



## Policy and Procedure Manual for Beacon Providers

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This document contains the Beacon policies and procedures for providers of the UniCare State Indemnity Plan members. Referenced materials, including level of care service descriptions and criteria, are available on Beacon's website at [www.beaconhealthoptions.com](http://www.beaconhealthoptions.com). Providers may also obtain a copy by emailing [provider.relations@beaconhealthoptions.com](mailto:provider.relations@beaconhealthoptions.com) or by calling the National Provider Service Line at 1-800-397-1630.

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# Introduction

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- 1.1. About this Provider Manual
- 1.2. Introduction to Beacon
- 1.3. Beacon's Behavioral Health Services
- 1.4. Transactions and Communications with Beacon

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## 1.1. About this Provider Manual

This Behavioral Health Provider Policy and Procedure Manual (the “Manual”) is a legal document incorporated by reference as part of your provider services agreement (PSA) with Beacon.

The Manual serves as an administrative guide outlining Beacon’s policies and procedures governing network participation, service provision, claims submission, and quality management and improvement. Detailed information regarding clinical processes, including authorizations, utilization review, care management, reconsiderations, and appeals, as well as information regarding credentialing and recredentialing, billing transactions and provider education and outreach are also included in this Manual.

The Manual and Beacon’s medical necessity criteria are posted on Beacon’s website. Providers may also request a printed copy of the Manual by calling Beacon’s toll-free telephone line.

Updates to the Manual, as permitted by the PSA, will be posted on the Beacon website, and notification will also be sent by postal mail and/or electronic mail. Beacon provides notification to network providers at least 30 days (or as required by State regulations) prior to the effective date of any policy or procedural change that affects providers, such as modification in payment or covered services. Beacon routinely communicates with providers via the “Beacon Bulletin” that is distributed to providers via mail, email and/or fax. These bulletins point providers to our website for supporting information to ensure adequate notice of any changes to existing policies or requirements.

## 1.2. Introduction to Beacon

Beacon Health Strategies LLC (Beacon), a Beacon Health Options company, is a limited liability, managed behavioral health care company. Beacon’s mission is to collaborate with health plan customers and contracted providers to improve the delivery of behavioral health care for members.

The Beacon Health Options family of companies serves more than 50 million individuals on behalf of more than 350 client organizations across the country.

## 1.3. Beacon’s Behavioral Health Services

Beacon’s behavioral health program provides members with access to a full continuum of behavioral health services through our network of contracted providers. The primary goal of the program is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings. Ensuring that all members receive timely access to clinically appropriate behavioral health care can achieve improved outcomes for members.

### **DEFINITION OF BEHAVIORAL HEALTH**

Beacon defines “behavioral health” as both acute and chronic psychiatric and substance use disorders as referenced in the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or

## ACCESSIBLE INTERVENTION AND TREATMENT

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

- Screen, evaluate, treat, and/or refer (as medically appropriate), any behavioral health problem. Primary care providers (PCPs) may treat for mental health and/or substance use disorders within the scope of their practice and bill using DSM and/or ICD-10 codes
- Inform members how and where to obtain behavioral health service
- Understand that members may self-refer to any behavioral health care provider without a referral from the member's PCP

Providers who need to refer members for further behavioral health care can contact Beacon.

## COVERED BENEFITS

Beacon facilitates care for the plan, state government entities and employers that cover a variety of benefit levels from traditional outpatient services to alternative levels of care to acute inpatient care and specialized services such as Applied Behavioral Analysis.

## 1.4. Transactions and Communications with Beacon

Beacon's website, [www.beaconhealthoptions.com](http://www.beaconhealthoptions.com), lists answers to frequently asked questions, Beacon's clinical practice guidelines, clinical articles, links to numerous clinical resources, and important news for providers.

## ELECTRONIC RESOURCES

Beacon is committed to helping providers manage administrative functions more effectively and efficiently. Therefore, in an effort to ensure provider satisfaction for our entire network, providers are now required to electronically conduct all routine transactions with Beacon via our online provider services.

### ProviderConnect

Beacon's secure HIPAA compliant portal, ProviderConnect, is a password protected site where *participating providers* conduct certain online activities directly 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen system issues). Currently, *participating providers* are given access to the following online activities:

- Authorization or *certification* requests for all levels of care
- Concurrent *review* requests and discharge reporting
- Verification of eligibility status
- Submission of inquiries to Beacon's Provider Customer Service
- Updates to practice profiles/records

Links to information and documents important to providers are located on the ProviderConnect page of our website. Because this site contains member-identifying information, users must register in order to gain access to the ProviderConnect application. To register please click on the following link <https://providerconnect.beaconhealthoptions.com/pc/eProvider/providerLogin.do> and have your Provider Number readily available.

## **PROVIDER ALERTS**

Beacon encourages providers to contact us.

Throughout the year Beacon sends providers alerts related to regulatory requirements, protocol changes, helpful reminders, and other topics. To receive these notices in the most efficient manner, we strongly encourage you to enter and update email addresses and other key contact information for your practice, through ProviderConnect.

## **COMMUNICATION OF MEMBER INFORMATION**

In keeping with HIPAA requirements, providers are reminded that personal health information (PHI) cannot be communicated via non-secure email, other than through Beacon's ProviderConnect. PHI may be communicated by telephone or secure fax. Be aware: It is a HIPAA violation to include any member identifying information or PHI in non-secure email through the Internet.

# Medicare and Medicaid Requirements

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- 2.1. About this Chapter
- 2.2. Provider Requirements

## 2.1. About this Chapter

The provisions in this chapter apply to services provided to Medicaid, Medicare Advantage, and Medicare and Medicaid (dual-eligible) members, as governed by federal and state regulations. These terms are intended to supplement the Medicare Advantage and Medicaid requirements found in the provider services agreement (PSA) for providers participating in Medicare Advantage and Medicaid. In the event of a conflict between this chapter and provisions found elsewhere in the manual, this chapter shall govern with respect to Medicaid, Medicare Advantage, and dual-eligible members.

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

## 2.2. Provider Requirements

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

- Not distribute any marketing materials, as such term is defined in 42 CFR Section 422.2260, to Medicare Advantage members or prospective Medicare Advantage members unless such materials have received the prior written approval of (a) Beacon and, if required, (b) CMS and/or the applicable plan. The provider shall further not undertake any activity inconsistent with CMS marketing guidelines as in effect from time to time. [42 CFR 422.2260, et seq.]
- Ensure that covered services are provided in a culturally competent manner. [42 CFR 422.112(a)(8)]
- Maintain procedures to inform Medicare Advantage members of follow-up care and, if applicable, provide training in self-care as necessary. [42 CFR 422.112(b)(5)]
- Document in a prominent place in the medical record of Medicare Advantage members if the member has executed an advance directive. [42 CFR 422.128 (b)(1)(ii)(e)]
- Provide continuation of care to Medicare Advantage members in a manner and according to timeframes set forth in the PSA, and if CMS imposes additional continuation of care criteria or timeframes applicable to Medicare Advantage members, the provider shall comply with such additional CMS requirements as well as any requirements set forth in the PSA. [42 CFR 422.504(g)(2)(i) and (ii) and 42 CFR 422.504(g)(3)]

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

- In the event that the provider provides influenza and/or pneumococcal vaccines to patients, for any Medicare Advantage member, the provider shall provide such vaccines to Medicare Advantage members with no cost sharing. [42 CFR 422.100(g)(1) and (2)]
- Not discriminate against any Medicare Advantage member based upon the member's health status. [42 CFR 422.110(a)]
- Be accessible to Medicare Advantage members 24 hours per day, seven days per week when medically necessary. [42 CFR 422.112(a)(7)]
- Comply, as set forth in the PSA, with all applicable federal laws including but not limited to those federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse such as the False Claims Act and the federal anti-kickback statute. [42 CFR 422.504(h)(1)]
- Agree that Beacon and/or the applicable plan may notify all affected Medicare Advantage members of the termination of the provider's participation in Beacon or the plan's provider network, as applicable. [42 CFR 422.111(e)]
- Disclose to CMS and to Beacon or the plan, quality and performance indicators, including disenrollment rates, member satisfaction rates and health outcomes to enable the plan to satisfy applicable CMS reporting requirements. [42 CFR 422.504 (f)(2)(iv)(A), (B), and (C)]
- Safeguard the privacy of any information that identifies a particular member and maintain records in an accurate and timely manner. [42 CFR 422.118]
- Maintain and distribute to all employees and staff written standards of conduct that clearly state the provider's commitment to comply with all applicable statutory, regulatory, and Medicare program requirements (Code of Conduct) and require all employees and staff to certify that they have read, understand, and agree to comply with the standards. Require employees and staff to certify that in administering or delivering Medicare benefits, they are free of any conflict of interest as set forth in the provider's conflict of interest policy. [42 CFR 422.503(b)(4)(vi)(A), (E), and (F)] (Beacon may request annual certifications and documentation necessary to satisfy a regulatory audit of Beacon or the plan.)
- Comply with the requirements of the compliance programs (which include measures to prevent, detect, and correct Medicare non-compliance as well as measures to prevent, detect, and correct fraud, waste, and abuse) of plans that are Part C and Part D sponsors. Comply with and participate in, and require employees and staff to comply with and participate in, training and education given as part of the plan's compliance plan to detect, correct, and prevent fraud, waste, and abuse. [42 C.F.R. §422.503 and 42 C.F.R. §423.504]
- Monitor employees and staff monthly against the List of Excluded Individuals and Entities posted by the Office of the Inspector General of the Department of Health and Human Services and any applicable State Office of the Inspector General on their respective websites, the Excluded Parties List System, and the System for Award Management. [42 CFR 422.503(b)(4)(vi)(F)]
- Provide Beacon with written attestations documenting satisfaction of the requirements set forth above specific to the provider's Code of Conduct, compliance with the plan's fraud, waste, and abuse training, and the performance of monthly monitoring of employees and staff. [42 CFR 422.503(b)(4)(vi)(A), (C), and (D)] The provider further acknowledges that:

- Beacon and/or plans may offer benefits in a continuation area for the members who move permanently out of the plan's service area. [42 CFR 422.54(b)]
- Beacon and/or plans will make timely and reasonable payment to, or on behalf of, a Medicare Advantage member for emergency or urgently needed services obtained by a member from a non-contracted provider or supplier to the extent provided by 42 CFR 422.100(b)(1)(ii).
- Though it may not be applicable to the services provided by the provider, the plan will make available, through direct access and/or without member cost share as, and to the extent required by CMS, out-of-area renal dialysis services and certain other services, such as mammography, women's preventive services and certain vaccines. [42 CFR 422.100(b)(1)(iv), 42 CFR 422.100(g)(1) and (2)]

# Provider Network Participation

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- 3.1. Network Operations
- 3.2. Contracting and Maintaining Network Participation
- 3.3. Access Standards
- 3.4. Beacon's Provider Database
- 3.5. Required Notification of Practice Changes and Limitations in Appointment Access
- 3.6. Adding Sites, Services, and Programs
- 3.7. Provider Credentialing and Recredentialing
- 3.8. Prohibition on Billing Members
- 3.9. Waiver Request Process

### 3.1. Network Operations

Beacon’s Network Operations Department, with Provider Relations, is responsible for the procurement and administrative management of Beacon’s behavioral health provider network. As such, their role includes contracting, credentialing and provider relations functions. Representatives may be reached by emailing [provider.relations@beaconhealthoptions.com](mailto:provider.relations@beaconhealthoptions.com), or by calling our National Provider Service Line between 8 a.m. and 8 p.m., Eastern Time (ET) Monday through Friday at 800.397.1630.

### 3.2. Contracting and Maintaining Network Participation

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

Participating providers who maintain approved credentialing status remain active network participants unless the PSA is terminated according to its stated terms and conditions. In cases where a provider is terminated, the provider may notify the member of the termination, but in all cases, Beacon will notify members when their provider has been terminated.

### 3.3. Access Standards

#### APPOINTMENT AVAILABILITY

Beacon uses a variety of mechanisms to measure a member’s access to health care with participating providers. Unless other appointment availability standards are required by a specific plan or government sponsored health benefit program, service availability is assessed based on the following standards for participating providers.

IF A MEMBER HAS A:	THEY MUST BE SEEN:
Life-threatening emergency	Immediately
Non-life-threatening emergency	Within six hours
Urgent needs	Within 48 hours
Routine office visit	Within 10 business days

### 3.4. Beacon’s Provider Database

Beacon maintains a database of provider information as reported to us by providers. The accuracy of this database is critical to Beacon’s operations for such essential functions as:

- Notification to the provider for process and policy updates
- Notification to the provider of recredentialing deadlines and submission requirements
- Mandatory reporting to the plan and state and federal agencies
- Periodic reporting to the plan for updating printed provider directories
- Identifying and referring members to providers who are appropriate and offer available services to meet the member’s individual needs and preferences
- Network monitoring to ensure member access to a full continuum of services across the entire geographic service area
- Network monitoring to ensure compliance with quality and performance standards, including appointment access standards

### 3.5. Required Notification of Practice Changes and Limitations in Appointment Access

Notice to Beacon is required for any changes in contact information, practice, access limitations, and any temporary or permanent inability to meet the appointment access standards in Section 3.3 above. All notifications of practice changes and access limitations must be submitted 90 days before the planned effective date or as soon as the provider becomes aware of an unplanned change or limitation.

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

**TABLE 3-1: REQUIRED NOTIFICATIONS**

TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	ProviderConnect	EMAIL
<b>General Practice Information</b>		
Change in address or telephone number of any services	Yes	Yes
Addition or departure of any professional staff	No	Yes
Change in linguistic capability, specialty, or program	Yes	Yes
Discontinuation of any covered service listed in Exhibit A of the provider’s PSA	No	Yes
TYPE OF INFORMATION	METHOD OF NOTIFICATION	
	ProviderConnect	EMAIL

Change in licensure or accreditation of provider or any of its professional staff	No	Yes
<b>Appointment Access</b>		
Change in licensure or accreditation of provider or any of its professional staff	Yes (license)	Yes
Change in hours of operation	Yes	Yes
Is no longer accepting new patients	Yes	Yes
Is available during limited hours or only in certain settings	Yes	Yes
Has any other restrictions on treating members	Yes	Yes
Is temporarily or permanently unable to meet Beacon standards for appointment access	Yes	Yes
<b>Other</b>		
Merger, change in ownership, or change of tax identification number (As specified in the PSA, Beacon is not required to accept assignment of the PSA to another entity.)	No	Yes
Adding a site, service, or program not previously included in the PSA; remember to specify: a. Location b. Capabilities of the new site, service, or program	No	Yes

### 3.6. Adding Sites, Services, and Programs

The PSA is specific to the sites and services for which the provider originally contracted with Beacon.

To add a site, service, or program not previously included in the PSA, the provider must notify Beacon in writing of the location and capabilities of the new site, service, or program. Beacon will determine whether the site, service, or program meets an identified geographic, cultural/linguistic, and/or specialty need in our network and will notify the provider of the determination.

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

### 3.7. Provider Credentialing and Recredentialing

Beacon conducts a rigorous credentialing process for network providers based on CMS and National Committee for Quality Assurance (NCQA) and other accreditation and regulatory guidelines. All providers must be approved for credentialing by Beacon to participate in the network and must comply with recredentialing standards by submitting all requested information within the specified timeframe. Privatesolo and group practice clinicians are individually credentialed, while facilities are credentialed as organizations. The processes for both are described below. To request credentialing information and application(s), email [provider.relations@beaconhealthoptions.com](mailto:provider.relations@beaconhealthoptions.com).

**TABLE 3-2: CREDENTIALING PROCESSES**

<b>INDIVIDUAL PRACTITIONER CREDENTIALING</b>	<b>ORGANIZATIONAL CREDENTIALING</b>
<p>Beacon individually credentials and recredentials the following categories of clinicians in private solo or group practice settings:</p> <ul style="list-style-type: none"> <li>▪ Psychiatrist</li> <li>▪ Physician certified in addiction medicine</li> <li>▪ Psychologist</li> <li>▪ Licensed clinical social workers</li> <li>▪ Master’s-level clinical nurse specialists certified in behavioral health/ psychiatric nurses</li> <li>▪ Licensed clinical mental health counselors</li> <li>▪ Licensed marriage and family therapists</li> <li>▪ Master’s-level licensed alcohol and drug counselors (MLADC)</li> <li>▪ Other behavioral health care specialists who are master’s level or above and who are licensed, certified, or registered by the state in which they practice</li> </ul>	<p>Beacon credentials and recredentials facilities and licensed outpatient agencies as organizations. Facilities that must be credentialed by Beacon as organizations include:</p> <ul style="list-style-type: none"> <li>▪ Licensed outpatient clinics and agencies, including hospital-based clinics</li> <li>▪ Freestanding inpatient behavioral health facilities – freestanding and within general hospital</li> <li>▪ Inpatient behavioral health units at hospitals</li> <li>▪ Inpatient detoxification facilities</li> <li>▪ Community mental health centers</li> <li>▪ Federally qualified health center (FQHC) substance use disorder (SUD) outpatient programs</li> <li>▪ SUD comprehensive programs</li> <li>▪ Other diversionary behavioral health and SUD services, including:               <ol style="list-style-type: none"> <li>1. Partial hospitalization</li> <li>2. Day treatment</li> <li>3. Intensive outpatient</li> <li>4. SUD residential</li> </ol> </li> </ul>

#### **INDIVIDUAL PRACTITIONER CREDENTIALING**

Beacon conducts a thorough credentialing process which includes primary source verification of the following items:

- License current and in good standing

- Active malpractice insurance
- Work history
- Education

Practitioners must submit a complete practitioner credentialing application with all required attachments. Incomplete applications cannot be processed. Providers are notified of any discrepancies found and any criteria not met. Providers have the opportunity to submit additional, clarifying information to correct the identified discrepancy. Discrepancies and/or unmet criteria may disqualify the practitioner for network participation.

Once the practitioner has been approved for credentialing and contracted with Beacon as a solo provider, or verified as a staff member of a contracted group practice, Beacon will notify the practitioner or the group practice's credentialing contact of the date on which the provider may begin to serve members of specified health plans.

## **ORGANIZATIONAL CREDENTIALING**

To be credentialed, facilities must be licensed or certified by the state in which they operate, and the license must be in force and in good standing at the time of credentialing or recredentialing. If the facility reports accreditation by The Joint Commission (TJC), Council on Accreditation of Services for Family and Children (COA), Council on Accreditation of Rehabilitation Facilities (CARF), or DNV GL HealthCare (DNV), such accreditation must be in force and in good standing at the time of credentialing or recredentialing of the facility. If the facility is not accredited by one of these accreditation organizations, Beacon accepts a CMS/State site survey in lieu of accreditation. IF no CMS/State site survey exists, the organizational application will be reviewed for rural status (does not require site visits) or if appropriate, conducts a site visit prior to rendering a credentialing decision. The facility must also show evidence of current malpractice insurance with adequate coverage levels.

The credentialed facility is responsible for credentialing and overseeing its clinical staff as Beacon does not individually credential facility-based staff.

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

## **RECREREDENTIALING**

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

It is critically important that providers keep their contact information, particularly email, mailing and credentialing address, updated with Beacon as this is the primary method for early communication of recredentialing notification. Recredentialing deadlines are firm, the consequences of not meeting these deadlines are that the provider is considered to be out-of-network and members are transitioned to innetwork providers if deadlines are not met. Assuring that Beacon has current contact information allows Beacon to notify providers with ample advanced notice of recredentialing requirements and deadlines and prevent termination.

### **3.8. Prohibition on Billing Members**

Members may not be billed for any covered service or any balance beyond reimbursement by UniCare except for any applicable copayment. Further, providers may not charge members for any services that are not deemed medically necessary upon clinical review or that are administratively denied. It is the provider's responsibility to check benefits prior to beginning treatment of the member, to obtain appropriate authorization to provide services, if applicable, and to follow the procedures set forth in this manual.

### **3.9. Waiver Request Process**

On occasions in which a provider possesses unique skills or abilities but does not meet the above credentialing criteria, a Beacon Waiver Request Form can be submitted. These waiver request forms will be reviewed by the Beacon Credentialing Committee, and providers will be notified of the outcome of the request. Once the practitioner has been approved for credentialing and contracted with Beacon, Beacon will notify the practitioner or the practice's credentialing contact of the date on which he or she may begin to serve members.

# Members, Benefits, and Member-Related Policies

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- 4.1. Behavioral Health and Substance Use Disorder Benefits
- 4.2. Member Rights and Responsibilities
- 4.3. Non-Discrimination Policy and Regulations
- 4.4. Confidentiality of Member Information
- 4.5. Member Eligibility

## 4.1. Behavioral Health and Substance Use Disorder Benefits

Access to behavioral health treatment is an essential component of a comprehensive health care delivery system. Members may access behavioral health services by self-referring to a network provider, by calling Beacon, or by referral through acute or Emergency Room (ER) encounters or other medical provider. PCP referral is not required for behavioral health services. Network providers are expected to coordinate care with a member's PCP and other treating providers whenever possible.

These benefits include coverage for:

- Autism Services
- Emergency care
- Inpatient care
- Medication-assisted treatment (MAT)
- Medication management
- Office services
- Outpatient services
- Psychological & Neuropsychological Testing
- Substance use disorder assessments / referrals
- Telehealth
- Therapy

### ADDITIONAL BENEFIT INFORMATION

- Benefits do not include payment for behavioral health care services that are not medically necessary.
- Neither Beacon nor the member's insurance plan is responsible for the costs of investigational drugs or devices or the costs of non-health care services such as the costs of managing research or the costs of collecting data that is useful for the research project but not necessary for the member's care.
- Co-payments are subject to change each plan year (co-payments can be verified on eServices, or by calling Beacon at 800-442-9300)
- Detailed information about authorization procedures is covered later in this manual.

## 4.2. Member Rights and Responsibilities

### MEMBER RIGHTS

Company and Provider Information

Members have the right to receive information about Beacon's services, benefits, practitioners, providers, member rights and responsibilities and clinical guidelines.

#### Respect

Members have the right to:

- Be treated with respect, dignity, and privacy regardless of race, gender, veteran status, religion, marital status, national origin, physical disabilities, mental disabilities, age, sexual orientation, or ancestry
- Receive information in a manner and format that is understandable and appropriate
- Oral interpretation services free of charge for any Beacon materials in any language
- Be free from restraint and seclusion as a means of coercion, discipline, convenience, or retaliation

### Member Input

Members have the right to:

- Have anyone they choose speak for them in contacts with Beacon
- Decide who will make medical decisions for them if they cannot make them
- Refuse treatment, to the extent allowed by the law
- Be a part of decisions that are made about plans for their own care
- Talk with providers about the best treatment options for their condition, regardless of the cost of such care, or benefit coverage
- Obtain information regarding personal treatment records with signed consent in a timely manner and have the right to request an amendment or correction be made to their medical records
- A copy of the member rights and responsibilities
- Tell Beacon what they think their rights and responsibilities as a member should be
- Exercise these rights without having their treatment adversely affected in any way

### Complaints

Members have the right to:

- Make complaints (verbally or in writing) about Beacon staff, services or the care given by providers
- Appeal if they disagree with a decision made by Beacon about their care; Beacon administers their appeal rights as stipulated under the benefit plan

### Confidentiality

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

### Access to Care, Services, and Benefits

Members have the right to know about covered services, benefits, and decisions about health care payment with their plan, and how to seek these services. They have the right to receive timely care consistent with their need for care.

### Claims and Billing

Members have the right to know the facts about any charge or bill they receive.

## MEMBER RESPONSIBILITIES

Members have the responsibility to provide information, to the best of their ability, which Beacon or their provider may need to plan treatment.

Members have the responsibility to learn about their condition and work with the provider to develop a plan for care. They have the responsibility to follow the plans and instructions for the care they agreed to with the provider.

Members are responsible for understanding their benefits, what's covered and what's not covered. They are responsible for understanding that they may be responsible for payment of services received that are not included in the Covered Services List for their coverage type.

Members have the responsibility to notify the plan and/or Beacon and the provider of changes such as address changes, phone number change, or change in insurance.

If required by the benefit, the member is responsible for choosing a primary care provider and site for the coordination of all medical care.

Members are responsible for contacting their behavioral health provider, if they have one, if they are experiencing a mental health or substance use disorder emergency.

Beacon's *Member Rights and Responsibilities* is available in both English and Spanish from Beacon's website ([www.beaconhealthoptions.com](http://www.beaconhealthoptions.com)). You can also request a copy by calling Beacon at 888-204-5581 (TTY: 711).

## 4.3. Non-Discrimination Policy and Regulations

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

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

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

## 4.4. Confidentiality of Member Information

All providers are expected to comply with federal, state and local laws regarding access to member information. With the enactment of the federal HIPAA and HITECH Act, members or their legal guardian give consent for the release of information regarding treatment, payment, and health care operations at the sign-up for health insurance. Treatment, payment, and health care operations involve many different

activities, including but not limited to:

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

## **MEMBER CONSENT**

At every intake and admission to treatment, providers should explain the purpose and benefits of communication to the member's PCP and other relevant providers. The behavioral health clinician should then ask the member or their legal guardian to sign a statement authorizing the clinician to share clinical status information with the PCP and for the PCP to respond with additional member status information. A sample form is available at [www.beaconhealthstrategies.com](http://www.beaconhealthstrategies.com) (see Provider Tools Web page) or providers may use their own form. The form must allow the member or their legal guardian to limit the scope of information communicated.

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

## **CONFIDENTIALITY OF MEMBER'S HIV-RELATED INFORMATION**

At every intake and admission to treatment, providers should explain the purpose and benefits of how Beacon works in collaboration with the health insurance plan to provide comprehensive health services to members with health conditions that are serious, complex, and involve both medical and behavioral health factors. Beacon coordinates care with the health insurance plan's medical and disease management programs and accepts referrals for behavioral health care management from the plan. Information regarding HIV infection, treatment protocols and standards, qualifications of HIV/AIDS treatment specialists, and HIV/AIDS services, resources and medications, and testing is available directly from the health plan. Beacon will assist behavioral health providers or members interested in obtaining any of this information by referring them to the plan's care management department. Beacon limits access to all health related information, including HIV-related information and medical records, to staff trained in confidentiality and the proper management of member information. Beacon's care management protocols require Beacon to provide any member with assessment and referral to an appropriate treatment source. Beacon follows all federal and state information laws and guidelines concerning the confidentiality of HIV-related information.

## 4.5. Member Eligibility

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

To check member eligibility, providers can access the secure provider Web portal online or call Provider Services.

### Provider Portal (ProviderConnect)

- Go to <https://www.valueoptions.com/pc/eProvider/providerLogin.do>
- Enter your User ID and password, then click Log In.
- Once logged in, click on “Specific Member Search” on the navigation bar or “Find a Specific Member” on the main menu under Eligibility and Benefits.
- Using our secure provider Web portal, you can check member eligibility by entering Member ID and Date of Birth. You may enter the member’s name to narrow the search.

To maintain compliance with HIPAA and all other federal and state confidentiality/privacy requirements, providers must have their practice or organizational TIN, NPI, as well as member’s full name, plan ID and date of birth, when verifying eligibility through our provider portal.

***Note: Member eligibility information on our provider portal is updated monthly. Eligibility information obtained by phone is accurate as of the day and time it is provided by Beacon. Beacon cannot anticipate and is not responsible for retroactive changes or disenrollments reported at a later date. We recommend that providers check eligibility frequently.***

# Quality Management and Improvement Program

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- 5.1. Quality Management and Improvement (QM and I) Program Overview
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## 5.1. Quality Management and Improvement (QM and I) Program Overview

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

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

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

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

### PROVIDER ROLE

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

To participate in Beacon's Provider Stakeholder Council, email [provider.relations@beaconhealthoptions.com](mailto:provider.relations@beaconhealthoptions.com).

## QUALITY MONITORING

Beacon monitors provider activity and utilizes the data generated to assess provider performance related to quality initiatives and specific core performance indicators. Findings related to provider compliance with performance standards and measures are also used in credentialing and recredentialing activities, benchmarking, and to identify individual provider and network-wide improvement initiatives.

Beacon's quality monitoring activities include, but are not limited to:

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

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

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

## 5.2. Treatment Records

### TREATMENT RECORD STANDARDS AND GUIDELINES

Member treatment records should be maintained in compliance with all applicable medical standards, privacy laws, state and federal rules and regulations, as well as Beacon's policies and procedures and in a manner that is current, comprehensive, detailed, organized and legible to promote effective patient care and quality review. Providers are encouraged to use only secure electronic medical record technology when available. Beacon's policies and procedures incorporate standards of accrediting organizations to which Beacon is or may be subject (e.g., NCQA and URAC), as well as the requirements of applicable state and federal laws, rules, and regulations.

References to 'treatment records' mean the method of documentation, whether written or electronic, of care and treatment of the member, including, without limitation, medical records, charts, medication records, physician/practitioner notes, test and procedure reports and results, the treatment plan, and any

other documentation of care and/or treatment of the member.

Progress notes should include what psychotherapy techniques were used, and how they benefited the member in reaching his/her treatment goals. Progress notes do not have to include intimate details of the member's problems but should contain sufficient documentation of the services, care, and treatment to support medical necessity of same. Intimate details documenting or analyzing the content of conversations during a private counseling session or a group, joint, or family counseling session should be maintained within the psychotherapy notes and kept separate from the member's treatment record made available for review and audit.

Member treatment record reviews and audits are based on the record keeping standards set out below:

- Each page (electronic or paper) contains the member's name or identification number.
- Each record includes the member's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
- All entries in the treatment record are dated and include the responsible clinician's name, professional degree, and relevant identification number (if applicable), and modality of treatment (office-based or telehealth (if telehealth video, phone or other modality)). The length of the visit/session is recorded, including visit/session start and stop times.
- Reviews may include comparing specific entries to billing claims as part of the record review. □ The record, when paper based is legible to someone other than the writer.
- Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the member has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
- Presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status and the results of a mental status exam, are documented.
- Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented, and revised in compliance with written protocols.
- Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
- A medical and psychiatric history is documented, including previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data, and relevant family information.
- For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events (when available), along with a developmental history (physical, psychological, social, intellectual and academic).
- For members 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs.
- A DSM (or the most current version of the DSM) diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data.
- Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable.
- Treatment plans are updated as needed to reflect changes/progress of the member. □ Continuity and coordination of care activities between the primary clinician, consultants, ancillary providers, and health care institutions are documented as appropriate.
- Informed consent for medication and the member's understanding of the treatment plan are documented.

- Additional consents are included when applicable (e.g., alcohol and drug information releases).
- Progress notes describe the member's strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives.
- Documented interventions include continuity and coordination of care activities, as appropriate.
- Dates of follow-up appointments or, as applicable, discharge plans are noted.

In addition to other requests for member treatment records included in this handbook and/or the provider agreement, member treatment records are subject to targeted and/or unplanned reviews by the Beacon Quality Management Department or its designee, as well as audits required by state, local, and federal regulatory agencies and accreditation entities to which Beacon is or may be subject to.

## TREATMENT RECORD REVIEWS

Participating providers are required to cooperate with treatment record reviews and audits conducted by Beacon and associated requests for copies of member records. For the purpose of conducting retrospective case reviews, treatment records for Beacon members should be maintained for the time period(s) required by applicable state and/or federal laws and/or regulations, and as detailed in the provider agreement.

Beacon may conduct treatment record reviews and/or audits:

- On an unplanned basis as part of continuous quality improvement and/or monitoring activities
- As part of routine quality and/or billing audits
- As may be required by clients of Beacon
- In the course of performance under a given client contract
- As may be required by a given government or regulatory agency
- As part of periodic reviews conducted pursuant to accreditation requirements to which Beacon is or may be subject
- In response to an identified or alleged specific quality of care, professional competency or professional conduct issue or concern
- As may be required by state and/or federal laws, rules, and/or regulations
- In the course of claims reviews and/or audits
- As may be necessary to verify compliance with the provider agreement
- Beacon treatment record standards and guidelines for member treatment record reviews conducted as part of quality management activities are set out in the quality management section of this handbook.

Treatment record reviews and/or audits may be conducted through on-site reviews in the participating provider's office or facility location, and/or through review of electronic or hard copy of documents and records supplied by the participating provider. Unless otherwise specifically provided for in the provider agreement and/or other sections of this handbook with respect to a particular type of record review or audit, participating providers must supply copies of requested records to Beacon within five business days of the request.

Beacon will use and maintain treatment records supplied by participating providers for review and/or audit in a confidential manner and in accordance with applicable laws and regulations regarding the privacy or confidentiality of protected health information and/or patient identifying information. Never send original records as they will not be returned at the completion of the review or audit. Only send those sections of the record that are requested. Unless otherwise specifically provided in the provider agreement, access to and any copies of member treatment records requested by Beacon or designees of Beacon shall be at no cost. Records are reviewed by licensed clinicians. Treatment records reviews and/or audits conducted as part of Quality Management activities include application of an objective instrument(s). The instrument(s) are reviewed at least annually; Beacon reserves the right to alter/update, discontinue and/or

replace such instruments in its discretion and without notice.

Following completion of treatment record reviews and/or audits, Beacon will give the participating provider a written report that details the findings. If necessary, the findings report will include a corrective action plan with specific recommendations that will enable the participating provider to more fully comply with Beacon standards for treatment records. Participating providers will grant access for members to the member's treatment records upon written request and with appropriate identification.

Participating providers should review member treatment records prior to granting access to members to ensure that confidential information about other family members and/or significant others that may be referenced and/or included therein is redacted.

### 5.3 Performance Standards and Measures

To ensure a consistent level of care within the provider network, and a consistent framework for evaluating the effectiveness of care, Beacon has developed specific provider performance standards and measures. Behavioral health providers are expected to adhere to the performance standards for each level of care they provide to members, which include but are not limited to:

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

Beacon Provider Quality Managers (PQMs) may work with providers to identify opportunities for improvement and develop Provider Quality Plans to be monitored on an ongoing basis.

### 5.4 Clinical Practice Guidelines

Beacon reviews and endorses clinical practice guidelines to support providers in making evidence-based care treatment decisions on various topics. The most up-to-date, endorsed, clinical practice guidelines are posted on the Beacon website at <https://www.beaconhealthoptions.com/providers/beacon/handbook/clinical-practice-guidelines/>.

We strongly encourage providers to use these guidelines and to consider these guidelines whenever they may promote positive outcomes for clients. Additionally, each year, Beacon measures providers' adherence to at least three (3) Clinical Practice Guidelines or Resources. Beacon will review a portion of its members' medical records using the tool posted on the Beacon website. Questions have been developed from the guidelines/ resources.

Beacon welcomes provider comments about the relevance and utility of the guidelines adopted by Beacon, any improved client outcomes noted as a result of applying the guidelines, and about providers' experience with any other guidelines. To provide feedback, or to request paper copies of the practice guidelines adopted by Beacon, contact us.

## 5.5 Screening Programs

Beacon supports the early detection and treatment of depressive and comorbid disorders to promote optimal health for members 13 years and older. A few helpful reminders:

Beacon offers many screening tools and programs available at no cost:

- [PCP/ Provider Toolkit](#)
- [Depression Screening Program \(PDF\)](#)
- [Comorbid Mental Health and Substance Use Disorder Screening Program \(PDF\)](#)

Use screening tools at the first visit and repeat at regular intervals as clinically indicated to identify potential symptoms that may need further evaluation.

### Depression

- Patient Health Questionnaire 9 (PHQ-9) is a brief, multi-purpose tool for assessing depression, and is available in English, Spanish, and a variety of other languages in [Beacon's PCP/ Provider Toolkit](#).
- When assessing for depression, remember to rule out bipolar disorders; you may choose to use the [Mood Disorder Questionnaire \(MDQ\)](#).

### Suicide

- Beacon endorses the National Action Alliance for Suicide Prevention's [Recommended Standard Care for People with Suicide Risk](#), which screens individuals for suicide and includes a list of screening tools in the Appendix.

### Comorbid issues

- Remember to screen for possible mental health disorders when a diagnosis of a substance use disorder is present and conversely to screen for a potential substance use disorder when a mental health disorder is present.

[The CRAFFT Screening Interview \(PDF\)](#) assesses for substance use risk specific to adolescents.

## 5.6 Outcomes Measurement

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

## 5.7 Coordination and Continuity of Care

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

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

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

### **EDUCATE MEMBERS AND OBTAIN MEMBER CONSENT**

Providers are expected to educate members about the benefits of care coordination and encourage them to grant consent for their clinical and environmental information to be shared among treatment providers. Notification requirements in this section can be fulfilled only with the member's consent. (See Chapter 4, Members and Member-Related Policies, for information about member consent.)

### **COMMUNICATION BETWEEN BEHAVIORAL HEALTH PROVIDERS AND PCPS, OTHER TREATMENT PROVIDERS**

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

- Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first
- Updates at least quarterly during the course of treatment
- Notice of initiation and any subsequent modification of psychotropic medications
- Notice of treatment termination within two weeks

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

- Presenting problem/reason for admission

- Date of admission
- Admitting diagnosis
- Preliminary treatment plan
- Currently prescribed medications
- Proposed discharge plan
- Behavioral health provider contact name and telephone number

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

- Status of immunizations
- Date of last visit
- Dates and reasons for any and all hospitalizations
- Ongoing medical illness
- Current medications
- Adverse medication reactions, including sensitivity and allergies
- History of psychopharmacological trials
- Any other medically relevant information

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

## **COMMUNICATION BETWEEN INPATIENT/DIVERSIONARY PROVIDERS AND PCPS, OTHER OUTPATIENT TREATMENT PROVIDERS**

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

- Date of discharge
- Diagnosis
- Medications
- Discharge plan
- Aftercare services for each type, including:

- Name of provider;
- Date of first appointment
- Recommended frequency of appointments
- Treatment plan

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

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

## 5.8 Transitioning Members from One Behavioral Health Provider to Another

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

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

## 5.9. Routine, Urgent, and Emergency Services

### DEFINITIONS

#### Routine Care

Routine care is health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.

#### Urgent Behavioral Health Situation

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

#### Emergency Services

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

### ACCESSIBILITY

Each provider shall provide covered services during normal business hours. Covered services shall be available and accessible to members, including telephone access 24 hours a day and seven days per

week, to advise members requiring urgent or emergency services. Providers not accepting new appointments must notify Beacon of this. This is extremely important to assure the Beacon's and our health plans' provider directories reflect accurate provider availability.

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

**Acceptable phone arrangements:**

1. Office phone is answered after hours by an answering service. All calls answered by an answering service must be returned within 30 minutes.
2. Office phone is answered after normal business hours by a recording in the language of each of the major population groups serviced, directing the member to call another number to reach another provider. Someone must be available to answer the designated provider's phone. Another recording is not acceptable.
3. Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact another designated medical practitioner.

**Unacceptable Phone Arrangements:**

1. Office phone is only answered during office hours.
2. Office phone is answered after hours by a recording, which tells the members to leave a message.
3. Office phone is answered after hours by a recording that directs members to go to an emergency room for any services needed.
4. Returning after-hours calls outside of 30 minutes.

**EMERGENCY PRESCRIPTION SUPPLY**

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

The 72-hour emergency supply can be dispensed any time a prior authorization cannot be resolved within 24 hours for a medication on the vendor drug program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a prior authorization, the pharmacy can submit an emergency 72-hour prescription. A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

## 5.10. Member Safety Program

Beacon has a defined procedure for the identification, reporting, investigation, resolution and monitoring of Potential Quality of Care (PQOC) concerns. PQOC concerns are those that decrease the likelihood of desired health outcomes and that are inconsistent with current professional knowledge. These types of issues may be identified from a variety of sources, including without limitation member and

provider/participating provider complaints, internal reviews, clients, government agencies and others. These concerns are resolved and monitored at both the region and network-wide level. Regional teams have a designated committee, in which the local medical director participates, that oversee the investigation and resolution of these issues through to completion.

Beacon's member safety program includes the following components: prospective identification and reporting and investigation of potential Serious Reportable Events (internal and external events), trend analysis of member and provider and client complaints, annual evaluation and updating of existing member safety policies, prevention activities and the promotion of evidenced-based practice by our network credentialed providers and Beacon employed clinicians.

Prior to 6/1/2020, Beacon's Member Safety Program utilized a model of Adverse Incidents and Quality of Care Concerns. Effective 6/1/2020, Beacon's Member Safety Program utilizes a model of Potential Quality of Care (PQOC) Concerns including Serious Reportable Events (SREs) and Trending Events (TE). Beacon adopted the National Quality Forum's (NQF) Serious Reportable Event classification system as a base for its Member Safety Program. This allows the use of a standard taxonomy across a wide variety of settings and supports standard definitions across our diverse organization. For some contracts the term adverse incident, sentinel event or major incident may be used interchangeably or may have a specific definition based on state requirements.

Serious Reportable Events (SRE) include, but are not limited to:

1. Surgical or Invasive Procedures (i.e., wrong site, wrong patient, wrong procedure, foreign object, and death of ASA class 1 patient)
2. Product or Device Events (i.e., contamination, device malfunction, and embolism)
3. Patient Protection Events (i.e. discharge of someone unable to make decisions, elopement, completed suicide, attempted suicide, and self-injurious behaviors)
4. Care Management Events (i.e., medication error, fall)
5. Environmental Events (i.e., electric shock, gas, burn, restraint, seclusion, restrictive interventions)
6. Potential Criminal Events (i.e., impersonation, abduction, physical assault, and sexual behavior)
7. Beacon Specific (such as disaster management, accidents, staff misconduct, standards of care, and natural death)

Trending Events (TE) include, but are not limited to the following categories/sub-categories:

- Provider inappropriate/unprofessional behavior
- Inappropriate boundaries/relationship with member
- Practitioner not qualified to perform services

- Aggressive behavior
- Displays signs of cognitive, mental health, or substance use concerns impacting the care being provided
- Clinical practice-related issues
- Abandoned member or inadequate discharge planning
- Timeliness, accuracy, or adequacy of diagnosis, assessment, or referral
- Delay in treatment
- Effectiveness of treatment
- Failure to coordinate care or follow clinical practice guidelines
- Failure to involve family in treatment when appropriate
- Medication error or reaction
- Treatment setting not safe
- Access to care-related issues
- Failure to provide appropriate appointment access
- Lack of timely response to telephone calls
- Prolonged in-office wait time or failure to keep appointment
- Provider non-compliant with American Disabilities Act (ADA) requirements
- Services not available or session too short
- Attitude and service-related issues
- Failure to allow site visit
- Failure to maintain confidentiality
- Failure to release medical records
- Fraud and abuse
- Lack of caring/concern or poor communication skills
- Poor or lack of documentation
- Provider/staff rude or inappropriate attitude
- Other monitored events
- Adverse reaction to treatment
- Failure to have or follow communicable disease protocols
- Human rights violations
- Ingestion of an unauthorized substance in a treatment setting
- Non-serious injuries (including falls)
- Property damage and/or fire setting
- Sexual behavior

Participating providers are required to report to Beacon within 24 hours all Potential Quality of Care (PQOC) concerns involving members by phone and by fax/electronic correspondence. Fax a copy of the completed Adverse Incident Report to 877-335-5452

Beacon investigates Potential Quality of Care Concerns (PQOC) and uses the data generated to identify opportunities for improvement in the clinical care and service members receive. Beacon tracks and trends PQOC concerns and when necessary, investigates patterns or prevalence of incidents and uses the data generated to identify opportunities for quality improvement.

Based on the circumstances of each incident, or any identified trends, Beacon may undertake an investigation designed to provide for member safety. As a result, participating providers may be asked to furnish records and/or engage in corrective action to address quality of care concerns and any identified or suspected deviations from a reasonable standard of care. Participating providers may also be subject to disciplinary action through the NCC based on the findings of an investigation or any failure to cooperate with a request for information pursuant to an adverse incident investigation.

## 5.11. Fraud, Waste, and Abuse

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

- **Fraud** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- **Waste** is thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of health care resources, including incurring costs because of inefficient or ineffective practices, systems, or controls.
- **Abuse** involves provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the program.

Examples of provider fraud, waste, and abuse include altered medical records, patterns for billing that include billing for services not provided, up-coding, or bundling and unbundling, or medically unnecessary care. This list is not inclusive of all examples of potential provider fraud.

Examples of member fraud, waste, and abuse include under/unreported income, household membership (spouse/absent parent), out-of-state residence, third party liability, or narcotic use/sales/distribution. This list is not inclusive of all examples of potential member fraud.

Beacon continuously monitors potential fraud, waste, and abuse by providers, members, and member representatives. Beacon reports suspected fraud, waste, and abuse to the plan, which initiates the appropriate investigation. The plan will then report suspected fraud, waste, or abuse in writing to the correct authorities.

## **FRAUD, WASTE, AND ABUSE PLAN**

Beacon interacts with employees, clients, vendors, providers, and members using standard clinical and business ethics while seeking to establish a culture that promotes the prevention, detection, and resolution of possible violations of laws and unethical conduct. Beacon's compliance and anti-fraud plan was established to prevent and detect fraud, waste, or abuse in the behavioral health system through effective communication, training, review, and investigation. The compliance and anti-fraud plan, which includes Beacon's code of conduct, is intended to be a systematic process aimed at monitoring operations, subcontractor, and provider compliance with applicable laws, regulations, and contractual obligations, as appropriate. Providers are required to comply with provisions of Beacon's plan where applicable, including without limitation cooperation with claims billing audits, post-payment reviews, benefit plan oversight and monitoring activities, government agency audits and reviews, and participation in training and education.

### **Elements of Fraud, Waste, and Abuse Plan**

Beacon has in place internal controls, policies, and procedures to prevent and detect fraud, waste, and abuse. Beacon's formal compliance and anti-fraud plan established clear goals, assignments, measurements, and milestones, which include the following elements:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards
2. The designation of a compliance officer and a compliance committee that are accountable to senior management
3. Effective training and education for the compliance officer and the organization's employees
4. Effective lines of communication between the compliance officer and the organization's employees
5. Enforcement of standards through well-publicized disciplinary guidelines
6. Provision of internal monitoring and auditing
7. Provision for prompt response to detected offenses, and for development of corrective action initiatives

Beacon has designated the Program Integrity Department for anti-fraud efforts.

## **FRAUD, WASTE, AND ABUSE REVIEWS/AUDITS**

### **Access to Treatment Records and Treatment Record Reviews/Audits**

Beacon may request access to and/or copies of member treatment records and/or conduct member treatment record reviews and/or audits:

1. Randomly as part of continuous quality improvement and/or monitoring activities
2. As part of routine quality and/or billing audits
3. As may be required by clients of Beacon
4. In the course of performance under a given client contract
5. As may be required by a given government or regulatory agency
6. As part of periodic reviews conducted pursuant to accreditation requirements to which Beacon is or may be subject
7. In response to an identified or alleged quality of care, professional competence, or professional conduct issue
8. As may be required by state and/or federal laws, rules and/or regulations
9. In the course of claims reviews and/or audits
10. As may be necessary to verify compliance with the provider agreement.

Beacon's treatment record standards and guidelines for member treatment record reviews conducted as part of quality management activities are set out in the quality management section of this handbook.

Unless otherwise specifically provided in the provider services agreement (PSA), access to and any copies of member treatment records requested by Beacon or designees of Beacon shall be at no cost.

Participating providers will grant access for members to the member's treatment records upon written request and with appropriate identification. Participating providers should review member treatment records prior to granting access to members to ensure that confidential information about other family members and/or significant others that may be referenced and/or included is redacted.

### **Claims Billing Audits**

Beacon reviews and monitors claims and billing practices of providers in response to referrals. Referrals may be received from a variety of sources, including without limitation:

11. Members
12. External referrals from state, federal, and other regulatory agencies
13. Internal staff
14. Data analysis
15. Whistleblowers

Beacon also conducts random audits. Beacon conducts the majority of its audits by reviewing records providers either scan or mail to Beacon, but in some instances on-site audits are performed as well.

Record review audits, or discovery audits, entail requesting an initial sample of records from the provider to compare against claims submission records. Following the review of the initial sample, Beacon may request additional records and pursue a full/comprehensive audit. Records reviewed may include but are not limited to financial, administrative, current and past staff rosters, and treatment records.

Beacon audits the 'treatment record' including but not limited to progress notes, medication prescriptions and monitoring, documentation of counseling sessions, the modalities and frequency of treatment furnished, and results of clinical tests. Treatment record audits may also include review of the summaries of the diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

Providers must supply copies of requested documents to Beacon within the required time, which varies based on the number of records requested, but will not be less than 10 business days when providers are asked to either scan or mail records to Beacon. For on-site audits, providers must make records available to Beacon's staff during the audit.

Providers are required to sign a form certifying all requested records and documentation were submitted or made available for the audit. Beacon will not accept additional or missing documentation and/or records once this form is signed, including records related to a request for an appeal. Beacon will not reimburse providers for copying fees related to providing of documents and/or treatment records requested in the course of a claims billing audit, unless otherwise specifically required by applicable state or federal law, rule, or regulation.

In the course of an audit, the documents and records provided are compared against the claims submitted by the provider. Claims must be supported by adequate documentation of the treatment and services rendered. A provider's strict adherence to these guidelines is required. A member's treatment record must include the following core elements: member name, date of service, rendering provider signature and/or rendering provider name and credentials, diagnosis code, start and stop times (e.g., 9:00 to 9:50), time-based CPT codes, and service codes to substantiate the billed services.

Documentation must also meet the requirements outlined previously in Section 5.4. Treatment Records. Beacon coordinates claims billing audits with appropriate Beacon clinical representatives when necessary. The lack of proper documentation for services rendered could result in denial of payment, or, if payment has already been issued, a request for a refund.

Following the review of the documents and records received, Beacon will provide a written report of the findings to the provider. In some instances, such report of the findings may include a request for additional records.

Beacon has established an audit error rate threshold of 10 percent to determine whether a provider has accurate, complete, and timely claim/encounter submissions for the audit review period. Depending on the audit error rate and the corresponding audit results, Beacon's report of findings may include specific requirements for corrective action to be implemented by the provider if the audit identifies improper or unsubstantiated billings. Requirements may include but are not limited to:

- **Education/Training:** Beacon may require the provider to work with the Provider Relations team to develop an educational/training program addressing the deficiencies identified. Beacon may provide tools to assist the provider in correcting such deficiencies.

- **Corrective Action Plan:** Beacon may require the provider to submit a corrective action plan identifying steps the provider will take to correct all identified deficiencies. Corrective action plans include, at a minimum, confirmation of the provider’s understanding of the audit findings and agreement to correct the identified deficiencies within a specific timeframe.
- **Repayment of Claims:** The audit report will specify any overpayments to be refunded. The overpayment amount will be based on the actual deficiency determined in the audit process, or the value of the claims identified as billed without accurate or supportive documentation. Beacon does not use extrapolation to determine recovery amounts. The provider will be responsible for paying the actual amount owed, based on Beacon’s findings, within 10 business days, unless the provider has an approved installment payment plan.
- **Monitoring:** Beacon may require monitoring of claims submissions and treatment records in 90day increments until compliance is demonstrated. The provider’s monitored claims are not submitted for payment until each is reviewed for accuracy and correctness.
- **National Credentialing Committee (NCC) Reporting/Contract Termination:** Beacon’s NCC may decide that the results of an audit warrant the provider’s involuntary disenrollment before the provider has satisfied any required corrective action plans or recoupments. If a provider reported to the NCC is not immediately disenrolled and is permitted to remain active by accepting a corrective action and/or recoupment plan, but later fails to follow through, the provider may be readdressed by the NCC and involuntarily disenrolled for breach of contract.

## Appeal

If the provider disagrees with an audit report’s findings, the provider may request an appeal of the audit report of findings. All appeals must be submitted in writing and received by Beacon on or before the due date identified in the report of findings letter. Appeals must include:

- A copy of the audit report of findings letter
- The provider’s name and identification number
- Contact information
- Identification of the claims at issue, including the name or names of the member(s), dates of service, and an explanation of the reason/basis for the dispute

Beacon will not accept additional or missing documentation and/or records associated with billing errors once the signed form certifying the original documentation was submitted prior to the audit.

The provider’s appeal will be presented to Beacon’s National Compliance – Program Integrity Subcommittee within 45 days of receiving the provider’s request for appeal. The subcommittee is composed of Beacon employees who have not been involved in reaching the prior findings. The subcommittee will review the provider’s appeal documentation, discuss the facts of the case, as well as any applicable contractual, state, or federal statutes. The Beacon staff member/auditor who completed the provider’s audit will present his/her audit findings to the subcommittee but will not vote on the appeal itself. The subcommittee will uphold, overturn, uphold in-part, or pend the appeal for more information.

Once a vote is taken, it will be documented and communicated to the provider within 10 business days of the subcommittee’s meeting. If additional time is needed to complete the appeal, Beacon will submit a

letter of extension to the provider requesting any additional information required of the provider and estimating a time of completion. If repayments or a corrective action plan (CAP) are required, the provider must submit the required repayments or CAP within 10 business days of receiving the subcommittee's findings letter, unless an installment payment plan is approved.

Beacon will take appropriate legal and administrative action in the event a provider fails to supply requested documentation and member records or fails to cooperate with a Beacon investigation or CAP.

Beacon may also seek termination of the provider agreement and/or actions to recover amounts previously paid on claims involved in the investigation or requests for records. Beacon will report any suspicion or knowledge of fraud, waste, or abuse to the appropriate authorities or regulatory agency as required or when appropriate.

## **REPORTING FRAUD, WASTE, AND ABUSE**

Providers and members can report fraud, waste, and abuse, or suspicious activity, such as inappropriate billing practices (e.g., billing for services not rendered, the use of CPT codes not documented in the treatment record). Reports and questions may be made in writing to Beacon at the address below, or by calling the Beacon Ethics Hotline, or by [Program.IntegrityReferrals@beaconhealthoptions.com](mailto:Program.IntegrityReferrals@beaconhealthoptions.com).

Beacon Health Options  
Attn: Program Integrity Department  
240 Corporate Boulevard, Suite 100  
Norfolk, VA 23502

## **COOPERATION WITH OVERSIGHT**

Beacon and providers must cooperate and assist any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud, abuse, or waste. Beacon is responsible for investigating possible acts of waste, abuse, or fraud for all services. If Beacon identifies that fraud, waste, or abuse has occurred based on information, data, or facts, Beacon must immediately notify relevant state and federal program integrity agencies following the completion of ordinary due diligence regarding a suspected fraud, waste, or abuse case.

## **5.12. Federal False Claims Act (FCA)**

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

### **SUMMARY OF PROVISIONS**

The FCA imposes civil liability on any person who knowingly:

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

2. Uses (or causes to be used) a false record or statement to get a claim paid by the federal government
3. Conspires with others to get a false or fraudulent claim paid by the federal government
4. Uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the federal government

## **PENALTIES**

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

## **QUI TAM (WHISTLEBLOWER) PROVISIONS**

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

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

A case cannot be brought more than six years after the committing of the violation or no more than three years after material facts are known or should have been known, but in no event more than 10 years after the date on which the violation was committed.

## **NON-RETALIATION AND ANTI-DISCRIMINATION**

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

## **REDUCED PENALTIES**

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

If any member or provider becomes aware of any potential fraud by a member or provider, contact us and ask to speak to the Compliance Officer or email Beacon at [compliance@beaconhealthoptions.com](mailto:compliance@beaconhealthoptions.com).

## 5.13. Member and Provider Complaints

Providers with complaints or concerns should contact Beacon at 888.217.3501 (TTY 711) and ask to speak with the clinical manager for the health plan. All provider complaints are thoroughly researched by Beacon and resolutions proposed within 20 business days.

If health plan members complain or express concerns regarding Beacon's procedures or services, health plan procedures, covered benefits or services, or any aspect of the member's care received from providers, they should be directed to call Beacon's Member Services Department at 877-633-6396

## 5.14. Grievance and Appeals Resolution

A member and/or the member's authorized member representative (acting on behalf of the member) may file a complaint/grievance with Beacon. Beacon reviews and provides a timely response and resolution of all delegated grievances that are submitted by members, authorized member representative (AMR), and/or providers. Every grievance is thoroughly investigated, and receives fair consideration and timely determination.

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

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

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

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

***Member and provider concerns about a denial of requested clinical service, adverse utilization management decision, or an adverse action, are not handled as grievances. See Chapter 6, Care Management and Utilization Management, Section 6.11 Request for Reconsideration of Adverse Determination.***

# Care Management and Utilization Management

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- 6.1. Care Management
- 6.2. Utilization Management
- 6.3. Medical Necessity
- 6.4. Medical Necessity Criteria
- 6.5. Utilization Management Terms and Definitions
- 6.6. Emergency Services
- 6.7. Return of Inadequate or Incomplete Treatment Requests
- 6.8. Notice of Inpatient/Diversionary Approval or Denial
- 6.9. Decision and Notification Timeframes
- 6.10. Request for Reconsideration of Adverse Determination

## 6.1. Care Management

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

When clinical staff or providers identify members who demonstrate medical comorbidity, a high utilization of services, and an overall clinical profile that indicates that they are at high-risk for admission or readmission into a 24-hour behavioral health or substance use treatment setting, they may be referred to Beacon's CM program. The ICM program may connect members with community support providers that offer outreach programs uniquely designed for adults with severe and persistent mental illness, dually diagnosed adults, pregnant women with behavioral health or substance use disorders, and children with serious emotional disturbances.

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

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

- Other complex, extenuating circumstances where the ICM team determines the benefit of inclusion beyond the standard criteria

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

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

ICM and Care Coordination are voluntary programs and member consent is required for participation. For further information on how to refer a member to care management services, contact Beacon's toll-free telephone line 844-231-7953.

## 6.2. Utilization Management

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

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

Beacon medical and clinical employees with responsibility for making UM decisions have been made aware that:

- All UM decisions are based on the approved medical necessity criteria. Additionally, criteria is applied with consideration to the individual needs of the member and an assessment of the local delivery system.
  1. Individual needs and characteristics of the member include: age, linguistic, or ethnic factors, co-morbidities and complications, progress of treatment, psychosocial situation, and home environment.
  2. Characteristics of the local delivery system available to the member include aspects such as availability of alternative levels of care, benefit coverage for the available alternatives, and ability of local providers to provide all recommended services within the estimated length of stay.
- Financial incentives based on an individual UM clinician's number of adverse determinations or denials of payment are prohibited
- Financial incentives for UM decision makers do not encourage decisions that result in under- utilization

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

## 6.3. Medical Necessity

All requests for authorization are reviewed by Beacon clinicians based on the information provided. Beacon's medical necessity criteria are applied to determine appropriate care for all members.

Medically necessary services are services that are:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM,) that threatens life, causes pain or suffering, or results in illness or infirmity.
- Expected to improve an individual's condition or level of functioning.
- Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
- Reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available.
- Not primarily intended for the convenience of the recipient, caretaker, or provider.
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

Additionally, the individual's needs and characteristics of the local service delivery system are taken into consideration.

## 6.4. Medical Necessity Criteria

Beacon's Medical Necessity Criteria (MNC), also known as clinical criteria, are reviewed and updated at least annually to ensure that they reflect the latest developments in serving individuals with behavioral health diagnoses. Beacon's Corporate Medical Management Committee (CMMC) adopts, reviews, revises and approves Medical Necessity Criteria per client and regulatory requirements.

Medical Necessity Criteria varies according to state and/or contractual requirements and member benefit coverage. To determine the proper Medical Necessity Criteria, use the following as a guide:

1. For all Medicare members, first identify relevant Centers for Medicare and Medicaid (CMS) National Coverage Determinations (NCD) or Local Coverage Determinations (LCD) Criteria.

2. If no CMS criteria exists for Medicare members and for all non-Medicare members, identify relevant custom Medical Necessity Criteria.
3. If no custom criteria exists for the applicable level of care and the treatment is substance use related, the American Society of Addiction Medicine (ASAM) criteria would be appropriate.  
\* *Exception: Substance Use Lab Testing Criteria is in InterQual® Behavioral Health Criteria.*
4. If the level of care is not substance use related, Change Healthcare’s InterQual® Behavioral Health Criteria would be appropriate.
5. If 1-4 above are not met, Beacon’s National Medical Necessity Criteria would be appropriate.

Beacon has five (5) types of MNC, depending on client or state contractual requirements and lines of business:

- A. Centers for Medicare and Medicaid (CMS) Criteria – National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) contained in the Medicare Coverage Database (<https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>).
- B. Change Healthcare’s InterQual Behavioral Health Criteria
- C. American Society of Addiction Medicine (ASAM) Criteria
- D. Custom criteria, including state or client specific levels of care
- E. Beacon’s National Medical Necessity Criteria

Medical Necessity Criteria is available online via hyperlinks whenever possible and is available upon request.

## 6.5. Utilization Management Terms and Definitions

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

**TABLE 6-1: UM TERMS AND DEFINITIONS**

TERM	DEFINITION
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<b>Adverse Determination</b>	<p>A decision to deny, terminate, or modify (an approval of fewer days, units or another level of care other than was requested, which the practitioner does not agree with) an admission, continued inpatient stay, or the availability of any other behavioral health care service, for:</p> <ol style="list-style-type: none"> <li>a. Failure to meet the requirements for coverage based on medical necessity</li> <li>b. Appropriateness of health care setting and level-of-care effectiveness</li> <li>c. Plan benefits</li> </ol>
<b>Adverse Action</b>	<p>The following actions or inactions by Beacon or the provider organization:</p> <ol style="list-style-type: none"> <li>1. Beacon’s denial, in whole or in part, of payment for a service failure to provide covered services in a timely manner in accordance with the waiting time standards</li> <li>2. Beacon’s denial or limited authorization of a requested service, including the determination that a requested service is not a covered service</li> </ol>
<b>TERM</b>	<b>DEFINITION</b>
	<ol style="list-style-type: none"> <li>3. Beacon’s reduction, suspension, or termination of a previous authorization for a service</li> <li>4. Beacon’s denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including, but not limited to, denials based on the following: <ol style="list-style-type: none"> <li>a. Failure to follow prior authorization procedures</li> <li>b. Failure to follow referral rules</li> <li>c. Failure to file a timely claim</li> </ol> </li> <li>5. Beacon’s failure to act within the time frames for making authorization decisions</li> <li>6. Beacon’s failure to act within the time frames for making appeal decisions</li> </ol>

<b>Non-Urgent Concurrent Review and Decision</b>	<p>Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments. A non-urgent concurrent decision may authorize or modify requested treatment over a period of time or a number of days or treatments, or deny requested treatment, in a non-acute treatment setting.</p>
<b>Non-Urgent Pre-Service Review and Decision</b>	<p>Any case or service that must be approved before the member obtains care or services. A non-urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment, in a non-acute treatment setting.</p>
<b>Post-Service Review and Decision (Retrospective Decision)</b>	<p>Any review for care or services that have already been received. A post-service decision would authorize, modify or deny payment for a completed course of treatment where a pre-service decision was not rendered, based on the information that would have been available at the time of a pre-service review.</p>
<b>Urgent Care Request and Decision</b>	<p>Any request for care or treatment for which application of the normal time period for a non-urgent care decision:</p> <ul style="list-style-type: none"> <li>▪ Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment; or</li> <li>▪ In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is requested.</li> </ul>
<b>TERM</b>	<b>DEFINITION</b>
<b>Urgent Concurrent Review Decision</b>	<p>Any review for a requested extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments in an acute treatment setting, when a member's condition meets the definition of urgent care, above.</p>
<b>Urgent Pre-Service Decision</b>	<p>Formerly known as a pre-certification decision, any case or service that must be approved before a member obtains care or services in an inpatient setting, for a member whose condition meets the definition of urgent care above. An urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment in an acute treatment setting.</p>

## PROCEDURES AND REQUIREMENTS

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

Administrative denials may be rendered when applicable authorization procedures, including timeframes, are not followed. Members cannot be billed for services that are administratively denied due to a provider not following the requirements listed in this manual.

## MEMBER ELIGIBILITY VERIFICATION

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

***Member eligibility can change and possession of a health plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check Beacon’s ProviderConnect.***

Authorization Process by Level of Care	
Level of Care	Process
Inpatient Mental Health	Submit clinical on expedited auth website. Call assigned concurrent reviewer for Continued Stay requests.
CCS	Initial 5 days authorization exempt. Call NE Access Line for Continued Stay requests.
ICBAT/CBAT	Submit clinical on expedited auth website. Call assigned concurrent reviewer for Continued Stay requests.
TCU	Call assigned reviewer for Pre-certification and concurrent review requests.
Partial Hospitalization Program (PHP)	Submit notice of admission on Provider Connects for 12 units over 21 days. Designated providers must call NE Access line for Precert. Call NE Access line to Precert if not allowed access to Provider Connect. Call assigned concurrent reviewer for Continued Stay requests.
Intensive Outpatient Program (IOP)	Submit notice of admission on Provider Connect for 20 units over 45 days. Call assigned concurrent reviewer for additional days.
DDAT/EATS	Submit notice of admission (NOA) on Provider Connect for initial 14 days. Call assigned concurrent reviewer for additional days.
ATS (ASAM Level 3.7/Level 4.0)	Submit notice of admission (NOA) on Provider Connect for initial 7 days. Call assigned concurrent reviewer for additional days.
Substance Use RTC (ASAM Level 3.5)	Submit notice of admission (NOA) on Provider Connect for initial 7 days. Call assigned concurrent reviewer for Continued Stay requests.
Substance Use PHP (level 2.5)	Call NE access line for Pre-certification, call assigned concurrent reviewer for Continued Stay requests.

<b>Substance Use IOP (level 2.1)</b>	Submit notice of admission on Provider Connect for 20 units over 45 days. Call assigned concurrent reviewer for additional days.
<b>rTMS</b>	Complete rTMS request form and return via email <a href="mailto:outpatient_team@beaconhealthoptions.com">outpatient_team@beaconhealthoptions.com</a> for both Pre-certification and continued stay requests.
<b>Psych Testing and Neuro Psych Testing</b>	No prior authorization is required for authorization
<b>ECT</b>	For Inpatient ECT call assigned reviewer to complete precertification medical necessity review. No authorization is required for Outpatient ECT.
<b>Community Support Program (CSP)</b>	Fax request to 855-685-5170 for precertification. Call 800-442-9300 for additional units.
<b>Routine Outpatient</b>	No prior authorization is required for initial authorization or additional units
<b>Day Treatment</b>	No prior authorization is required for initial authorization or additional units
<b>Family Stabilization Team</b>	Telephonic review required. Call 800-442-9300

## 6.6. Emergency Services

### DEFINITION

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

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

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

### EMERGENCY SCREENING AND EVALUATION

Plan members must be screened for an emergency medical condition. An after-hours assessment usually takes place at an Emergency Department of a local hospital. A master’s-level clinician, in conjunction with a psychiatrist, if necessary, completes the assessment. An assessment may determine the need for an emergency outpatient appointment, immediate care in a hospital, or another community residential alternative.

After the emergency evaluation is completed, and if admission to a level of care that requires a notice of admission is needed, the emergency services clinician must call Beacon to complete a clinical review. The emergency services clinician is responsible for locating a psychiatric bed, but may request Beacon's assistance in this process. Beacon may contact an out-of-network facility in cases where there is not a timely or appropriate placement available within the network. In cases where there is no in-network or out-of-network psychiatric facility available, Beacon will authorize boarding the member on a medical unit until an appropriate placement resource becomes available.

### **BEACON CLINICIAN AVAILABILITY**

All Beacon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage, and referral procedures. Beacon clinicians are available 24 hours a day, seven days a week to take emergency calls from members, their guardians, and providers.

### **DISAGREEMENT BETWEEN BEACON AND ATTENDING EMERGENCY SERVICE PHYSICIAN**

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

## **6.7. Return of Inadequate or Incomplete Treatment Requests**

All requests for authorization must be original and specific to the dates of service requested and tailored to the member's needs. Beacon reserves the right to reject or return authorization requests that are incomplete, lacking in specificity, or incorrectly filled out. Beacon will provide an explanation of action(s) which must be taken by the provider to resubmit the request.

## **6.8. Notice of Inpatient/Diversiory Approval or Denial**

Verbal notification of approval is provided at the time of pre-service or continuing stay review. Notice of admission or continued stay approval is mailed to the member or member's guardian and the requesting facility.

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

All member notifications include instructions on how to access interpreter services, how to proceed if the notice requires translation or a copy in an alternate format, and toll-free telephone numbers for TDD/TTY

capability, in established prevalent languages.

### **TERMINATION OF OUTPATIENT CARE**

Beacon requires that all outpatient providers set specific termination goals and discharge criteria for members. Providers are encouraged to use the medical necessity criteria (accessible through ProviderConnect) to determine if the service meets medical necessity for continuing outpatient care.

## **6.9. Decision and Notification Timeframes**

Beacon is required by the state, federal government and NCQA render utilization review decisions in a timely manner to accommodate the clinical urgency of a situation. Beacon has adopted the strictest timeframe for all UM decisions to comply with the various requirements. Beacon's internal timeframes for rendering a UM determination and notifying members of such determination begin at the time of Beacon's receipt of the request. Note, the maximum timeframes may vary on a case-by-case basis in accordance with state, federal government or NCQA requirements.

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

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

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

# Appeals

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- 7.1. Provider Grievances and Appeals
- 7.2. Member Grievances, Appeals, and Fair Hearings
- 7.3. Clinical Appeals
- 7.4. Administrative Appeals Process
- 7.5. External Appeal Process

## 7.1. Provider Grievances and Appeals

Grievance and appeal standards vary and are governed by state and by contract. In general, the guidelines below apply. Providers have the right to file a grievance or an appeal with Beacon regarding Contractual issues.

Providers can appeal on behalf of the member if the member agrees in writing to allow the provider to serve as their “authorized representative.”

### HOW TO SUBMIT A PROVIDER GRIEVANCE OR APPEAL

- Calling the National Provider Service Line at 800.397.1630 to speak with a representative
- Emailing [provider.relations@beaconhealthoptions.com](mailto:provider.relations@beaconhealthoptions.com)

## 7.2. Member Grievances, Appeals, and Fair Hearings

Members have the right to file a grievance or appeal. They also have the right to request a state hearing once they have exhausted their appeal rights. As a Beacon provider, we may contact you to obtain documentation when a member has filed a grievance or appeal or has requested a state hearing. State and federal agencies require Beacon to comply with all requirements, which include aggressive resolution timeframes. Members are encouraged to call or write to Beacon to let us know of any complaints regarding Beacon or the health care services they receive. Members or legal guardians may file a grievance or appeal with Beacon. Member Service representatives and providers, with the member’s written consent, may also file a grievance or appeal with Beacon. Members, legal guardians, or providers can reach Beacon by calling Beacon’s toll-free telephone line to learn more about these procedures.

### MEMBER GRIEVANCES

Any time a member informs us that they are dissatisfied with Beacon, or one of our providers, it is a grievance. A member has 30 calendar days from the date of an event causing dissatisfaction to file a grievance orally or in writing with Beacon. Beacon investigates all grievances. If the grievance is about a provider, Beacon calls the provider’s office to gather information for resolution. Beacon has five working days of receipt of the grievance to notify the member that the grievance has been received and when resolution of the grievance is expected. An investigation and final resolution of a grievance shall be completed within 30 days of the date the grievance is received by Beacon.

### MEMBER APPEALS

Members have the right to appeal an adverse action or decision made by Beacon. An adverse action is:

- The denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure of the Beacon to provide services in a timely manner

- The failure of Beacon to complete the authorization request in a timely manner as defined in 42 CFR 438.408

Members have the right to appeal the decisions or actions listed above if they contact Beacon within 180 calendar days of receiving the notice of adverse action. Any timely oral appeal must be followed by a written appeal that is signed by the member within 10 calendar days. Within 1 business day of receipt of an appeal, Beacon shall provide the member with written notice that the appeal has been received and the expected date of its resolution, unless an expedited resolution has been requested.

Beacon will respond to the appeal within 30 calendar days of when it was received unless an extension is requested by member or Beacon can demonstrate that additional information is needed. An extension shall be no longer than 14 days. An appeal will be expedited when it is determined the resolution time for a standard appeal could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Expedited appeals will be resolved within three working days of the receipt of the request.

## **STATE FAIR HEARING**

A member must exhaust the appeals process prior to filing a request for a state fair hearing. A state fair hearing will be provided by the state if the plan has denied, terminated, or reduced services or has failed to give a member timely service.

A request for a state fair hearing can be made orally, in writing, or by completing a Request for Hearing form. Members must request a state fair hearing within 90 days from the date on the appeal decision letter.

If the member or member's appointed representative files a state fair hearing to dispute a decision to terminate, suspend, or reduce, a previously authorized course of treatment that was ordered by an authorized provider where the original period covered by the original authorization has not expired and the member requests an extension of benefits, the member must continue to receive the services if the request for state fair hearing is submitted within 10 days from the mail date on the written appeal decision letter. The benefits shall be continued or reinstated until the member or member's appointed representative withdraws the state fair hearing, 10 days after the plan mails the resolution of the appeal, unless the member has requested a state fair hearing within that 10-day timeframe, or the time period or service limits of a previously authorized service have been met.

If services are continued during the state fair hearing process and the state upholds the plan's decision to terminate, suspend, or reduce, the member may be liable for payment of the services received through the date of the decision by the state. Therefore, the member may have to pay for these services while the hearing is pending, or if the final decision is not in the member's favor.

Please note: For California health plans, a member must exhaust the plan grievance system before filing a state fair hearing. A state fair hearing must be requested within 120 days of a plan's determination. (DHCS Mega-Rule: Requirement 27).

## 7.3. Clinical Appeals

### OVERVIEW

A plan member and/or the member's appeal representative or provider (acting on behalf of the member) may appeal an adverse action/adverse determination. Both clinical and administrative denials may be appealed. Appeals may be filed either verbally, in person, or in writing. Appeal policies are made available to members and/or their appeal representatives as enclosures in all denial letters, and upon request.

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

### PEER REVIEW

A peer review conversation may be requested at any time by the treating provider, and may occur prior to or after an adverse determination, or upon request for a reconsideration. Beacon UR clinicians and physician advisors are available daily to discuss denial cases by phone by calling Beacon's toll-free telephone line.

### URGENCY OF APPEAL PROCESSING

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

### DESIGNATION OF AUTHORIZED MEMBER REPRESENTATIVE

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

## 7.4. Administrative Appeals Process

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

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

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

- **First Level** administrative appeals can be submitted in writing to the appeals coordinator at Beacon. Provide any supporting documents that may be useful in making a decision. (Do not submit medical records or any clinical information.) An administrative appeals committee reviews the appeal and a decision is made within 30 calendar days of the receipt of an appeal. A written notification is sent within two business days of the appeal determination.
- **Second Level** administrative appeals can be submitted in writing to the chief operations officer at Beacon. A decision is made within 30 calendar days of receipt of appeal information and notification of decision is sent within two business days of appeal determination.

## 7.5 External Appeal Process

Requests for an External Appeal:

If you are not satisfied with the appeal decision, the member or their appeal representative have the right to seek external appeal. An external appeal is a complete reexamination of your case by an independent review organization (IRO). To file an external appeal, the member or their appeal representative must send us a letter within four (4) months of receiving the adverse determination letter and explain the reason for their disagreement with our decision. Members are not required to bear any costs when requesting a case be sent for external review to an IRO. Beacon will forward your letter and the entire case file to the IRO. The IRO will send final written outcome of the appeal within 45 calendar days of the request for the review. All decisions rendered by the IRO are final and binding.

Expedited External Review:

Any request for an expedited external review shall be in writing, from a physician, stating that the delay in providing or continuation of health care services that are the subject of the adverse determination, would pose an immediate threat to the member's health. The member or their appeal representative have the right to request continuation of service throughout the appeal process but must do so within two business days of receipt of the adverse determination letter. The member does not have to complete all levels of internal appeal before requesting an expedited external appeal, this may be done at the same time an internal expedited appeal is requested with Beacon. The external review panel will send final written outcome of an expedited external review within 72 hours of the request for the review.

# Billing Transactions

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- 8.1. General Claims Policies
- 8.2. Electronic Billing

## 8.1. General Claims Policies

This chapter presents all information needed to submit claims. Effective July 1<sup>st</sup>, 2018, all claims need to be submitted directly to UniCare for UniCare State Indemnity Plan members. UniCare complies with HIPAA 5010 Transaction Standards and Code Sets, and with the electronic data interchange (EDI) standards for health care required by the Health Insurance Portability and Accountability Act (HIPAA).

## 8.2. Electronic Billing

To improve productivity and efficiency UniCare accepts claims submitted electronically. You can send claims to UniCare through a clearinghouse or by using free web-based transactions. The electronic Payer ID number for UniCare is 80314.

For more information about UniCare electronic claims you may:

- Visit <https://www.unicarestateplan.com/provElecClmFiling.html>
- Call UniCare e-Solutions at 800.470.9630 during regular business hours □  
Email [e-solutions.support@unicare.com](mailto:e-solutions.support@unicare.com)