-down.
5. Select an option from the **Type of Care** drop-down.
6. Enter a date in the **Admit Date** field.
7. Enter a time in the **Admit Time** field.
8. Select either **Yes** or **No** in the **Has the member already been admitted to the facility?** field.

> *Note:*
> - *This question displays <u>only</u> if the level of service is Inpatient/HLOC/Specialty.*
> - *This question is <u>required</u> if the level of service is Inpatient/HLOC/Specialty and any combination of type of service, level of care, and type of care is selected.*

9. Attach any applicable documents and click **Next**.



Figure 58: Requested Services Header

A page containing three tabs displays.

**Note**
*Only the fields with asterisks (*) are required.*

## Level of Care/Diagnosis

The Level of Care/Diagnosis page is completed first.

### Information Requested by Clinician for Inclusion in this Request

This section contains information entered on the Focus of Next Clinical Review page in Service/CareConnect. Clinicians use that screen to enter information they would like to see from the provider on the next request. The information entered by the clinician is displayed in ProviderConnect so that the provider can make sure to include it in the request that he/she is submitting. (The information is read-only.) Note that:

- If the most recent previous review is blank, neither the field nor the field label displays as no information was entered for the review.
- If multiple concurrent reviews occur, only the most recently added Focus of Next Clinical Review narrative displays.

### Level of Care

This section contains level of care and type of service as well as contact and primary care coordination information fields.

1. Verify the level of care and type of service.
2. Select the **Treatment Includes ECT** checkbox if applicable.
3. Select the **Treatment Includes Psych Testing** checkbox if applicable.
4. Enter aftercare follow-up contact information for the member.
- Phone #
- E-mail
- Validate E-mail

   *Note: Phone #, E-mail, or N/A is required. If N/A, the provider must explain why aftercare follow-up information is not available.*

5. Enter primary care coordination information.
- PCP Contacted Status (REQUIRED)

   *Note: If the PCP contacted status is either **Care Plan Sent to PCP** or **PCP Contacted**, the PCP contact name and date are required.*

- PCP Contacted Name
- Date Contacted
6. Enter at least one contact name and phone number.

Figure 59: Level of Care – Contact & Primary Care Coordination Information

### Diagnosis

This section comprises the standard DSM-5 Diagnosis page. (Refer to Diagnosis in the Inpatient/HLOC/Specialty Level of Service – ITR Form section of this chapter for detailed information.)

### Medical Implications

This section contains the following fields and is required if the Primary Medical Diagnostic Category entered on the Diagnosis page is other than **None** or **Unknown**.

- Are there any comorbid medical conditions that impact the treatment of the diagnosed MHSU conditions?
- Is the member receiving appropriate medical care for the comorbid medical conditions?

### Metabolic Assessment Tool

This section contains the BMI functionality from the case management referral follow-up workflow.

1. Enter BMI information.
   *-or-*
   Select the **BMI not assessed** checkbox.
2. Enter the results of the metabolic syndrome assessment.
3. Enter additional information about the reason for not obtaining BMI if applicable. If the recommendation is to follow up, enter the details about the follow-up when they become available.

Figure 60: Metabolic Assessment Tool

### *Clinical Presentation/Medication/Treatment*

The Clinical Presentation/Medication/Treatment page displays next.

### *Information Requested by Clinician for Inclusion in this Request*

This section contains information entered on the Focus of Next Clinical Review page in Service/CareConnect. Clinicians use that screen to enter information they would like to see from the provider on the next request. The information entered by the clinician is displayed in ProviderConnect so that the provider can make sure to include it in the request that he/she is submitting. (The information is read-only.) Note that:

- If the most recent previous review is blank, neither the field nor the field label display as no information was entered for the review.
- If multiple concurrent reviews occur, only the most recently added Focus of Next Clinical Review narrative displays.

### *Symptomatology*

This section contains the following fields along with these instructions: "*Please explain the reason for current admission (describe symptoms) and include the precipitant (what stressor or situation led to this decompensation). If this is a concurrent request, please list both the progress that has been made to date and what symptoms still remain.*"

- Narrative Entry
- Member's Risk to Self
  - o Danger to Self Symptom Complex*

    | *\* Required if member's risk to self is a 2 or 3.* |
    | --- |

- Member's Risk to Others
  - o Danger to Others Symptom Complex*

    | *\* Required if member's risk to others is a 2 or 3.* |
    | --- |

- Substance Use
- Urine drug screen?*

  | *\*Urine drug screen is required for the RFS workflow if member's substance use is a 2 or 3 OR Type of Service = Substance Use OR Primary Behavioral Diagnostic Category for the incoming request is one of the following:*<br>o *Alcohol-Related Disorders*<br>o *Cannabis-Related Disorders*<br>o *Combined Other Substance Disorders*<br>o *Hallucinogen-Related Disorders*<br>o *Inhalant-Related Disorders*<br>o *Opioid-Related Disorders*<br>o *Sedative-, Hypnotic-, or Anxiolytic-Related Disorders*<br>o *Stimulant-Related Disorders* |
  | --- |

- Outcome of UDS
- Date of Urine Drug Screen
- Positive for*

> **\****At least one substance or "Other" must be selected if the outcome of the urine drug screen is positive.*

- Blood Alcohol\*

> *\* Blood Alcohol or N/A is required for the RFS workflow if member's substance use is a 2 or 3 OR Type of Service = Substance Use OR Primary Behavioral Diagnostic Category for the incoming request is one of the following:*
> o  *Alcohol-Related Disorders*
> o  *Cannabis-Related Disorders*
> o  *Combined Other Substance Disorders*
> o  *Hallucinogen-Related Disorders*
> o  *Inhalant-Related Disorders*
> o  *Opioid-Related Disorders*
> o  *Sedative-, Hypnotic-, or Anxiolytic-Related Disorders*
> o  *Stimulant-Related Disorders*

- Blood Alcohol N/A\*

> *\*Checkbox is required if **Blood Alcohol** is left blank.*

### Primary Issues/Symptoms Addressed in Treatment

This section comprises a number of symptom complexes. Note that:
- For each symptom complex that is "triggered" as being required when completing a request for service, the applicable sections are automatically expanded upon accessing the Clinical Presentation/Medication/Treatment tab.
- Sections can also be manually expanded/collapsed.
- If a particular symptom complex is expanded, the associated Narrative Entry textbox is also expanded by default. If a particular system complex is required, then the associated Narrative Entry is also required.

The following directive displays just below the section title: "*Symptom complexes are utilized for gathering clinical information specific to the primary behavioral diagnosis and/or risk. At times more than one complex may be identified for completion. Providing all the requested information in the identified complex(es) will assist in completing the authorization process and determining medical necessity. If this is a concurrent request, please update the identified complexes with any new information for each complex based on the individual's current symptomatology.*"

### Recovery and Resiliency

This section contains a Narrative Entry textbox along with the following instructions: "*Please outline the recovery and resiliency environment to support this individual's long-term recovery plan. Please include personal strengths, support systems available to support the recovery and details around living environment, as well as outline any identified needs or supports that need to be put in place to assist in the successful recovery.*"

### Medications

This section enables the provider to view and modify information regarding current and historical medications for the member. He/she can also add new medications as needed.

### Add a Medication

Upon clicking **Add Medication**, the system displays data entry fields for adding a new medication. (If there are no medications on file for the member, the system displays a blank set of data entry fields upon accessing this page.)

The system also displays a separate medication-related Narrative Entry textbox along with the following instructions: "*For this medication, please enter any details concerning dosage, side effects, adherence, effectiveness, prescribing provider and any specific target symptoms.*"

Clicking the **Add Medication** button again adds a new medication record. Medications are saved upon submitting the request for services.

Note | *Up to 10 medications can be added per request for services.*
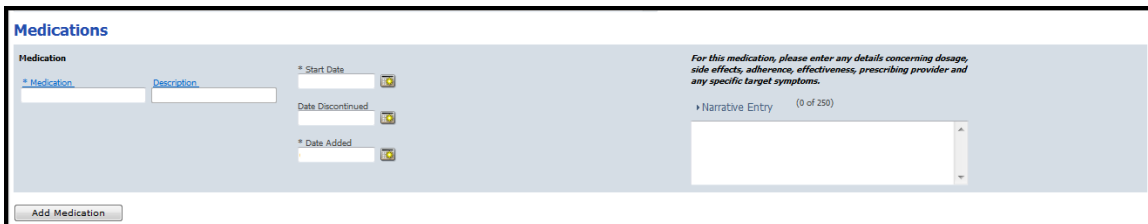


Figure 61: Add a Medication

### Best Practices Endorsement

This section utilizes the Primary Behavioral Diagnostic Category entered on the Diagnosis page for the incoming request and dynamically updates the Best Practice Guidelines Related to Primary Behavioral Diagnosis hyperlink with the PDF document associated to that particular diagnostic category. (If there is no match, then a generic PDF document displays.)

Respond either **Yes** or **No** to the following statement: "*I endorse that I follow Best Practice Guidelines for the Primary Behavioral Diagnosis.*"

If the answer is **No**, you must give a reason why you do not endorse best practice guidelines related to the primary behavioral diagnosis.

Note | *The best practices endorsement statement is required.*

### Additional Information on Selected Conditions

This section utilizes the Primary Behavioral and Medical Diagnostic Categories entered on the Diagnosis page for the incoming request and automatically displays hyperlinked descriptions for those categories. (The system can display up to five hyperlinked descriptions per category. Upon selecting a particular link, the system opens the applicable Achieve Solutions® web page.)

> **Note**
> *If no active hyperlinks exist for a particular diagnostic category, the following message appears: "No links to display."*

### Discharge Information

This section contains the following instructions: "*Discharge planning considerations should include obtaining releases to speak to and coordinate care with the providers that individual will be transitioning to as well as confirming that appointments are timely scheduled. Discharge planning should be included as a component of the treatment throughout the entire stay. (HEDIS measures require follow-up within 7 days to discharge. Requirements may be sooner based on individual circumstances.)*"

Complete the following information.
1. Planned Discharge Level of Care
2. Other Planned Discharge Level of Care (if applicable)
3. Planned Discharge Residence
4. Other Planned Discharge Residence (if applicable)
5. Expected Discharge Date

> **Note**
> *Planned Discharge Level of Care and Planned Discharge Residence are required for all requests for services. Expected Discharge Date is required for concurrent requests for services.*

**Discharge Information**

Discharge planning considerations should include obtaining releases to speak to and coordinate care with the providers that individual will be transitioning to as well as confirming that appointments are timely scheduled. Discharge Planning should be included as a component of the treatment throughout the entire stay. (HEDIS measures require follow-up within 7 days to discharge. Requirements may be sooner based on individual circumstances.)

| * Planned Discharge Level of Care | * Planned Discharge Residence |
|---|---|
| OTHER | OTHER |
| Other Planned Discharge Level of Care | Other Planned Discharge Residence |
| | Expected Discharge Date (MMDDYYYY) |

Figure 62: Discharge Information

### *Additional Information*

The Additional Information page contains parent-specific custom fields from the ITR form and displays for concurrent requests for services *only*. If there is no parent-specific information for a particular parent, the following message displays: "No additional information is required."

# Medication Management Level of Service

If the **Medication Management** level of service is selected, the number of steps in the process is reduced and only three tabs are displayed.

1. Select **Medication Management** from the **Level of Service** drop-down.
2. Click **Next**.

The Diagnosis page displays next.

3. Enter the **Contact Name** and **Phone Number** of the person to be contacted if additional information is needed.
4. Enter the member's diagnosis information. (Refer to the Diagnosis section under Outpatient ORF2 authorization requests.)

The Requested Services page displays next.

5. Select an option from the **Place of Service** drop-down.
6. Click **Add/Modify Service Classes** and select the appropriate service class from the list. (Up to 20 service classes can be selected.)

The number of visits/units auto-populate. If more than one service is requested:

7. Enter information on additional lines.
8. Enter the number of visits in the **Visits/Units** field.
9. Go back and modify the **Visits/Units** field in the previous line so that the **Total Visits/Units** amount does not exceed 20.
10. Click **Submit**.

The Determination Status page displays next.

# Decrease Approved Visits

VSP and in-network providers can choose to decrease the number of visits approved for the request for services (RFS). When units are offered for potential auto-approval, accepting that number of units or requesting fewer units may result in automatic authorization. Requests for a greater number of units will need to pend for further review.

To decrease the number of approved visits:
1. Click **Reject**.

The following pop-up window displays.
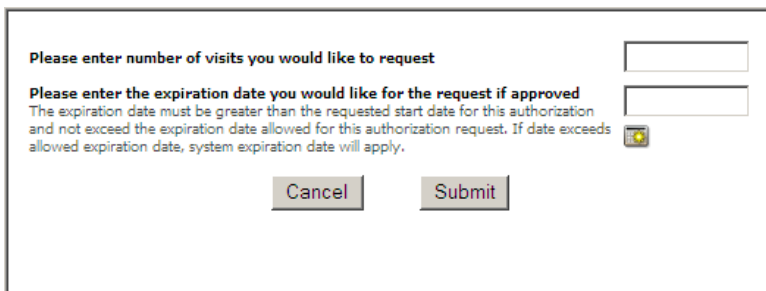


Figure 63: Number of Visits & Expiration Date Pop-up

2. Enter the new number in the **Please enter number of visits you would like to request** field.
3. Optionally enter a date in the **Please enter the expiration date you would like for the request if approved** field.

*Note: The expiration date must be greater than the requested start date for this authorization and not exceed the expiration date allowed for this authorization request. If the date exceeds the allowed expiration date, the system expiration date applies.*

4. Click **Submit**.

The Requested Services page displays.

5. Complete the fields on the Requested Services page if necessary.
6. Verify the **Visits/Units** amount.
7. Click **Submit**.

The Results page displays reflecting the modified amount of visits/units.

# 11     Enter an ABA Authorization Request

The following Applied Behavioral Analysis (ABA) outpatient workflows/pages are available for providers to evaluate and determine the appropriate course of treatment for members with Autism Spectrum Disorder or other Intellectual Developmental Disabilities.

- ABA Assessment
- ABA Services

## ABA Assessment Workflow
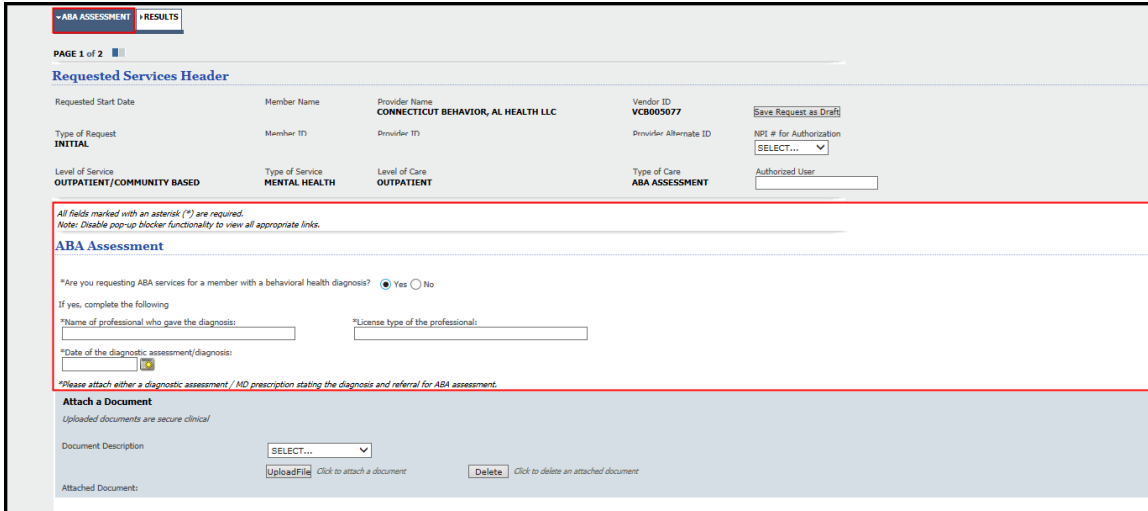
The ABA Assessment workflow is initiated upon a provider completing the requested services header information as follows.

- Level of Service – Outpatient
- Type of Service – Mental Health
- Level of Care – Outpatient
- Type of Care – ABA Assessment

The following initial Yes/No question displays upon clicking **Next**: "Are you requesting ABA services for a member with a behavioral health diagnosis?"

If the answer to this question is **Yes**, the following fields must be completed.

- Name of professional who gave the diagnosis
- License type of the professional
- Date of the diagnostic assessment/diagnosis

Figure 64: ABA Assessment

## Attach a Document

The provider is required to upload supporting documentation for both initial and concurrent requests.

The provider then completes the standard Diagnosis page. (Refer to the Diagnosis section of the Enter an Authorization Request (RFS) chapter for detailed information.)

# ABA Services Workflow

The ABA Services workflow is initiated upon a provider completing the requested services header information as follows.

- Level of Service – Outpatient
- Type of Service – Mental Health
- Level of Care – Outpatient
- Type of Care – ABA Services

The following initial Yes/No question displays upon clicking **Next**: "Are you requesting ABA services for a member with a behavioral health diagnosis?"

If the answer to this question is **Yes**, the provider must "complete the following information and documentation" and "if previously submitted, please indicate." (Select the **Already submitted** checkbox if documentation has already been submitted.)

- Name of professional who gave the diagnosis
- License type of the professional
- Date of the diagnostic assessment/diagnosis
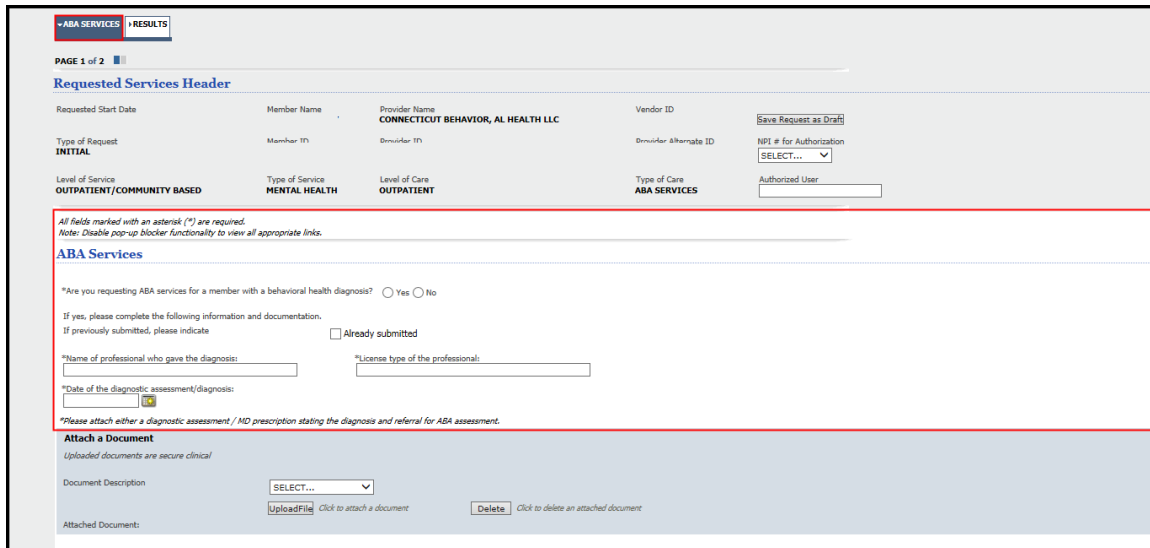


Figure 65: ABA Services

## Attach a Document

- Supporting documentation is *required* if the answer to the "Are you requesting ABA services for a member with a behavioral health diagnosis?" question is **Yes**.
- Supporting documentation is *not required* if the answer to the Are you requesting ABA services for a member with a behavioral health diagnosis?" question is **No**.
- Supporting documentation is *not required* if the provider has indicated that documentation has already been submitted.

The provider then completes the standard Diagnosis page. (Refer to the <u>Diagnosis</u> section of the <u>Enter an Authorization Request (RFS)</u> chapter for detailed information.)
The following required fields display below the Diagnosis page.

- Is member receiving other professional services?
  - o If the answer to this question is **Yes**, the provider must select one or more of the services listed or select **Other**.
- Is member taking any medication?
  - o If the answer to this question is **Yes**, the provider must enter the applicable information.

The provider then completes the *Current Impairments* and *Current Skills Impairments* sections.

![Note]

- Ratings for *Current Impairments* are: 0 (none), 1 (mild/mildly incapacitating), 2 (moderate/moderately incapacitating), 3 (severe/severely incapacitating), or ANC (assessment not completed)
- Ratings for *Current Skills Impairments* are: 0 (age appropriate), 1 (1 to 2 years below), 2 (3 to 4 years below), 3 (5 or more years below), or ANC (assessment not completed)

The following free text field displays next: "Please outline areas of progress since last review, as well as areas that need to be focus of future treatment. If there has been a lack of progress, please indicate the actions to adjust or change treatment plan to address lack of progress. Include a summary of the Transition/Discharge Plan and any additional resources or referrals that are needed for the member and their family."

*This field is required for concurrent requests for services only.*

The following instructions display next: "Please refer to http://www.beaconhealthoptions.com/providers/Forms/Clinical/ABA-Provider-Progress-Report-Guidelines.pdf to download Beacon Health Options ABA report guidelines**."**

"Providing the following components in the report will help determine medical necessity."

- Member's basic bio-psychosocial
- Member's skill impairments
- List of data source/tools used
- Intervention plan (including baseline data)
- Transition & discharge plan

- Member's strengths/capabilities
- Crisis Plan
- Parent training
- Coordination of care
- Description of supervision

*The provider is required to upload documentation for concurrent ABA services only.*

## Concurrent ABA Services

The following fields display only for concurrent ABA requests for services.
- Follow-up considerations for concurrent review.
- Number of member behavior goals targeted during current authorization period.
- How many member behavior goals were met?
- Number of new member behavior goals added for next authorization period.
- Re-assessment tools used. Check all that apply.
  *Note: The provider must select one or more of the re-assessment tools listed or select **Other**.*
- During recent authorization period were there any gaps in treatment?

# 12 ABA Tracking Measures
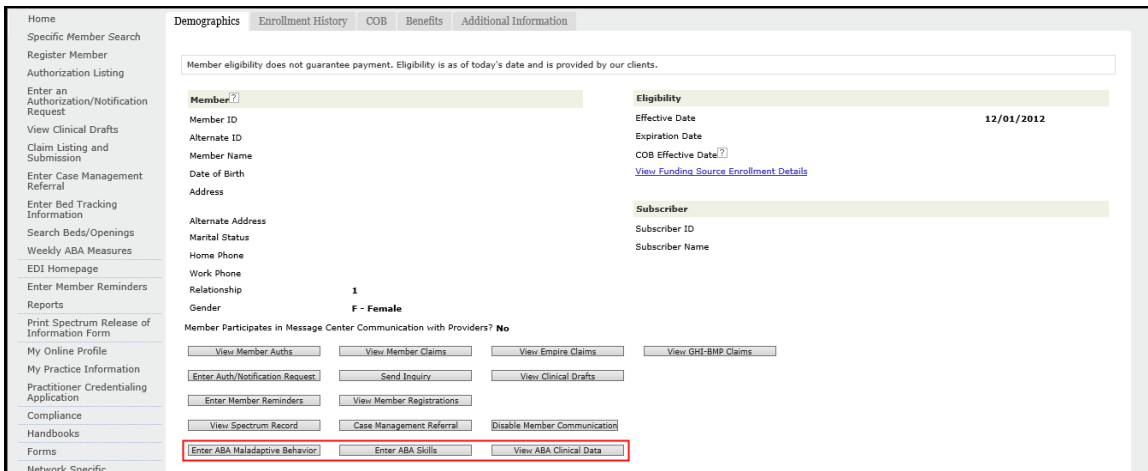
Applied Behavioral Analysis (ABA) Maladaptive Behavior and Skills Data Tracking functionality is available in ProviderConnect for providers who have the appropriate clinical function(s) assigned to their user security role.

To access this feature:
1. Click on Weekly ABA Measures. (The member search page displays.)
2. Search for the appropriate member. (The Demographics page displays.)

From the Demographics page the user can:
- Enter weekly maladaptive behavior updates for the current member,
- Enter weekly skills updates for the current member, or
- View ABA clinical data.



Figure 66: ABA Maladaptive Behavior & ABA Skills Data Tracking Buttons

# Enter ABA Maladaptive Behavior

Clicking the **Enter ABA Maladaptive Behavior** button redirects the user to the ABA Maladaptive Behavior page for him/her to enter weekly maladaptive behavior updates for the member.

**Note** | *This button also displays if accessing the Demographics page via the **Specific Member Search** or **Find a Specific Member** option.*

## Read-only Information

The following read-only fields display in the page header.

- Record #
- Member Name
- Member ID
- Date of Birth
- Age

The user is prompted to select the week for which he/she will be entering/editing data.

**Note** | *The **No Maladaptive Behavior Data to report this week** checkbox should be selected if there is no data to report for the current week. (This checkbox is required if no data is entered.)*

The user can also search for an existing maladaptive behavior data record by selecting the appropriate week from the calendar.

Upon making a selection, the following read-only fields display.

- **Added By** – Displays the ID of the person who submitted the maladaptive behavior data.
- **Date Added** – Displays the date the maladaptive behavior data was submitted.
- **Changed By** – Displays the ID of the person who last edited the maladaptive behavior data.
- **Date Changed** – Displays the date the maladaptive behavior data was last edited.

## Data Entry Fields

The following fields display in tabular format.

- **Baseline** – Contains checkboxes associated with each of the behavior types. Baseline selections (checkmarks) apply only to the week those particular behavior types are first evaluated. They do not carry over to subsequent weeks. (That is, the checkboxes are cleared.)
- **Behavior Type** – Contains a read-only list of behavior types.
- **Behavior Name** – Allows the user to select a behavior associated with a particular behavior type. If **Other**, a 25-character textbox displays for the user to enter the other behavior. (Behavior names are based on behavior type.)
- **Measurement Type** – Allows the user to select a measurement type for the behavior.
- **Measurement Units** – Allows the user to select a measurement unit for the measurement type. (Default measurement units are based on measurement type.)
- **Interval Units** – Allows the user to enter the interval units. (Only numeric values are permitted and can include decimals.)
- **Data Value** – Allows the user to enter a data value. (Only numeric values are permitted and can include decimals.)

## Submit ABA Maladaptive Behavior Data

Upon clicking **Submit**, the system validates the data and displays the determination status. (See: Weekly ABA Measures Confirmation)

# Enter ABA Skills

Clicking the **Enter ABA Skills** button redirects the user to the ABA Skills page for him/her to enter weekly skills updates for the member.

> **Note**
>
> *This button also displays if accessing the Demographics page via the **Specific Member Search** or **Find a Specific Member** option.*

## Read-only Information

The following read-only fields display in the page header.

- Record #
- Member Name
- Member ID
- Date of Birth
- Age

The user is prompted to select the week for which he/she will be entering/editing data.

> **Note**
>
> *The **No Skills Data to report this week** checkbox should be selected if there is no data to report for the current week. (This checkbox is <u>required</u> if no data is entered.)*

The user can also search for an existing skills record by selecting the appropriate week from the calendar.

Upon making a selection, the following read-only fields display.

- **Added By** – Displays the ID of the person who submitted the skills data.
- **Date Added** – Displays the date the skills data was submitted.
- **Changed By** – Displays the ID of the person who last edited the skills data.
- **Date Changed** – Displays the date the skills data was last edited.

## Data Entry Fields

The following sections display. Each section contains a number of textboxes in which the user can enter values ranging from 1 – 20.

- Readiness Skills
  - Attending
  - Fine Motor
  - Gross Motor
  - Motor Imitation
  - Routine/Schedule
  - Visual Performance
- Language/Communication
  - Intraverbals
  - Label/Tact
  - Receptive Language
  - Request/Mands
  - Social Interactions
  - Syntax and Grammar
  - Vocal Imitation
- Daily Living/Self-Help
  - Chores
  - Dressing
  - Eating
  - Grooming
  - Play and Leisure
  - Toileting
  - Vocational
- Social Skills
  - Group Instruction
  - Pragmatic Language
  - Social Interaction
- Academics
  - Math
  - Reading
  - Spelling
  - Writing
- Generalized Responding
  - Academics
  - Cognitive Functioning
  - Daily Living/Self Help
  - Language/Communications
  - Readiness Skills
  - Safety
  - Social Skills

## Submit ABA Skills Data

Upon clicking **Submit**, the system validates the data and displays the determination status. (See: Weekly ABA Measures Confirmation)

## View ABA Clinical Data

Upon clicking the **View ABA Clinical Data** button, the system authenticates the submitter ID and then passes the member number parameters to IntelligenceConnect. Upon success of the user authentication and the above parameters being passed, the user is redirected to the IntelligenceConnect application where he/she can view the ABA Maladaptive Behaviors and ABA Skills Graphical Reports.

> *This button also displays if accessing the Demographics page via the **Specific Member Search** or **Find a Specific Member** option.*

## Weekly ABA Measures Confirmation

Upon clicking **Submit** on either the ABA Maladaptive Behavior or ABA Skills page, the system validates the data and redirects the user to the appropriate Determination Status page. The following information displays on this page.

- Member Name
- Member ID
- Member DOB
- Record #
- Type of Request
- From – To (Dates)
- Submission Date
- Provider Name & Address
- Provider ID

Clicking the **Enter Maladaptive Behavior Data** button redirects the user to the <u>ABA Maladaptive Behavior</u> page.

Clicking the **Enter ABA Skills** button redirects the user to the <u>ABA Skills</u> page.

Users also have the ability to:
- Print the maladaptive behaviors/skills results,
- Print the maladaptive behaviors/skills request,
- Download the maladaptive behaviors/skills request, or
- Return to the ProviderConnect home page.

# 13 Review an Authorization – EAP CAF
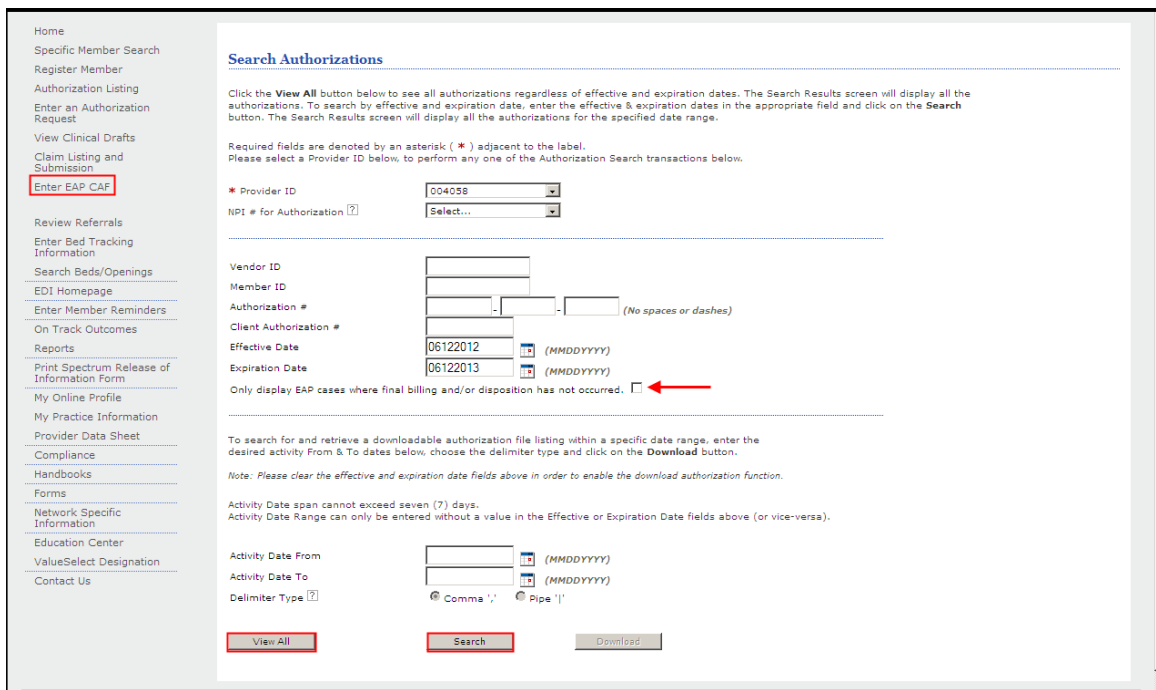
The *Review an Authorization Request* function enables providers to electronically perform an authorization search by provider ID. Network providers authorized to perform EAP Services can submit their one-page version of the CAF-1 / Billing Form from within this section.

Upon clicking [Review an Authorization](#), the Search Authorizations page displays.

*The provider ID auto-populates along with the current date.*

1. Enter the member ID, authorization #, and/or authorization dates on the Search Authorizations page.
2. Select the **Only display EAP cases where final billing and/or disposition has not occurred** checkbox if you want only those EAP authorizations that are tied to open EAP cases <u>and</u> that meet the stated conditions to be returned in the search results.
3. Click either **Search** or **View All**.



Figure 67: Search Authorizations

The Authorization Search Results page displays.

Figure 68: Authorization Search Results

4. Click on the Authorization # adjacent to the appropriate service.

   *Note: Member IDs also display as links, but were deleted to protect members' privacy.*

The Auth Summary page displays.

5. Click the **Auth Details** tab to view the authorization details.

The Auth Details page displays.

6. Click the **Enter EAP CAF** button on either the Auth Summary tab or Auth Details tab to start the CAF (Case Activity Form) entry process.

**EAP Case Activity and Billing Form**

CAF Date
**06/14/2013**

Client Company/Organization
**AT&T INC.**

*Billing Type
SELECT... ▾

**Participant Relationship to Employee**

PARTICIPANT INFORMATION

Member ID

Member Name

Member DOB
**10/06/1984**

Gender
**Male**

*Statement of Understanding Signed?  ○ Yes  ○ No

*Participant Relationship to Employee  SELF  ▾

**EAP Clinician**

Provider Name
**SEMEL, MARY**

Provider ID
**004058**

Provider Alternate ID
**2663233002**

Tax ID
**070344922**

* NPI Number
SELECT...  ▾

**Assessed Problem**

*One Assessed Problem indicator is required

○ Adult/Elder Care  ○ Drugs  ○ Hyperactivity/Learning  ○ Medical

◉ Alcohol  ○ Eating Disorder  ○ Impulse Control  ○ Mixed Alcohol/Drug Abuse

○ Anxiety  ○ Family Problems  ○ Job/Occupational  ○ Thought Disorder

○ Child Care  ○ Financial Problems  ○ Legal  ○ Situational/Adjustment

○ Depression  ○ Grief/Loss  ○ Marital / Relationship

**Risk and Functional Assessment**

Indicate Impairment Level at Case Opening and Case Closing

Key:  **0** = No Evidence of Impairment   **1** = Mild   **2** = Moderate   **3** = Severe   **N/A** = Not Assessed

**CASE OPENING**

**CASE CLOSING**

*Member`s Risk to Self
--COMPLETED--

*Member`s Risk to Others
--COMPLETED--

*Mood Disturbances (Depression or Mania)
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

*Anxiety
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

*Thinking/ Cognition/ Memory/ Concentration Problems
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

*Impulsive/ Reckless/ Aggressive Behavior
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

*Activities of Daily Living Problems
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

*Medical/ Physical Conditions
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

*Substance Abuse/ Dependence
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

*Job/ School Performance Problems
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

*Social Functioning/ Relationships/ Marital/ Family Problems
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

Member`s Risk to Self
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

Member`s Risk to Others
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

Mood Disturbances (Depression or Mania)
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

Anxiety
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

Thinking/ Cognition/ Memory/ Concentration Problems
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

Impulsive/ Reckless/ Aggressive Behavior
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

Activities of Daily Living Problems
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

Medical/ Physical Conditions
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

Substance Abuse/ Dependance
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

Job/ School Performance Problems
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

Social Functioning/ Relationships/ Marital/ Family Problems
○ 0 ○ 1 ○ 2 ○ 3 ○ N/A

**Case Closing**

Is this a case closing with no dates of service to submit claim for?  ○ Yes ○ No

Problem Status at Case Closing
SELECT...  ▾

Case Disposition
SELECT...  ▾
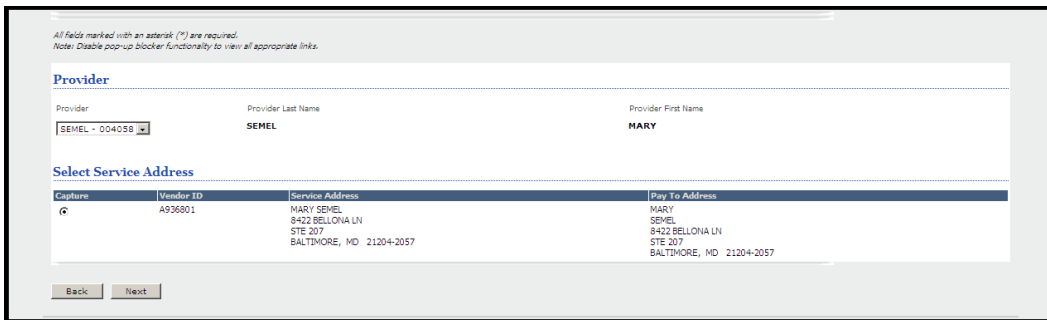
**Primary Referral Type**

○  No Referral Beyond EAP

○  Medical Treatment

○  Community Resource

○  Substance Abuse Treatment

○  Psychiatric Treatment

Figure 69: Case Activity Form (CAF)

7. Enter all the EAP Case Activity and Billing Information and click **Next**. Providers have the ability to submit an EAP CAF without executing a claim submission by answering **Yes** to the **Is this a case closing with no dates of service to submit claim for?** question. The claims section is bypassed, leaving the date of service blank.

The Select Service Address page displays next.
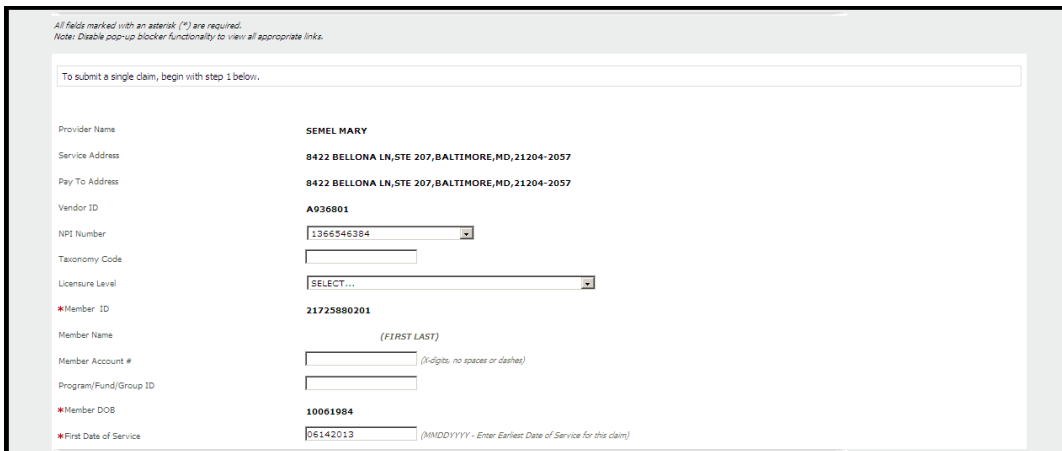


Figure 70: Select a Service Address

8. Enter the necessary information and click **Next**.
9. The Step 1 of 2 page for submitting a claim displays. Enter the applicable information and click **Next**.



Figure 71: Step 1 of 2

10. The Step 2 of 2 page for submitting a claim displays. Enter the applicable information and click **Submit**.

Figure 72: Step 2 of 2

The Case Activity & Billing process is complete.

---

*The following **Submission Printing Options** display at the bottom of the results page.*
- *Print Submission Result*
- *Print Submission*
- *Download Submission*

---



Figure 73: CAF Results

# 14 Save Request as a Draft

This functionality allows a provider to save an authorization request as a work in progress prior to submission. The provider has the option to save the authorization on each tab/page. The draft is maintained on the home page for 30 days. After 30 days, the request is removed and a new request is required.

To save an authorization request as a draft:
1. Click on Enter an Authorization/Notification Request.
2. Click **Next** on the Disclaimer page.
3. Complete the **Member ID** and **Date of Birth** fields and click **Search**.
4. Review the demographic information if necessary and click **Next**.
5. Select the service address and click **Next**.
6. Complete the Requested Services Header.
7. Attach any applicable documents and click **Next.**
8. Click **Save Request as Draft**.

The **Save Request as Draft** button can also be selected on any of the subsequent pages.

> *The Authorized User link allows creators of clinical drafts to authorize other users to update and/or submit saved drafts. (Refer to the Authorized User section at the end of this chapter for detailed information.)*

Note

Upon clicking **Save Request as Draft**, a pop-up window displays advising the user how long the draft is available for viewing and modification.

Upon clicking **OK**, the user receives a message stating that the draft request has been successfully saved.

To view saved drafts, click on View Clinical Drafts.

Users can view a read-only version of the draft by clicking the **View** button. To modify or continue with the Request for Authorization, the user may click the **Open** button. To delete a draft, the user may place a checkmark inside the box to the left of the draft and then click the **Delete Request Drafts** button. Clinical Request Drafts that have expired within the last 30 days display at the bottom of the page.

> *If attachments were added, they need to be reattached when the draft is opened. Attachments do not remain after saving a request as a draft.*

Note

# Authorized User

Creators of clinical drafts have the ability to allow other users to update and/or submit saved drafts via the Authorized User link. This functionality applies to all Requests for Services (RFS) workflows, the Individual Care Plan workflow (MRLD parent code), the Wellness Recovery Treatment Plan workflow (BHK parent code), and the Special Program Application and Comprehensive Service Plan workflows (ILL parent code).

If a user is not associated with other users, the **Authorized User** field label is fixed (i.e., static). If only one user was saved, the authorized user ID displays in this field. If multiple users were saved, the word "Multiple" displays in this field.

Following are some of the attributes of this functionality.
- The system will store a record for each authorized user of a saved draft.
- Users who belong to a group will be able to authorize multiple users to a draft.
- When a saved draft is reopened for editing by the originating user, the Authorized User link will remain available to enable the originating user to access the pop-up to change authorized users.
- A Select Authorized User(s) pop-up window will display a list of users who can be authorized to have access to the originating user's saved draft request. The pop-up can be accessed from the Authorized User link when the logged on user is in a group with other users who have clinical access.
  - The user will be able to select authorized users by clicking a checkbox next to each user.
  - The user will have the option to select all associated users.
  - There will be an option to clear all the selected users.
  - The pop-up will display users associated with the logged in user who have clinical access to View/Save Draft Requests.
  - If a user is associated with the logged in user but does not have the appropriate clinical security, that user will not appear in the pop-up.
  - The list will be sorted in ascending order by user ID and cannot be re-sorted.

## View Clinical Drafts

The View Clinical Drafts page displays the **Authorized User** field with the updated saved draft information. A read-only pop-up window displays the authorized users associated with a Saved Draft or an Expired Draft (Clinical Request Drafts and Plan Drafts).

# 15 **Enter a Notification**

The *Enter a Notification* feature enables providers to electronically submit notifications using the Notification (NTFN) form. The purpose of this form is to meet the data collection and reporting requirements of the Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinic (CCBHC) Grant and to lessen the administrative burden on the providers responsible for creating these notifications/authorizations. That is, the NTFN form allows for an authorization to be generated without requiring clinical information. (Note that not all workflows may have access to this form.)

The NTFN form contains the following tabs.
- Notification
- Results

## Contact Information

Contact information is entered first.
- Admitting Physician
- Admitting Physician Phone#
- Attending Physician
- Attending Physician Phone#
- Preparer
- Preparer Phone#
- Utilization Review Contact
- Utilization Review Contact Phone#
- Utilization Review Contact Fax

## Primary Care Coordination Information

Primary care coordination information is entered next.
- PCP Contacted Status

> *Note: If the PCP contacted status is either **Care Plan Sent to PCP** or **PCP Contacted**, the PCP contact name and date are required.*

- PCP Contacted Name
- Date Contacted

## Diagnosis Information

Diagnosis information is entered last.
- Behavioral Diagnoses
- Primary Medical Diagnosis
- Social Elements Impacting Diagnosis
- Functional Assessment

(Refer to the Diagnosis section of the Enter an Authorization Request (RFS) chapter for detailed information.)

## Additional Information

The form also includes a 2,000-character text field for the user to provide any additional information that would be helpful in processing the request.

Clicking **Submit** redirects the user to the Determination Status page.

# 16 Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge

Providers have the ability to easily submit concurrent reviews, step/transfer reviews, and discharges via the Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge link. This link displays on the ProviderConnect home page if the provider has any authorizations that expired within the last 90 days or are expiring in 90 days. Note that:

- If there are no authorization records for the provider at all, this link does not display.
- If there are authorizations for the provider but none with an expiration date that falls within the 180-day span, the link displays, but the provider receives a message indicating there are no records to display.
- If this feature has been disabled for all parent codes for which the provider has authorizations, this link does not display.

Upon clicking this link, a subset of the provider's authorizations displays on the Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge page. Any inpatient or outpatient authorizations that expired within the last 90 days or are expiring in 90 days will be listed on this page in descending order by expiration date. Be aware, however, that if all the authorization detail lines for a particular authorization contain a reason code of VVO (Void) or if the authorization has been suppressed in Service/CareConnect, the authorization will not display. If this feature has been disabled for a particular parent code, then any authorizations associated with that parent code will not display.

The date range can be changed for which the provider wishes to see authorizations by changing the authorization expiration from/to dates. Results can be sorted by:

- Auth #
- Client Auth #
- Effective Date
- Expiration Date
- Level of Service
- Type of Service
- Level of Care
- Type of Care

The Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge page contains the following action buttons.

- **Process Concurrent Review**

  > *Note: Selecting this option does not necessarily mean the review will be a concurrent review. It could be an initial review depending on what occurs in the application upon clicking **Next** on the Requested Services Header page.*

- **Process Step/Transfer Review**

  > *Note: This button is disabled for outpatient authorizations.*

- **Enter Discharge Information**

  > *Note: Activates the discharge information workflow. This button will be disabled if the authorization has already been discharged. It will also be disabled for any psychological testing authorizations.*

Upon selecting an authorization and starting either a concurrent or step/transfer review, the following pop-up window displays.
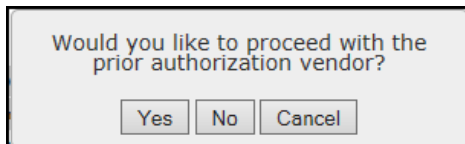


Figure 74: Proceed with the prior authorization vendor?

- Yes – Bypasses the vendor selection page. Instead of the user choosing a vendor, the system uses the vendor from the selected authorization for the new request. Certain fields pre-populate automatically on the Requested Services Header page depending on whether the user is performing a concurrent or a step/transfer review.
- No – Displays the standard Select Service Address page.
- Cancel – Closes the window.

# Process an Initial Review, Concurrent Review, Step/Transfer Review, or Discharge

Upon starting an authorization/notification request from either the ProviderConnect home page or member demographics, the Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge page displays if the member/provider combination has any inpatient or outpatient authorizations that expired within the last 90 days or are expiring in 90 days.

*Note: If this feature has been disabled for the member's parent code, this page does not display regardless of whether the member/provider combination has any inpatient or outpatient authorizations that expired within the last 90 days or are expiring in 90 days.*

This page contains the following action buttons.

- **Process Initial Review**

  *Note: Selecting this option does not necessarily mean the review will be an initial review. It could be a concurrent review, depending on what occurs in the application upon clicking **Next** on the Requested Services Header page.*

- **Process Concurrent Review**

  *Note: Selecting this option does not necessarily mean the review will be a concurrent review. It could be an initial review, depending on what occurs in the application upon clicking **Next** on the Requested Services Header page.*

- **Process Step/Transfer Review**

  *Note: This button is disabled for outpatient authorizations.*

- **Enter Discharge Information**

  *Note: Activates the discharge information workflow. This button will be disabled if the authorization has already been discharged. It will also be disabled for any psychological testing authorizations.*



Figure 75: Process an Initial Review, Concurrent Review, Step/Transfer Review, or Discharge

# Process a Concurrent Review, Discharge Review, or Step/Transfer Review

The Auth Summary and Auth Details pages also contain the following action buttons.

*Note: If this feature has been disabled for the member's parent code, these buttons do not display.*

- **Process Concurrent Review**

    *Note: Selecting this option does not necessarily mean the review will be a concurrent review. It could be an initial review, depending on what occurs in the application upon clicking **Next** on the Requested Services Header page.*

- **Complete Discharge Review**
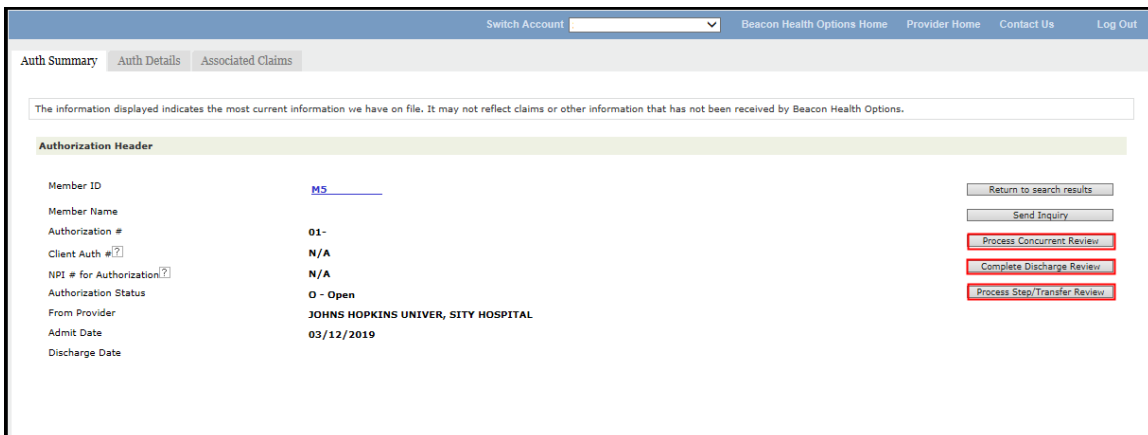
    *Note: Activates the discharge information workflow. This button will be disabled if the authorization has already been discharged. It will also be disabled for any psychological testing authorizations.*

- **Process Step/Transfer Review**

    *Note: This button is disabled for outpatient authorizations.*

The **Process Concurrent Review** and **Process Step/Transfer Review** buttons are disabled:

- For any psychological testing authorizations,
- For any authorizations that have a level of service other than inpatient or outpatient (e.g., EAP), or
- If the Prior Authorization Listing for Concurrent Review, Step/Transfer Review feature has been disabled for the member's parent code.



Figure 76: Process a Concurrent Review, Discharge Review, or Step/Transfer Review

# 17 Recent Provider Summary Vouchers

Users can view recent provider summary vouchers by clicking on <u>View My Recent Provider Summary Vouchers</u>.

Provider summary vouchers can be retrieved by:
- Searching Provider Summary Vouchers by Provider

  *Note: This is the default.*
- Searching Provider Summary Vouchers by Check

The search results contain records that match the search criteria. A specific provider summary voucher can be viewed by clicking on the <u>View</u> link.



Figure 77: Search a Provider Summary Voucher

# 18 Claim Listing and Submission

In this section of ProviderConnect, a user can enter a claim, submit a claim, and search for a claim.

Upon clicking either [Claim Listing and Submission]() or [Review a Claim](), the Claims page displays with three sections titled New Claims, Search Claims, and Search Other Claims.
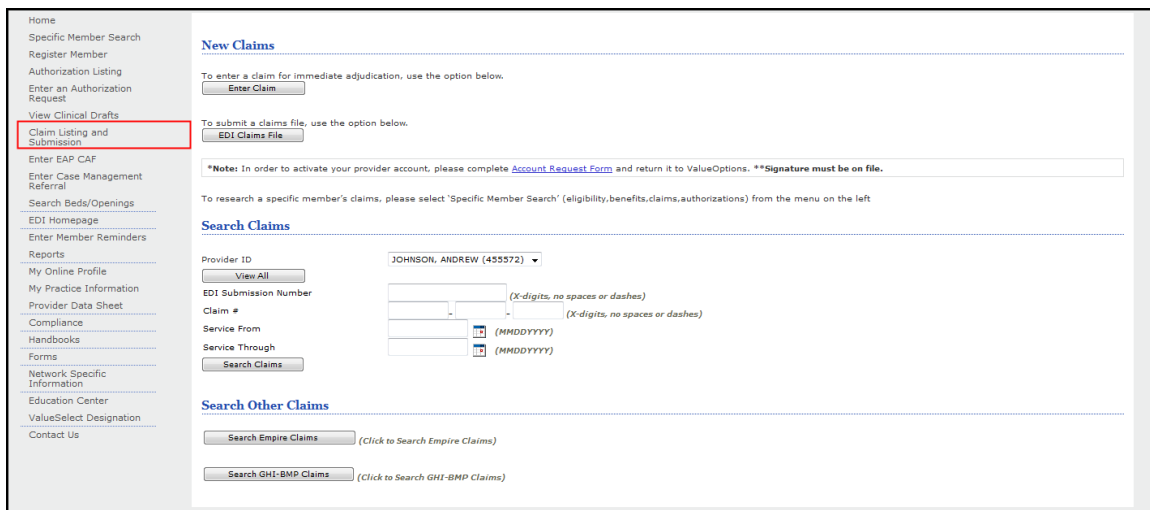


Figure 78: Claims

This page contains several options.

- Click the **Enter Claim** button to enter a claim for immediate adjudication. For detailed information, refer to the [Enter a Claim]() section.

> *Note:*
> o *Providers need their vendor number. This number can be obtained from Provider Relations.*
> o *Name fields are not required. If a name is entered, make sure the spelling is correct or an error message displays.*
> o *The patient's date of birth must be entered, not the member's date of birth.*

- Click the **EDI Claims File** button to submit an electronic claim. For detailed information, refer to the [EDI Homepage]() chapter.
- Complete the Search Claims section and click **Search** to search for a provider-specific claim. For detailed information, refer to the [View Member Claims]() section.
- Click the **Search Empire Claims** button if the claim is specific to the Empire Client. For detailed information, refer to the [View Empire Claims]() section.

- Click the **Search GHI-BMP Claims** button if it is a GHI-BMP claim. For detailed information, refer to the [View GHI-BMP Claims](#) section.

Slight differences appear between the directions in the referenced sections and the directions for Claims Listing and Submission (because the information is member-specific instead of provider-specific). The majority of the directions are the same, however.

# 19 Viewing OnTrack Outcomes

The [View My Outcomes with On Track](#) link gives providers the ability to have seamless connectivity to the OnTrack Outcomes Tools on the Collaborative Outcomes Resource Network (ACORN). The Beacon Health Options *OnTrack* program is a client-centered outcomes-informed care program. The goal of *OnTrack* is to provide clinicians with state-of-the-art easy to use tools that promote improved client outcomes. *OnTrack* is designed to support clinicians as they help their clients achieve their goals. Beacon clinicians can use *OnTrack* for all of their EAP, commercially insured or private pay clients, including, if they choose, those clients who are not Beacon members.

Upon clicking either **On Track Outcomes** or **View My Outcomes with On Track,** the On Track Outcomes Tool displays.
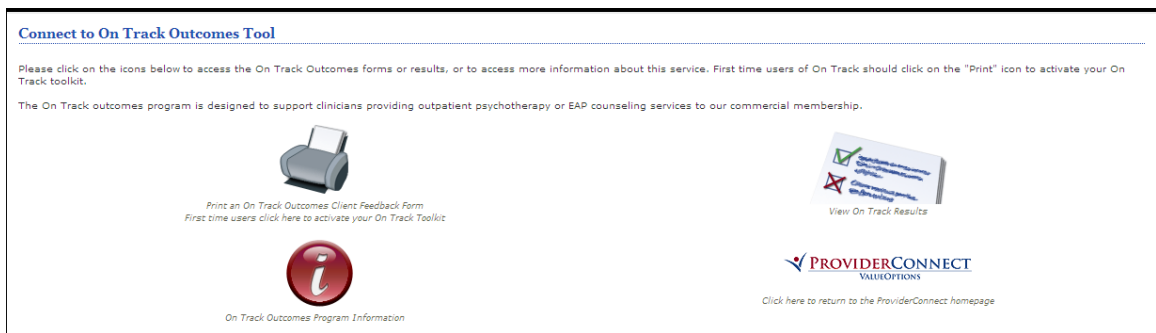


Figure 79: OnTrack Outcomes Tool

To view OnTrack program information, click the **On Track Outcomes Program Information** icon.

The OnTrack Toolkit is hosted for Beacon Health Options on the ACORN (A Collaborative Outcomes Resource Network) platform. The ACORN site contains a variety of outcomes forms that can be viewed and printed.

# 20 My Online Profile
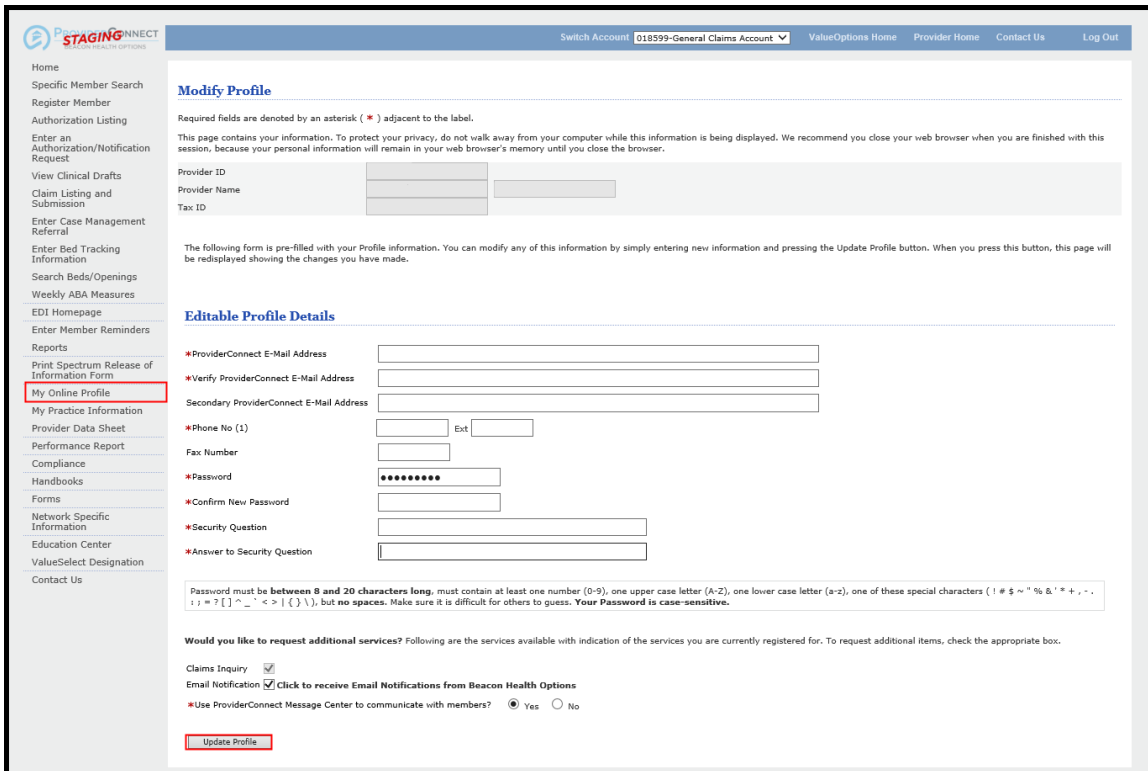
In this section of ProviderConnect, providers can access and modify their own profile information.

Upon clicking My Online Profile, a page displays that contains the following sections.
- The Modify Profile section contains information that cannot be changed (e.g., Provider ID, Provider Name, and Tax ID).
- In the Editable Profile Details section, however, the user can edit information (e.g., E-mail Address, Phone Number, and Password).

To edit provider information:
1. Update the information in the Editable Profile Details section as appropriate.
2. Click **Update Profile**.



Figure 80: My Online Profile

# 21 My Practice Information

In the *My Practice Information* section of ProviderConnect, information on provider practices can be accessed.

Click on My Practice Information to view provider contact information.



Figure 81: View Provider Contact Information

1. Enter the provider's last name in the **Last Name** field.
2. Enter provider's first name, if needed, in the **First Name** field.
3. Select a state, if needed, from the **State** drop-down.
4. Click **Search**.

The Provider Search Results page displays.

5. Click on the Last Name for the appropriate provider.

Figure 82: Provider Search Results

The Provider Details page displays. Detailed information about the provider displays on this page (e.g., Name, Address, Specialties).

# 22 Provider Data Sheet

The Provider Data Sheet (PDS) is Beacon's online provider re-credentialing application and is accessible to providers only at the time re-credentialing is needed. Providers are notified via telephone, fax, e-mail, or mail when re-credentialing is due and the PDS is available.

To access this section, click the Provider Data Sheet link on the navigation bar. The PDS contains the following tabs.

- Provider
- Referral
- Practice
- Education
- License/Certification
- Insurance
- Work History

- EAP Counselor
- Disability Provider
- FFD Specialist
- Provider Profile
- W-9
- Supporting Documentation
- Attestation

1. Review the Provider Information, and make any necessary corrections or additions. Click **Save & Next** to continue.

   *Note: A red asterisk (\*) indicates a required field.*



Figure 83: Provider Information

2. Enter the necessary Referral Information. Click **Save & Next** to continue.

## 2. REFERRAL INFORMATION

**A. LICENSED DISCIPLINE:** Indicate the discipline under which you are LICENSED and/or CERTIFIED at the highest level to practice independently.

- ☐ APN W/ Prescriptive Authority
- ☐ APN W/O Prescriptive Authority
- ☐ Addictionologist
- ☐ Alcohol/Drug/Substance Abuse Counselor
- ☐ Art Therapist
- ☐ Child Psychiatrist
- ☐ Child/Adolescent Psychiatrist
- ☐ Developmental Behavioral Pediatrician
- ☐ EAP
- ☐ Geriatrics Psychiatrist
- ☐ LIC/CERT Psychological Examiner
- ☐ LLP- Limited License Psychologist
- ☐ Licensed Clinical Psychologist (Doctorate level)
- ☐ Licensed Clinical Social Worker (Highest level)
- ☐ Licensed Marriage and Family Therapist (Highest level)

- ☐ Licensed Professional Counselor/Mental Health Counselor (Highest level)
- ☐ Licensed/Certified Social Worker (Highest level)
- ☐ MD Developmental Behavioral Pediatrician
- ☐ Master's Level Psychologist
- ☐ Other Psychologist
- ☐ Other Social Worker (Not at highest level)
- ☐ Other with ability to specify
- ☐ Pastoral Counselor
- ☐ Physician - Non Psychiatrist
- ☐ Physician Assistant
- ☐ Psychiatric Clinical Nurse Specialist
- ☐ Psychiatrist
- ☐ Qualified Mental Health Practitioner (Nebraska)
- ☐ Unlicensed Provider

Other (specify): [_____]

**B. Population Treated:**
Identify the percentage of your practice dedicated to the following patient population categories (must total 100%)

| Population | % of Practice | Are You Currently Accepting New Patients? | | Modality | % of Practice |
|---|---|---|---|---|---|
| | | Yes | No | | |
| Child(0-5) | [___] | ○ | ○ | Inpatient | [___] |
| Child(6-12) | [___] | ○ | ○ | Day Treatment | [___] |
| Adolescent(13-17) | [___] | ○ | ○ | Outpatient | [___] |
| Adult(18-64) | [___] | ○ | ○ | Intensive Outpatient Programs | [___] |
| Geriatric(65+) | [___] | ○ | ○ | | |
| **Total: 0%** | | | | **Total: 0%** | |

**C. Language:**
Identify any foreign language(s) or sign language that you use fluently in treating patients (select no more than 5):

| | | | |
|---|---|---|---|
| ☐ ARABIC | ☐ GUJARATHI | ☐ NONE | ☐ SUDANESE |
| ☐ ARMENIAN | ☐ HAITIAN CREOLE | ☐ NORWEGIAN | ☐ SWEDISH |
| ☐ BOSNIAN | ☐ HEBREW | ☐ PERSIAN | ☐ TAGALOG |
| ☐ CANTONESE | ☐ HINDI | ☐ POLISH | ☐ TAGALOG (FILIPINO) |
| ☐ CHINESE | ☐ HUNGARIAN | ☐ PORTUGUESE | ☐ TAMIL |
| ☐ CZECH | ☐ ITALIAN | ☐ RUSSIAN | ☐ THAI |
| ☐ DUTCH | ☐ JAPANESE | ☐ SERBO-CROATION | ☐ UNKNOWN |
| ☐ FARSI (PERSIAN) | ☐ KANNADA | ☐ SIGN LANGUAGE | ☐ URDU |
| ☐ FRENCH | ☐ KOREAN | ☐ SOMALI | ☐ VIETNAMESE |
| ☐ GERMAN | ☐ MANDARIN | ☐ SPANISH | ☐ YIDDISH |
| ☐ GREEK | ☐ MON-KHMER | | |

Other (specify): [_____]

**D. ANSWERING SERVICE:** Indicate how you can be reached after hours:

Answering Service Name*
[_____]   ☐ **Check box for No Answering Service (Self)**

Phone #*          Pager or Beeper #
[_____] Ext: [_____]   [_____] Ext: [_____]

Voice Mail #
[_____] Ext: [_____]

**E. CLINICAL EXPERTISE (SPECIALTIES):** From the list below, rank order a maximum of six (6) specialty areas for which you have training and expertise. For example "1" means primary specialty, "2" means secondary specialty, etc. If you indicate more than six specialties, they will not be documented. These specialties will be used to assist *ValueOptions®, Inc.* in making clinically appropriate referrals. Please remember to select applicable specialties when applying for the specialty networks.

1. [-- Select Specialty -- ▾]
2. [-- Select Specialty -- ▾]
3. [-- Select Specialty -- ▾]
4. [-- Select Specialty -- ▾]
5. [-- Select Specialty -- ▾]
6. [-- Select Specialty -- ▾]

**F. THERAPEUTIC MODALITIES:** From the list below, rank order a maximum of six (6) modality areas that you use when treating patients. For example "1" means primary modality, "2" means secondary, etc. These modalities will be used to assist *ValueOptions®, Inc.* in making clinically appropriate referrals. Please remember to select applicable modalities when applying for the specialty networks.

1. [-- Select Specialty -- ▾]
2. [-- Select Specialty -- ▾]
3. [-- Select Specialty -- ▾]
4. [-- Select Specialty -- ▾]
5. [-- Select Specialty -- ▾]
6. [-- Select Specialty -- ▾]

**G. VOLUNTARY INFORMATION:** To meet the needs of *ValueOptions® Inc.* clients and members, voluntary information is maintained about providers **for referral and statistical purposes only.** This information is released to members only upon *specific* request. If you wish to provide this information, select from the following categories:

[-- Select Ethnicity -- ▾]

**H. HOSPITAL PRIVILEGES (Physicians Only):** List below, if applicable, your current hospital privileges and the type of hospital privilege granted to you by your admitting facility. **The Primary Admitting Facility should be the facility at which you admit/treat most of your patients.**

Do you currently hold hospital privileges?  ○ Yes  ○ No

**Edit Name Address City/ST/Zip Delete**
No Records Found

⊕ **Add Hospital Privilege**

If you **do not** have admitting privileges, list the name(s) of an in-network physician or facility below to whom you would refer.

First Name          Last Name          Facility Name
[_____]          [_____]          [_____]

* You may call the National Network Services Line at (800) 397-1630 to verify network participation.

Figure 84: Provider Referral Information

3. Enter the provider's Practice Information. Click **Save & Next** to continue.

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**3. PRACTICE INFORMATION**

**A. PRACTICE INFORMATION**
No records are currently attached to this provider

⊕ **Add Additional Practice Location**

**B. DEMOGRAPHIC DATA:**

ValueOptions®, Inc., is contracted with various public agencies at the Federal, State and Local levels. Some of these contracts require us to verify the business size of our Network providers/facilities as well as their socioeconomic status. The collection of this data will not be used for credentialing purposes. This information will be used in aggregate to supply data to the Federal or State government as part of a government contracting process. **These questions should be answered considering the Group TIN in which claims are filed if you are part of a Group. If you are an individual practitioner/sole proprietor, the questions should be answered based on the TIN in which you file your claims.** In order to assist us in facilitating this process, we ask you complete the questions below for the TIN in which your claims are filed.

What is the North American Industrial Classification System Code (NAICS) for this business?
[-- Select NAICS Code -- ▼]
If not listed in drop-down selection list above, please enter the NAICS that matches your companies concern here:
Other (specify): [          ]

**Click here** 📄 for some of the common NAICS codes for providers of healthcare services with their applicable average annual size standard. If your business type is not listed below, contact the Small Business Administration in your area for assistance or for a complete listing of all NAICS codes, please visit **http://www.sba.gov/size** .

This information is for demographic reporting purposes only and will **not** be used for credentialing. This information may be used in the aggregate to supply data to the federal or state government as part of a government contracting process. **The information will be disclosed only for the purposes stated.**
If this information is applicable to your business, please answer the following questions.

Are you an employee of a professional or other corporation?                  ○ Yes ○ No

Is this business considered a small business as defined by the Small Business Administration?    ○ Yes ○ No
● **Small Business** means a concern that is independently owned and operated, not dominant in the field of operation in which it is operating under Government Contracts and meets size standards set by the Small Business Administration (SBA). Small Business size varies by NAICS, see chart above. The number of employees or annual gross revenue indicates the maximum allowed for a concern to be considered a small business. Small Business size examples: A business is considered small business if its annual gross revenues (an average for the last three years) are less than the amount specified for its NAICS number (see above section for examples).

Is this business considered a Women-Owned Small Business?                  ○ Yes ● No
● **Woman Owned Small Business** means a concern that is at least 51 percent owned by one or more women and whose management and daily business operations are controlled by one or more women and meets size standards to be considered small (see above).

Is this business considered a Small Disadvantaged Business?                  ● Yes ○ No
● **Small Disadvantaged Business** means a concern that is at least 51 percent owned by a disadvantaged person(s) and that person(s) provides daily management and control of the firm. The following are considered disadvantaged groups (all must be U.S. citizens): Black Americans; Hispanic Americans; Native Americans (American Indians, Eskimos, Aleuts, and Native Hawaiians); Asian Pacific Americans (persons with origins from Japan, China, the Philippines, Vietnam, Korea, Samoa, Guam, U.S. Trust Territory of the Pacific Islands [Republic of Palau], Commonwealth of the Northern Mariana Islands, Laos, Cambodia [Kampuchea], Taiwan; Burma, Thailand, Malaysia, Indonesia, Singapore, Brunei, Republic of the Marshall Islands, Federated States of Micronesia, Macao, Hong Kong, Fiji, Tonga, Kiribati, Tuvalu, or Nauru; Subcontinent Asian Americans (persons with origins from India, Pakistan, Bangladesh, Sri Lanka, Bhutan, the Maldives Islands or Nepal), and Members of other groups designated by the SBA. Individual/concern other than one of the proceeding, currently certified for participation in the Minority Small Business and Capital Ownership Development Program under section 8 (a) of the Small Business Act.

Is this business considered 8(a) certified? If yes, please include copy of certification.    ○ Yes ● No
● **8(a) Certified** means a concern that has received a certification for this Program from the Small Business Administration.
⬆ **Upload 8(a) Certificate**

Is this business considered a Veteran-Owned Small Business?                  ○ Yes ● No
● **Veteran Owned Small Business** means a concern that is at least 51 percent owned by one or more veterans and whose management and daily business operations are controlled by one or more veterans and meets size standards to be considered small (see above).

Is this business considered a Service Disabled Veteran-Owned Small Business?    ○ Yes ● No
● **Service-Disabled Veteran-Owned Small Business** means a concern owned and controlled by a service disabled veteran. The term "service-disabled veteran" means a veteran with a disability that is service connected (as defined in section 101 (16) of title 38, United States Code) and meets size standards to be considered small.

Is this business considered a HUBZone Small Business? If yes, please include copy of certification.    ○ Yes ● No
● **HUBZone Small Business** A firm can be found to be a qualified HUBZone concern, if it is small; it is located in an "historically underutilized business zone" (HUBZone); it is owned by one or more U.S. Citizens; at least 35 percent of its employees reside in a HUBZone. Must be certified by the U.S. Small Business Administration (SBA). SBA in your area can help to determine if you're located in a HUBZone and help you receive certification. Copy of the certification needs to be submitted with your credentialing application.
⬆ **Upload HUBZone Certificate**

Is this business considered a large business as defined by the Small Business Administration?    ○ Yes ○ No
● **Large Business** means a concern that does not qualify for a small business as defined above.

Is this business considered a Historically Black College/Minority Institution?    ○ Yes ○ No
● **Historically Black College** means institutions determined by the Secretary of Education to meet the requirements of 34 CFR 608.2. The term also means any nonprofit research institution that was an integral part of such college or university before November 14, 1986. Minority Institution means institution of higher education meeting the requirements of section 1046(3) of the Higher Education Act of 1965 (20 USC 1135d-5 (3)): Enrollment of a single minority or a combination of minorities exceeds 50 percent of the total enrollment. The term also includes Hispanic serving institutions as defined in section 316(6) (1) of such Act (20 USC 1059c(b).

If your business could be classified as a minority-owned business, which of the following categories would it fall under?
*This question is optional.*
○ Caucasian                                   ○ Hispanic (Mexican, Puerto Rican, Cuban, Central or South
○ Black (African, Jamaican or West Indian descent)    American, or other Spanish culture or origin)
○ Native American or Alaskan Native (Persons    ○ Asian or Pacific Islander (persons having origins in any of the original
   having origins in any of the original peoples of       peoples of the Far East, Southeast Asia, the Indian subcontinent of the
   America)                                          Pacific Islands)

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Figure 85: Provider Practice Information

4. Enter the provider's Education Information. Click **Save & Next** to continue.



Figure 86: Provider Education Information

5.  Enter the provider's License/Certification Information, and upload or fax a copy of his/her current certificate(s). Click **Save & Next** to continue.



Figure 87: License/Certification Information

6.  Enter the provider's Malpractice Insurance Carrier Information, and upload or fax a copy of his/her current malpractice insurance face sheet. Click **Save & Next** to continue.



Figure 88: Malpractice Insurance Information

7. Enter the provider's Work History Information. Click **Save & Next** to continue.



Figure 89: Work History Information

8. If applicable, enter the EAP Counselor Information. Click **Save & Next** to continue.



Figure 90: EAP Counselor Only

9. If applicable, enter the necessary Disability Provider Network Information. Click **Save & Next** to continue.



Figure 91: Disability Provider Network Only Information

10. If applicable, enter the Fitness for Duty Assessment Specialist Network Information (FFD Specialist). Click **Save & Next** to continue.

**10. FITNESS FOR DUTY ASSESSMENT SPECIALIST NETWORK ONLY**

Please note that ValueOptions® is not currently credentialing new practitioners for this network. If completed, your responses will be used for informational purposes only.

Does this apply?*  ● ○
Yes  No

Are you interested in participating in the Fitness for Duty specialty network?  ○ ○
Yes  No

If yes, go on.
Do you meet the minimum VO criteria for your licensure level AND the criteria for the specialty FFD network?  ○ ○
Yes  No

If yes, complete the following for the Fitness for Duty specialty network in its entirety.

Check the box for the discipline that applies to you and answer the questions for that discipline.

**A. ☐ Psychiatrist or Addictionist**

1. Are you a member of the American Academy of Psychiatry and the Law?  ○ ○
Yes No

2. Do you hold current and valid ASAM certification?  ○ ○
Yes No

3. Do you have at least 2 years of experience engaged in Fitness for Duty (FFD) evaluations?  ○ ○
Yes No

4. Have you evaluated clinical cases where fitness for duty and/or substance abuse was the primary issue?  ○ ○
Yes No

**B. ☐ Psychologist**

1. Do you hold ABBP certification?  ○ ○
Yes No

2. Do you have at least 2 years of experience engaged in Fitness for Duty (FFD) evaluations?  ○ ○
Yes No

3. Have you evaluated clinical cases where fitness for duty and/or substance abuse was the primary issue?  ○ ○
Yes No

**C. All Fitness for Duty Assessment Specialist applicants complete the following:**

1. Are you willing to function as part of an FFD team assigned to one or more specific locations?  ○ ○ ○
Yes No N/A

2. Are you able to schedule and perform a face-to-face FFD evaluation within 24 hours if requested, provide feedback immediately after the evaluation if requested (with the exception of psychological testing results), and complete and return an FFD form to ValueOptions® within 3 business days?  ○ ○ ○
Yes No N/A

3. Are you willing to engage in on-going dialogue with ValueOptions® care managers on an as-needed basis?  ○ ○ ○
Yes No N/A

4. Are you willing to testify in legal/court proceedings when requested?  ○ ○ ○
Yes No N/A

5. Have you performed at least 25 evaluations where substance abuse and/or FFD was an issue during the last 2 years?  ○ ○ ○
Yes No N/A

6. Are you familiar with alcohol and drug testing policies and procedures?  ○ ○ ○
Yes No N/A

7. Are you familiar with workplace issues?  ○ ○ ○
Yes No N/A

8. Do you have experience working with and evaluating employees who are in federally regulated safety sensitive jobs?  ○ ○ ○
Yes No N/A

9. If you are a psychologist have you utilized psychological tests as part of your FFD evaluation process?  ○ ○ ○
Yes No N/A

10. If you perform psychological testing are you able to schedule it within 72 hours of a request, and send a completed written report to ValueOptions® within 3 business days after completion of the testing?  ○ ○ ○
Yes No N/A

11. Are you eligible or do you hold NCAC, ICADC or state-level addictions treatment certification/licensure?  ○ ○ ○
Yes No N/A

12. Are you willing to allow ValueOptions® to request a criminal background check on you?  ○ ○ ○
Yes No N/A

**D. Indicate in the grid below your level of experience (number of cases) with each of the issues identified:**

| Trigger for a Fitness for Duty Evaluation | Number of cases seen where this was the primary cause for evaluation | |
|---|---|---|
| | ...In the last 2 years | ...In my career |
| Positive test on a random drug/alcohol screen | | |
| Positive drug/alcohol test result where test was administered for reasonable cause | | |
| Unusual/aberrant/bizarre behavior in the workplace | | |
| Return to work post-critical incident | | |
| Sub-standard work performance | | |
| Absenteeism | | |
| Pre-employment screening | | |
| Change in job responsibilities to a level involving potential for increased safety hazard(s) | | |
| Column Totals | | |

**E. Check the settings in which you have performed Fitness for Duty evaluations:**
☐ Industry  ☐ Fire, Police, Safety  ☐ Military  ☐ Oil, Mineral, Forestry
☐ Health Care  ☐ Utilities (Water, Gas, Electric, etc.)  ☐ Other (specify):

Figure 92: FFD Specialist Information

11. Answer all the Provider Profile Information. If the **Yes** option button is selected, please provide an explanation in the Comments section at the bottom of the page. Click **Save & Next** to continue.



**11. PROVIDER PROFILE**

**A. Please answer all provider profile questions.**

NOTE: If "yes" is checked, please explain fully in the **space provided.**

Yes No N/A

1. **Health Status:** Do you have any physical, mental, or emotional condition, including but not limited to any history of drug or alcohol abuse, which currently impairs your ability to render the professional services which are the subject of this application? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to safely and competently render the professional services, which are the subject of this application.
2. **Insurance Coverage:** Has your professional liability insurance coverage ever been denied, canceled, or non-renewed or initially refused upon application?
3. **License:** Has your medical or professional license in any state ever been revoked, suspended, placed on probation, conditional status, or limited?
   a. Have you ever voluntarily surrendered your license?
   b. Are formal charges pending against you at this time?
4. **DEA:** Has your DEA Registration Certificate ever been suspended, revoked, subjected to probation, placed on conditional status, or limited?
5. **Hospital Privileges or Participation Status:** Has any hospital ever dismissed you from its staff?
   a. Has any hospital ever refused or denied you privileges or any health plan or other provider network entity refused or denied you participation?
   b. Have you ever voluntarily surrendered your hospital privileges?
   c. Have you voluntarily ended your participation status with a health plan or other provider network entity while under investigation or in lieu of investigation?
   d. Has any hospital ever limited, suspended, revoked or terminated your staff privileges or otherwise dismissed you from its staff?
   e. Has any health plan or provider network entity ever limited, suspended, revoked or terminated your participation status?
6. **Hospital or Provider Network Sanctions:** Have you ever surrendered your hospital clinical privileges or health plan/provider network participation due to possible censure, restriction, suspension, revocation or termination of such privileges and/or provider network participation?
7. **Professional Membership(s):** Has your membership in any professional society or association ever been canceled, revoked, or censured?
8. **Criminal Offenses:** Have you ever been arrested, charged with or convicted of a felony or involved in charges relating to moral or ethical turpitude, including crimes with children?
   a. Have you ever been named as a defendant in any criminal proceeding?
9. **Board Discipline:** Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county, state or national professional society; hospital medical or clinical staff)?
10. **Malpractice Action:** Has any malpractice action against you been brought or settled in the past 5 years or has there been any unfavorable judgment(s) against you in a malpractice action?
    a. To your knowledge, is any malpractice action against you currently pending?
    b. If your answer to question 10 above is yes, please mark the number of malpractice claims pending and/or closed:
       One   Two   More than 2(please give number)
    c. Have you ever been a defendant in any lawsuit involving your practice where there has been an award or payment of $100,000 or more?
    d. Have you had any malpractice claims where there has been an award or payment of $100,000 or more?
11. **Medicare/Medicaid:** Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by any Medicare, Medicaid or TRICARE program?
12. **Medicare Participation:** Are you a Medicare participating provider?(Note: N/A=not eligible)
    a. If you answered yes above, you have completed or will complete the required annual trainings for Medicare,including Fraud,Waste and Abuse training, and agree to provide verification if requested.(Note: if NO is checked, please explain fully)
13. **State Medical Assistance/Medicaid Program Participation:** Are you a participating provider in the State Medical Assistance Program(s) where you practice (i.e., Medicaid, Medi-Cal, MaineCare)? (Note: N/A = not eligible)
14. **Comments:** If you answered yes to questions 1-11 or no to question 12.a, please explain fully in this space.

Figure 93: Provider Profile Information

12. Enter the necessary information for the Substitute for Form W-9 Request for Taxpayer Identification Number. Click **Save & Next** to continue.



Figure 94: W-9

13. Follow the directions on this page to complete and upload any additional contract-specific Supporting Documentation as necessary. Click **Save & Next** to continue.

*Note: Customized text along with a link can be added to this tab as necessary.*



Figure 95: Supporting Documentation

14. Read the Attestation/Participation Statement. If manually signing and faxing the Attestation form, follow the instructions on this page. (After indicating their intention to fax the form, users should print the document *prior to saving*.)



Figure 96: Attestation Information

# Electronically Sign the Attestation

To electronically sign the form, do the following:

1. Click in the highlighted **Click here to sign this document electronically** area on the Attestation page. The Welcome to the Provider Esignature Process page displays.
2. Review the steps on the Welcome to the Provider Esignature Process page to apply an electronic signature.
3. Click on Proceed to ESIGN Disclosure.

The US Federal Consumer Disclosure – E-Sign Act page displays.

4. Carefully read the information on the this page.
5. Click on Yes to signify consent to complete and sign the document electronically. The Signature Information page displays.
6. Enter the user's name to apply to the attestation document on the Signature Information page.
   *Note: Enter the name as you would normally write it when signing a paper document, using upper and lower case letters as appropriate.*
7. Click the **Submit** button to display the Attestation/Participation Statement that the user is being asked to electronically sign.
8. Click in the highlighted **Click Here to Sign** area to electronically sign the document. A Thank You page displays stating that the document has been successfully signed.
9. Follow the instructions on the Thank You page to download a copy of the document and save it to your computer.

After the user saves the signed attestation locally or closes the Esign confirmation window, a pop-up window displays indicating that the form has been submitted to Beacon Health Options. At that point, if any of the required tabs were left blank, a pop-up window displays informing the user to enter information for the missing tabs. The completed PDS application is automatically submitted once the user has applied his or her Esignature.

Following is an example of the pop-up window that displays when a practitioner has submitted his or her PDS application.

Figure 97: Practitioner Final Submission Pop-up

There are also options on the PDS to **Print current page**, **Print all pages**, or **Close**.

# 23 **Facility Data Sheet**

The Facility Data Sheet (FDS) is Beacon's online facilities and organizational provider re-credentialing application and is similar to the Provider Data Sheet (PDS). Like the PDS, it is accessible only at the time re-credentialing is needed. Facilities are notified via telephone, fax, e-mail, or mail when re-credentialing is due and the FDS is available.

Click on Provider Data Sheet to access the FDS. The FDS contains the following tabs.
- General Information
- License/Accreditation
- Insurance
- Demographic
- Service Locations & Programs
- Addenda
- Supporting Documentation
- Roster of Providers
- Participation Statement

1. Review the General Information, and make any necessary corrections or additions. Click **Save & Next** to continue.

   *Note: A red asterisk (\*) indicates a required field.*



Figure 98: General Information

2.  Enter the facility's License/Accreditation Information, and upload or fax a copy of their current certificate(s). Click **Save & Next** to continue.



Figure 99: License/Accreditation Information

3. Enter the facility's Malpractice Insurance Carrier Information, and upload or fax a copy of their current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates. Click **Save & Next** to continue.



Figure 100: Insurance Information

4.  Enter the facility's Demographic Data, and upload or fax a copy of their current 8(a) and HUBZone certificate(s) if applicable. Click **Save & Next** to continue.

## 4. DEMOGRAPHIC

**K. DEMOGRAPHIC DATA:**

ValueOptions®, Inc., is contracted with various public agencies at the Federal, State and Local levels. Some of these contracts require us to verify the business size of our Network providers/facilities as well as their socioeconomic status. The collection of this data will not be used for credentialing purposes. This information will be used in aggregate to supply data to the Federal or State government as part of a government contracting process. **These questions should be answered considering the Facility TIN in which claims are filed.** In order to assist us in facilitating this process, we ask you complete the questions below for the TIN in which you claims are filed.

What is the North American Industrial Classification System Code (NAICS) for this business?

--- Please Select --- ▼

If not listed in drop-down selection list above, please enter the NAICS that matches your companies concern here:

Other (specify): [        ]

**Click here** 🔲 for some of the common NAICS codes for providers of healthcare services with their applicable average annual size standard. If your business type is not listed below, contact the Small Business Administration in your area for assistance or for a complete listing of all NAICS codes, please visit **http://www.sba.gov/size** .

This information is for demographic reporting purposes only and will <u>not</u> be used for credentialing. This information may be used in the aggregate to supply data to the federal or state government as part of a government contracting process. **The information will be disclosed only for the purposes stated.** If this information is applicable to your business, please answer the following questions.

Are you an employee of a professional or other corporation?                          ○ Yes  ○ No

Is this business considered a small business as defined by the Small Business Administration?                                                                                  ○ Yes  ○ No

● **Small Business** means a concern that is independently owned and operated, not dominant in the field of operation in which it is operating under Government Contracts and meets size standards set by the Small Business Administration (SBA). Small Business size varies by NAICS, see chart above. The number of employees or annual gross revenue indicates the maximum allowed for a concern to be considered a small business. Small Business size examples: A business is considered small business if its annual gross revenues (an average for the last three years) are less than the amount specified for its NAICS number (see above section for examples).

Is this business considered a Women-Owned Small Business?                          ○ Yes  ○ No

● **Woman Owned Small Business** means a concern that is at least 51 percent owned by one or more women and whose management and daily business operations are controlled by one or more women and meets size standards to be considered small (see above).

Is this business considered a Small Disadvantaged Business?                          ○ Yes  ○ No

● **Small Disadvantaged Business** means a concern that is at least 51 percent owned by a disadvantaged person(s) and that person(s) provides daily management and control of the firm. The following are considered disadvantaged groups (all must be U.S. citizens): Black Americans; Hispanic Americans; Native Americans (American Indians, Eskimos, Aleuts, and Native Hawaiians); Asian Pacific Americans (persons with origins from Japan, China, the Philippines, Vietnam, Korea, Samoa, Guam, U.S. Trust Territory of the Pacific Islands [Republic of Palau], Commonwealth of the Northern Mariana Islands, Laos, Cambodia [Kampuchea], Taiwan; Burma, Thailand, Malaysia, Indonesia, Singapore, Brunei, Republic of the Marshall Islands, Federated States of Micronesia, Macao, Hong Kong, Fiji, Tonga, Kiribati, Tuvalu, or Nauru; Subcontinent Asian Americans (persons with origins from India, Pakistan, Bangladesh, Sri Lanka, Bhutan, the Maldives Islands or Nepal), and Members of other groups designated by the SBA. Individual/concern other than one of the proceeding, currently certified for participation in the Minority Small Business and Capital Ownership Development Program under section 8 (a) of the Small Business Act.

Is this business considered 8(a) certified? If yes, please include copy of certification.    ○ Yes  ○ No

● **8(a) Certified** means a concern that has received a certification for this Program from the Small Business Administration.

⬆ **Upload 8(a) Certificate**

Is this business considered a Veteran-Owned Small Business?                          ○ Yes  ○ No

● **Veteran Owned Small Business** means a concern that is at least 51 percent owned by one or more veterans and whose management and daily business operations are controlled by one or more veterans and meets size standards to be considered small (see above).

Is this business considered a Service Disabled Veteran-Owned Small Business?        ○ Yes  ○ No

● **Service-Disabled Veteran-Owned Small Business** means a concern owned and controlled by a service disabled veteran. The term "service-disabled veteran" means a veteran with a disability that is service connected (as defined in section 101 (16) of title 38, United States Code) and meets size standards to be considered small.

Is this business considered a HUBZone Small Business? If yes, please include copy of certification.                                                                                   ○ Yes  ○ No

● **HUBZone Small Business** A firm can be found to be a qualified HUBZone concern, if it is small; it is located in an "historically underutilized business zone" (HUBZone); it is owned by one or more U.S. Citizens; at least 35 percent of its employees reside in a HUBZone. Must be certified by the U.S. Small Business Administration (SBA). SBA in your area can help to determine if you're located in a HUBZone and help you receive certification. Copy of the certification needs to be submitted with your credentialing application.

⬆ **Upload HUBZone Certificate**

Is this business considered a large business as defined by the Small Business Administration?                                                                                  ○ Yes  ○ No

● **Large Business** means a concern that does not qualify for a small business as defined above.

Is this business considered a Historically Black College/Minority Institution?        ○ Yes  ○ No

● **Historically Black College** means institutions determined by the Secretary of Education to meet the requirements of 34 CFR 608.2. The term also means any nonprofit research institution that was an integral part of such college or university before November 14, 1986. Minority Institution means institution of higher education meeting the requirements of section 1046(3) of the Higher Education Act of 1965 (20 USC 1135d-5 (3)): Enrollment of a single minority or a combination of minorities exceeds 50 percent of the total enrollment. The term also includes Hispanic serving institutions as defined in section 316(6) (1) of such Act (20 USC 1059c(b).

If your business could be classified as a minority-owned business, which of the following categories would it fall under?
*This question is optional.*

| | ○ Hispanic (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin) | ○ Black (African, Jamaican or West Indian descent) | ○ Native American or Alaskan Native (Persons having origins in any of the original peoples of America) | ○ Asian or Pacific Islander (persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent of the Pacific Islands) |
|---|---|---|---|---|
| ○ Caucasian | | | | |

Figure 101: Demographic Data

5. The Service Locations & Programs page lists all the service locations that were active at the time the data sheet was created. (That is, the data sheet is a "snapshot" of the service locations that were active on the day the data sheet was created.) When the page is first accessed the service location headings display in **red**, indicating that the user needs to take action. The user must verify each service location as well as the programs for each location in order to submit the application.



Figure 102: Service Locations and Programs

- Click anywhere in the heading to collapse/expand a specific service location.
- Click the DELETE icon to delete a specific service location. (If a service location is deleted in error, click the UNDO DELETE icon to undo the deletion.)
- Click the VERIFY icon to verify a specific service location. The following pop-up window displays.

Figure 103: Verify Service Location

- Click **Verify & Next** to confirm the information is correct.
  *-or-*
- Update the information as necessary. Click **Verify & Next**.
  *-or-*

- Click the ***Check here if this location should be removed from our records***
  checkbox to remove the location from Beacon's records. Click **Verify & Next**.

Once the service location information is verified, the system displays any programs associated with the location.



Figure 104: Verify Programs

- Review the program information and make any necessary updates.
- Click **Verify & Save** when finished.

Click **Save & Next** to continue.

6. Complete the Program Addenda Questionnaire. Click **Save & Next** to continue.

**6. Program Addenda Questionnaire**

If you answer No to any of the questions below, please provide a written explanation and include the practice location(s) to which the explanation applies in the Comment box related to the section.

**Inpatient Psychiatric**

| | | Y | N |
|---|---|---|---|
| 1. | Does your facility provide 24 hours/ 7 day per week skilled nursing staff coverage? | ☐ | ☐ |
| 2. | Does your facility accept admissions 24 hours a day / 7 days per week? | ☐ | ☐ |
| 3. | Does your program have written admission and discharge criteria? | ☐ | ☐ |
| 4. | Does your facility provide medical diagnostic services on-site or by contract? | ☐ | ☐ |
| 5. | Does your facility provide a full range of treatment programming 7 days per week, with structured programming provided a minimum of 6 hours per day? | ☐ | ☐ |
| 6. | Does your facility provide individualized treatment plans? | ☐ | ☐ |
| 7. | Are emergency psychiatric/medical services available on-site or by contract? | ☐ | ☐ |
| 8. | Does your program have oversight by a medical director? | ☐ | ☐ |
| 9. | Must have an initial visit with an attending physician within 24 hours of admission for evaluation and treatment planning and a documented daily visit with an attending licensed prescribing provider. | ☐ | ☐ |

Comments: _____

**Residential Treatment Program/RTC**

| | | Y | N |
|---|---|---|---|
| 1. | Does your facility provide 24 hours/ 7 day per week supervision of residents by a skilled licensed staff? | ☐ | ☐ |
| 2. | Does your facility provide multidisciplinary licensed staff (i.e. nurses, social workers, counselors, etc.)? | ☐ | ☐ |
| 3. | Does your program have written admission and discharge criteria? | ☐ | ☐ |
| 4. | Does your facility provide a full range of social and recreational therapies? | ☐ | ☐ |
| 5. | Does your facility provide individualized treatment plans? | ☐ | ☐ |
| 6. | Does your facility provide a full range of treatment programming 7 days per week, with structured programming provided a minimum of 6 hours per day? | ☐ | ☐ |
| 7. | Does your facility require and/or encourage family involvement in treatment? | ☐ | ☐ |
| 8. | Are emergency psychiatric/medical services available on-site or by contract? | ☐ | ☐ |
| 9. | Does your program have oversight by a medical director? | ☐ | ☐ |
| 10. | Does your facility perform criminal background checks on staff? | ☐ | ☐ |
| 11. | Does your facility have a documented patient visit with a Psychiatrist at least 1 time per week? | ☐ | ☐ |

Comments: _____

**Partial Hospitalization**

| | | Y | N |
|---|---|---|---|
| 1. | Does your facility/program provide supervision by a physician? | ☐ | ☐ |
| 2. | Does your facility/program have written Admission and Discharge criteria? | ☐ | ☐ |
| 3. | Does your facility/program provide physician medication management? | ☐ | ☐ |
| 4. | Does your facility/program staffing include psychiatry, nursing, psychology, and social work? | ☐ | ☐ |
| 5. | Does your facility/program have chemical dependency education and treatment (CD only) | ☐ | ☐ |
| 6. | Does your facility/program provide individualized treatment plans? | ☐ | ☐ |
| 7. | Does your facility/program have a full program schedule to provide individual and group therapy? | ☐ | ☐ |
| 8. | Does your program have oversight by a medical director? | ☐ | ☐ |
| 9. | Must have a documented patient visit with a Psychiatrist at least 1 time per week. (Psych only) | ☐ | ☐ |
| 10. | Does your facility/program operate at least 3 to 5 days/week and at least a minimum of 6 hours/day? | ☐ | ☐ |

Indicate program days and hours of operation:

| | |
|---|---|
| Monday | _____ |
| Tuesday | _____ |
| Wednesday | _____ |
| Thursday | _____ |
| Friday | _____ |

Comments: _____

**RESPITE CARE**

| | | Y | N |
|---|---|---|---|
| 1. | Does your agency use specially-trained staff to implement the treatment plan? | ☐ | ☐ |
| 2. | Does your agency have written policies explaining the procedures and criteria for respite provider training and selection? | ☐ | ☐ |
| 3. | Does your agency provide medical consultation 24 hours a day / 7 days per week? | ☐ | ☐ |
| 4. | Does your agency provide 24 hours a day / 7 days per week supervision of residents? | ☐ | ☐ |
| 5. | Does your agency provide written procedures for handling medical and/or psychiatric emergencies? | ☐ | ☐ |
| 6. | Does your agency require and/or encourage family involvement in treatment? | ☐ | ☐ |
| 7. | Does your program have oversight by a director who is a licensed clinician? | ☐ | ☐ |

Comments: _____

**ELECTROCONVULSIVE OUTPATIENT THERAPY**

1. There are no questions associated with this program.

Comments: _____

**ELECTROCONVULSIVE INPATIENT THERAPY**

1. There are no questions associated with this program.

Comments: _____

Figure 105: Addenda Information

7. Follow the directions on this page to complete and upload any additional contract-specific Supporting Documentation as necessary. Click **Save & Next** to continue.



Figure 106: Supporting Documentation

8. Use the Roster of Providers page to:
   - Manually add providers to the roster
   - Make any necessary corrections to the existing roster
   - Upload a copy of a staff roster

Click **Next** to continue.



Figure 107: Roster of Providers

9. Read the Participation Statement. If manually signing and faxing the Participation form, follow the instructions on this page. (After indicating their intention to fax the form, users should print the document *prior to saving*.) (Refer to the Electronically Sign the Attestation section of the Provider Data Sheet chapter for detailed information.)



Figure 108: Participation Information

# 24 Update Demographic Information

This functionality allows a provider to see all his/her active service locations along with the associated telephone numbers, fax numbers, and billing locations. Providers make and submit changes as needed from within ProviderConnect.

To update demographic information, click on Update Demographic Information. (This link is controlled outside the application. Providers have access to this link only at certain times.)

The Provider Demographics Summary page displays.

> A ❓ icon is available on the various demographics pages that displays additional information upon pausing on the icon.

This page contains the following sections.
- Provider Demographics
- Service Location Information

Figure 109: Provider Demographics Summary Example

## Provider Demographics

The top portion of the Provider Demographics Summary page displays the provider's mailing address along with other provider-related information.

1. Click the "edit" ( 🖊 ) icon to update provider demographic information.

The Enter & Verify Mailing Address page displays.

2. Edit the following information as necessary.
   - Address Line 1/Line 2
   - City/State/Zip Code
   - Country
   - Phone #
   - Phone extension
   - Fax #
   - Fax extension
   - Website address
   - ProviderConnect E-mail (Verify e-mail)
   - Correspondence E-mail (Verify e-mail)



**Enter & Verify Mailing Address**

| | |
|---|---|
| Address Line 1 * | 212 ANYPLACE AVE |
| Address Line 2 | STE 200 |
| City * | FAIRFAX |
| State * | VA |
| ZIP Code * | 22031-2228 |
| Country | UNITED STATES  **Note:** only US addresses are eligible |
| Phone | ( 703  ) XXX  - 9100  Extension: |
| Fax | ( 703  ) XXX  - 9102  Extension: |
| Website address: | HTTPS://WWW.TEST.ORG |
| ProviderConnect Email: * | provider.email@valueoptions.com |
| Verify: | |
| Correspondence Email: * | EMAIL@ANYWHERE.COM |
| Verify: | |

* Required Field

Figure 110: Enter & Verify Mailing Address

Upon clicking **Continue**, the user is presented with three options.
- **Cancel** – Cancels the changes and returns the user to the Provider Demographics Summary page.
- **Back** – Returns the user to the previous page.
- **Submit** – Sends the changes to Network Operations. Once a decision is made by Network Operations to approve or reject a specific change, the system sends a message to the provider's message center indicating the status of the update.

While on the Enter & Verify Mailing Address page, the user can also cancel any changes or reset the page.

## Service Location Information

The bottom portion of the Provider Demographics Summary page displays the provider's service locations.

- Clicking the SHOW ( ![SHOW] ) icon reveals the billing location for a specific service location.
- Clicking the HIDE ( ![HIDE] ) icon re-hides the billing information.
- Clicking the Show Hours ( ![Show Hours] ) icon expands the office hours display, allowing the provider to add and update service location office hours.
- Clicking the Hide Hours ( ![Hide Hours] ) icon collapses the office hours display.

## Edit a Service Location

Providers have the ability to edit service locations. To edit a service location:

1. Click the "edit" ( ![edit] ) icon for the appropriate record.
2. Select between the following name formats by moving the right-pointing blue arrow up or down.
   - First MI Last
   - Facility/Group Name
3. Edit the following information as necessary.
   - Location name

     *Note: Editable only if the location does not have a tax ID.*

   - Phone #
   - Phone extension
   - Fax #
   - Fax extension
   - Office Hours
4. Click **Save**.

Figure 111: Edit a Service Location

Providers also have the ability to remove a specific service location. The following message displays: "If this location is being replaced by a new location, please select Cancel and add the new location first via the 'Add New Service Address' button below. You will be prompted during the process on whether the new location is replacing an existing one. Otherwise, if this location is not being replaced, please select OK to continue."

## Invalidate a Service Location

A checkbox is available on the Service Location Information page that enables providers to invalidate a particular service location. Upon selecting this checkbox, a pop-up window displays advising the provider to contact MMIS to have the information updated.

*Used only for the attestation process.*



Figure 112: Invalidate a Service Location

## Add a Service Address

Providers have the ability to add service addresses. To add a service address, click the **Add New Service Address** button. The Enter New Service Location Information page displays.

Depending on the person's answer to the **Service is also Billing Address** question, this is either a two-step or three-step process.

- Two-Step Process – The service location is the same as the billing address. (Checkbox selected.)
- Three-Step Process – The service location is not the same as the billing address. (Checkbox not selected.)



Figure 113: Add a Service Location

### Two-Step Process

### Step 1of 2

Complete the follow information.

- Date patients will be seen at the new location
- Practitioner Name/Facility/Group Name
- Federal Tax ID
- Tax ID Type
- Address Line 1/Line 2
- City/State/Zip Code
- Country
- Phone #
- Phone extension

- Fax #
- Fax extension
- Office Hours

Upon clicking **Continue**, the QAS verification process verifies/standardizes the address.

### *Step 2 of 2*

Answer the **Will this New Service Location replace an existing one?** question.
- If **Yes**, select the service location to replace. (This location will be terminated.)
  *-or-*
- If **No**, the system selects the first provider/vendor combination encountered (in the same state) and proceeds to copy the location information into the new service location. (If the provider does not have any existing locations in the same state, the system displays an error message.)

## *Three-Step Process*

### *Step 1of 3*

Complete the follow information.
- Date patients will be seen at the new location
- Practitioner Name/Facility/Group Name
- Address Line 1/Line 2
- City/State/Zip Code
- Country
- Phone #
- Phone extension
- Fax #
- Fax extension
- Office Hours

Upon clicking **Continue**, the QAS verification process verifies /standardizes the address.

### *Step 2 of 3*

Answer the **Will this New Service Location replace an existing one?** question.
- If **Yes**, select the service location to replace. (This location will be terminated.)
  *-or-*
- If **No**, the system selects the first provider/vendor combination encountered (in the same state) and proceeds to copy the location information into the new service location. (If the provider does not have any existing locations in the same state, the system displays an error message.)

Upon clicking **Continue to Billing Selection**, the billing address maintenance page displays.
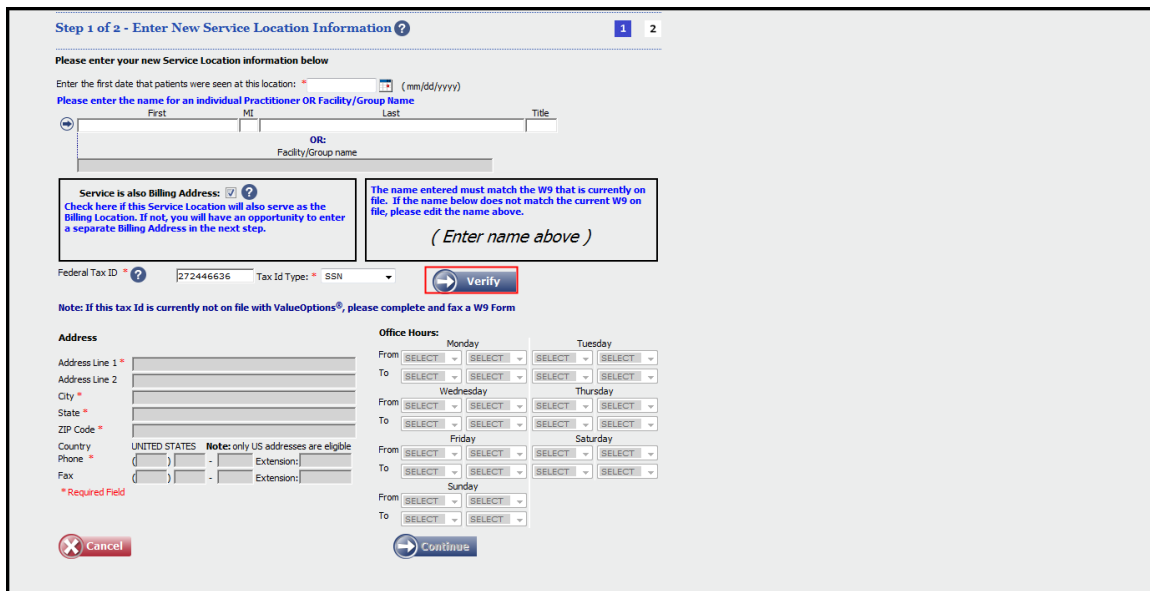
### Step 3 of 3
1.  Optionally select a replacement billing location.
2.  Enter the effective date of the change request.

Practitioners and facilities can also create new billing addresses.

## Add a New Federal Tax ID

Providers have the ability to request the addition of Federal Tax IDs that do not already exist in NetworkConnect. To add a Federal Tax ID:
1.  Enter the new tax ID in the **Federal Tax ID** field.
2.  Select a tax ID type from the **Tax ID Type** drop-down.
3.  Click **Verify**.



Figure 114: Add a New Federal Tax ID

The system verifies whether or not the tax ID entered matches a tax ID currently on file.
*   If a match is found, the system indicates as such.
*   If a match is not found, the system displays a hyperlink for the provider to download a blank W-9 form to complete, save, and then upload or he/she can upload a previously saved W-9. The provider must also select a reason for requesting a new tax ID.

Figure 115: Download a W-9 Form

## Billing Location Information

Providers have the ability to edit the billing information for a specific service location. They can also replace a specific billing location. If a provider chooses to replace a billing location, the billing address maintenance page displays for him/her to select the replacement location. (The provider *must* also enter the effective date of the change request.)

To edit a billing location:
1. Click the **SHOW** (  ) icon for the appropriate record.
2. Click the "edit" (  ) icon.
3. Edit the following information as necessary.
   - Phone #
   - Phone extension
   - Fax #
   - Fax extension
4. Click **Save**.

Both practitioners and facilities can create new billing locations by clicking the **Add New Billing Address** button on the billing address maintenance page. The provider can also add a new Federal Tax ID if needed. (Refer to the Add a New Federal Tax ID section of this chapter for detailed information.)

# 25 Performance Report

The *Performance Report* section of ProviderConnect allows provider information to be entered and saved. Upon clicking Performance Report, a performance report card displays.



Figure 116: Performance Report Card

# 26 Compliance

The *Compliance* section of ProviderConnect contains regulatory information, HIPAA information, resources, and technical assistance contact information. Click on Compliance to access the Compliance page.

## beacon
health options

Site Search

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## Compliance

It is the policy of ValueOptions® to comply with all local, state, and federal laws governing its operations; to conduct its affairs in keeping with the moral, legal and ethical standards of our industry; and to support the government's efforts to reduce healthcare fraud and abuse. The ValueOptions Corporate Compliance Program establishes a culture within the organization that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law, and federal, state, and private payor health care program requirements. Agents, subcontractors, vendors, and consultants who represent the company are expected to adhere to the Compliance Program. For more information, please read the Code of Conduct and Ethics in its entirety.

▸ **Privacy Statement**

▸ **National Provider Identifier (NPI)**

▸ **Fraud and Abuse**

▸ **ValueOptions' E-Commerce Initiative**

▸ **Code of Conduct and Ethics**

▸ **Client Specific Documents**

ValueOptions is also a HIPAA-compliant organization. Under HIPAA Privacy Rule at 164.514(h) a covered entity prior to making any disclosure permitted under the privacy regulations must (1) verify the identity of a person requesting protected health information (PHI) and the authority of such person to have access to protected health information under this regulation, if the identity or any such authority of such person is not known to the covered entity. Accordingly, ValueOptions requires that anyone requesting access to PHI be appropriately identified and authenticated. Members and personal representatives, for example, are required to provide the member identification number or subscriber number *and* the member's or subscriber's date of birth. You or your administrative staff are identified and authenticated in a number of ways and may be asked for your federal tax identification number (TIN), your national provider identification number (NPI), or physical address as part of this verification process. Having this information available prior to making contact with ValueOptions will expedite your request.

The links below provide additional information regarding submitting electronic HIPAA transactions to ValueOptions.

▸ **How to Submit Electronic Claims in HIPAA 837 Format**

▸ **Behavioral Health Revenue Codes Approved by NUBC (PDF)**

**ECLW Resources**

▸ **EDI Claims Link for Windows® 3.5 Quick Start Guide (PDF)**
  (NOTE: Please read before installing EDI Claims Link 3.5)

▸ **EDI Claims Link for Windows® 3.5 User's Manual (PDF)**

▸ **EDI Claims Link for Windows® 3.5 (Application)**

▸ **How to Run ECLW Installation Video**

▸ **How to Run ECLW Update Video**

▸ **Provider and Patient Data Maintenance Video**

▸ **Institutional Claim Instructional Video**

▸ **Professional Claim Instructional Video**

**ValueOptions EDI Resources**

▸ **ValueOptions Companion Guide**

▸ **837 Implementation Guide Information**

▸ **Special Billing Instructions**

**ValueOptions Claims and Authorization Resources**

▸ **Guide To Online Authorization Requests (PDF)**

▸ **Guide To Direct Claim Submission for Professional Claims (PDF)**

▸ **Guide to Changing or Reprocessing Professional Claims Online (PDF)**

▸ **Guide to EAP Claim Submission Online (PDF)**

**General Information**

▸ **How to Send Secure E-mail to ValueOptions Employees (WORD)**

▸ **How to Setup a Secure Email Account (PDF)**

▸ **How to Check a Secure Email (PDF)**

▸ **Where to Learn More About HIPAA**

Contact Information If you need technical assistance, please contact us at (888) 247-9311.

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Figure 117: Compliance

- Read the Beacon policies and technical assistance information.
- Click on the links to access additional information.

# 27 **Provider Handbook**

This section of ProviderConnect allows providers to access the Beacon Health Options Provider Handbook. The handbook is a guide to Beacon's policies and procedures for individual providers, affiliates, group practices, programs, and facilities. It provides important information regarding the managed care features incorporated in Beacon's provider contract. The handbook reflects the policies that are applicable to Beacon's "general" commercial product lines.

Click on Handbooks to access the provider handbook.

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## Provider Handbook

The Provider Handbook outlines the ValueOptions® standard policies and procedures for individual providers, affiliates, group practices, programs and facilities. Providers are encouraged to carefully review the Handbook as well as visit the Network-Specific page to verify which policies and procedures are applicable to them.

This handbook is an extension of the provider agreement and includes guidelines on doing business with ValueOptions, including policies and procedures for individual providers, affiliates, group practices, programs and facilities. Together, the provider agreement, addenda, and this handbook outline the requirements and procedures applicable to participating providers in the ValueOptions network(s). This handbook replaces in its entirety the previous version.

Questions, comments and suggestions regarding this handbook should be directed to ValueOptions at (800) 397-1630.

Please click below to launch the Provider Handbook and the Provider Handbook Appendices. You will need Adobe® Reader to view the Handbook. If you do not have access to this software, you may download and install these applications on your computer.

ValueOptions Provider Handbook (PDF)

‣ Section 1.0 Overview

‣ Section 2.0 About ValueOptions

‣ Section 3.0 Contact Information

‣ Section 4.0 E-Commerce Initiative

‣ Section 5.0 Electronic Resources

‣ Section 6.0 Participating Providers

‣ Section 7.0 Credentialing & Re-Credentialing

‣ Section 8.0 Sanctions

‣ Section 9.0 Appeals of National Credentialing Committee (NCC)/Provider Appeals Committee (PAC) Decisions

‣ Section 10.0 Office Procedures

‣ Section 11.0 Services to Members

‣ Section 12.0 Participating Provider Complaints, Grievances & Appeals

‣ Section 13.0 Claims Procedures & E-Commerce Requirements

‣ Section 14.0 Utilization Management

‣ Section 15.0 Appeal of Adverse Determinations

‣ Section 16.0 Quality Management/Quality Improvement

**Appendices**

Appendix 1 Handbook Glossary (PDF)

‣ Appendix 2 List of Forms & Reference Documents

  ‣ Clinical Criteria

  ‣ Treatment Guidelines

  ‣ Resource Documents

    ‣ Member Rights (English) (PDF)

    ‣ Member Rights (Spanish) (PDF)

    ‣ EDI Resource Document – E-Support Services for ProviderConnect and Electronic Claims (PDF)

    ‣ Provider Summary Voucher Form Sample (PDF)

    ‣ CMS 1500 Claim Form (Version 02/12) (PDF)

    ‣ Tips for Completing the CMS 1500 (PDF)

    ‣ UB04 Claim (PDF)

    ‣ Tips for Completing the UB04 (PDF)

    ‣ Clinical Department Hours of Operation (PDF)

  ‣ Forms

    ‣ Administrative

    ‣ Clinical

    ‣ EAP

‣ Appendix 3: State/Government Program/Network Specific Provision and/or Supplements

‣ Appendix 4: Medicare Advantage Specific Provisions (PDF)

‣ Appendix 4A: New York State Specific – Medicare Advantage/Medicare-Medicaid Dual Eligible Required Provisions (Fully Integrated Duals Advantage (FIDA)) (PDF)

‣ Appendix 5: EAP Handbook (PDF)

‣ Appendix 5A: MOS Handbook (PDF)

**Provider Handbook Updates**

‣ Provider Handbook Updates and Edits Log (PDF)

**Important Notice**

ValueOptions reserves the right to interpret and construe any terms or provisions in this Handbook and to amend it, at its sole discretion, at any time. To the extent that there is an inconsistency between the Handbook and the provider contract, ValueOptions reserves the right to interpret such inconsistency. ValueOptions' interpretation shall be final and binding.

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Figure 118: Provider Handbook

Information on the following topics can be accessed from this page.

- Clinical Criteria
- Treatment Guidelines
- Member Rights
- Tips for Completing the CMS-1500 Claim Form

# 28 Forms

Users can select, view, and print a variety of forms in this section of ProviderConnect. Click on **Forms** to access the Provider Online Services page.

1. Click on <u>Forms</u> to expand the section.
2. Select a **Type of Form** from the options that appear in the expanded section.
3. Click on the applicable <u>Form Name</u>.

Some examples of the forms that can be accessed from this page are:
- CMS-1500 Claim Form
- UB04 Claim Form
- Outpatient Treatment Report Forms
- Inpatient and Higher Levels of Care Authorization Requests
- Psychological Evaluation Forms

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# Network-Specific Information

Users can access network-specific information in this section of ProviderConnect. Click on Network Specific Information to access the Network-Specific page.

## Network-Specific

▸ **Applied Behavior Analysts**

▸ **California Counties (CMHDA)**

▸ **Charter Oak Behavioral Health**

▸ **ValueOptions® Colorado Partnerships for Colorado Medicaid**

▸ **Connecticut Behavioral Health Partnership (CT BHP)**

▸ **Emblem Behavioral Health Services Program**

▸ **Empire Plan**

▸ **Evergreen Health Care (EHC) and Evergreen Health Insurance (EHI)**

▸ **First Coast Advantage (FCA) – Molina Transition**

▸ **Florida Health Partners**

▸ **Franciscan Missionaries of Our Lady Health System**

▸ **Fully Integrated Duals Advantage (FIDA)**

▸ **Georgia Collaborative**

▸ **Group Insurance Commission — GIC (Beacon Health Strategies)**

▸ **Horizon Behavioral Health℠**

▸ **Horizon Behavioral Health℠ — ABA Providers**

▸ **Horizon NJ Health**

▸ **Illinois Mental Health Collaborative for Access and Choice**

▸ **Kaiser Permanente of Northern California**

▸ **Kaiser Permanente of Southern California**

▸ **Long Island Behavioral Health Management**

▸ **Massachusetts Behavioral Health Partnership**

▸ **MedStar Family Choice**

▸ **MedStar Family Choice – DC Medicaid**

▸ **Michelin**

▸ **Michigan Engagement Center**

▸ **Military OneSource**

▸ **MVP Health Care**

▸ **New York City Health Plans**

▸ **North Carolina Health Choice**

▸ **North Carolina Medicaid**

▸ **NC State Health Plan (PPO)**

▸ **NCOC State Government and HealthPlans**

▸ **North Florida Behavioral Health Partners**

▸ **Northeast Engagement Center Health Plans**

▸ **NorthSTAR**

▸ **Rocky Mountain Health Plans®**

▸ **Telehealth**

▸ **United States Coast Guard**

▸ **University of Maryland Health Advantage**

▸ **Value Behavioral Health of Pennsylvania**

▸ **ValueOptions® Arkansas**

▸ **ValueOptions® of California**

▸ **ValueOptions® of Kansas**

▸ **ValueOptions® Maryland**

▸ **Warrior Assistance Program**

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Figure 119: Network-Specific Information

Some examples of network-specific information that can be accessed from this page are:

- Beacon Health Options Colorado Partnerships for Colorado Medicaid
- North Carolina Medicaid
- NorthSTAR
- Beacon Health Options of California

# 30 Education Center

A user can access articles, training/workshops, and provider tools in the *Education Center* section of ProviderConnect. Click on Education Center to access the Provider Online Services page.

1. Click on Education Center to expand the section.
2. Click on the applicable topic link.

# 31   ValueSelect Designation

Users can access a description of the ValueSelect Network Program by clicking on [ValueSelect Designation](#).

**VALUEOPTIONS®**
Innovative Solutions. Better Health.

**ValueSelect℠**
**Program Description**

The ValueSelect℠ designation recognizes network outpatient providers for engaging in activities that promote clinical effectiveness, member access to services, member satisfaction, and administrative efficiency. ValueSelect℠ providers are eligible for a number of valuable benefits, including distinction in our provider referral search engine.

**ValueSelect Eligibility Criteria**

To promote continued network excellence, ValueOptions® has updated the program criteria for 2011. Over 4,000 providers currently qualify for the ValueSelect℠ designation.

Providers are eligible for ValueSelect℠ based on the following criteria, which will be implemented beginning with the Spring 2011 eligibility review cycle:
- **Accessibility:** Seeing five or more ValueOptions® members in the past 12 months (or at least 10 commercial members for clinics), and,
- **Administrative efficiency:** conducting transactions using ValueOptions® ProviderConnect℠ portal within the past 12 months, and,
- **ValueSelect Activities:** Engaging in one or more of the following activities -
  - Participation in the On Track Outcomes Program
  - Submitting at least 75% of non-EAP claims electronically
  - Having clients complete the ValueOptions® Patient Treatment Survey
  - Having a CEAP credential

As part of its semi-annual designation process, ValueOptions® also reviews any complaints received for a provider within the past 2 years. An excessive number of complaints that are considered substantiated will disqualify a provider from ValueSelect℠.

To help providers monitor their performance on ValueSelect℠ and other practice pattern metrics, ValueOptions® distributes a semi-annual ValueSelect℠ Provider Performance Report. This report is available to high volume providers through the ProviderConnect℠ web portal.

**Benefits of the ValueSelect℠ Designation**
Outpatient providers who qualify for ValueSelect℠ enjoy a number of benefits:
- **Opportunity for increased referrals** – ValueSelect℠ providers are identified in the ValueOptions® provider search engine, ReferralConnect.
- **Free CEU/CMEs** – ValueOptions® has partnered with Essential Learning to provide online CEU courses at NO CHARGE to ValueSelect℠ providers. Providers are able to access this web portal and sign up for self-paced online courses through ProviderConnect. In addition, ValueSelect℠ providers receive invitations to participate in live CME, CEU or professional development (PDH's) seminars offered at no charge.
- **Training Discounts** – ValueOptions® has partnered with Behavioral Tech, LLC a nationally renowned evidenced-based practice (EBP) training firm. Behavioral Tech offers a 10% discount on training for ValueSelect℠ providers.
- **Access to Achieve Solutions** – ValueSelect℠ providers have access to Achieve Solutions®, ValueOptions® award-winning website that offers valuable mental health resources, assessment tools and articles that may be shared with clients.

Figure 120: ValueSelect Network Program Description

# 32 Contact Us

This section of ProviderConnect contains a summary of contact information. Click on Contact Us to access the Contact Us page.

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## Contact Us

**Interested in joining the network?**

Please call (800) 397-1630.

**Claims - General Information**

If you have questions about claims in general, call (800) 888-3944.

**Claims Submission/ Address**

Reference the address on the member's identification card, as the address may vary based on payment location.

**Member Benefits, Eligibility, and Authorizations**

If you have a question about authorization or benefits, call the (800) number on the back of the member's identification card.

**Member Customer Service**

To reach Member Customer Service, call the (800) number on the back of the member's identification card.

**Provider Supporting Documentation**

To send supporting documentation such as malpractice or insurance cover sheets please fax to (866) 612-7795

**Regional Offices**

If you have general questions and would like to contact Provider Relations in your region, visit the list of our regional offices.

**Electronic Claims Submission/ EDI Helpdesk**

If you have a technical question about ProviderConnect (website), or EDI Claims Link, please contact the EDI Help Desk at (888) 247-9311 from 8 am — 6 pm Eastern Standard Time.

Fax: (866) 698-6032

E-mail: e-supportservices@valueoptions.com

    **Mailing Address:**
    ValueOptions®
    Attn: EDI Helpdesk
    PO Box 1287
    Latham, NY 12110

**Credentialing Status**

To obtain information pertaining to your network status, contact our National Provider Line at (800) 397-1630 from 8 am - 8 pm Eastern Time.

**Fraud and Abuse**

Reports of fraud and abuse, or suspicions thereof, can be made in writing to:
    **Mailing Address:**
    ValueOptions®
    Corporate Headquarters
    ATTN: Special Investigations Unit
    240 Corporate Boulevard, Suite 100
    Norfolk, VA 23502

**Clinical Appeals**

To request a clinical appeal on a member's behalf, call the (800) number included in the adverse determination letter you received.

**Administrative Appeal**

To request an administrative appeal, call the (800) number included in the administrative denial letter you received.

**Complaints/Grievances**

To file a complaint/grievance, call the (800) number on the back of the member's identification card to speak to Customer Service.

**Adverse Incident**

Report all adverse incidents to the Clinical Care Manager with whom you conduct reviews.

**Duty to Warn**

Report all potential situations to the Clinical Care Manager with whom you conduct reviews.

**Provider Coverage During Absences**

Contact the Clinical Care Manager with whom you conduct reviews during absences (i.e. coverage while on vacation). Or call the number on the card to provide coverage information.

**Changing your Provider Profile (e.g. Name, address)**

"Change of Address" forms can be found at www.valueoptions.com and may be submitted by using one of the following options:

Fax: (866) 612-7795
    **Mail Address:**
    ValueOptions®
    c/o Practitioner Maintenance
    P.O. Box 41055
    Norfolk, VA 23541

*NOTE: A change of address requires an accompanying W-9 form which is also located at www.ValueOptions.com.*

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Figure 121: Contact Us

Some examples of contact information that can be accessed from this page are:

- Claims – General Information
- Provider Supporting Documentation
- Regional Offices

# 33 Log Out of ProviderConnect

To log out of ProviderConnect, click the Log Out link in the upper right-hand corner of the screen. The login page redisplays.

# 34 Role-Based Security

## Overview

ProviderConnect offers the ability to control user access to sensitive areas within the application via role-based security. Providers can:

- Create New Login Accounts
- Deactivate Login Accounts
- Control User Access to Certain Areas within ProviderConnect

In addition to user roles, which are assigned either during ProviderConnect online registration or via FileConnect Admin, the system contains user statuses (that is, user types) that are also assigned via FileConnect Admin. These statuses are:

- Standard User –
  - Is not managed by another user
  - Does not manage other users
  - Has access to certain areas of ProviderConnect depending on his/her assigned user role and/or submitter type. For example:
    - Standard users with the user role of "Connecticut" have access to certain functions that other standard users may not.
    - Standard users with a submitter type of "General Claims Submitter" have access to certain functions that other standard users may not.
- Super User –
  - Is an administrative user
  - Manages other users' login accounts
  - Has the ability to:
    - Create new login accounts
    - Deactivate (disable) a managed user
    - Control access to specific areas within ProviderConnect
- Managed User –
  - Is managed by a super user
  - Has access to only those functions to which he/she has been granted access

*Managed users are associated to a particular super user via FileConnect Admin.*

Note

For a user to become a super user:
Contact the EDI Help Desk at 1-888-247-9311 from 8:00 am – 6:00 pm EST or by e-mail at e-support.Services@beaconhealthoptions.com. (The EDI Help Desk will set up your account and e-mail you once setup is complete. Please expect a turnaround time of 5 business days for completion.)

If a super user leaves the facility:
Contact the EDI Help Desk at 1-888-247-9311 from 8:00 am – 6:00 pm EST or by e-mail at e-support.Services@beaconhealthoptions.com. (The managed users can be reassigned to another super user by the EDI Help Desk. The super user's account will need to be de-activated by the EDI Help Desk.)

For a managed user to become a super user:
Contact the EDI Help Desk at 1-888-247-9311 from 8:00 am – 6:00 pm EST or by e-mail at e-support.Services@beaconhealthoptions.com. (The request must include at least one user that the super user will manage.)

## Managing Users

As previously stated, super users can:
- Create a new login account
- Control access to certain areas of ProviderConnect
- Deactivate a managed user

## Create a New Login Account

If a super user has existing managed users, he/she can create new login accounts by copying another managed user's account.
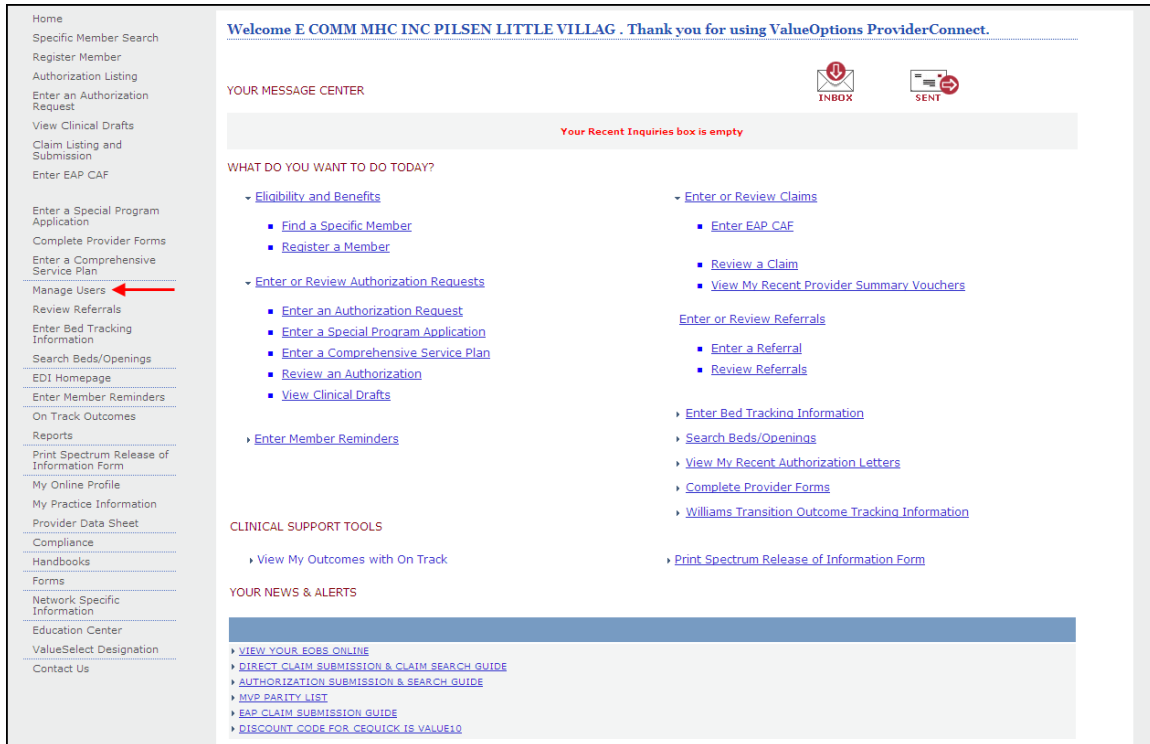1. Click the Manage Users link on the main menu.
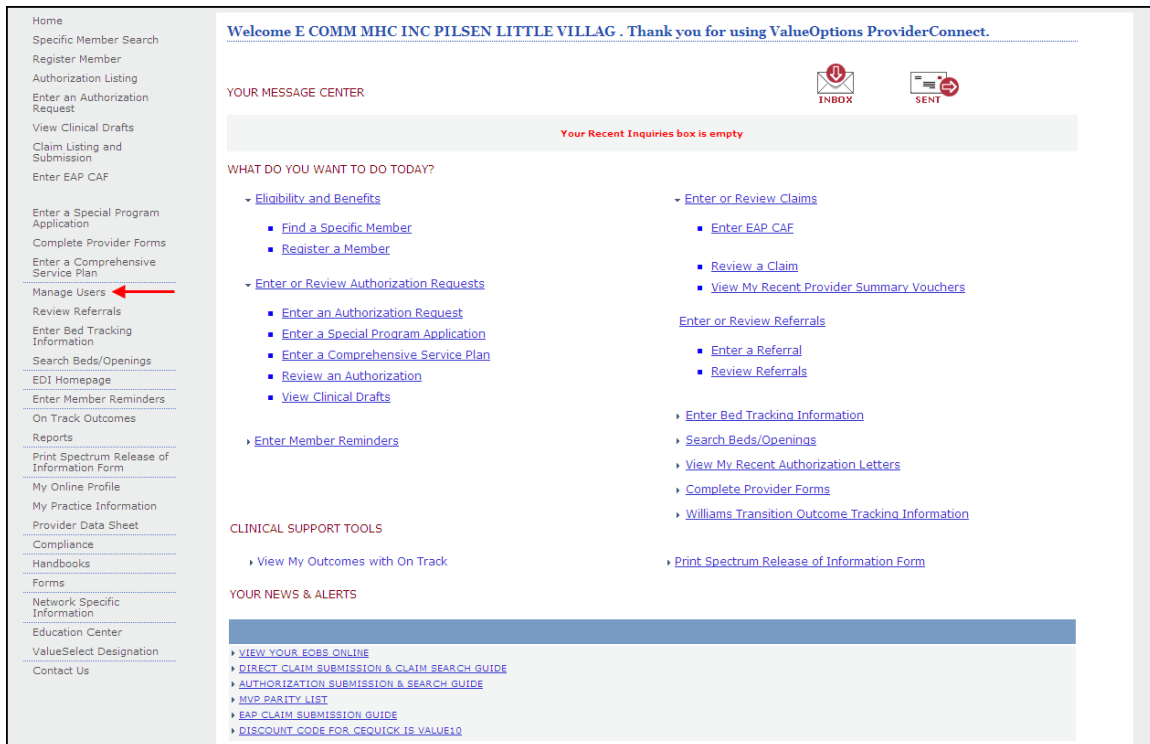
Figure 122: Manage Users Link

The Manage Users page displays.
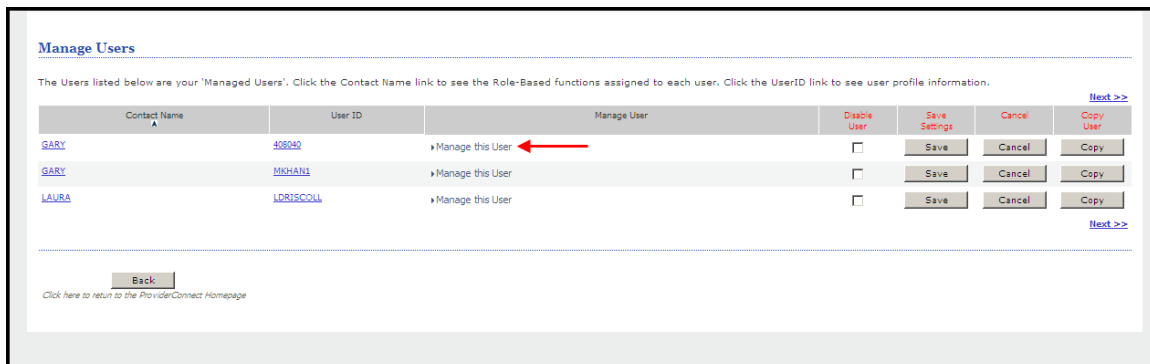


Figure 123: Manage this User

2. Click on the appropriate Manage this User link to create a duplicate account for a new user that contains the same attributes as the managed user who is being copied.

The following page displays.

Figure 124: Copy User

3. Click **Copy**.

The Copy User page displays with some of the fields already pre-populated.



Figure 125: Copy User Page

4. Edit any pre-populated information as necessary.
5. Complete the remaining fields and click **Submit**.

> *Note: A red asterisk (\*) indicates a required field.*

## Control Access to Certain Areas of ProviderConnect

If a super user has existing managed users, he/she can control a specific user's access to ProviderConnect.

1. Click the Manage Users link on the main menu.



Figure 126: Manage Users Link

The Manage Users page displays.
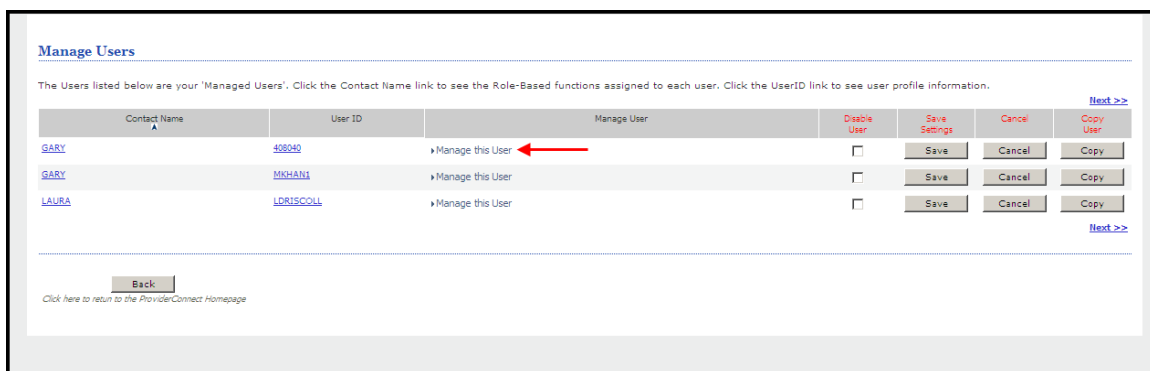


Figure 127: Manage this User

2. Click on the appropriate Manage this User link to expand the section.

Upon clicking <u>Manage this User</u>, the following page displays where the user can allow access to a specific function category (e.g., Claims Review) by selecting the appropriate checkbox. (More than one category can be selected.)

> *A logged in super user may not have access to all the function categories.*



Figure 128: Function Categories

3. Click **Save** when finished.

## Deactivate a Managed User

If a super user has existing managed users, he/she can deactivate (disable) any of those users.

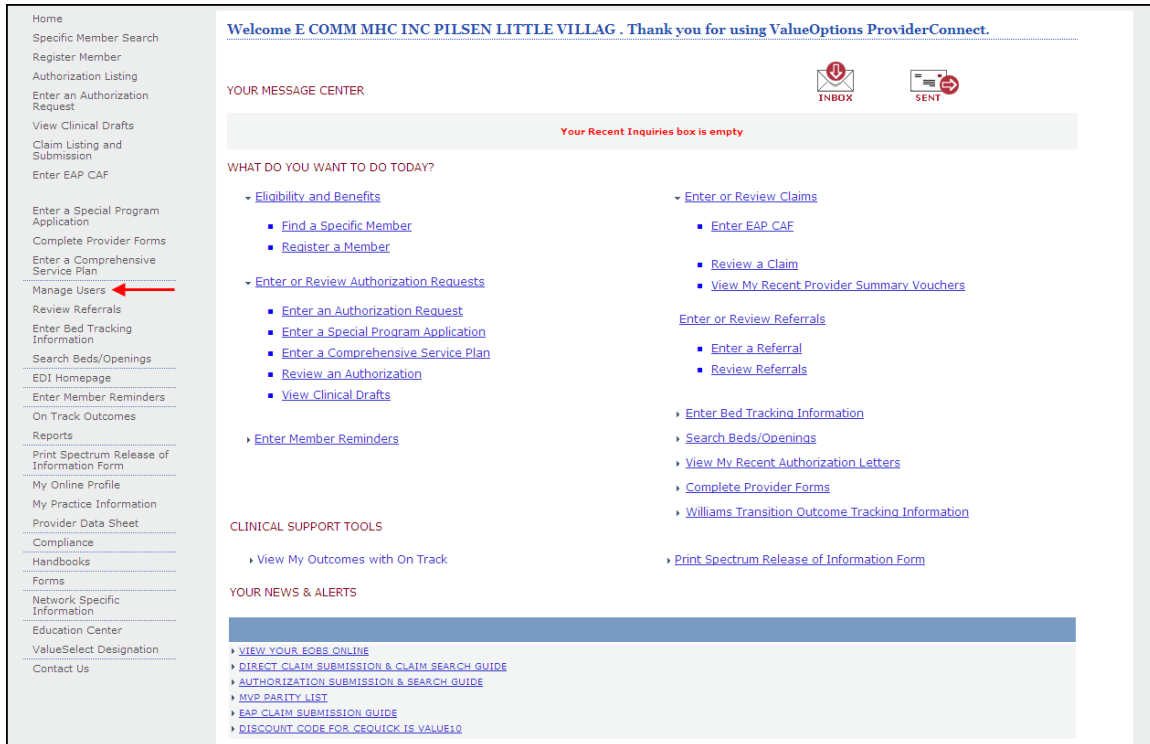1. Click the Manage Users link on the main menu.



Figure 129: Manage Users Link
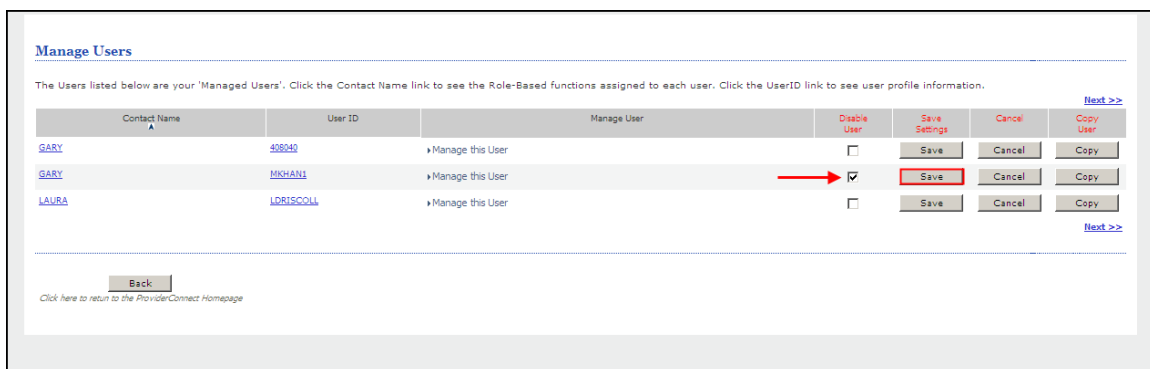
The Manage Users page displays.



Figure 130: Deactivate User

2. Select the **Disable User** checkbox for the managed user you wish to deactivate.
3. Click **Save**.

The following message displays the next time the deactivated user attempts to log in: "Your account has been disabled. Please contact e-Support Services by email at e-support.Services@beaconhealthoptions.com or by phone 888-247-9311 to activate your account."

# 35 Glossary of Terms

| Term | Definition |
|------|-----------|
| ABA | Applied Behavioral Analysis. The process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement of behavior. |
| CAF | Case Activity Form. Network providers authorized to perform EAP Services can submit their one-page version of this form via ProviderConnect. |
| Clinical Draft | An authorization request that a provider has created and saved but not submitted. Creators of clinical drafts can authorize other users to update and/or submit saved drafts. |
| COB | Coordination of Benefits. A provision which requires that when a member is covered by two or more group health plans, payment will be divided between them so the combined coverage will pay up to 100% of eligible expenses. |
| Compliance | This part of ProviderConnect contains regulatory and HIPAA information, resources, and technical assistance contact information. |
| Comprehensive Service Plan | Refers to the Comprehensive Service Plan workflow for parent code ILL. |
| CSR | Customer Service Representative. A Beacon staff member who responds to provider inquiries. |
| DOB | Date of Birth. Refers to a member's birth date. |
| EDI | Electronic Data Interchange. The structured transmission of data between organizations by electronic means. Used to transfer electronic documents or business data from one computer system to another computer system. |
| FDS | Facility Data Sheet. The FDS is Beacon's online facility and organizational provider re-credentialing application. (Also see PDS) |
| HIPAA | Health Insurance Portability and Accountability Act of 1996. The primary goal of this law is to help employees take their health benefits with them upon a move from one employer to another. The law also includes an Administrative Simplification provision with the goals of improving:<br>• Efficiency of the health care system by encouraging the use of electronic information systems.<br>• Privacy and security protections for individually identifiable health information. |
| Individual Care Plan | Refers to the Individual Care Plan workflow for parent code MRLD. |
| ITR | Inpatient Treatment Report. The ITR and ITR2 forms are both used to enter IP/HLOC requests for services. |

| *Term* | *Definition* |
|---|---|
| Member Reminders | Appointment and/or medication reminders entered for a member. |
| OnTrack Outcomes | The Beacon Health Options *OnTrack* program is a client-centered outcomes-informed care program that provides clinicians with state-of-the-art easy to use tools that promote improved client outcomes. |
| ORF1 | Outpatient Review Form 1. A short form used for routine OP requests for services requiring limited clinical information. |
| ORF2 | Outpatient Review Form 2. A longer form that captures more detailed clinical information via both required and optional data fields. |
| PDS | Provider Data Sheet. The PDS is Beacon's online provider re-credentialing application. |
| Performance Report | This part of ProviderConnect allows information about a provider to be entered and saved. Displays in the form of a performance report card. |
| RFS | Request for Services. Providers can electronically submit requests for services for Outpatient, Inpatient, and Medication Management services using the Enter an Authorization/Notification Request function. |
| Special Program Application | Refers to the Special Program Application workflow for parent code ILL. |
| ValueSelect Designation | A designation that recognizes network outpatient providers for engaging in activities that promote clinical effectiveness, member access to services, member satisfaction, and administrative efficiency. |
| VSP | Value Service Provider. Designation that is reserved for top-of-the-line Beacon providers. |
| Wellness Recovery Treatment Plan | Refers to the Wellness Recovery Treatment Plan workflow for parent code BHK. |

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