This document contains chapters 1-9 of Beacon’s Behavioral Health Policy and Procedure Manual for providers serving Neighborhood Health Plan of Rhode Island members. Note that links within the manual have been activated in this revised version. Additionally, all referenced materials are available on this website. Chapters 5-8, which contain all level-of-care service descriptions and criteria will be posted on eServices; to obtain a copy, please email provider.relations@beaconhs.com or call 800-215-0058.
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Neighborhood Health Plan of Rhode Island & Beacon Health Strategies

Neighborhood Health Plan of Rhode Island (Neighborhood) was founded and incorporated as a health maintenance organization (HMO) in December 1993 by the 14 Rhode Island Community Health Centers and obtained its license to operate as an HMO on Dec. 1, 1994. Neighborhood is guided by its mission to partner with the Community Health Centers to improve access and health in Rhode Island, especially for vulnerable populations. Its members are enrolled in a variety of Medicaid managed care programs, including RtteCare, Substitute Care, Children with Special Health Care Needs and Rhody Health Partners.

On Nov. 1, 2001, Neighborhood began its contractual engagement with Beacon Health Strategies (Beacon) to manage the delivery of behavioral health (BH) services for all Neighborhood members. Neighborhood has delegated to Beacon the responsibility for behavioral health, which includes: Utilization Management; Service Accessibility and Availability, Referral and Triage; Provider Contracting; Quality Management and Improvement; Preventive Health Services; Credentialing and Re-credentialing; Member Rights and Responsibilities; Treatment Record Compliance; and Claims Processing and Claims Payment and Fraud and Abuse Detection.

Purpose of the Neighborhood Behavioral Health (BH) Program

Provider Policy and Procedure Manual

This manual is an administrative guide outlining Beacon Health Strategies’ policies and procedures governing service provision, claims submission, and quality management and improvement requirements. Chapters 1-4 and 9 contain information relevant to all BH providers. The remaining chapters focus on specific levels of care (i.e., Inpatient, Diversionary, Outpatient and Emergency Services). Providers can access a description of benefits at the Neighborhood website: www.nhpri.org.

On an as-needed basis, Beacon will forward any new and/or revised policies and procedures to all contracted providers. This manual, associated forms and any subsequent updates therein, can be found posted on our website, www.beaconhealthstrategies.com.

Full Continuum of BH Services

Beacon’s Neighborhood BH program offers a full range of clinically appropriate mental health and substance abuse services that are beyond the customary scope and practice of a primary care provider. Beacon’s BH program is designed to ensure timely access to medically necessary, high quality care in clinically appropriate and cost-effective therapeutic settings.
Beacon’s BH program includes a wide range of services delivered by a multilingual, culturally competent, community-based network of providers with demonstrated expertise in treating high-risk and complex populations. Available services include:

- Acute Inpatient Psychiatric Programs
- Level III, Level IV Detoxification
- Acute Residential Treatment Services
- Partial Hospitalization Programs
- Intensive Outpatient Programs
- Day Treatment
- Psychological and Neuropsychological Testing
- Crisis Stabilization Programs
- Enhanced Substance Abuse Services for Pregnant & Parenting Women
- Methadone Services
- Emergency Services Intervention
- Outpatient BH Services
- Enhanced Outpatient Services
- Observation Beds
- Support Services

For more information on benefits, visit Neighborhood’s website at www.nhpri.org as well as Beacon’s website at www.beaconhealthstrategies.com.

**Access to Outpatient BH Care**

Neighborhood members may access outpatient BH services through any of the following avenues:

- Self-referring to a network provider
- Referral from their primary care provider or primary nurse practitioner
- By calling Beacon directly
- Referral through emergency services, such as crisis intervention programs and emergency room encounters.
Forms, Charts and Tables

Beacon continually updates its website with downloadable forms and other useful BH management tools. Providers wishing to make copies of the forms, charts and tables contained in this manual, may do so by accessing downloadable forms directly from the Beacon’s website, www.beaconhealthstrategies.com.

Information Requests

For more information regarding the content or use of Beacon’s Neighborhood BH Program Provider Policy and Procedure Manual, please contact:

Beacon Health Strategies
Provider Relations Department
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393
800.215.0058 or 781.994.7556
Provider.relations@beaconhs.com
CHAPTER 2
ADMINISTRATIVE POLICIES

Member Eligibility Verification
Provider Relations
Network Participation
Appointment Access Standards
Adding or Changing Service Sites
Credentialing
Beacon’s Access to Member Information
Transactions and Communications with Beacon
Fraud and Abuse
Member Eligibility Verification

As member eligibility changes occur frequently, Beacon recommends and strongly encourages providers to verify Neighborhood Health Plan (Neighborhood) 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. We encourage providers to check the member’s identification card, to verify identity with a government-issued photo ID and to verify current eligibility information via Beacon’s eServices platform, www.beaconhealthstrategies.com.

Neighborhood Member Cards

Upon enrollment, every Neighborhood member is issued an identification card. Members are expected to carry their ID card at all times and to call their primary care practitioner before seeking services, except in cases of life-threatening emergencies. However, these cards are not dated, nor are they returned when a member becomes ineligible. Therefore, the possession of a membership card does not ensure that a person is currently enrolled or eligible with Neighborhood. A Neighborhood Health Plan of Rhode Island member card contains the following information:

- Member’s name
- Neighborhood identification number
- Member’s date of birth
- Member’s group number
- Member’s primary care site name and phone #
- Co-payment information (if a co-payment applies)
- Office visit (OV) co-payment amount
- Pharmacy (Rx) co-payment amount
- Emergency room (ER) co-payment amount

Note that Rtte Care members also receive a Medical Assistance Card. This card provides the member’s social security number, which is needed when verifying the member’s eligibility using the Rhode Island Rtte Care Eligibility Verification Line (HP) as described below.

Eligibility Verification by Telephone

To verify eligibility for Neighborhood Rtte Care members, providers may consult the Rhode Island Rtte Care Eligibility Verification Line by calling 401-784-8100. HP provides automated eligibility information 24 x 7, but requires the provider to enter the member’s name and social security number. If the member is eligible, the provider will be told of his/her eligibility along with the name of the member’s health plan. Live personnel are available at HP during business hours.

To verify eligibility for Neighborhood members (when the social security number is not available), providers can contact Neighborhood Member Services at 401.459.6020 (8:30 a.m. to 5 p.m., Monday - Friday) or may call Beacon directly at 800.215.0058. Providers may also verify member eligibility online at www.beaconhealthstrategies.com, which requires only a member identification number.
Provider Relations

Beacon’s Provider Relations Department is available to answer questions from participating providers during the hours of 8:30 a.m. - 6 p.m., Monday through Thursday, and 8:30 a.m. - 5 p.m. on Friday and can be accessed at provider.relations@beaconhs.com.

Network Participation

A “participating provider” is an individual practitioner, private group practice, licensed outpatient agency, or facility that has signed a Provider Services Agreement (PSA) or Letter of Agreement (LOA) with Beacon, agreeing to provide mental health and/or substance abuse services to Neighborhood members, to accept reimbursement directly from Beacon according to the rates set forth in Exhibit A, and to adhere to all other terms in the PSA or LOA including this provider manual.

As described later in this chapter, providers must be fully credentialed by Beacon prior to becoming contracted, and must comply with recredentialing requirements to maintain active participation in the network. Provider’s active status is in force unless terminated in accordance with the PSA or LOA.

Non-Discrimination

In signing the Beacon Provider Services Agreement (PSA), providers agree to treat Neighborhood members without discrimination. Providers may not refuse to see a member based on the member’s insurance coverage, financial status or for any other reason. Providers may not close their practice to Neighborhood members unless it is closed to all patients. The exception to this rule is that a provider may decline to treat a member for whom it does not have the capability or capacity to provide appropriate services or when there is a direct conflict of interest. In that case, the provider should direct the member to call Beacon for assistance in locating needed services. State and federal laws prohibit discrimination against any individual who is a member of a 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.

Beacon/Neighborhood Network Database

Beacon maintains a live database of providers on its website at www.beacon-healthstrategies.com. Providers and members may search this database by provider name, type, city, state, specialty, or language spoken. Providers are encouraged to check the database regularly, to ensure that the information about their practice is up-to-date.

After Hours/Vacation Coverage

Providers shall maintain a system of 24 hour on-call services for all members under treatment and shall ensure that all members in treatment are aware of how to contact the treating or covering provider after-hours and during provider vacations. Answering machines alone are considered acceptable as 24 hour on-call services only if the message content provides a mechanism for the member to speak directly to the treating or covering provider (pager, answering service, or mobile telephone number) and also instructs the member to call 911 or proceed directly to the nearest emergency room if the caller feels their situation is an emergency.
Appointment Access Standards

Standards

Beacon is required to monitor accessibility of appointments within our network, based on the following standards:

For Routine Care:
Appointment must be offered within five business days.

For Urgent Care:
Appointment must be offered within 24 business hours.

For Non-Life Threatening Emergency Care:
Immediate access is required.

Psychopharmacology Services:
Appointment must be offered within 14 calendar days.

Required Notification of Practice Changes and Limitations in Appointment Access

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

Providers are encouraged to check the database regularly to ensure that the information about their practice is up-to-date. For the following practice changes and access limitations, the provider’s obligation to notify Beacon is fulfilled by updating information using the methods indicated below:
Table 2-3: Required Notifications

<table>
<thead>
<tr>
<th>Type of Information</th>
<th>Method of Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice Information</td>
<td><strong>eServices</strong> Email</td>
</tr>
<tr>
<td>Change in address or telephone number of any service</td>
<td>Yes Yes</td>
</tr>
<tr>
<td>Addition or departure of any professional staff</td>
<td>Yes Yes</td>
</tr>
<tr>
<td>Change in linguistic capability, specialty or program</td>
<td>Yes Yes</td>
</tr>
<tr>
<td>Discontinuation of any covered service listed in Exhibit A of provider’s PSA</td>
<td>Yes Yes</td>
</tr>
<tr>
<td>Change in licensure, accreditation, sanctions or debarment of provider or any of its professional staff</td>
<td>Yes Yes</td>
</tr>
<tr>
<td>Appointment Access</td>
<td></td>
</tr>
<tr>
<td>Change in licensure or accreditation of provider or any of its professional staff</td>
<td>Yes Yes</td>
</tr>
<tr>
<td>(license)</td>
<td></td>
</tr>
<tr>
<td>Change in hours of operation</td>
<td>Yes Yes</td>
</tr>
<tr>
<td>Is no longer accepting new patients</td>
<td>Yes Yes</td>
</tr>
<tr>
<td>Is available during limited hours or only in certain settings</td>
<td>Yes Yes</td>
</tr>
<tr>
<td>Has any other restrictions on treating members</td>
<td>Yes Yes</td>
</tr>
<tr>
<td>Is temporarily or permanently unable to meet Beacon standards for appointment access</td>
<td>Yes Yes</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Change in designated account administrator for the provider’s eServices accounts</td>
<td>No* Yes</td>
</tr>
<tr>
<td>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.)</td>
<td>No* Yes</td>
</tr>
<tr>
<td>Adding a site, service or program not previously included in the PSA; remember to specify:</td>
<td>No* Yes</td>
</tr>
<tr>
<td>a) location; and</td>
<td></td>
</tr>
<tr>
<td>b) capabilities of the new site, service, or program. See additional information below.</td>
<td></td>
</tr>
</tbody>
</table>

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

Notification of access limitations may be made by contacting Provider Relations as specified above. Providers may also leave a message on our Got Openings (“GO”) Line, (781) 994-7594. To help us provide timely appointments, we also encourage providers with unexpected same-day or same-week openings to call the “GO” Line stating name and phone number, practice/organization, specific site location, days and times available, and whether openings are with psycho-pharmacologists or therapists.
Adding or Changing Service Sites

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

If a provider wishes to add a site, service or program not previously included in the PSA, the provider should notify Beacon in writing of the location and capabilities of the new site, service or program. Beacon will determine whether the site meets an identified geographic, cultural/linguistic and/or specialty need in our network and will notify the provider of its determination. If Beacon agrees to add the new site, service or program to its network, we will advise the provider of applicable credentialing requirements (see next section), and will request a list of individual clinicians practicing at the new site, service or program. When the credentialing process (if applicable) is complete, the site, service or program will be added to Beacon’s database and an updated Exhibit A (fee schedule) will be mailed to the provider.

Credentialing

Beacon individually credentials and recredentials independent behavioral health care practitioners, including those individuals practicing under the umbrella of a group practice. The specific types of practitioners credentialed include the following:

- Psychiatrists and other physicians (i.e., pediatricians specializing in behavioral or developmental pediatrics, physicians specializing in Addiction Medicine, or physicians specializing in other needed specialties as deemed necessary by Beacon for its practitioner network operation) who are licensed as either an MD or DO in the states in which they practice. Psychiatrists must be board-certified with the ABMS or meet post-graduate training requirements as follows:
  - General Psychiatry - 4 years post-grad training
    - Child and Adolescent Psychiatry - 2 years, following 3 or 4 years of General Psychiatry training
    - Geriatric Psychiatry - 1 year, following 4 years of General Psychiatry training
    - Addiction Psychiatry - 1 year, following 4 years of General Psychiatry training
- Doctoral-level practitioners who are state-certified or licensed to practice independently by the state(s) in which they practice (i.e., PhD, PsyD, EdD, DMin., etc.)
- Master’s-level practitioners who are state-certified or licensed to practice independently by the state(s) in which they practice (i.e., Licensed Independent Clinical Social Worker (LICSW), Licensed Marriage and Family Therapist (LMFT), etc.)
- Master’s-level Clinical Nurse Specialists, Advanced Practice Registered Nurses, and Psychiatric Nurse Specialists who are certified or licensed to practice by the state(s) in which they practice (i.e., RNCS, RNPC, APRN, CNS in psychiatry, etc.).
- Specialists certified or licensed in Addiction Medicine by the state(s) in which they practice (i.e., Certified Alcohol Counselors [CAC], Certified Alcohol and Substance Abuse Counselors [CASAC], Licensed Chemical Dependency Professional [LCDP, CDP], only if said clinicians are able to practice independently)
Beacon credentials facilities and licensed outpatient agencies as organizations; i.e., we do not individually credential employed and contracted clinical staff. Facilities and outpatient agencies must submit a complete roster of all clinical staff to Beacon at the time of credentialing and must provide updated rosters to Beacon regularly as clinical staff change. Facility and/or outpatient agencies are also responsible for ensuring that all clinical staff meet credentialing standards in accordance with NCQA and state and federal law. Facilities and/or outpatient agencies shall notify Beacon if any license, permit, certificate or other approval is denied suspended, revoked, not renewed, not extended or is otherwise terminated for all clinical staff employed or contracted by the organization. Additionally, facilities and/or outpatient agencies shall notify Beacon immediately if any clinical staff is deemed a Rhode Island Medicaid excluded provider, and shall ensure that such clinical staff does not provide services to members until such license, permit, certificate or other approval is reinstated. Facilities and/or outpatient agencies shall also maintain in full force and effect any accreditation by the Joint Commission or by any other recognized accreditation body specified in the provider application and shall notify Beacon if such accreditation is denied, suspended, revoked, not renewed or not otherwise extended or is otherwise terminated. In these settings, all licensed behavioral health professionals listed above may treat members. In addition, services may be provided by clinicians who have completed clinical counseling master’s-level degrees, and meet the following credentialing criteria:

Master’s-level mental health counselors are approved to function in all contracted hospital-based and agency/clinic-based services sites. Behavioral health program eligibility criteria will include the following:

1. Master’s degree or above in a mental health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university

2. An employee or contractor within a hospital or mental health clinic licensed in Rhode Island and who meets all applicable federal, state and local laws and regulations

3. Supervised in the provision of services by a Licensed Independent Clinical Social Worker, a licensed psychologist, a licensed master’s-level Clinical Nurse Specialist, or licensed psychiatrist meeting Beacon’s credentialing requirements

4. Is covered by the hospital or mental health/substance abuse agency’s professional liability coverage at a minimum of $1,000,000/$3,000,000

5. Absence of Medicare/Medicaid sanctions

In order to continue treating Neighborhood members, providers must comply with recredentialing standards by submitting requested information within the specified timeframe.

Disclosures

Providers shall disclose periodically at Beacon’s request, any and all relationships the provider holds with employees, consultants, subcontractors, and governing individuals, including any individual with a direct or indirect controlling interest of any percentage in the provider, and anyone who has been: (a) convicted of a criminal offense as described in Sections 1128(a) and 1182(b)(1),(2), or (3) or the Social Security Act; or (b) has had civil monetary penalties or assessments imposed under Section 1129A of the Social Security Act.
The provider shall also provide within thirty five (35) days request by Beacon, Neighborhood Health Plan of Rhode Island, Rhode Island Department of Health (DHS) or DHSS, information regarding the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during a 12-month look-back period up until the date of the request; and 2) any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during a five (5)-year look-back period up to the date of the request.

Beacon’s Access to Member Information

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

- submission and payment of claims
- seeking authorization for extended treatment
- QI initiatives, including information regarding the diagnosis, treatment and condition of Members in order to ensure compliance with contractual obligations
- Member information reviews occur 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

Through Beacon’s contract with providers, Beacon is able to review patient charts as needed. Chart reviews may take place on site at a provider facility, or the provider may be required to copy and send specified sections of a member’s record to Beacon. Any questions that a provider may have regarding Beacon’s access to Neighborhood member information should be directed to Beacon’s privacy officer at 781.994.7500.
Transactions and Communications with Beacon

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

Electronic Media

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

1) eServices

   eServices, Beacon’s secure web portal, supports all provider transactions, while saving providers time, postage expense, billing fees, as well as reducing paper waste. eServices is completely free to contracted providers and is accessible through HYPERLINK “http://www.beaconhealthstrategies.com” 24/7. Many fields are automatically populated to minimize errors and improve claim approval rates on first submission. Claim status is available within two hours of electronic submission; all transactions generate printable confirmation; and transaction history is stored for future reference.

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

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

   Subsequent users are activated by the account administrator upon registration. To fully protect member confidentiality and privacy, providers must notify Beacon of a change in account administrator and when any users leave the practice. The account administrator should be an individual in a management role, with appropriate authority to manage other users in the practice or organization. The provider may reassign the account administrator at any time by emailing provider.relations@beaconhs.com.

2) Interactive Voice Recognition

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

   In order to maintain compliance with HIPAA and all other federal and state confidentiality/privacy requirements, providers must have their practice or organizational tax identification number (TIN), national provider identifier (NPI), as well as the member’s full name, plan ID and date of birth, when verifying eligibility through eServices and through Beacon’s IVR.
3) Electronic Data Interchange

Electronic data interchange (EDI) is available for claim submission and eligibility verification directly by the provider to Beacon or via an intermediary. For information about testing and set-up for EDI, [HYPERLINK] download Beacon’s 837 & 835 companion guides.

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

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

Table 2-1: Electronic Transaction Availability

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Verify member eligibility, benefits and copayment;</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes (HIPAA 270/271)</td>
</tr>
<tr>
<td>Check number of visits available</td>
<td>Yes</td>
<td></td>
<td>Yes (HIPAA 270/271)</td>
</tr>
<tr>
<td>Submit outpatient authorization requests;</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>View authorization status;</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Update practice information</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submit claims;</td>
<td>Yes</td>
<td></td>
<td>Yes (HIPAA 837)</td>
</tr>
<tr>
<td>Upload EDI claims to Beacon; and view EDI upload history</td>
<td>Yes</td>
<td></td>
<td>Yes (HIPAA 837)</td>
</tr>
<tr>
<td>View claims status and print EOBs;</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes (HIPAA 835)</td>
</tr>
<tr>
<td>Print claims reports and graphs;</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Download electronic remittance advice;</td>
<td>Yes</td>
<td></td>
<td>Yes (HIPAA 835)</td>
</tr>
<tr>
<td>EDI acknowledgment &amp; submission reports;</td>
<td>Yes</td>
<td></td>
<td>Yes (HIPAA 835)</td>
</tr>
<tr>
<td>Pend authorization requests for internal approval;</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access Beacon’s level-of-care criteria &amp; provider manual</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Email

Beacon encourages providers to communicate with Beacon by email addressed to provider.relations@beaconhs.com using your resident email program or internet mail application.

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

Communication of Member Information

In keeping with HIPAA requirements, providers are reminded that personal health information (PHI) should not be communicated via electronic mail, other than through Beacon’s eServices. PHI may be communicated by telephone or secure fax. It is a HIPAA violation to include any patient-identifying information or protected health information in non-secure email through the internet.

Fraud and Abuse

Provider compliance with all state and federal requirements regarding Medicaid fraud and abuse is required, including but not limited to, Sections 1124, 1126(b)1, 1126(b)2, 1126(b)3, 1128, 1156, 1892, 1902(a)68, and 1903(j)2 of the Social Security Act and chapter 40-8.2-2 of the General Laws of Rhode Island. Chapter 40-8.2-2 of the General Laws of Rhode Island addresses medical assistance fraud and defines “prohibited acts” and various courses of action that may be pursued by the state in instances of such acts, including civil actions, criminal actions, barring program participation, and suspension of payment.

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

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

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
Examples of fraud and/or abuse

- Billing for services not furnished
- Duplicate billing
- Billing for services that do not meet professionally recognized standards for care
- Billing for "phantom" providers
- Upcoding or inappropriate billing that results in a loss to the RIteCare/Medicaid program
- Unbundling
- Inappropriate or lack of documentation to support items or services billed
- Falsifying certificates of medical necessity, plans of treatment, and medical records to justify payment
- Soliciting or receiving kickbacks
- Violating RIte Care/Medicaid policies, procedures, rules, regulations and/or statutes

Beacon continuously monitors potential fraud and abuse by providers and members, as well as member representatives. Beacon reports suspected fraud and abuse to Neighborhood Health Plan of Rhode Island (Neighborhood) in order to initiate the appropriate investigation. Neighborhood will then report suspected fraud or abuse in writing to the Center for Child and Family Health.

According to Rhode Island law, any provider who knowingly and willfully participates in any offense either as a principal or as an accessory, or conspirator shall be subject to the same penalty as if the provider had committed the substantive offense. If any member or provider becomes aware of the potential of any fraud, be it member or provider, please contact us at 800.215.0058 and ask to speak to the compliance officer.

Federal False Claims Act

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

Summary of provisions

The FCA imposes civil liability on any person who knowingly:

1. presents (or causes to be presented) to the federal government a false or fraudulent claim for payment or approval;
2. uses (or causes to be used) a false record or statement to get a claim paid by the federal government;
3. conspires with others to get a false or fraudulent claim paid by the federal government; and
4. uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the federal government.
Penalties

The FCA imposes civil penalties and is not a criminal statute. Persons (including organizations and entities such as hospitals) may be fined a civil penalty of not less than $5,500 nor more than $11,000, plus triple damages, except that double damages may be ordered if the person committing the violation furnished all known information within (30) days. The amount of damages in healthcare 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 upon the contribution of the individual to the success of the case. If the government declines to pursue the case, the successful qui tam relator will be entitled to between 25 and 30 percent of the proceeds of the case, plus reasonable expenses and attorney fees and costs awarded against the defendant.

A case cannot be brought more than six years after the committing of the violation or no more than three years after material facts are known or should have been known but in no event more than 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 self-disclosure protocol allows providers to conduct their own investigations, take appropriate corrective measures, calculate damages and submit the findings that involve more serious problems than just simple errors to the agency.

If any member or provider becomes aware of any potential fraud by a member or provider, please contact us at 781.994.7500 and ask to speak to the compliance officer.
Beacon’s Quality Management and Improvement Program
Preventive Health
Continuity and Coordination
Collaborative Model of Continuous Quality Management and Improvement
Member Rights
Neighborhood Member Responsibilities
Non-Discrimination Policy
Grievance Resolution Procedures
Incident Reporting Procedures
Beacon’s Quality Management and Improvement Program

Neighborhood delegates to the Beacon Quality Management and Improvement (QM&I) Department the responsibility of continually monitoring and improving the quality and effectiveness of behavioral health (BH) services delivered to Neighborhood members. The Beacon QM&I Department partners with members and providers to identify opportunities for improvement. Through collaborative relationships, we develop effective and efficient mechanisms for ensuring that improvements are made throughout the continuum of services provided to members.

Beacon’s QM&I program is based on the principles of continuous quality improvement (CQI). The integration of these principles into our organization and throughout the provider network supports the overall goal of the Neighborhood BH program, which is to improve the health and well-being of the Neighborhood membership. These principles are as follows:

- Evaluate the effectiveness of the services delivered to Neighborhood members
- Identify areas for targeted improvements
- Develop QI action plans to address improvement needs
- Monitor the effectiveness of those changes over time

In an ongoing effort to improve the delivery of care and ensure that patient safety is maintained, Beacon continually monitors and evaluates the effectiveness of BH services provided to members. Quality monitoring activities include, but are not limited to:

- Site visits, including medical record review
- Satisfaction surveys and focus groups (member and provider)
- Profiling on provider performance, performance specifications and other measures
- Member grievances
- Incident reports
- Provider QI initiative results

Quality monitoring will also occur to ensure that providers are communicating with members’ PCPs, schools, other BH providers and collateral supports, including relevant state agencies. Based upon the data generated from our monitoring activities, Beacon, in collaboration with its provider and member advisory councils, develops QI initiatives and outcomes measures to meet identified improvement needs.

Chart Reviews

Beacon reviews medical records and utilizes data generated to monitor and measure provider performance in relation to the application of medical necessity criteria, implementation of quality initiatives, and specific core performance indicators.

Provider performance on the following indicators is captured during medical record reviews:

- Continuity and coordination of care with other BH providers, primary care providers, involved state agencies and schools and other collaterals
- Use of screening tools for identification of substance abuse problems
- Use of screening tools for assessment of behavioral health problems in children and adolescents
• Treatment planning
• Explanation and documentation of member rights and responsibilities

When Beacon requests a medical record from a provider, the entire medical record is required. (Please reference Treatment Record Standards in Chapter 4 of this manual.) Contents of the record must include the following:

**Required Outpatient Medical Record Elements Checklist**

- Telephone intake/request for treatment
- Initial diagnostic evaluation
- Face sheet
- Initial treatment plan
- Signed consent for treatment
- Updated treatment plans
- Signed informed consent for medication, if applicable
- Progress notes
- Copy of Extended Care Review Form, if applicable
- Signed record releases
- Signed consents for communication with care providers
- Medication record, if applicable
- Signed document indicating review of patient’s rights
- PCP Communication Form
- Termination and/or transfer summary, if applicable

**Required Inpatient Medical Record Elements Checklist**

All of the above noted elements are required for inpatient charts with the addition of the following:

- Referral information
- Medication records
- Admission history and physical
- Consultations
- Admission evaluations
- Laboratory and x-ray reports
- Physician orders
- Discharge summary and discharge review form

Beacon requires providers to obtain informed consent for the release of charts from members.
Performance Standards and Measures

To ensure a consistent level of care within the Beacon provider network for Neighborhood members, as well as a consistent framework for evaluating the effectiveness of care, Beacon has developed specific provider performance standards and measures. BH providers are expected to adhere to the performance standards for each level of care they provide to members. Performance measures include:

- 7- and 30-day ambulatory care rate
- Availability of routine, urgent and emergent appointments
- PCP communication

Provider QI Initiatives

As defined by the Provider Services Agreement, all providers agree to participate in ongoing QI initiatives implemented by Neighborhood and Beacon that may take place at the individual provider level or at a network-wide level. Providers must comply with all initiatives, including participation in selected clinical studies. Per the Provider Services Agreement, providers are required to deliver services, establish internal structures to monitor performance and report on any Quality Management and Improvement initiatives as requested.

Satisfaction Surveys and Focus Groups

Satisfaction with services is a core component of Beacon’s approach to monitoring quality. Member and provider satisfaction information is regularly gathered by Beacon through surveys, focus groups and advisory councils.

Practice Guidelines

Beacon, in partnership with Neighborhood, is committed to ensuring that all Neighborhood members receive high quality behavioral health treatment based on scientifically proven methods. Toward that end, we have made available on www.beaconhealthstrategies.com, evidenced-based guidelines for the treatment of the most prevalent diagnoses.

We would like you to consider including these guidelines, as well as other guidelines that are selected and distributed by Beacon. We ask you and your clinicians to consider Beacon’s guidelines whenever you think that they may promote positive outcomes for clients.
Practice Guideline Feedback

Beacon would like to hear from you and your clinical staff about the relevance and utility of the Beacon guidelines. For example, if you choose to use the guidelines, do you find that client outcomes are improved? If you do not elect to include these guidelines as reference materials for your clinical department, we would like to hear from you about why you choose not to do so. Further, if you are using other guidelines or parameters, we would appreciate hearing about the guidelines you are using and your experience with them. If you do not have access to the Internet, please contact Beacon’s Quality Management and Improvement Department at 781.994.7500 and request copies of the guidelines be mailed to you. If you have questions or comments you would like to share, please contact the director of Clinical Management or director of Quality Management and Improvement by telephone at 781.994.7500, or electronically at General.information@beaconhs.com.

Preventive Health

The objective of Beacon’s prevention program is to establish preventive, screening, educational and disease management programs to decrease the incidence, emergence or worsening of BH disorders. Beacon undertakes the design and implementation of prevention initiatives in concert with Neighborhood, providers, members and other stakeholders. Through ongoing treatment record reviews, Beacon looks for evidence of provider knowledge and use of screening tools and other standardized forms of detection of common BH conditions. Beacon also uses the annual member survey to inquire whether their provider asked questions regarding alcohol or drug abuse. This list is just a sampling of methods by which we evaluate at least annually the effectiveness of prevention efforts. Preventive health materials and resources are posted on our website, www.beaconhealthstrategies.com. This site includes:

- Program descriptions
- Educational resources
- Screening tools
- Program results and evaluations

For providers who do not have access to the Internet, copies of the information on any Beacon preventive health initiatives can be obtained by calling the Beacon Quality Management and Improvement Department at 800.215.0058.

In general, providers can help with prevention efforts by using screening tools supplied by Beacon or those of the providers’ choosing. Providers can also help by keeping members informed and educated about behavioral health issues in general, and alcohol and pediatric BH problems in particular. Please contact the director of Quality Management and Improvement by telephone at 781.994.7500, or electronically at General.information@beaconhs.com if you would like assistance with, or would like to collaborate on, prevention initiatives.
Continuity and Coordination

Both Beacon and Neighborhood are committed to fully integrating Neighborhood members’ medical care with the BH treatment they receive. Beacon recognizes the importance of working collaboratively to create a coordinated treatment system where all providers work together to support the member in a seamless system of care. To this end, Beacon works closely with Neighborhood to develop specific programs and provider procedures that standardize communication and linkage between Neighborhood members’ primary care and BH providers, as well as among BH providers. Linkage among all providers (primary care, mental health and substance abuse providers, as well as state agencies) supports member access to medical and BH services, reduces the occurrence of over- and under-utilization and provides coordination within the treatment delivery system. Communication among providers also improves the overall quality of both primary care and BH services by increasing the early detection of medical and BH problems, facilitating referrals for appropriate services and maintaining continuity of care.

Beacon and Neighborhood have developed specific programs and provider protocols to increase coordination and communication throughout the continuum of medical, BH and collateral providers. It is essential that BH providers work with members to understand the added benefits of coordination and work actively with them in the understanding of how the linkage occurs and the importance of informed consent.

Overview of the PCP and BH Provider Communication Program

To improve the coordination of care between PCPs and BH providers, Neighborhood and Beacon have implemented a program that contractually requires Neighborhood PCPs and BH providers to coordinate care through ongoing communication directly related to their patient’s health status.

With informed member consent, BH providers are required to provide PCPs with information related to their BH treatment needs and current treatment plans. Likewise, PCPs are required, with member consent, to provide the BH provider with any relevant health status information. The information shared between BH providers and PCPs will be included in the member’s clinical record and reviewed during retrospective and random chart reviews.

Timeframes and Definitions

All contracted providers are required to adhere to the following time frames and level-of-care categorizations for PCP notification regarding a Neighborhood member’s admission to treatment:
Acute Programs

*Precertification is required; in an emergency, notification to occur within 24 hours:

- Inpatient Psychiatric Treatment
- Inpatient Detoxification
- Acute Residential Treatment Programs
- Acute Substance Abuse Residential Treatment
- Crisis Stabilization Services
- Partial Hospitalization Programs
- Intensive Outpatient Programs
- Day Treatment Programs
- Enhanced Outpatient Services

Outpatient Programs

- Methadone Maintenance: Admission review form required within one week of intake; extended care request form required two weeks prior to the end of the existing authorization.
- Outpatient Services: Outpatient Review Form (ORF) needed for visits beyond 12 in a calendar year
- Ambulatory Detoxification

Providers are required to update PCPs and other OP providers on their member’s BH status at the point of admission and at discharge from acute care programs or on a quarterly basis for outpatient programs.

Member Consent

At intake/admission to all treatment, all providers must explain the purpose and benefits of communication to PCPs and other relevant providers. The responsible staff must then ask the member to sign a Consent to Release Information Form. (See Appendix B for a sample consent form that may be used.)

Each Neighborhood member has the option of signing the Consent to Release Information Form, limiting the scope of information communicated, or refusing to release any information. If a member refuses to release information, the provider should clearly document the member’s reason for refusal in the narrative section on the form. Providers may substitute a similar consent form if desired.

BH Provider’s Initial Communication to PCP

With the Member’s informed consent, the BH provider should initiate the following communication protocol:

Call or fax the communication form to the PCP within the designated time period after admission to BH services. Providers may use Beacon’s BH – PCP Communication Form located in the Provider Tools section of Beacon’s web site at www.beacon-healthstrategies.com, or their own form that must include the following information:
Presenting problem/reason for admission
Preliminary treatment plan
Date of admission
Currently prescribed medication(s)
Admitting diagnosis
Proposed discharge plan
BH provider contact name and telephone number

PCP Communication to BH Provider

When a member consents, BH providers can expect that the PCP will fax or mail all relevant medical/health status information to the facility within three business days of the request. PCPs will include the following health information:

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

Discharge Status Communications

At the time of discharge from any level of care, and at least quarterly for outpatient BH services, BH providers must follow the following discharge procedures with a member’s informed consent:

Acute Care Providers

Within 24 hours of the planned discharge, notify the PCP of the pending discharge. Within three days of discharge, fax or mail the following member information to the PCP:

- 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
Technical Assistance to Providers

Beacon provides each provider with clear guidelines defining the purpose of PCP communication and the essential elements to be communicated. Sample communication forms, which can be adapted or modified, are provided in Appendix B. Beacon is available to provide ongoing assistance/training as needed.

PCP/BH Provider Identification

At the time of the initial clinical review, Beacon’s Clinical Department will provide acute care facilities with the name and telephone/fax number of the member’s PCP, as needed. Outpatient Providers are advised to contact Beacon to verify the name and telephone/fax number of the member's PCP.

If a provider is having difficulty identifying a member’s PCP, Beacon’s Member Services staff are available for assistance.

It is the responsibility of all Neighborhood members to notify their provider of the name(s) of any/all BH providers from whom they are actively receiving treatment. Neighborhood Member Responsibilities state that the member will provide information, to the extent possible, to Beacon and treating providers that is necessary to provide effective medical and behavioral health services for the member in care (self, minors, members under guardianship).

Monitoring Provider Compliance

For acute care providers, during the first continued stay review, the Beacon clinician will ask the treating provider if the member has consented to release information to their PCP and OP providers, if applicable. At each subsequent review, the Beacon clinician will confirm that the provider received the medical information form from the PCP and contacted the OP provider, if applicable. Beacon routinely monitors compliance with this important initiative via chart reviews and Performance Measure Data Sheet, site visits and telephonic reviews as indicated.

Collaborative Model of Continuous Quality Management and Improvement

Beacon strives to improve the quality of care delivered to Neighborhood members through a collaborative model of Continuous Quality Management and Improvement. Toward this end, Beacon engages participation from its provider community in all aspects of our Quality Management and Improvement Program. Additionally, members are encouraged to provide feedback on their experiences with BH services.

Role of the Provider Advisory Council

The Provider Advisory Council (PAC), chaired by Beacon’s state program director, consults on changes in policies and procedures including: purchasing specifications, profiling instruments, CQI efforts, outcome measures, satisfaction surveys, credentialing and recredentialing. The PAC is also instrumental in the development of clinical practice guidelines, collaboration on prevention initiatives and review of level-of-care (LOC) criteria. If you are interested in learning more about Beacon’s Provider Advisory Council, please call Beacon’s state program director at 800.215.0058.
Training and Development

Beacon’s QM&I and Clinical departments are available to provide technical assistance and training to providers on an as-needed basis. Providers who wish training or technical assistance on any aspect of this manual are welcome to contact Beacon’s Provider Relations at provider.relations@beaconhs.com.

Examples of available technical assistance programs and training include:

- Development of QI initiatives
- Treatment planning
- Solution-focused treatment
- State agency coordination assistance
- PCP – BH coordination procedures
- Development and implementation of prevention programming, including screening activities
- Development of internal utilization review, case management and utilization management programs

Member Rights

Neighborhood and Beacon are firmly committed to ensuring that members are active and informed participants in the planning and treatment phases of their behavioral health services. We believe that members become empowered through ongoing collaboration with their healthcare providers, which is crucial to achieving positive healthcare outcomes. We also share the belief that members must be fully informed of their rights to access treatment and to participate in all aspects of treatment planning. All Neighborhood members seeking/receiving mental health and/or substance abuse care have the following rights presented herein and on Beacon’s website www.beaconhealthstrategies.com.

Member Rights

1. You have the right to get information about Beacon’s services, benefits, practitioners, providers, member rights and responsibilities, and clinical guidelines.

2. You have the right to be treated with respect as an individual in a manner that protects your privacy and dignity, regardless of race, gender, veteran status, religion, marital status, national origin, physical disabilities, mental disabilities, age, sexual orientation, or ancestry.

3. You have the right to have the confidentiality of all communication regarding your mental health and substance abuse care maintained by Beacon staff and its providers and practitioners, to the extent required by law.

4. You have the right to participate with practitioners and providers in your own treatment planning and decision making about your care, and to include family members as appropriate and/or requested. Treatment-planning discussions may include all appropriate and medically necessary treatment options, regardless of benefit design and/or cost implications.
5. You have the right to give or refuse consent for treatment and/or communication of treatment information to your primary care doctor and other behavioral health providers.

6. You have the right to obtain information regarding your own treatment record with signed consent.

7. You have the right to appeal any denial by Beacon Health Strategies of any aspect of care or service.

8. You have the right to report a complaint or concern (or have a designee do so on your behalf) verbally or in writing, about the care you have received.

9. You have the right to contact Beacon’s Office of Ombudsman to get a copy of, and/or make recommendations about the Member Rights and Responsibilities statement.

10. You have the right to participate in the Member Advisory Council and/or make recommendations about the Member Rights and Responsibilities statement.

**Posting Member Rights**

All contracted providers must display in a highly visible and prominent place, a statement of Members’ Rights and Responsibilities. This statement must be posted and made available in languages consistent with the demographics of the population(s) served. This statement can either be Beacon’s statement or a similar statement, such as one required by state licensing authorities.

**Informing Members of their Rights**

In addition to a posted statement of member rights, providers are also required to:

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

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

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

4. Inform members that clinicians working at Beacon do not receive any financial incentives to limit or deny any medically necessary care.
Neighborhood Member Responsibilities

As enrolled members of Neighborhood Health Plan, members agree to the following responsibilities:

1. You are responsible for choosing a primary care provider and site to coordinate all medical care.

2. You are responsible for carrying your Neighborhood member ID card and showing the card whenever you go for treatment.

3. You are responsible for providing information, to the best of your ability, to Beacon and treating providers that is necessary to ensure your effective behavioral healthcare.

4. You have the responsibility, to the best of your ability, to understand your mental health and substance abuse healthcare needs and to participate in your treatment, including developing, following and revising treatment and aftercare plans.

The member rights and responsibilities can be accessed on our website at www.beaconhealthstrategies.com.

Non-Discrimination Policy

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. Accordingly, except as specifically permitted or required by regulations relative to institutional providers, no provider shall deny any medical service to a member eligible for such service unless the provider would, at the same time and under similar circumstances, deny the same service to a person who is not a member of public assistance (e.g., no new members are being accepted, or the provider does not furnish the desired service to any member). A provider shall not specify a particular setting for the provision of services to a member that is not also specified for non-members in similar circumstances.

No provider shall engage in any practice, with respect to any Neighborhood member, that constitutes unlawful discrimination under any other state or federal law or regulation, including but not limited to, practices that violate the provisions of 45 CFR Part 80 (relative to discrimination on account of race, color, or national origin), 45 CFR Part 84 (relative to discrimination against handicapped persons), and 45 CFR Part 90 (relative to age discrimination).

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

It is our joint goal to ensure that all members receive BH care that is accessible, respectful, culturally competent, and maintains the dignity of the member.
Clinical Laboratory Improvement Amendments (CLIA) of 1988

The contractor shall agree to use only laboratory testing sites, whether directly or through its subcontracted agreements, that hold either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. The contractor also agrees to ensure conformance that those laboratories with certificates of waiver will provide only the eight types of test permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

Grievance Resolution Procedures

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

GRIEVANCES AND APPEAL OF GRIEVANCE RESOLUTION

Member Complaints

Neighborhood has retained responsibility for responding to any member complaints or grievances NOT related to Beacon utilization review determinations. Members who wish to file a complaint about any aspect of administrative process, service or provider-related issue should be asked to call the Neighborhood Member Services Department at 401.459.6020. Beacon will assist Neighborhood in the investigation and resolution of member complaints. Neighborhood’s Member Handbook explains the complaint resolution process in detail. However, an important fact is that Neighborhood will investigate and respond to all member complaints within five days of receiving the complaint. Members will be notified within 30 days of the plan’s decision regarding the complaint.

Provider Complaints

Providers who have concerns or complaints about any aspect of Beacon’s administrative processes, services or procedures are asked to call the director of Network Operations for Neighborhood at 800.215.0058. Provider concerns, complaints or appeals regarding Beacon utilization review determinations will be resolved according to the procedures in the following section of this chapter.

Beacon will investigate and respond to provider complaints within five days of the receipt of the complaint. Providers will be notified within 30 days of Beacon’s decision regarding the complaint.

COMPILATION OF GRIEVANCE DATA

Grievance/appeals that relate to specific providers may be used by Beacon in its provider profiling and network reprocurement efforts, and will be noted in individual provider credentialing files.
Incident Reporting Procedures

Overview

Beacon requires that providers direct all reports of adverse incidents to Beacon’s Clinical Department at 800.215.0058 on the same day as the incident occurs. In addition, the Beacon network provider is required to fax a copy of the Provider Incident Report Form (for both sentinel events and other reportable incidents) to Beacon’s ombudsperson at 781.994.7642.

Sentinel Events

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

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

Sentinel events include the following:

1. All medicolegal deaths
   - Any death required to be reported to the medical examiner or in which the medical examiner takes jurisdiction

2. Any Absence Without Authorization (AWA) involving a patient involuntarily admitted or committed and/or who is at high risk of harm to self or others

3. Any serious injury resulting in hospitalization for medical treatment
   - A serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is subsequently medically admitted.

4. Any sexual assault or alleged sexual assault

5. Any medication error or suicide attempt that requires medical attention beyond general first aid procedures

6. Any physical assault or alleged physical assault by a staff person against a member

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

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

Providers are required to report all other reportable incidents to their Beacon clinical case manager on the same day as the occurrence. Providers may access the Clinical Department 24 hours a day and must notify the Beacon clinician in the after-hours when necessary to remain in compliance with this requirement.

Other reportable incidents include:

1. Any non-medicolegal death
2. Any Absence Without Authorization from a facility involving a member who does not meet the criteria for a sentinel event as described above
3. Any physical assault or alleged physical assault by or against a member that does not meet the criteria of a sentinel event
4. Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization
   • A serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted.
5. Any unscheduled event that results in the temporary evacuation of a program or facility, such as a small fire that requires fire department response.

Provider Preventable Conditions – This term means both “adverse events,” which describe harm to a patient as a result of medical care or harm that occurs in a healthcare setting, or “provider preventable conditions,” which refer to a specific list of serious events, such as surgery on the wrong patient. These definitions are in accordance with the National Quality Forum guidelines, which dictate events that should never occur in a healthcare setting.

Beacon is required to monitor provider preventable conditions. Therefore, Beacon requires that providers notify Beacon on the same day the provider preventable condition occurs. Beacon will investigate all potential quality-of-care problems, including but not limited to, member-specific occurrences of “provider preventable conditions.” After the conclusion of the investigation, Beacon has the right to request corrective action plans from the provider including recoupment, if indicated.
Introduction

Beacon Health Strategies (Beacon) requires each provider to have its own internal Utilization Management (UM) program to continually assess quality of care, access to care and compliance with medical necessity criteria. Quality UM is vital to providing culturally and linguistically appropriate treatment to Neighborhood Health Plan of Rhode Island (Neighborhood) members. Providers should monitor access, quality and cost of treatment to manage their program more effectively. An effective UM program encourages and allows providers to examine patterns of utilization, lengths of stay and the quality of treatment. The decision to accept or provide treatment is the responsibility of the member and his or her behavioral health provider(s).

The initial appointment must be offered in the following time frame:

- **Emergency** – immediately (response within one hour)
- **Urgent** – within twenty-four (24) hours
- **Routine outpatient** – within five (5) business days
- **Psychopharmacology services** – within fourteen (14) days
- **Outpatient appointment following an acute stay** – within seven (7) calendar days

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

The decision to provide treatment or service to a member is the responsibility of the attending provider. If the requesting provider (or designee) and/or member does not provide the necessary information for Beacon to make a medical necessity determination, Beacon may deny certification.

Beacon physician or psychological advisors are available to discuss denial cases with treating practitioners.

You may contact a Beacon physician advisor, or a Beacon UR clinician, at 800.215.0058.

Utilization Review Process

Beacon does not require prior authorization for emergency services rendered in hospital emergency rooms and does not deny hospital emergency room claims when claim payment has been delegated. When the attending provider has determined the healthcare services being delivered to the member to be an emergency, the member may be treated without prior authorization, and Beacon is contacted for required pre-authorization as soon as is reasonably possible in compliance with Beacon protocols and the provider’s contractual agreements.
For any child who is under the age of 18 whose health insurance is publicly funded, emergency services intervention and evaluation must be provided by a provider certified by the Department of Children Youth and Families (DCYF) as a condition for admission to an inpatient psychiatric facility. The pre-authorization procedure required for authorization by the managed care company/health plan (MCO/HP) may be waived by the certified emergency service provider to protect the well-being of the child and family in accordance with emergency certification procedures under Rhode Island General Law 40.1-5-7, Emergency certification.

Beacon does not require a PCP referral to obtain authorization for routine outpatient behavioral health services. A member may initiate outpatient services without prior authorization. For those members who have a pre-determined number of visits without authorization, providers submit necessary clinical information via outpatient treatment requests (OTR) to Beacon to obtain continued authorization. All utilization review (UR) decisions for covered services requiring pre-authorization are based on the application of medical necessity criteria and benefit plan in effect at the time of the service. Non-certification (denial) decisions are never made on the basis of pre-review screening information.

Beacon evaluates the services requested by the attending provider when authorizing services in terms of capabilities, locations and competencies of the Beacon provider network to ensure that members receive the care that best meets their individual behavioral health needs in the most appropriate treatment setting.

All decisions regarding authorization are made as expeditiously as the case requires, but no longer than timeliness standards listed in later in this chapter is the section titled “Determination Timeframes” (Chapter 4, page 4-10 & 4-11). If the requesting provider (designee) does not provide the necessary information for Beacon to make a medical necessity determination, Beacon may deny certification. Any negotiation/agreement with an attending provider or facility to modify a request submitted is not coerced by Beacon UR clinicians, Beacon physician advisors or psychologist advisors (PA). All adverse determinations (denial decisions) must be made by a PA. Beacon PAs are not compensated, paid a bonus, or given an incentive, based on making an adverse determination.

Beacon’s process for conducting utilization review is typically based on chart review and/or direct communications from the evaluating/requesting provider (designee). Beacon UR clinicians may engage in direct discussions with members or family/guardians for members whose benefits are funded by the Rhode Island Department of Human Services, (e.g., Rite Care, Rhody Health Partners, Children with Special Needs, and Substitute Care members). These direct discussions occur only, as deemed necessary, on a case-by-case basis in order to facilitate discharge planning, consider treatment options or alternatives, and other functions for cost-effective, medically necessary care. These direct discussions may be used to assess a member’s medical and/or mental health status and are carried out according to state and/or federal laws and contract-specific workflows and requirements.

Beacon will not retrospectively deny coverage for behavioral health services when prior approval has been issued unless such approval was based upon inaccurate information material to the review, or the healthcare services were not consistent with the provider’s submitted plan of care and/or any restrictions included in the prior approval.
Beacon physician and psychologist advisors are available to discuss by telephone, adverse determinations based on medical necessity with attending physicians and other licensed practitioners. Beacon offers and provides a mechanism for direct communication between the Beacon PA and the attending provider (or provider designated by attending physician) concerning such medical care. Such equivalent two-way direct communication shall include a telephone conversation and/or facsimile or electronic transmission, if mutually agreed upon. If the attending provider is then not reasonably available or does not want to participate in a peer-to-peer review, an adverse determination can be made.

Definitions

**Medical necessity** (The RI Department of Human Services’ definition of medical necessity is used by Beacon UR clinicians and physician advisors in all UR decision making that involves RI Medicaid members): Medical necessity or “medically necessary” service means medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health-related condition, including such services necessary to prevent a decremental change in either medical or mental health status. Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or the service provider.

**Emergent**: Any decision for treatment provided in the event of the sudden onset of a medical or mental condition that the absence of immediate medical attention could reasonably be expected, by a prudent lay person, to result in placing the patient’s health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction to any bodily organ or part.

**Urgent pre-service**: Any decision for a course of treatment necessary to treat a symptomatic mental health or substance abuse condition requiring treatment beginning within a 24 hour period of the onset of such a condition in order that the patient’s health status does not decline as a consequence.

**Urgent concurrent**: Any reviews for extension of a previously approved ongoing course of treatment over a period of time or a number of days or treatment in an acute setting.

**Non-urgent pre-service decisions**: Any treatment or service that must be approved in advance of a member obtaining that treatment or service. A non-urgent pre-service decision would include treatment over a period of time or a number of days or treatments in a routine outpatient treatment setting.

**Non-urgent concurrent**: Any decision for a course of treatment over a period of time or a number of days or treatments in a non-acute ambulatory setting that includes routine outpatient services.

**Post-service** (formerly retrospective decisions): Any decision for a completed course of treatment where a pre-service decision was not rendered. This definition shall not include reviews conducted when the review agency has been obtaining ongoing information and are considered non-urgent review decisions.
Determinations Timeframes

Beacon is required by the state, federal government, NCQA and URAC to render decisions in a timely manner to accommodate the clinical urgency of a situation. Beacon has adopted the strictest time frame for all decisions in order to be in compliance with the various requirements. Below please find a table summarizing Beacon’s internal time frames for rendering a determination.

Timeliness of Clinical Reviews Rhode Island

* Time frame to decision begin on the date request is received from member/attending provider

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Decision</th>
<th>Verbal Notification</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Urgent</td>
<td>Within 24 hours and/or prior to the date of service</td>
<td>To provider same day as decision</td>
<td>To member/provider within 24 hours</td>
</tr>
<tr>
<td>2. Non-Urgent</td>
<td>Within 5 CD</td>
<td>Within 5 CD</td>
<td>Within 5 CD</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Urgent</td>
<td>Within 24 hours and/or prior to end of current certified period</td>
<td>To provider same day as decision</td>
<td>To member/provider within 24 hours</td>
</tr>
<tr>
<td>2. Non-Urgent</td>
<td>Within 4 CD and/or prior to end of current certified period</td>
<td>Within 4 CD and/or prior to end of current certified period</td>
<td>Within 4 CD and/or prior to end of current certified period</td>
</tr>
<tr>
<td>Post-service</td>
<td>Within 30 CD</td>
<td>To provider same day as decision and/or within 1 BD</td>
<td>Within 30 CD</td>
</tr>
</tbody>
</table>

BD = Business Days          CD = Calendar Days

Beacon includes – and sends with each written notification of an adverse medical necessity decision – an appeal attachment that includes the following information:

- The member may file the appeal or may be represented by an attorney.
- The time frames for the submission of both internal and external appeals
- The member may ask a family member or friend (authorized member representative [AMR]) to help or act on his or her behalf but when designating someone other than a provider, must provide written consent to Beacon in order to designate an AMR.
- Appealing party has the opportunity to submit written comments, documents, records, and other information relating to their appeal to the appeals coordinator.
- Prior to a second-level appeal decision, the appellant is afforded an opportunity to inspect the utilization review file and add information to the file.
• Appealing party is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents (i.e., benefit provisions, guidelines, protocols, and/or other criteria on which the denial decision was based), records and other information relevant to the member’s claim for benefits.

Clinical Appeals

Clinical Appeals Submitted by Members or Providers

When Beacon denies authorization based on our clinical determination that the requested service does not meet medical necessity as defined by level-of-care criteria, a clinical appeal may be filed by the member or his or her attorney, the provider acting on behalf of the member, or by a designated appeal representative, also known as an authorized member representative (AMR). If the member is designating an appeal representative to appeal on his or her behalf, the member must complete and return a signed and dated Designation of Appeal Representative Form with his or her appeal request.

Beacon Health Strategies Appeal Coordinator - 800.215.0058

Appeal requests should be submitted to:

Beacon Health Strategies, LLC
Attn: Appeals Coordinator
500 Unicorn Park, Suite 401
Woburn, MA 01801

For every clinical appeal submitted within the required time frames, Beacon provides:

• A timely response and resolution to appeal requests
• A thorough investigation by a qualified physician
• A fair consideration and timely determination

Members who are not satisfied with the outcome of an appeal submitted to Beacon may request a fair hearing with the Rhode Island Department of Human Services (DHS) and should do so within 30 days of receiving the Level II decision letter. **Members must exhaust Beacon’s internal appeal process before requesting a DHS fair hearing.** To do this, the member or member representative must contact DHS directly at 401.462.5300 (English or Spanish) or 401.462.3363 (TTY), and a Rhody Health Partner member must contact the Adults in Managed Care Helpline at 401.784.8877. Additionally, a Rite Care or Rhody Health Partners members can contact Rhode Island Legal Services at 401.274.2652 at any point for help with the appeal.

Rite Care and Rhody Health Partners members may also contact the Rhode Department of Health (DOH) at 401.222.2231 to register complaints at any time during the appeal process.
Beacon Appeals Process

Beacon has two levels of internal appeal, and notifies members of their external appeal rights when Beacon’s second internal level appeal upholds an adverse determination. External appeals are conducted by external review agencies approved by the Rhode Island Department of Health. Both internal levels of appeal must be exhausted before Beacon can process a request for an external appeal.

An expedited pre-service or concurrent review appeal is available when a member/AMR and/or provider requests an expedited appeal because the member’s presenting condition threatens life or limb, or is of such severity that not conducting an expedited appeal would threaten the member’s safety. Expedited appeals will also be granted to all requests concerning admission, continued stays or other behavioral healthcare services for a member who has received emergency services but has not been discharged from a facility. Emergency is defined as the sudden onset of a medical or mental condition that the absence of immediate medical attention could reasonably be expected, by a prudent layperson, to result in placing the patient’s health in serious jeopardy, serious impairment to bodily or mental function, serious dysfunction of any bodily organ or part. In the event that an expedited appeal decision upholds the adverse determination, the member has the right to initiate an additional level of appeal, standard or expedited.

All internal appeal reviews include a full investigation and documentation of the substance of the appeal, including any aspects of clinical care involved, actions taken, all documents, records, or other information submitted, without regard to whether such information was submitted or considered in the initial consideration of the case. Beacon physician/psychologist advisors (PAs) are entitled to review only that information which is reasonably relevant to the utilization review process. Beacon complies with all state and federal laws regarding the confidentiality of medical records.

All medical necessity appeals are conducted by a Beacon PA who holds an active, unrestricted license to practice psychiatry, (the same license status as the ordering practitioner), in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. No reviewer will be compensated, paid a bonus, or given an incentive, based on upholding an adverse determination.

During second level appeals, the Beacon PA must be a licensed practitioner with the same license status as the ordering practitioner, who has the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

Requirements of Beacon PA who reviews an appeal include:

- PA cannot have been involved in a prior review, at either the adverse determination or appeal review, of the case under consideration, nor the subordinate of such individual
- No PA who has participated in the direct care of the patient (whose care is the subject of the review) may serve as a reviewer in the case under appeal.
- Other healthcare professionals consulted in connection with the adverse determination under appeal shall not be consulted for any related appeal reviews, nor shall the subordinate of any such healthcare professional.
Appeal files are maintained on site for two years and then transferred to a secure/confidential storage for a period of 10 years. Copies of Beacon’s appeal policy and procedures are available upon request to members, providers and or the facility rendering the service.

**Timeframes for Beacon Appeal Decision-making**

For expedited (urgent) appeals, pre-service and concurrent, the decision timeframes for the two levels of appeal combined may not exceed 72 hours from receipt of request. In order to ensure that Beacon meets the expedited appeal time standard, the decision of each of the two levels of appeal must not exceed the earlier of the one calendar day or 24 hours of receipt of request for appeal review.

For standard (non-urgent) pre-service or concurrent or post-service appeals, the decision for each of the two levels must be made no later than 14 calendar days after receipt of the request for appeal review.

**Appeal Decision Timelines – Level I and II Appeals**

*Time frame to decision begin on the date request is received from member/attending provider.

<table>
<thead>
<tr>
<th></th>
<th>Pre-Service Expedited</th>
<th>Standard</th>
<th>Concurrent Expedited</th>
<th>Concurrent Standard</th>
<th>Post Service Non-Urgent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acknowledgement Letter</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member</td>
<td>N/A</td>
<td>Within 5 CD</td>
<td>N/A</td>
<td>Within 5 CD</td>
<td>Within 5 CD</td>
</tr>
<tr>
<td>Provider</td>
<td>N/A</td>
<td>Within 5 CD</td>
<td>N/A</td>
<td>Within 5 CD</td>
<td>Within 5 CD</td>
</tr>
<tr>
<td>Decision Made</td>
<td>Within 24 hours</td>
<td>Within 14 CD</td>
<td>Within 24 hours</td>
<td>Within 14 CD</td>
<td>Within 14 CD</td>
</tr>
<tr>
<td>Decision - Verbal Notification</td>
<td>Day decision is rendered</td>
<td>Within 14 CD</td>
<td>Day decision is rendered</td>
<td>Within 14 CD</td>
<td>Within 14 CD</td>
</tr>
<tr>
<td></td>
<td><strong>Decision - Notification Letter</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member</td>
<td>Day decision is rendered</td>
<td>Within 14 CD</td>
<td>Day decision is rendered</td>
<td>Within 14 CD</td>
<td>Within 14 CD</td>
</tr>
<tr>
<td>Provider</td>
<td>Day decision is rendered</td>
<td>Within 14 CD</td>
<td>Day decision is rendered</td>
<td>Within 14 CD</td>
<td>Within 14 CD</td>
</tr>
</tbody>
</table>

CD = Calendar Days
Members/AMR and/or providers appeal submission timelines:

Time frame begins on the date noted on the written notification of the adverse determination.

**LEVEL I APPEAL**

Must be submitted to Beacon within 90 calendar days of the date an adverse determination is communicated in writing and may do so either by telephone or written notification.

**LEVEL II APPEAL**

Must be submitted to Beacon within 60 calendar days of the date an adverse determination is communicated in writing and may do so either by telephone or written notification.

**LEVEL III APPEAL**

Must be submitted to Beacon within 60 calendar days of the date an adverse determination is communicated in writing and may do so either by telephone or written notification.

**Procedural Denials (Administrative)**

Procedural denials are non-clinical denials and are issued for reasons that may include, but are not limited to, the following situations:

- a. A contracted in-network provider/facility or out-of-network provider who has a signed ‘single case agreements’ with Beacon and has not followed the protocols set forth in the Beacon Provider Policy and Procedure Manual or as stated in the ‘single case agreement’ for any services that require pre-authorization or continued authorization.

- b. The services requested are not part of the member’s health plan benefits.

- c. The member’s coverage was not in effect at the time the services was rendered.

- d. The behavioral health request is in excess of the annual benefit limitations defined in the member subscriber agreement.

Appeals concerning procedural (administrative) denials must be submitted to Beacon no later than 60 days from receipt of the denial. The provider is instructed to submit in writing the nature of the grievance and documentation to support an overturn of the initial decision. The procedural appeal is brought to the Appeals Committee for review. The determination of the Procedural Appeals Committee is communicated to the provider within 30 business days of the initiation of the procedural appeal.
Case Management Program

Case management is defined as a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet a consumer’s health needs through communication and available resources to promote quality, cost-effective outcomes along the continuum of care.

Beacon Health Strategies’ Intensive Case Management (ICM) program, through collaboration with members and their treatment providers, is designed to ensure the coordination of care, including assessment, case management planning, discharge planning and mobilization of resources to facilitate an effective outcome for cases with high-risk clinical factors and/or high financial exposure. Elders, adults, adolescents and children at clinical risk because of the mental health, psychosocial and/or co-morbid problems are referred and reviewed to evaluate for potential impact through the Intensive Case Management program. The primary goal of the program is always to facilitate effective outcomes for members.

Beacon case managers work collaboratively with the member to advocate for, and assist with, linkage to necessary supports and services and to facilitate coordination with family and other involved parties. An individualized care plan is developed with input from the member and the member’s healthcare team and establishes short and long-term goals for the Intensive Case Management plan and identifies resources to assist in meeting these goals.

Care coordination is short-term case management for members who do not meet ICM criteria, but have need for ongoing case management services due to barriers to care, co-morbid medical issues, and/or fragmentation of services.

Mobile case management is a resource available to high-risk members and their providers. Mobile case managers are available to meet with members, providers and state agencies in the community as well as in acute care settings.

Additionally, many of Beacon’s clinical and administrative staff is on-site at the Neighborhood office on 299 Promenade Street. This unique integrated model allows for efficiency in serving the medical and behavioral health provider community as well as meeting both the clinical and behavioral health needs of our membership. Beacon’s clinical staff works closely with Neighborhood’s to coordinate member care.

For further information on how to refer a member to case management services, please contact Beacon’s Clinical Referral Line at 800.215.0058.

Communities of Care Program

The Communities of Care Program (CoC) is the coordination of care and services provided to members who have experienced four or more emergency room (ER) visits during the most recent 12-month period. These members often require help navigating the healthcare system to reduce ER utilization and promote re-direction to primary medical and behavioral health care to enhance a member’s ability to self-manage their acute and chronic conditions. These members’ needs often exceed those of routine case management practices.

Initial identification of members eligible for CoC is completed by Neighborhood’s Medical Management Department using data collected through claims utilization.
The claims data is evaluated on a monthly basis to assess member utilization. If members have been to the ER four or more times in the most recent 12-month period, he/she will qualify for Communities of Care interventions. CoC interventions include peer navigation and/or case management. Members will be stratified into three categories based on their utilization patterns.

**Dedicated Provider Model (CoC Dedicated):** Members are identified based on the following criteria:

- use of three or more different ERs in a consecutive 180-day period; or
- use of six or more difference pharmacies in a consecutive 180-day period; or
- use of four or more PCPs in a consecutive 180-day period; or
- use of three or more different (outpatient) behavioral health specialists in a consecutive 180-day period; or
- received controlled substances from four or more different providers in a consecutive 180-day period.

**Select Moderate Provider Model (CoC Moderate):** Members are identified based on the following criteria:

- $10,000 or more total Medicaid expenses within the last calendar year
- Does NOT meet criteria for Dedicated Provider Model

**Select Light Provider Model (CoC Light):** Members are identified based on the following criteria:

- Less than $10,000 total Medicaid expenses within the last calendar year
- Does NOT meet criteria for Dedicated Provider Model

For additional information on the Communities of Care Program, please contact Neighborhood Customer Service at 401.459.6020.

**Treatment Record Standards**

To ensure that the appropriate clinical information is maintained within the Neighborhood member treatment record, providers must use the documentation requirements below, based upon NCQA standards; these standards are distributed to all practitioners and appropriate staff via the Beacon website and Beacon Provider Manual. Beacon’s goal is to establish treatment record standards that facilitate communication, coordination and continuity of care and to promote efficient, confidential and effective treatment.
Member Identification Information

The member’s name and identification number appear on each page contained within the treatment record.

The treatment record contains the following member information:
- The member’s address
- Employer or school
- Home and work telephone number
- Marital/legal status
- Appropriate consent forms
- Guardianship information, if applicable

Treatment Record Entries

All treatment record entries (e.g., progress notes, treatment notes, treatment plan and updates) include the following treating clinician information:
- Clinician’s name
- Professional degree
- Licensure
- Identification number, if applicable
- All treatment record entries are signed and dated.
- The record is written legibly.

Medication Information

Treatment records contain medication logs documenting the following:
- All medications prescribed
- Dosage of each medication
- Dates of initial prescriptions
- Information regarding allergies and adverse reactions are clearly noted.
- Lack of known allergies and sensitivities to substances are clearly noted.

Medical and Psychiatric History

The treatment record contains a clearly documented account of the member’s medical and psychiatric history. An account of the member’s previous treatment is clearly documented, which includes:
- Previous dates of treatment
- Names of providers
- Therapeutic interventions
- Effectiveness of previous interventions
- Sources of clinical information
- Relevant family information
- Results of relevant laboratory tests
- Previous consultation and evaluation reports
Information for Children and Adolescents

A complete developmental history, to include the following developmental information:

- Physical, including immunizations
- Psychological
- Social
- Intellectual/academic
- Prenatal and perinatal events are noted.

Substance Abuse Information

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

- Cigarettes
- Alcohol
- Illicit, prescribed, and over-the-counter drugs

Diagnostic Information

- Risk management issues (e.g., imminent risk of harm, suicidal ideation/intent, elopement potential) are prominently documented and updated according to provider procedures.
- All relevant medical conditions are clearly documented and updated as appropriate.
- The treatment record clearly documents the member’s presenting problems and the psychological and social conditions that affect his or her medical and psychiatric status.
- A complete mental status evaluation is included in the treatment record, which documents the member’s:
  - Affect
  - Judgment
  - Speech
  - Insight
  - Mood
  - Attention/concentration
  - Thought content, including memory
  - Impulse control
- The treatment record contains a clearly documented DSM-IV diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information.
Treatment Planning

- All Neighborhood members have a clearly documented treatment plan contained within the treatment record that is consistent with the member’s diagnoses.
- All treatment plans contain objective and measurable goals with clearly defined time frames for achieving goals or resolving the identified problems.
- The treatment record contains documentation of used treatment interventions and their consistency with stated treatment goals and objectives.
- Diagnoses are updated in treatment plans on a quarterly basis.
- Preventative services are offered; members are screened for risk factors.

Informed Member Consent for Treatment

The treatment record contains documentation of the member’s informed consent of the following:

- Implementation of the proposed treatment plan
- Any prescribed medications
- Consent forms related to inter-agency communications
- Individual consent forms are used for each release of information to a new party.
- Consent to release information to the payer, managed care organization or health plan (MCO/HP). In doing so, the provider is communicating to the member that treatment progress and attendance will be shared with the payer.
- For adolescents, ages 12-17, the treatment record contains consent to discuss substance abuse issues with their parents.

Treatment Documentation

- The treatment record contains ongoing progress notes that document the member’s progress towards goals, as well as their strengths and limitations in achieving said goals and objectives.
- The treatment record contains documentation of referrals to diversionary levels of care and services if the member requires increased interventions resulting from homicidality, suicidality or the inability to function on a day-to-day basis.
- Documentation of referrals and/or member participation in preventive and self-help services (e.g., stress management, relapse prevention, Alcoholics Anonymous, etc.) is included in the treatment record.
- The treatment record contains documentation of the member’s response to medications and somatic therapies.
- Staff receives periodic training in confidentiality of member information.
Coordination and Continuity of Care (see BH PCP Communication Protocol)

- The treatment record contains documentation of communication and coordination among BH providers, primary care physicians, ancillary providers and healthcare facilities.
- The treatment record contains the appropriate consent to release information documentation and/or the member’s reason for not providing consent.
- Documentation of dates of follow-up appointments, discharge plans and referrals to new providers are contained within the treatment record.

Organized Treatment Record Keeping Systems/Standards for Availability of Treatment Records

- Treatment records are organized and stored in a manner to allow easy retrieval.
- Treatment records are stored in a secure manner to allow access by authorized personnel only.

Beacon randomly requests treatment records from providers to ensure that the treatment needs of the membership are being met. Additionally, Beacon may also conduct review of treatment records during routine on-site visits. Providers are expected to meet a standard of 80 percent on the treatment record audit tool; if they do not, they are required to undertake remediation efforts in meeting established criteria. Providers receive detailed feedback based on Beacon’s audits of treatment records.
Beacon Health Strategies Level-of-Care Criteria

Overview

Service Descriptions
Beacon Health Strategies Level-of-Care Criteria

Beacon’s level-of-care criteria (LOCC) are reviewed and updated, at least annually, and as needed when new treatment applications and technologies are adopted as generally accepted medical practice. Beacon’s level-of-care criteria were developed from the comparison of national, scientific and evidence-based criteria sets, including but not limited to, those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). Beacon uses these criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member’s needs, strengths, and treatment history in determining the best placement for a member.

Beacon’s level-of-care criteria are the basis for all medical necessity determinations. The LOCC are accessible through eServices and/or our web site, www.beacon-healthstrategies.com. Providers can also contact Beacon to request a copy at 800-215-0058.

Inpatient Behavioral Health

For any child who is under the age of 18 whose health insurance is publicly funded, emergency services intervention and evaluation must be provided by a provider certified by the Department of Children Youth and Families (DCYF) as a condition for admission to an inpatient psychiatric facility. The pre-authorization procedure required for authorization through Beacon may be waived by the certified Emergency Service Provider (ESP) to protect the well-being of the child and family in accordance with emergency certification procedures under Rhode Island General Law 40.1-5-7, Emergency Certification. Once a child has safely arrived at the receiving inpatient facility, the inpatient facility will contact Beacon in accordance with pre-authorization guidelines.

Overview

This chapter contains information on level-of-care criteria and service descriptions for inpatient BH treatment including:

- Inpatient Psychiatric Treatment
- Level IV Detoxification – Medically Managed
- Level III Detoxification – Medically Monitored
- Substance Abuse Treatment Residential Services for Adults

For all treatment services, members must meet medical necessity criteria. Medically necessary services are those services that (1) are calculated to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a disability, or result in illness or infirmity; and (2) for which there is no comparable medical service or site of service available or suitable for the member requesting the service that is more conservative and less costly; and (3) are of a quality that meets generally accepted standards of healthcare.
The term “medical necessity,” “medically necessary,” or “medically necessary service” means medical, surgical or other services required for the prevention, diagnosis, cure or treatment of a health related-condition, including such services necessary to prevent a decremental change in either medical or mental health status. Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider. This language is in accordance with the DHS definition of medical necessity.

Beacon’s level-of-care criteria will be applied to determine appropriate care for all members. In general, treatment requests for members will only be authorized if the specific medical necessity criteria for the level of care requested are met. However, there is one exception to this framework:

If the member is lacking social supports, and the provider has appropriately sought such and was unable to secure an administrative decision, on the basis of the reviewer’s judgment an exception may be made to approve/continue a higher level of care.

Beacon’s inpatient service rates are all inclusive with the single exception of electro-convulsive therapy (ECT). Routine medical care is also included in the per diem rate for inpatient treatment. Any medical care above and beyond routine must be reported to Beacon for coordination of benefits with the health plan.

Service Descriptions

Inpatient Psychiatric Treatment

Inpatient care is the most intensive level of psychiatric treatment. This level of care is used to stabilize individuals who are experiencing an acute psychiatric condition with sudden onset and short, severe duration. A structured treatment milieu and 24-hour medical and skilled nursing care are fundamental to inpatient treatment. Daily contact between the member and physician is required. Behavioral health (BH) providers may also have physical and mechanical restraint, isolation and locked units available as additional resources.

Level IV Detoxification

Level IV Detoxification is a 24-hour medically directed evaluation program, providing care and treatment to members with psychoactive substance abuse disorders in a medically managed inpatient setting. All resources of a general hospital are available, including life-support care and psychiatric treatment. This service provides 24-hour physician availability. Daily contact between the member and physician is required. Primary nursing care and observation are available 24 hours per day and counseling services are readily available. A multidisciplinary team of addiction professionals and addiction-certified clinicians is used to provide treatment services. Although the treatment is specific to substance use disorders, the multidisciplinary team and available support services allow for the combined treatment of coexisting, acute biomedical and other behavioral health conditions. The member needs the medical intensity offered in a hospital setting and is unable to be adequately treated in a less intensive level of care.
The following criteria govern authorization for admission to acute inpatient detoxification facilities. Referrals for inpatient substance abuse treatment may originate from Emergency Service Providers (ESPs), self-referral, physicians, emergency rooms, state agencies or other ancillary programs. In the event the member does not meet admission criteria for Level IV Detoxification (inpatient substance abuse treatment), the assessing facility may refer the member to an acute substance abuse treatment facility (Level III Detoxification).

**Level III Detoxification** – Medically Monitored

Medically monitored detoxification provides a planned regimen of 24-hour medically monitored evaluation with care and treatment provided in a licensed acute care setting to members with psychoactive substance use disorders. Typically, physician involvement includes 24-hour consultation availability, daily interaction with specified members, and overall monitoring of medical care. Twenty-four hour nursing care and observation are provided to members. Staff trained in addiction treatment offer daily counseling services.

This level of care does not require the full resources of a general hospital with life-support equipment and may not have on-site psychiatric services but will arrange for psychiatric consultation services as clinically indicated. Appropriate members for this level of care are at risk for severe withdrawal syndrome; require 24-hour medically monitored nursing care and observation; do not require the medical and clinical intensity of a hospital-based acute detoxification service; and cannot be effectively treated in a less intensive level of care. Referrals for Level III Detoxification can originate from ESPs, self-referral, physicians, emergency rooms, state agencies or other ancillary programs.

**Residential Substance Abuse Treatment for Adults**

Substance Abuse Acute Residential Treatment (SAART) programs are 24-hour, therapeutically planned treatment and learning environments for adults who have a primary substance use disorder diagnosis. The goal of services is to stabilize members who are in early recovery and to increase their retention in treatment. In addition to group treatment, SAART provides individual treatment and maintains the least restrictive environment that allows for normalization. SAART is a less intensive level of care than both Level III and Level IV detoxification. Members placed at this level of care need further assessment, stabilization and short-term intensive substance use and rehabilitative residential treatment services. Members have sufficient potential to respond to active treatment and need a protected and structured environment, and for whom outpatient, partial hospital or acute inpatient treatments are not appropriate.

**Administratively Necessary Days - ADMIN/STATE**

Administratively Necessary Days (ADMIN) is a payment structure, not a level of care, within an inpatient setting. In this scenario, a member no longer meets acute inpatient level of care and is waiting to be discharged to a placement other than their home but the placement is not yet available.

Typically, these members are solely children/adolescents, who are in an acute inpatient setting and who are also in the care and/or custody of the Department of Children, Youth and Family (DCYF).
Beacon Health Strategies Level-of-Care Criteria

Overview

Service Descriptions
Beacon Health Strategies Level-of-Care Criteria

Beacon’s level-of-care criteria (LOCC) are reviewed and updated, at least annually, and as needed when new treatment applications and technologies are adopted as generally accepted medical practice. Beacon’s level-of-care criteria were developed from the comparison of national, scientific and evidence-based criteria sets, including but not limited to, those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). Beacon uses these criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member’s needs, strengths, and treatment history in determining the best placement for a member.

Beacon’s level-of-care criteria are the basis for all medical necessity determinations. The LOCC are accessible through eServices and/or our web site, www.beacon-healthstrategies.com. Providers can also contact Beacon to request a copy at 800.215.0058.

Overview

This chapter contains information on level-of-care criteria and service descriptions for the following diversionary mental health services:

- Observation Beds (OBS)*
- Crisis Stabilization Services
- Acute Residential Treatment Services
- Residential Treatment for Substance Use Disorders
- Partial Hospital Programs
- Day Treatment Programs
- Intensive Outpatient Programs
- Enhanced Outpatient Services (EOS) - Child/Adolescent and Adult
- Ambulatory Detoxification

*Note: Some of these services may not be available in the Rhode Island behavioral health service delivery system. Ongoing evaluation of gaps in the continuum is a priority for both entities.

For all treatment services, members must meet medical necessity criteria. Medically necessary services are those services that:

1. are available to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions in the Member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a disability, or result in illness or infirmity;

2. for which there is no comparable medical service or site of service available or suitable for the member requesting the service that is more conservative and less costly; and

3. are of a quality that meets generally accepted standards of health care.
Beacon reimburses diversionary services through an all-inclusive “per diem” rate. Routine medical care costs are included in the per diem rate, and any medical care beyond routine must be coordinated with Neighborhood Health Plan of Rhode Island.

Service Descriptions

Observation/Holding Beds

Observation/holding (OBS) beds allow time for extended assessment or observation and are used when additional information about the member’s condition is likely to result in a more appropriate referral to a less intensive level of care (e.g., suicidal person who is intoxicated may clear in 12-24 hours). OBS beds are generally used for the duration of 24 hours or less.

Crisis Stabilization Services

Community-based crisis stabilization services provide short-term psychiatric treatment within structured, community-based therapeutic environments. Each program provides continuous 24-hour observation and supervision for members who do not require the intensive medical treatment of hospital care. The purpose of this level of care is to stabilize a member who is in crisis and to prevent an unnecessary hospital admission. Immediate and intense involvement of family and community support for post-discharge follow-up is an important aspect of this level of care. In general, episodes appropriate for crisis stabilization are brief and allow sufficient time to arrest the escalating problems, resolve the crisis, access appropriate community supports and return the member to a less restrictive level of care.

Community-based crisis stabilization services provide full medical and psychiatric assessment and services; the development of a treatment plan; crisis-oriented individual and family counseling; family and support system consultation/interventions; discharge planning and linkage; as well as a community-based residential setting.

Facility-based crisis stabilization services are ideally suited for members with serious and persistent forms of mental illness who are decompensating because they have failed to take their medication, or because of the dynamics of the psychiatric disorder (e.g., members who present with certain personality disorders).

Acute Residential Treatment Services

Acute Residential Treatment Service (ARTS) is a community-based short-term hospital step-down or diversionary service that provides complete psychiatric evaluation and treatment on a 24-hour basis in a staff secure setting. Acute residential treatment is not equivalent to acute, intermediate or long-term hospital care; rather its design is to maintain the member in the least restrictive environment to allow for stabilization and integration. Consultations and psychological testing as well as routine medical care are included in the per diem rate.

An ARTS serves members who have sufficient potential to respond to active treatment, who need a protected and structured environment and for whom outpatient, partial hospitalization or acute hospital inpatient treatments are not appropriate. Acute residential treatment is planned according to each member’s needs, and realistic discharge goals are set at admission. There is full participation in treatment by the member and his or her family members/guardian, when appropriate.
Residential Treatment for Substance Use Disorders (III.5)

Residential Treatment Programs for Substance Use Disorders (RESRE) are 24-hour, therapeutically planned treatment and learning environments for adults 18 and older, with a primary substance use disorder. The goal of RESRE is to stabilize members in early recovery and to increase their retention in treatment. In addition to group treatment, it provides individual treatment and maintains the least restrictive environment, which allows for normalization; it is a less intensive level of care (LOC) than both ARTS and Level IV Detoxification. Members placed at this LOC need further assessment, stabilization and short-term intensive substance use residential treatment.

RESRE serves adult substance using members with sufficient potential to respond to active treatment, who need a protected and structured environment, and for whom outpatient, partial hospital or inpatient treatments are not appropriate. RESRE can usually be completed in less than 30 days, provided realistic discharge-oriented goals are set at admission, and there is full participation by the member and family, where appropriate.

Partial Hospital Program Services

A Partial Hospitalization Program (PHP) is a short-term acute psychiatric treatment service that provides a comprehensive behavioral health evaluation and treatment in a structured multidisciplinary therapeutic setting for members who do not require the intensity of 24-hour-per-day treatment. PHPs for adults, children, and adolescents have program hours for 5 - 7 hours a day at least five days per week (though seven days is preferable). PHPs provide daily psychiatric evaluation, treatment and acute management comparable to that provided by an inpatient setting. A PHP may be provided by either hospital-based or freestanding community-based facilities for members experiencing symptoms of such intensity that they are unable to be safely treated in a less intense setting and would otherwise require admission to an inpatient level of care.

When children and adolescents are receiving treatment in a partial program, behavioral health treatment must include, at a minimum, consultation and participation with the child’s caretaker, step-down referral and intake appointment with a behavioral health provider or child program for ongoing treatment, a referral for medication management as indicated, and collateral contact with school and other community-based supports.

Day Treatment Program Services

Day treatment is a structured program focused on enhancing current levels of functioning and skills while maintaining community living. Members who no longer require a higher level of care may have significant residual symptoms that require extended intervention in order to maintain their community living. For example, a member with schizophrenia in partial remission may need extended treatment to re-acquire functional adaptive behaviors.

The goal of day treatment is to assist members with behavioral health disorders to achieve and maintain their highest level of functioning and work toward appropriate developmental goals. The services provided include: individual and family behavioral health therapies, and psychosocial and adjunctive treatment modalities to enable the individual to attain adequate functioning in the community. Home visits may be made but are part of the all-inclusive site-based reimbursement rate.
Intensive Outpatient Program Services

Intensive Outpatient Program Services (IOP) is a clinically intensive therapeutic service similar to PHP, offering intensive treatment to members who can be safely treated in a less intensive setting than a PHP but require a higher level of intensity than that available in routine outpatient therapy. IOP programs are available to children, adolescents, and adults for mental health and/or substance abuse treatment. A traditional site-based IOP must have at least 3 - 4 program hours (day or evening) daily and be available at least 3 - 5 days per week. IOPs must include the provision of 24/7 crisis management services; individual, group and family therapy; medication evaluation and management services; as needed, as well as coordination of collateral contacts and care management/discharge planning services. IOPs are required to provide active treatment comparable to that provided by a partial hospitalization program setting; treatment may be provided by either hospital-based or freestanding outpatient programs to members who are experiencing symptoms of such intensity that they are unable to be safely treated in a less intense setting and would otherwise require admission to a PHP.

For children and adolescents, the IOP provides services similar to an acute level of care for those who have a supportive environment to return to in the evening. As the child decreases participation and returns to reliance on community supports and school, the IOP consults with the child’s caretakers and other providers to implement behavior plans or participate in the monitoring or administration of medications.

Enhanced Outpatient Services

Enhanced Outpatient Services (EOS) are comprehensive clinical services provided to a member, and to the member’s caregiver, by a treatment team that includes both a licensed therapist and a case manager. Treatment provided by an EOS team may take place in an office-based setting, in the member’s home, or in the community. The EOS treatment team is able to respond in an acute fashion and provide varying levels of service intensity. The team members are assigned by a licensed clinical agency that has the expertise to meet the unique treatment needs of each child/family. EOS services may be used to assist a member, or his or her caregiver, in transitioning from a higher level of care, such as inpatient care, back to the community, and/or to prevent members from requiring more intensive levels of care.

Adult Enhanced Outpatient Services

Adult Enhanced Outpatient Services (Adult EOS) are comprehensive clinical services provided to an adult member and to the member’s family and/or caregiver, if applicable, by an Adult EOS team that includes both a licensed behavioral health therapist and case manager. Treatment provided by an Adult EOS team may take place in the member’s home and/or in the community. The Adult EOS team is able to respond to the individual needs of the member as well as those of his or her family and can provide varying levels of service intensity. Adult EOS may be used to assist a member and his or her family as a member transitions from a higher level of care (e.g., inpatient care) back to the community or to stabilize the member in the community so he or she does not require a more intensive level of care (LOC). Adult EOS is appropriate when the member requires more than outpatient therapy in the home setting.
CHAPTER 6: DIVERSIONARY SERVICES

Outpatient Support Program

Outpatient Support Program (OSP) provides outpatient case management services to members whose clinical profile or service utilization indicates that they are at high risk for readmission into 24-hour psychiatric or addiction treatment settings and/or high cost. This level of care is designed to respond with maximum flexibility to the individual member’s needs. The intensity and amount of support provided is customized for each member and will vary according to members’ individual needs over time. OSP is expected to complement other services already in place for the member. The OSP worker does not replace the role of the member’s outpatient behavioral health therapist, but provides brief outpatient case management services as necessary.

OSP services for adults include intensive, short-term outreach and support as well as face-to-face contact with members in their homes or in other non-clinical settings. OSPs may assist a member to attend his or her mental health, substance abuse, or medical appointments; may facilitate member access to his or her outpatient behavioral health therapist for crisis intervention; or may assist a member to establish links with other natural community supports.

OSP services for children and adolescents are aimed at stabilizing and maintaining a child or adolescent in a community setting such as home, foster care or shelter. OSP services may include direct support to get a child or adolescent to his or her behavioral health treatment sessions or medical appointment and/or identifying and obtaining community services the child needs to continue to maintain stability in the community.

Diversionary Level of Care Authorization Procedures

<table>
<thead>
<tr>
<th>LOC:</th>
<th>Observation Bed</th>
<th>Crisis Stabilization Programs</th>
<th>Psychiatric Acute Residential Treatment (ARTS)</th>
<th>Residential Treatment for Substance Use Disorders</th>
<th>Partial Hospitalization Programs</th>
<th>Intensive Outpatient Program</th>
<th>Enhanced Outpatient Services</th>
<th>Outpatient Support Program</th>
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</thead>
<tbody>
<tr>
<td>Pre-Certification Review:</td>
<td>Yes 24/7. Call Beacon at 800.215.0058 with assessment disposition.</td>
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<tr>
<td>Post Admission Process:</td>
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<tr>
<td>PCP Communication Care:</td>
<td>Yes. Required at point of admission and discharge.</td>
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<tr>
<td>7-Day Continuing:</td>
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<tr>
<td>14-Day Medication:</td>
<td>Appointment must be scheduled prior to discharge.</td>
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</tbody>
</table>
Overview

Beacon Health Strategies Level-of-Care Criteria

Service Descriptions

Outpatient Authorization Procedures

Outpatient Methadone Authorization Procedures
Overview

This chapter contains information on level of care criteria and service descriptions for the following outpatient behavioral health services:

- Outpatient Behavioral Health Services
- Methadone Maintenance
- Ambulatory Detoxification
- Outpatient Psychiatric Home-Based Treatment (HBT)

Beacon Health Strategies Level-of-Care Criteria

Beacon’s level-of-care criteria (LOCC) are reviewed and updated, at least annually, and as needed when new treatment applications and technologies are adopted as generally accepted medical practice. Beacon’s level-of-care criteria were developed from the comparison of national, scientific and evidence-based criteria sets, including but not limited to, those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). Beacon uses these criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member’s needs, strengths, and treatment history in determining the best placement for a member.

Beacon’s level-of-care criteria are the basis for all medical necessity determinations. The LOCC are accessible through eServices and/or our web site, www.beacon-healthstrategies.com. Providers can also contact Beacon to request a copy at 800.215.0058.

For all treatment services, members must meet medical necessity criteria. Medically necessary services are those services that:

1. are designed to prevent, diagnose, prevent the worsening of, alleviate, or correct conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a disability, or result in illness or infirmity; and

2. for which there is no comparable medical service or site of service available or suitable for the member requesting the service that is more conservative and less costly; and

3. are of a quality that meets generally accepted standards of healthcare.
Service Descriptions

Outpatient Behavioral Health (BH) Services

Outpatient behavioral health treatment is an essential component of a comprehensive healthcare delivery system. Individuals with major mental illnesses, chronic and acute medical illnesses, chemical dependencies, family problems, and a vast array of personal and intra-personal challenges can be assisted in coping with difficulties through comprehensive outpatient treatment. Behavioral health treatment should be aimed at helping members achieve a greater sense of well-being and return to or surpass their baseline level of functioning. Efficiently designed interventions can assist individuals and families to cope effectively with stressful life situations and challenges.

The first 12 outpatient visits do not require prior authorization. For authorization following completion of the member’s initial 12 visits, providers will submit clinical information to be reviewed against the criteria outlined below. Please note that visits for psychopharmacology monitoring and management [90862] are not subject to this pre-authorization process.

Providers now have the ability to request outpatient visits and check on authorization decisions directly on Beacon’s website. The virtual “form” takes less than five minutes to complete and allows you to eliminate the inefficient paper and fax submission practices. The easily navigated outpatient review template offers valuable time-saving features, such as simple drop-down menus, relevant clinical checklists, and free text fields. After submitting the request, the completed form can be printed and retained in a confidential case record or distributed to clinicians, either office-based or mobile, as a treatment reference guide. Clinicians on the Beacon outpatient team are available for telephonic support as well as on-site demonstrations for network providers wherever geographically feasible. Because ‘eServices’ is a secure application, a user name and password are required. They can be easily obtained by participating in a quick online registration process. For any questions/comments about eServices and to sign up, please visit the provider section at www.beaconhealthstrategies.com; call us at 781.994.7556; or email us at eServices@beaconhs.com.

Methadone Maintenance

Methadone treatment involves the daily administration of methadone to opiate-addicted members in order to eliminate the physiological craving for the drug. The administration of methadone is combined with regular counseling, medical screening, urine testing, AIDS education, case management and other services. Take-home doses are allowed for more stable members for up to one week at a time. The goals of treatment include eliminating illicit opiate use, eliminating IV drug use, reducing or eliminating alcohol or other drug problems, improving health status, and improving the member’s level of functioning.
Methadone treatment is a long-term service of varying duration depending on individual need. This level of care is provided only to a member who has been addicted to opiates for at least one year and who has not responded well to other treatment interventions. Members using the service are often abusing or dependent on a variety of substances, and no longer have a strong psychosocial support system. Beacon allows up to daily dosing for methadone and methadone-related counseling (individual counseling, family counseling or group counseling) up to four times a week. Providers should note that the rate for dosing includes the methadone, urine screens and other laboratory tests used by the provider. Providers should not bill separately for these laboratory services.

Ambulatory Detoxification (Level I-D and Level II-D)

Ambulatory detoxification (detox) is both a level of care and a specialized service that is appropriate and beneficial for certain types of chemically dependent members. It is non-inpatient, based on the premise that some members do not require the structure of an inpatient detox, nor do they necessarily require close medical supervision. This least restrictive level of care may be the most effective for appropriate members. Ambulatory detox allows members to remain in contact with job and family, thus maintaining their integration in the community.

The philosophy of ambulatory detox should be based on modalities of rapid physician access for medical (and if necessary psychiatric) evaluation and supervision of detox. The program should have the capability to appropriately dispense detox medications. The program should incorporate daily group treatment and 12-step programming, as well as individual and/or family work, as appropriate. Individual sessions should be set up for the same day as the physician evaluation. For both Levels I and II Detox, a physician evaluates the member at the start of treatment, is available as needed to re-evaluate, and is available by telephone 24/7 for emergencies. For Level II, a physician is on-site daily and evaluates at least twice during a three- to five-day detox.

Outpatient Psychiatric Home-Based Therapy (HBT)

Home-based therapy (HBT) is a short-term program for patients who require additional support to successfully transition from an acute hospital setting to their home and community. The program brings the clinician to the member, when there are delays or barriers to the member’s timely access to a therapist. The HBT appointment is scheduled to occur within 48 hours of discharge from an acute mental health inpatient setting. The Beacon UR clinician may request that the HBT nurse/therapist visit the member in the hospital prior to discharge, to explain the HBT program and ensure the member’s willing participation in the service. This level of care (LOC) requires a safe home environment that poses no safety risk to the HBT clinician.

The HBT clinician does not replace the outpatient therapist, but reinforces the aftercare plan; assists to overcome any potential or identified barriers to care helps identify resources for necessary community-based services; and bridges any delays or gaps in service. The HBT clinician may also work with the member’s family to increase understanding of the member’s condition and the importance of adherence. HBT may also be deployed to help a member avert acute hospitalization during a brief period of destabilization.
Outpatient Authorization Procedures

Outpatient Behavioral Health

Neighborhood Members

Allowed up to 12 medically necessary sessions per member (not per provider) per calendar year without prior authorization. Services include:

- Diagnostic Assessment
- Individual, Couple and Family Therapy
- Medication Management (does not count against the initial visits)*
- Group Counseling
- Case Consultation
- Substance Abuse Counseling

Exceptions – *Psychopharmacology (90862) not included in initial sessions and does not require prior authorization

EXTENDED TREATMENT

Extended Care Outpatient Review Form is required.

www.beaconhealthstrategies.com to obtain this form.

Complete request and forward to Beacon two weeks prior to using all initial visits. Forms may be submitted through Beacon’s eServices or

Fax: 781-994-7634
or
Mail:
Beacon Health Strategies
500 Unicorn Park Drive
Suite 401
Woburn, MA 01801-3393

Forms must be fully completed, legible, original and specifically tailored to meet the individual member’s needs. Reviews of clinical requests are expedited using Beacon’s eServices.

Approved requests for extended care receive a prior authorization (PA) number, which is sent to the provider in a certification letter. This letter specifies number of units (sessions) approved.

Note: Beacon may only authorize Extended Care Outpatient Review forms from the date received; late requests may not be authorized.

PCP COMMUNICATION

- PCP should be contacted at initiation of treatment and periodically as updates occur.
- BH provider must receive and document informed consent for communication.
Outpatient Methadone Authorization Procedures

**Precertification**

Methadone Admission Review forms (provided by Beacon to methadone providers) are required after initial intake session. Forms must be faxed to Beacon’s Clinical Department within one week.

Fax: 781-994-7634.

Methadone services are authorized for up to six months following the receipt of the Admission Review Form. Biannual authorization periods end on 6/30 and 12/31 of each calendar year.

**EXTENDED TREATMENT**

*Extended Care Outpatient Review Form is required.*

[www.beaconhealthstrategies.com](http://www.beaconhealthstrategies.com) to obtain this form.

Complete request and forward to Beacon two weeks prior to using all initial visits. Forms must be fully completed, legible, original and specifically tailored to meet the individual member’s needs.

Fax: 781-994-7634

or

Mail:

Beacon Health Strategies
500 Unicorn Park Drive
Suite 401
Woburn, MA 01801-3393

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*Note: Beacon may only authorize Extended Care Outpatient Review forms from the date received; late requests may not be authorized.*

**PCP COMMUNICATION**

- PCP should be contacted at initiation of treatment and periodically as updates occur
- BH provider must receive and document informed consent for communication.
CHAPTER 8
SPECIAL PROCEDURES: INCLUDING PSYCHOLOGICAL TESTING AND ELECTROCONVULSIVE THERAPY (ECT)

Overview

Service Descriptions

Special Procedures and Emergency Services

Service Authorization Procedures
Overview

This chapter outlines special services including:

- Psychological Testing
- Electroconvulsive Therapy

Service Descriptions

Psychological Testing

Psychological testing uses standardized assessment tools to gather information relevant to a member’s intellectual and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall cognitive functioning related to a member’s mental health or substance abuse status. Test results may have important implications for treatment planning.

A licensed psychologist performs psychological testing. Psychology assistants (doctoral-level or doctoral candidates) may test Neighborhood members and interpret test results, provided that the evaluation is conducted in a clinical setting and that the testing is directly supervised and co-signed by a qualified licensed psychologist. Psychology assistants may not test Neighborhood members under the supervision of a psychologist in an independent practice setting.

Beacon reserves the right to request psychological testing assessments/summaries after approving the service. It is strongly recommended that psychological testing providers ask the member to sign a consent-to-release information form (see www.beaconhealthstrategies.com).

Please note: Most Beacon network inpatient and acute residential treatment facilities have an all-inclusive per diem rate that covers any needed psychological testing. Beacon does not reimburse individual providers for psychological testing conducted during the course of an inpatient stay or at an acute residential treatment program.

Electroconvulsive Therapy (ECT)

Electroconvulsive Therapy (ECT) is the initiation of seizure activity with an electric impulse while the member is under anesthesia. This procedure is administered in a hospital facility licensed to do so. ECT may be administered on either an inpatient or outpatient basis, depending on the member’s mental and medical status.

The principal indication for ECT is major depression with melancholia. The symptoms that predict a good response to ECT are early morning awakening, impaired concentration, pessimistic mood, motor restlessness, speech latency, constipation, anorexia, weight loss, and somatic or self-deprecatory delusions, all occurring as part of an acute illness.

Providers must complete a work-up, including medical history, physical examination, and any indicated pre-anesthetic lab work to determine that there are not contra-indications to ECT and that there are no less intrusive alternatives to ECT before scheduling administration of ECT. The member must provide separate written informed consent to ECT. Consent to other forms of psychiatric treatment is not considered to include consent to ECT. The member should be fully informed of the risks and benefits of this procedure and of any alternative somatic or non-somatic treatments.
Special Procedures and Emergency Services Service Authorization Procedures

<table>
<thead>
<tr>
<th>Psychological Testing</th>
<th>Precertification Review</th>
<th>Post Admission Review</th>
<th>Discharge Review</th>
<th>PCP Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>Yes, follow routine communication protocol</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Electroconvulsive Therapy (ECT)</th>
<th>Inpt</th>
<th>OP</th>
<th>Yes</th>
<th>N/A</th>
<th>Yes, follow routine communication protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Yes</td>
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</tbody>
</table>

| Sexual Abuse Evaluations       | Yes  | No | N/A | Yes, follow routine communication protocol |

Psychological Testing

Beacon reimburses for the following procedure codes for psychological testing:

**96101 - Psychological Testing**

Includes psycho-diagnostic assessment of personality and intellectual abilities, (e.g., WAIS-R, Rorschach, TAT, MMPI) with interpretation and report, per hour.

**96118 – Neuropsychological Testing**

Includes assessment of neuropsychological functioning, which is tailored to the clinical needs of clients. Uses a variety of assessment devices, which focus on cognitive ability, attention, concentration, language functions, visual perceptual and visual motor functions, executive functions, memory, and motor skills. Requires specialized neuropsychological training collected and verified at point of contracting via credentialing.

Prior Authorization for Psychological Testing

Beacon offers a three-level set of criteria for psychological testing. See the document entitled, “Psychological Testing – Prior Authorization Form,” in located at www.beaconhealthstrategies.com for a description of these levels. Each level automatically translates to an authorization for a given number of units/hours authorized by Beacon and is associated with an increasing level of complexity as the levels increase from 1 to 3. Psychologists will be asked to review these criteria and select a level for each testing client. Providers need to indicate the number of units requested within a specific level.

Psychologists will then use Beacon’s Psychological Testing Request for Authorization Form (same form as above) to indicate which level they are requesting for each client. No other documentation is requested from the provider to receive authorization for testing unless you believe the client will need more than 10 hours of testing. If more than 10 hours are requested, the provider will need to complete Beacon’s original testing request form (See www.beaconhealthstrategies.com). Psychologist providers who do testing with Neighborhood members will be asked to submit completed testing reports periodically to monitor quality.
General Claim Policies
Coding
Provider Education and Outreach
Claim Transaction Overview
This chapter presents all information needed to submit claims to Beacon. Beacon strongly encourages providers to rely on electronic submission, either through EDI or eServices in order to achieve the highest success rate of first-submission claims.

General Claim Policies

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

Definition of “Clean Claim”

A clean claim, as discussed in this provider manual, the provider services agreement, and in other Beacon informational materials, is defined as one that has no defect and is complete including required, substantiating documentation of particular circumstance(s) warranting special treatment without which timely payments on the claim would not be possible.

Electronic Billing Requirements

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

Provider Responsibility

The individual provider is ultimately responsible for accuracy and valid reporting of all claims submitted for payment. A provider using the services of a billing agency must ensure through legal contract (a copy of which must be made available to Beacon upon request) the responsibility of a billing service to report claim information as directed by the provider in compliance with all policies stated by Beacon.

Limited Use of Information

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

Prohibition of Billing Members

Providers are not permitted to bill health plan members under any circumstances for covered services rendered, excluding co-payments when appropriate.

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

Beacon’s Right to Reject Claims

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

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

Claim Turnaround Time

All clean claims will be adjudicated within thirty (30) days from the date on which Beacon Health Strategies receives the claim.

Claims for Inpatient Services

- The date range on an inpatient claim for an entire admission (i.e., not an interim bill) must include the admission date through the discharge date. The discharge date is not a covered day of service but must be included as the “to” date. Refer to authorization notification for correct date ranges.

- Beacon accepts claims for interim billing that include the last day to be paid as well as the correct bill type and discharge status code. On bill type X13, where X represents the “type of facility” variable, the last date of service included on the claim will be paid and is not considered the discharge day.

- Providers must obtain authorization from Beacon for all ancillary medical services provided while a plan member is hospitalized for a behavioral health condition. Such authorized medical services are billed directly to the health plan.

- Beacon’s contracted reimbursement for inpatient procedures reflect all-inclusive per diem rates.

Coding

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

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

- Beacon accepts only ICD-9 diagnosis codes listing approved by CMS and HIPAA. In order to be considered for payment by Beacon, all claims must have a Primary ICD-9 diagnosis in the range of 290-298.9, 300.00-316. All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.

- Claims for inpatient and institutional services must include the appropriate discharge status code. Table 7-1 lists HIPAA-compliant discharge status codes.
### Table 7-1: Discharge Status Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Discharged to Home/Self Care</td>
</tr>
<tr>
<td>02</td>
<td>Discharged/Transferred to a Short-term General Hospital for Inpatient Care.</td>
</tr>
<tr>
<td>03</td>
<td>Discharged/Transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care</td>
</tr>
<tr>
<td>04</td>
<td>Discharged/Transferred to Intermediate Care Facility (ICF)</td>
</tr>
<tr>
<td>05</td>
<td>Discharged/Transferred to a Designated Cancer Center or Children’s Hospital</td>
</tr>
<tr>
<td>06</td>
<td>Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care</td>
</tr>
<tr>
<td>07</td>
<td>Left Against Medical Advice or Discontinued Care</td>
</tr>
<tr>
<td>08</td>
<td>Discharged/Transferred Home/IV Therapy</td>
</tr>
<tr>
<td>09</td>
<td>Admitted as Inpatient to this Hospital</td>
</tr>
<tr>
<td>20</td>
<td>Expired</td>
</tr>
<tr>
<td>30</td>
<td>Still Patient or Expected to Return for Outpatient Services</td>
</tr>
</tbody>
</table>

* All UB04 claims must include the 3-digit bill type codes according to the Table 7-2 below:

### Table 7-2: Bill Type Codes

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

Modifiers can reflect the discipline and licensure status of the treating practitioner or are used to make up specific code sets that are applied to identify services for correct payment. Table 7-3 lists HIPAA-compliant modifiers accepted by Beacon. Please see your Exhibit A for Modifiers for which you are contracted.

Table 7-3: Modifiers

<table>
<thead>
<tr>
<th>HIPAA Modifier</th>
<th>Modifier Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AH</td>
<td>Clinical psychologist</td>
</tr>
<tr>
<td>AJ</td>
<td>Clinical social worker</td>
</tr>
<tr>
<td>HA</td>
<td>Child/adolescent program</td>
</tr>
<tr>
<td>HB</td>
<td>Adult program, non-geriatric</td>
</tr>
<tr>
<td>HC</td>
<td>Adult program, geriatric</td>
</tr>
<tr>
<td>HD</td>
<td>Pregnant/parenting women’s program</td>
</tr>
<tr>
<td>HE</td>
<td>Mental health program</td>
</tr>
<tr>
<td>HF</td>
<td>Substance abuse program</td>
</tr>
<tr>
<td>HG</td>
<td>Opioid addiction treatment program</td>
</tr>
<tr>
<td>HH</td>
<td>Integrated mental health/substance abuse program</td>
</tr>
<tr>
<td>HI</td>
<td>Integrated mental health and mental retardation/developmental disabilities program</td>
</tr>
<tr>
<td>HJ</td>
<td>Employee assistance program</td>
</tr>
<tr>
<td>HK</td>
<td>Specialized mental health programs for high-risk populations</td>
</tr>
<tr>
<td>HL</td>
<td>Intern</td>
</tr>
<tr>
<td>HM</td>
<td>Less than bachelor degree level</td>
</tr>
<tr>
<td>HN</td>
<td>Bachelor’s degree level</td>
</tr>
<tr>
<td>HO</td>
<td>Master’s degree level</td>
</tr>
<tr>
<td>HP</td>
<td>Doctoral level</td>
</tr>
<tr>
<td>HQ</td>
<td>Group setting</td>
</tr>
<tr>
<td>HR</td>
<td>Family/ couple with client present</td>
</tr>
<tr>
<td>HS</td>
<td>Family/ couple without client present</td>
</tr>
<tr>
<td>HT</td>
<td>Multi-disciplinary team</td>
</tr>
<tr>
<td>HU</td>
<td>Funded by child welfare agency</td>
</tr>
<tr>
<td>HW</td>
<td>Funded by state mental health agency</td>
</tr>
<tr>
<td>HX</td>
<td>Funded by county/local agency</td>
</tr>
<tr>
<td>SA</td>
<td>Nurse practitioner (This modifier required when billing 90862 performed by a nurse practitioner.)</td>
</tr>
<tr>
<td>SE</td>
<td>State and/or federally funded programs/services</td>
</tr>
<tr>
<td>TD</td>
<td>Registered nurse</td>
</tr>
</tbody>
</table>
### Time Limits for Filing Claims

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

- Within **90** days of the dates of service on outpatient claims
- Within **90** days of the date of discharge on inpatient claims

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the **90**-day filing limit will deny. Requests for timely filing exceptions are described later in this chapter.

### Coordination of Benefits (COB)

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

- When it is determined that Beacon is the secondary payer, claims must be submitted with a copy of the primary insurance’s explanation of benefits report and received by Beacon within 90 days of the date on the EOB.

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

Summary

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

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

How the Program Works

• A quarterly approval report is generated that lists the percentage of claims paid in relation to the volume of claims submitted.

• All providers below 75 percent approval rate have an additional report generated listing their most common denials and the percentage of claims they reflect.

• An outreach letter is sent to the provider’s billing director as well as a report indicating the top denial reasons. A contact name is given for any questions or to request further assistance or training.

Claim Inquiries and Resources

Online
• Chapter 2 of this Manual
• Beacon’s Claims Page
• Read About eServices
• eServices User Manual
• Read About EDI
• EDI Transactions - 837 Companion Guide
• EDI Transactions - 835 Companion Guide
• EDI Transactions - 270-271 Companion Guide

Email Contact
• Provider.relations@beaconhs.com
• EDI.Operations@beaconhs.com

Telephone
• Interactive Voice Recognition (IVR): 888.210.2018
  You will need your practice or organization’s tax ID, the member’s identification number and date of birth, and the date of service.

• Claims Hotline: 888.249.0478
  Hours of operation are 8:30 a.m. to 5:30 p.m. Monday through Thursday, 9:00 a.m. to 5:00 p.m. Friday.
Electronic Media Options

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

- **Electronic Data Interchange (EDI)** supports electronic submission of claim batches in HIPAA-compliant 837P format for professional services and 837I format for institutional services. Providers may submit claims using EDI/837 format directly to Beacon or through a billing intermediary. If using Emdeon as the billing intermediary, two identification numbers must be included in the 837 file for adjudication:
  - Beacon’s payor ID is 43324; and
  - Beacon’s health plan-specific ID.

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

- **IVR** provides telephone access to member eligibility, claim status and authorization status.

Claim Transaction Overview

Table 7-4 below, identifies all claim transactions, indicates which transactions are available on each of the electronic media, and provides other information necessary for electronic completion. Watch for updates as additional transactions become available on EDI, eServices and IVR.

**Table 7-4: Claim Transaction Overview (continued on next page)**

<table>
<thead>
<tr>
<th>Transaction</th>
<th>Access on:</th>
<th>Applicable When:</th>
<th>Timeframe for Receipt by Beacon</th>
<th>Other Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EDI</td>
<td>eServices</td>
<td>IVR</td>
<td></td>
</tr>
<tr>
<td>Member Eligibility Verification</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>• Completing any claim transaction; and • Submitting clinical authorization requests</td>
</tr>
<tr>
<td>Submit Standard Claim</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Submitting a claim for authorized, covered services, within the timely filing limit</td>
</tr>
</tbody>
</table>
### Resubmission of Denied Claim

<table>
<thead>
<tr>
<th>Y</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous claim was denied for any reason except timely filing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 90 days after the date on the EOB.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Claims denied for late filing may be resubmitted as reconsiderations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Rec ID is required to indicate that claim is a resubmission.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 60-Day Waiver* (Request for waiver of timely filing limit)

<table>
<thead>
<tr>
<th>N</th>
<th>N</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>A claim being submitted for the first time will be received by Beacon after the original 90-day filing limit, and must include evidence that one of the following conditions is met:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Provider is eligible for reimbursement retroactively; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Member was enrolled in health plan retroactively; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Services were authorized retroactively.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Third party coverage is available and was billed first. (A copy of the other insurance’s explanation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 90 days from the qualifying event.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Waiver requests will be considered only for these 3 circumstances. A waiver request that presents a reason not listed here, will result in a claim denial on a future EOB.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as reconsideration request.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Beacon’s waiver determination is reflected on a future EOB with a message of Waiver Approved or Waiver Denied: if waiver of the filing limit is approved, the claim appears adjudicated; if the request is denied, the denial reason appears.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Request for Reconsideration of Timely Filing Limit*

<table>
<thead>
<tr>
<th>N</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim falls outside of all timeframes and requirements for resubmission, waiver and adjustment. Submitting a reconsideration is not a guarantee of payment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 60 days from the date of payment or or nonpayment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future EOB shows “Reconsideration Approved” or “Reconsideration Denied” with denial reason.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 7-4: Claim Transaction Overview (continued from previous)

<table>
<thead>
<tr>
<th>Request to Void Payment</th>
<th>N</th>
<th>N</th>
<th>N</th>
<th>• Claim was paid to provider in error; and • Provider needs to return the entire paid amount to Beacon.</th>
<th>n/a</th>
<th>Do NOT send a refund check to Beacon.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request for Adjustment</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>• The amount paid to provider on a claim was incorrect; • Adjustment may be requested to correct: - Underpayment (positive request); or - Overpayment (negative request)</td>
<td>• Positive request must be received by Beacon within 90 days from the date of original payment; • No filing limit applies to negative requests.</td>
<td>• Do NOT send a refund check to Beacon. • A Rec ID is required to indicate that claim is an adjustment. • Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount and, if money is owed to provider, re-payment of the claim at the correct amount. • If an adjustment appears on an EOB and is not correct, another adjustment request may be submitted based on the previous incorrect adjustment. • Claims that have been denied cannot be adjusted, but may be resubmitted.</td>
</tr>
<tr>
<td>Obtain Claim Status</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Available 24/7 for all claim transactions submitted by provider.</td>
<td>n/a</td>
<td>Claim status is posted within 48 hours after receipt by Beacon.</td>
</tr>
<tr>
<td>View/Print Remittance Advice (RA)</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Available 24/7 for all claim transactions received by Beacon.</td>
<td>n/a</td>
<td>Printable RA is posted within 48 hours after receipt by Beacon.</td>
</tr>
</tbody>
</table>
* Please note that waivers and reconsiderations apply only to the claims filing limit; claims are still processed using standard adjudication logic and all other billing and authorization requirements must be met. Accordingly, an approved waiver or reconsideration of the filing limit does not guarantee payment, since the claim could deny for another reason. Submission of a request for a waiver or reconsideration is a request to override the timely filing limit; the request will be reviewed and could be denied.

**Paper Claim Transactions**

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

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

Mail paper claims to:

Beacon Health Strategies  
Neighborhood Health Plan of Rhode Island Claims Department  
500 Unicorn Park Drive, Suite 401  
Woburn, MA 01801-3393

Beacon does not accept claims transmitted by fax.

**Professional Services: Instructions for Completing the CMS 1500 Form (see next page)**

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**Beacon Discourages Paper Transactions**

**BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS EARLIER IN THIS CHAPTER.**

Paper submissions have more fields to enter, a higher error rate / lower approval rate, and slower payment.

Table 7-5 below lists each numbered block on the [HYPERLINK] CMS 1500 form with a description of the requested information and indicates which fields are required in order for a claim to process and pay.
Table 7-5: CMS 1500 Form *(continued on next page)*

<table>
<thead>
<tr>
<th>Table Block #</th>
<th>Required?</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No</td>
<td>Check Applicable Program</td>
</tr>
<tr>
<td>1a</td>
<td>Yes</td>
<td>Member’s Touchstone ID Number</td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
<td>Member’s Name</td>
</tr>
<tr>
<td>3</td>
<td>Yes</td>
<td>Member’s Birth date and Sex</td>
</tr>
<tr>
<td>4</td>
<td>Yes</td>
<td>Insured’s Name</td>
</tr>
<tr>
<td>5</td>
<td>Yes</td>
<td>Member’s Address</td>
</tr>
<tr>
<td>6</td>
<td>No</td>
<td>Member’s Relationship to Insured</td>
</tr>
<tr>
<td>7</td>
<td>No</td>
<td>Insured’s Address</td>
</tr>
<tr>
<td>8</td>
<td>Yes</td>
<td>Member’s Status</td>
</tr>
<tr>
<td>9</td>
<td>Yes</td>
<td>Other Insured’s Name (If Applicable)</td>
</tr>
<tr>
<td>9a</td>
<td>Yes</td>
<td>Other Insured’s Policy or Group Number</td>
</tr>
<tr>
<td>9b</td>
<td>Yes</td>
<td>Other Insured’s Date of Birth and Sex</td>
</tr>
<tr>
<td>9c</td>
<td>Yes</td>
<td>Employer’s Name or School Name</td>
</tr>
<tr>
<td>9d</td>
<td>Yes</td>
<td>Insurance Plan Name or Program Name</td>
</tr>
<tr>
<td>10a-c</td>
<td>Yes</td>
<td>Member’s Condition Related to Employment</td>
</tr>
<tr>
<td>11</td>
<td>No</td>
<td>Member’s Policy, Group or FICA Number (If Applicable)</td>
</tr>
<tr>
<td>11a</td>
<td>No</td>
<td>Member’s Date of Birth (MM, DD, YY) and Sex (check box)</td>
</tr>
<tr>
<td>11b</td>
<td>No</td>
<td>Employer’s Name or School Name (If Applicable)</td>
</tr>
<tr>
<td>11c</td>
<td>No</td>
<td>Insurance Plan Name or Program Name (If Applicable)</td>
</tr>
<tr>
<td>11d</td>
<td>No</td>
<td>Is there another health benefit plan?</td>
</tr>
<tr>
<td>12</td>
<td>Yes</td>
<td>Member’s or Authorized Person’s Signature and Date On File</td>
</tr>
<tr>
<td>13</td>
<td>No</td>
<td>Member’s or Authorized Person’s Signature</td>
</tr>
<tr>
<td>14</td>
<td>No</td>
<td>Date of Current Illness</td>
</tr>
<tr>
<td>15</td>
<td>No</td>
<td>Date of Same or Similar Illness</td>
</tr>
<tr>
<td>16</td>
<td>No</td>
<td>Date Client Unable to Work in Current Occupation</td>
</tr>
<tr>
<td>17</td>
<td>No</td>
<td>Name of Referring Physician or Other Source (If Applicable)</td>
</tr>
<tr>
<td>17 B</td>
<td>No</td>
<td>NPI of referring Physician</td>
</tr>
<tr>
<td>18</td>
<td>No</td>
<td>Hospitalization Dates Related to Current Services (If Applicable)</td>
</tr>
<tr>
<td>19</td>
<td>Yes</td>
<td>Former Control Number (Record ID If Applicable)</td>
</tr>
<tr>
<td>20</td>
<td>No</td>
<td>Outside Lab?</td>
</tr>
<tr>
<td>21</td>
<td>Yes</td>
<td>Diagnosis or Nature of Illness or Injury</td>
</tr>
<tr>
<td>22</td>
<td>No</td>
<td>Medicaid Resubmission Code</td>
</tr>
<tr>
<td>23</td>
<td>Yes</td>
<td>Prior Authorization Number (If Applicable)</td>
</tr>
<tr>
<td>24a</td>
<td>Yes</td>
<td>Date of Service</td>
</tr>
<tr>
<td>24b</td>
<td>Yes</td>
<td>Place of Service code (HIPAA Compliant)</td>
</tr>
</tbody>
</table>
Table 7-6 below lists each numbered block on the [HYPERLINK] UB04 claim form, with a description of the requested information and whether that information is required in order for a claim to process and pay.
### Table 7-6: UB04 Claim Form (continued on next page)

<table>
<thead>
<tr>
<th>Block #</th>
<th>Required?</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>Provider Name, Address, Telephone #</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>Untitled</td>
</tr>
<tr>
<td>3</td>
<td>No</td>
<td>Provider’s Member Account Number</td>
</tr>
<tr>
<td>4</td>
<td>Yes</td>
<td>Type of Bill (See Table 7-2 for 3-digit codes.)</td>
</tr>
<tr>
<td>5</td>
<td>Yes</td>
<td>Federal Tax ID Number</td>
</tr>
<tr>
<td>6</td>
<td>Yes</td>
<td>Statement Covers Period (Include date of Discharge)</td>
</tr>
<tr>
<td>7</td>
<td>Yes</td>
<td>Covered Days (Do not include date of Discharge)</td>
</tr>
<tr>
<td>8</td>
<td>Yes</td>
<td>Member Name</td>
</tr>
<tr>
<td>9</td>
<td>Yes</td>
<td>Member Address</td>
</tr>
<tr>
<td>10</td>
<td>Yes</td>
<td>Member Birth Date</td>
</tr>
<tr>
<td>11</td>
<td>Yes</td>
<td>Member Sex</td>
</tr>
<tr>
<td>12</td>
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<td>16</td>
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<td>Discharge Hour</td>
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<td>Discharge Status (See Table 7-1: Discharge Status Codes)</td>
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<td>18-28</td>
<td>No</td>
<td>Condition Codes</td>
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<td>30</td>
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<td>31-34</td>
<td>No</td>
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<td>35-36</td>
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<td>No</td>
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<td>39-41</td>
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<td>Revenue Code (If Applicable)</td>
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<td>43</td>
<td>Yes</td>
<td>Revenue Description</td>
</tr>
<tr>
<td>44</td>
<td>Yes</td>
<td>Procedure Code (CPT) (Modifier may be placed here beside the HCPCS code. See Table 7-3 for acceptable modifiers.)</td>
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<td>Service Date</td>
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<td>Non-Covered Charges</td>
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<td>Modifier (if applicable - See Table 7-3 for acceptable modifiers.)</td>
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### Table 7-6: UB04 Claim Form *(continued)*

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<td>Release Of Information Authorization Indicator</td>
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<td>Assignment Of Benefits Authorization Indicator</td>
</tr>
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<td>Yes</td>
<td>Prior Payments (If Applicable)</td>
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<td>No</td>
<td>Estimated Amount Due</td>
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<td>No</td>
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<td>Prior Authorization Number (If Applicable)</td>
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<td>A-Q Other Diagnosis</td>
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<td>Attending Physician NPI First and Last Name (required)</td>
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<td>Operating Physician NPI</td>
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Paper Resubmission

**Beacon Discourages Paper Transactions**

**BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS EARLIER IN THIS CHAPTER.**

Paper submissions have more fields to enter, a higher error rate / lower approval rate, and slower payment.

- See Table 7-4 for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.
- If the resubmitted claim is received by Beacon more than 90 days from the date of service, the REC.ID from the denied claim line is required and may be provided in either of the following ways:
  - Enter the REC.ID in box 64 on the UB04 claim form, or in box 19 on the CMS 1500 form; or.
  - Submit the corrected claim with a copy of the EOB for the corresponding date of service.
- The REC.ID corresponds with a single claim line on the Beacon EOB. Therefore, if a claim has multiple lines, there will be multiple REC.ID numbers on the Beacon EOB.
- The entire claim that includes the denied claim line(s) may be resubmitted regardless of the number of claim lines; Beacon does not require one line per claim form for resubmission. When resubmitting a multiple-line claim, it is best to attach a copy of the corresponding EOB.
- Resubmitted claims cannot contain original (new) claim lines along with resubmitted claim lines.
- Resubmissions must be received by Beacon within 90 days after the date on the EOB. A claim package postmarked on the 90th day is not valid.
- If the resubmitted claim is received by Beacon within 90 days from the date of service, the corrected claim may be resubmitted as an original. A corrected and legible photocopy is also acceptable.

**Paper Submission of 90-Day Waiver**

- See Table 7-4 for an explanation of waivers, when a waiver request is applicable, and procedural guidelines.
- Watch for notice-of-waiver requests becoming available on eServices.
- Download the [HYPERLINK](#) 90-Day Waiver Form.
- Complete a 90-Day Waiver Form for each claim that includes the denied claim(s), per the instructions below.
- Attach any supporting documentation.
- Prepare the claim as an original submission with all required elements.
- Send the form, all supporting documentation, claim and brief cover letter to:

Beacon Health Strategies
Claim Department/90-Day Waivers
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393
Completion of the 60-Day Waiver Request Form

To ensure proper resolution of your request, complete the 90-Day Waiver Request Form as accurately and legibly as possible.

1. **Provider Name:**
Enter the name of the provider who provided the service(s).

2. **Provider ID Number:**
Enter the provider ID Number of the provider who provided the service(s).

3. **Member Name:**
Enter the member’s name.

4. **Health Plan Member ID Number:**
Enter the plan member ID number.

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

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

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

8. **Provider Signature**
A 90-day waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept “signature on file”.

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

**Paper Request for Adjustment or Void**

Beacon Discourages Paper Transactions

**BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS EARLIER IN THIS CHAPTER.**

Paper submissions have more fields to enter, a higher error rate / lower approval rate, and slower payment.

- See Table 7-4 for an explanation of adjustments and voids, when these requests are applicable, and procedural guidelines.
- **Do not send a refund check to Beacon.** A provider who has been incorrectly paid by Beacon must request an adjustment or void.
- Prepare a new claim as you would like your final payment to be, with all required elements; place the Rec.ID in box 19 of the CMS 1500 claim form, or box 64 of the UB04 form; or
- Download and complete the [HYPERLINK] Adjustment/Void Request Form per the instructions below.
- Attach a copy of the original claim.
- Attach a copy of the EOB on which the claim was paid in error or paid an incorrect amount.
Send the form, documentation and claim to:

Beacon Health Strategies
Claim Departments – Adjustment Requests
500 Unicorn Park Drive, Suite 401
Woburn, MA  01801-3393

**To Complete the Adjustment/Void Request Form**

To ensure proper resolution of your request, complete the Adjustment/Void Request Form as accurately and legibly as possible and include the attachments specified above.

1. **Provider Name:**
   Enter the name of the provider to whom the payment was made.

2. **Provider ID Number:**
   Enter the Beacon provider ID Number of the provider that was paid for the service. If the claim was paid under an incorrect provider number, the claim must be **voided** and a new claim must be submitted with the correct provider ID Number.

3. **Member Name**
   Enter the member’s name as it appears on the EOB. If the payment was made for the wrong member, the claim must be **voided** and a new claim must be submitted.

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

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

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

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

8. **Check All that Apply**
   Place an “X” on the line(s) which best describe the reason(s) for requesting the adjustment/void. If “Other” is marked, describe the reason for the request.

9. **Provider Signature**
   An adjustment/void request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept “Signature on file”.

10. **Date**
    List the date that the form is signed.