This document contains chapters 1-6 of Beacon’s Behavioral Health Policy and Procedure Manual for providers serving Humana – CareSource™. Note that links within the manual have been activated in this revised version. Additionally, all referenced materials are available on this website. Chapters 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 877.380.9729.
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CHAPTER 1

Introduction

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1.1 Beacon/Humana – CareSource™ Partnership

Humana – CareSource™ has partnered with Beacon Health Strategies, LLC to manage the delivery of behavioral health services for its members. Beacon Health Strategies, LLC is a limited liability, managed behavioral health care company. Established in 1996, Beacon’s mission is to collaborate with our health plan customers and contracted providers to improve the delivery of behavioral healthcare for the members we serve.

Presently, Beacon provides care management services to 7.5 million members through its partnerships with client plans and care management organizations. Most often co-located at the physical location of our plan partners, Beacon’s “in-sourced” approach deploys utilization managers, care managers and provider network professionals into each local market where Beacon conducts business. This approach facilitates better coordination of care for members with physical, behavioral and social conditions and is designed to support a “medical home” model. Quantifiable results prove that this approach improves the lives of individuals and their families and helps plans to better integrate behavioral health with medical health.

Humana – CareSource™ has delegated behavioral health related functions to Beacon. These include:

1) Contracting and credentialing of behavioral health providers
2) Utilization review and medical management for behavioral health services
3) Administrative appeals (Humana – CareSource™ will process clinical appeals)
4) Claims processing and payment;
5) Member rights and responsibilities;
6) Quality management and improvement;
7) Member services, including management of the Behavioral Health Hotline
8) Referral and triage;
9) Ensuring service accessibility and availability
10) Treatment record compliance; and
11) Care management.
1.2 Beacon/ Humana – CareSource™ Behavioral Health Program

The Humana – CareSource™ behavioral health program provides members with access to a full continuum of behavioral health services through our network of contracted providers. The primary goal of the program is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings. By ensuring that all Plan members receive timely access to clinically appropriate behavioral health care services, Humana – CareSource™ and Beacon believe that quality clinical services can achieve improved outcomes for our members.

1.3 Network Operations

Beacon’s Network Operations Department, with Provider Relations, is responsible for procurement and administrative management of Beacon’s behavioral health provider network. Beacon’s role includes contracting, credentialing and provider relations functions for all behavioral health contracts. Representatives are easily reached by email via provider.relations@beaconhs.com, or by phone between 8:30 AM and 6:00 PM eastern standard time (EST) Monday through Thursday, and 8:30 AM to 5:00 PM EST on Fridays at 877.380.9729.

1.4 Contracting and Maintaining Network Participation

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

Participating providers who maintain approved credentialing status remain active network participants unless the PSA is terminated in accordance with the terms and conditions set forth therein. In cases where a provider is terminated, providers may notify the member of their termination. Beacon will also always notify members when their provider has been terminated and work to transition
members to another participating provider to avoid unnecessary disruption of care.

1.5 About This Provider Manual

This Behavioral Health Provider Policy and Procedure Manual (hereinafter, the “Manual”) is a legal document incorporated by reference as part of each provider’s Beacon/Humana Provider Services Agreement.

The Manual serves as an administrative guide outlining Beacon’s policies and procedures governing network participation, service provision, claims submission, quality management and improvement requirements, in Chapters 2-3. Detailed information regarding clinical processes, including authorizations, utilization review, care management, reconsiderations and appeals are found in Chapters 4 and 5. Chapter 6 covers billing transactions. Beacon’s level-of-care criteria (LOCC) are accessible through eServices or by calling Beacon. Additional information is provided in the following appendix listed below:

Appendix A: Links to Clinical and Quality Forms

The Manual is posted on both Humana – CareSource™ and Beacon’s websites and on Beacon’s eServices; only the version on eServices includes Beacon’s LOCC. Providers may also request a printed copy of the Manual by calling Humana – CareSource™ at 1.855.852.7005 or Beacon at 877.380.9729.

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

1.6 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:

a) **eServices**

On **eServices**, Beacon’s secure web portal supports all provider transactions, while saving providers’ time, postage expense, billing fees, and reducing paper waste. **eServices** is completely free to Beacon providers contracted for Humana – CareSource™ and is accessible through [www.beaconhealthstrategies.com](http://www.beaconhealthstrategies.com) twenty four hours a day, seven days a week.

Many fields are automatically populated to minimize errors and improve claim approval rates on first submission. Claim status is available within 2 hours of electronic submission, all transactions generate printable confirmation, and transaction history is stored for future reference.

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

[Click here](http://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.*

b) **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 member’s full name, Plan ID and date of birth, when verifying eligibility through **eServices** and through Beacon’s **IVR**.

c) **Electronic Data Interchange**

Electronic data interchange (**EDI**) is available for claim submission and eligibility verification directly by providers to Beacon or via an intermediary. For information about testing and setup for EDI, 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 43324 and Beacon’s Health Plan 045.

**TABLE 1-1: ELECTRONIC TRANSACTIONS 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>Yes</td>
<td>Yes (HIPAA 270/271)</td>
</tr>
<tr>
<td>Submit authorization requests</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>View authorization status;</td>
<td>Yes</td>
<td></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 and 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 and 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.

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

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

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

1.7 Access Standards

Humana – CareSource™ members may access behavioral health services 24 hours a day, seven days a week by contacting Humana – CareSource™’s member services line 855.852.7005 or by calling the Humana – CareSource™ Behavioral Health Hotline at 877.380.9729. Members do not need a referral to access behavioral health services and authorization is never required for emergency services. Humana – CareSource™ and Beacon adhere to State and National Committee for Quality Assurance (NCQA) guidelines for access standards for member appointments. Contracted providers must adhere to the following:

TABLE 1-2: APPOINTMENT STANDARDS AND AFTER HOURS ACCESSIBILITY:

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Appointment Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care with Crisis Stabilization</td>
<td>Within twenty four (24) hours</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within forty eight (48) hours</td>
</tr>
<tr>
<td>Post Discharge from Acute Hospitalization</td>
<td>Within 7 days of discharge</td>
</tr>
<tr>
<td>Other routine referrals/appointments</td>
<td>Within sixty (60) days</td>
</tr>
</tbody>
</table>

Access standards for Humana – CareSource™’s behavioral health network are established to ensure that members have access to services within sixty (60) miles or a maximum of sixty (60) minutes of their address.

In addition, Humana – CareSource™ providers must adhere to the following guidelines to ensure members have adequate access to services:
### Service Availability

<table>
<thead>
<tr>
<th>On-Call</th>
<th>Hours of Operation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 24-hr on-call services for all members in treatment; and</td>
<td>• Services must be available 24 hours per day, 7 days per week;</td>
</tr>
<tr>
<td>• Ensure that all members in treatment are aware of how to contact the treating or covering provider after hours and during provider vacations.</td>
<td>• Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours; and</td>
</tr>
<tr>
<td></td>
<td>• After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.</td>
</tr>
</tbody>
</table>

### Crisis Intervention

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

### Outpatient Services

- Outpatient providers should have services available Monday through Friday from 9 a.m. to 5 p.m. at a minimum; and
- Evening and/or weekend hours should also be available at least 2 days per week.

### Interpreter Services

- Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency.

### Cultural Competency

- Providers must ensure that members have access to medical interpreters, signers and TTY services to facilitate communication when necessary and ensure that clinicians and agency are sensitive to the diverse needs of Humana – CareSource™ members.

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Providers are required to meet these standards, and to notify Beacon if they are temporarily or permanently unable to meet the standards. If a provider fails to provide services within these access standards – notice is sent out within one business day informing the member and provider that the waiting time access standard was not met.

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### 1.8 Provider Credentialing & Recredentialing

Beacon conducts a rigorous credentialing process for network providers based on Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) guidelines. All providers must be approved for credentialing by Beacon in order to participate in Beacon’s behavioral health services network, and must comply with recredentialing standards by submitting requested information within the specified timeframe. Private solo and group practice clinicians are individually credentialed, while facilities are credentialed as organizations; the processes for both are described below.

To request credentialing information and an application(s), please email provider.relations@beaconhs.com.
### TABLE 1-3: CREDENTIALING PROCESS

<table>
<thead>
<tr>
<th>Individual Practitioner Credentialing</th>
<th>Organizational Credentialing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon individually credentials and recredentials the following categories of clinicians in private solo or group practice settings:</td>
<td>Beacon credentials and recredentials facilities and licensed outpatient agencies as organizations. Facilities that must be credentialed by Beacon as organizations include:</td>
</tr>
<tr>
<td>• Psychiatrists;</td>
<td>• Licensed outpatient clinics and agencies including hospital-based clinics;</td>
</tr>
<tr>
<td>• Psychologists;</td>
<td>• Freestanding inpatient behavioral health facilities – freestanding and within general hospitals;</td>
</tr>
<tr>
<td>• Master's level therapists, designated by the applicable KY licensing board(s) as independently-licensed providers;</td>
<td>• Inpatient behavioral health units at general hospitals;</td>
</tr>
<tr>
<td>• Other behavioral healthcare specialists who are master's level or above and who are licensed, certified, or registered by the State of KY and who fall within the scope of eligible provider types by the Credentialing Committee.</td>
<td>• Other outpatient behavioral health and substance abuse services as delineated by the State of KY.</td>
</tr>
</tbody>
</table>

#### INDIVIDUAL PRACTITIONER CREDENTIALING

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

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

#### ORGANIZATIONAL CREDENTIALING

In order to be credentialed, facilities must be licensed or certified by the state in which they operate and the license must be in force and in good standing at the time of credentialing or recredentialing. If the facility reports accreditation by The Joint Commission, the Council on Accreditation of Services for Family and Children (COA), or the Council on Accreditation of Rehabilitation Facilities (CARF), such accreditations must be in force and in good standing at the time of the initial credentialing cycle, as well as at the time of each subsequent recredentialing cycle for the facility. If the facility is not accredited by one of these accreditation organizations, Beacon conducts a site visit prior to rendering a credentialing decision.

The credentialed facility is responsible for credentialing and overseeing its clinical staff as Beacon does not individually credential facility-based staff. Behavioral health program eligibility criteria include applicable accreditation requirements.

Once the facility has been approved for credentialing and has been contracted with Beacon to serve
members of one or more health plans, all licensed or certified behavioral health professionals approved by Beacon may treat members in the facility setting, and these practitioners must hold current, non-restricted licenses in their area of practice.

**RECREDENTIALING**

All practitioners and organizational providers are processed via re-credentialing within 36 months of the previous credentialing/recredentialing approval date in accordance with State regulations and Beacon’s Policies. Practitioners and providers must continue to meet Beacon’s established credentialing criteria and quality of care standards for continued participation in Beacon’s behavioral health provider network including but not limited to:

A. A current license to practice;
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;
C. A valid DEA number, if applicable;
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and
F. A current signed attestation statement by the applicant regarding:
   1. The ability to perform the essential functions of the position, with or without accommodation;
   2. The lack of current illegal drug use;
   3. A history of loss, limitation of privileges or any disciplinary action; and

Prior to making a recredentialing decision, Beacon will also verify information about sanctions or limitations on practitioner from:

A. The national practitioner data bank;
B. Medicare and Medicaid;
C. State boards of practice, as applicable; and
D. Other recognized monitoring organizations appropriate to the practitioner’s specialty.

Failure to comply with recredentialing requirements, including timelines, may result in removal from the network.
All practitioners and organizational providers are given thirty (30) days, following the initial adverse decision, to file an appeal with the Credentialing Committee and to submit additional information in support of their appeal. If no appeal is initiated, the decision of the Credentialing Committee shall be implemented, and Beacon’s Director of Credentialing and Data reports Beacon’s action to the appropriate regulatory bodies, including the National Practitioner Data Bank and the appropriate licensing agencies and authorities, in accordance with local, state, and federal requirements, if it is a reportable situation.

If an appeal is initiated, the Credentialing Committee is notified. The practitioner or organizational provider is notified of the date on which the Credentialing Committee will review the appeal, which will be within thirty (30) days of receipt of the appeal request. The practitioner or organizational provider may attend the Credentialing Committee meeting and personally present their case to the Committee on that date and/or may be represented by an attorney or another person of the practitioner or facility/organization’s choice. Either Beacon or the provider may elect to engage, at their own expense, a court stenographer to attend the hearing and prepare a transcription. If the other party wishes to obtain a copy of the transcript, that party shall pay one-half the cost of the court stenographer.

The Credentialing Committee again reviews the case and makes a decision based on the additional information.

Beacon notifies the practitioner or organizational provider of the committee’s decision regarding the appeal, including the specific reasons for the decision within ten (10) business days of the meeting.

If the practitioner or organizational provider is not satisfied with the first appeal decision, the decision may be appealed a second time to Beacon’s Appeals Panel. The procedures for the first level appeal described above, are also applicable to the second level appeal. The appeal shall be completed prior to the implementation of any proposed action(s).

The Appeals Panel makes a decision regarding this second and final appeal. The panel may either reaffirm the previous Credentialing Committee decision or overturn it. The Appeals Panel’s decision is final.

Beacon notifies the practitioner or organizational provider of the decision within ten (10) business days of the Appeals Panel’s decision.

Results of the final Beacon review are reported to the appropriate regulatory bodies, if required, including the National Practitioner Data Bank and the appropriate licensing agencies and authorities, in accordance with local, state, and federal requirements.
1.9 Prohibition on Billing Members

Health plan members may not be billed for any covered service or any balance after reimbursement by Beacon except for any applicable co-payment. 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 this manual.

OUT OF NETWORK PROVIDERS

Out of network behavioral health benefits are limited to those covered services that are not available in the existing Humana – CareSource™/Beacon network, emergency services and transition services for members who are currently in treatment with an out of network provider who is either not a part of the network or who is in the process of joining the network. Out of network providers must complete a single case agreement with Beacon (SCA). Out of network providers may provide one evaluation visit for Humana – CareSource™ members without an authorization upon completion and return of the signed SCA. After the first visit, services provided must be authorized. Authorization requests for outpatient services can be obtained through Beacon’s electronic outpatient request for (eORF) which can be requested by calling Beacon at 877.380.9729 or on Beacon’s website www.beaconhealthstrategies.com. If this process is not followed, Beacon may administratively deny the services and the out of network provider must hold the member harmless.

PROVIDER DATABASE

Beacon and Humana – CareSource™ maintain a database of provider information as reported to us by providers. The accuracy of this database is critical to operations, for such essential functions as:

- Member referrals
- Regulatory reporting requirements
- Network monitoring to ensure member access to a full continuum of services across the entire geographic service area; and
- Network monitoring to ensure compliance with quality and performance standards including appointment access standards.

Provider-reported hours of operation and availability to accept new members are included in Beacon’s provider database, along with specialties, licensure, language capabilities, addresses and contact information. This information is visible to members on our website and is the primary information source for us to use when assisting members with referrals. In addition to contractual and regulatory requirements pertaining to appointment access, up-to-date practice information is equally critical to ensuring appropriate referrals to available appointments. The table below lists required notifications. Most of these can be updated via Beacon’s eServices portal or by email.

**TABLE 1-4: REQUIRED NOTIFICATIONS**

<table>
<thead>
<tr>
<th>Type of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice Information</td>
</tr>
<tr>
<td>Change in address or telephone number of any service;</td>
</tr>
<tr>
<td>Addition or departure of any professional staff;</td>
</tr>
<tr>
<td>Change in linguistic capability, specialty or program;</td>
</tr>
</tbody>
</table>
Discontinuation of any covered service listed in the Behavioral Health Services Agreement;
Change in licensure or accreditation of provider or any of its professional staff.
Change in licensure or accreditation of provider or any of its professional staff.
Change in hours of operation;
Is no longer accepting new patients;
Is available during limited hours or only in certain settings;
Has any other restrictions on treating members; or
Is temporarily or permanently unable to meet Beacon standards for appointment access.
Change in designated account administrator for the provider’s eServices accounts;
Merger, change in ownership, or change of tax identification number

Adding a site, service or program not previously included in the Behavioral Health Services Agreement, remember to specify:
 a) Location; and
 b) Capabilities of the new site, service, or program.

**ADDING SITES, SERVICES AND PROGRAMS**

Your contract with Beacon is specific to the sites, rates and services for which you originally specified in your Provider Services Agreement.

To add a site, service or program not previously included in your PSA, you should notify Beacon of the location and capabilities of the new site, service or program. Beacon will coordinate with Humana – CareSource™ to determine whether the site, service or program meets an identified geographic, cultural/linguistic and/or specialty need in our network.
CHAPTER 2

Members, Benefits and Member-Related Policies

2.1 Members, Benefits and Member-Related Policies

Additional Benefit Information

2.2 Member Rights and Responsibilities

Member Rights
Member Responsibilities
Posting Member Rights and Responsibilities
Informing Members of Their Rights and Responsibilities
Non-Discrimination Policy and Regulations
Confidentiality of Member Information
Member Consent
Confidentiality of Members’ HIV-Related Information
Humana - CareSource™ Health Plan Eligibility
2.1 Members, Benefits and Member-Related Policies

Humana – CareSource™ covers behavioral health services to members located in Region 3. Under the Plan, the following levels of care are covered, provided that services are medically necessary, delivered by contracted network providers, and that the authorization procedures outlined in this manual are followed. Please refer to your contract with Humana – CareSource™ for specific information about procedure and revenue codes and rates for each service.

- Inpatient mental health
- Crisis stabilization
- Emergency room visits
- Medical detoxification
- Psychiatric residential treatment facilities (PRTF)
- Extended care units (ECU- EPSDT Special Service)
- Residential substance abuse rehabilitation (EPSDT special service- through age 21 only)
- Substance abuse rehabilitation (for pregnant/post-partum women only)
- Outpatient mental health services
- Outpatient and community based substance abuse services for pregnant/postpartum women
- Electroconvulsive Therapy (ECT)
- Psychological and neuropsychological testing
- Community Mental Health Center Services, such as therapeutic rehabilitation, targeted case management etc.
- Impact Plus services

Access to behavioral health treatment is an essential component of a comprehensive health care delivery system. Plan members may access behavioral health services by self-referring to a network provider, by calling Beacon, or by referral through acute or emergency room encounters. Members may also access behavioral health services by referral from their primary care practitioner (PCP); however a PCP referral is never required for behavioral health services. Network providers are expected to coordinate care with a member’s primary care and other treating providers whenever possible.

ADDITIONAL BENEFIT INFORMATION

- Benefits do not include payment for behavioral health care services that are not medically necessary.
- Neither Beacon nor the health plan is responsible for the costs of investigational drugs or devices or the costs of non-healthcare services such as the costs of managing research or the costs of collecting data that is useful for the research project but not necessary for the enrollee’s care.
- Authorization is required for all services except emergency services. Detailed information about authorization procedures is covered in Chapter 4 of this manual.
2.2 Member Rights and Responsibilities

MEMBER RIGHTS
Humana – CareSource™ and Beacon are firmly committed to ensuring that members are active and informed participants in the planning and treatment phases of their behavioral care. We believe that members become empowered through ongoing collaboration with their health care providers, and that collaboration among providers is also crucial to achieving positive health care outcomes.

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

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

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

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

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

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

Right to Clinical/Treatment Information
Members and their legal guardian have the right to, upon submission of a written request; review the member’s medical records. Members and their legal guardian may discuss the information with the designated responsible party at the provider site.

Right to Appeal Decisions Made by Beacon
Members and their legal guardian have the right to appeal Beacon’s decision not to authorize care at the requested level-of-care, or Beacon’s denial of continued stay at a particular level-of-care according to the clinical appeals procedures described in Chapter 6. Members and their legal guardians may also request the behavioral health or substance use health care provider to appeal on their behalf according to the same procedures. Members may request assistance...
from Beacon or Humana – CareSource™ in filing an appeal or a state hearing once their appeal rights have been exhausted.

**Right to Submit a Complaint or Concern to Beacon**
Members and their legal guardians have the right to file a complaint or grievance with Beacon or the Plan regarding any of the following. Member grievances will be handled directly by Humana – CareSource™.

- The quality of care delivered to the member by a Beacon contracted provider.
- The Beacon utilization review process.
- The Beacon network of services.
- The procedure for filing a complaint or grievance as described in Chapter 3.

**Right to Contact Beacon Ombudsperson**
Members have the right to contact Beacon’s Office of Ombudsperson to obtain a copy of Beacon’s Member Rights and Responsibilities statement. The Beacon Ombudsperson may be contacted at 1.877.380.9729 or by TTY at 1.866.727.9441.

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

In addition to these rights members also has the right to:
- Report suspected Fraud and Abuse
- Keep appointments or call to cancel
- Request a copy of their medical record (with no charge) and ask that a record be changed or corrected if needed
- Get help free of charge if member does not speak English or need help in understanding information.
- Be able to get help with sign language if the member is hearing impaired
- Contact the United States Department of Health and Human Services Office of Civil Rights and/or Bureau of Civil Rights at the address below with any compliant of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran’s status, ancestry, health status or need for health services.

Office of Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave. Suite 240
Chicago, Illinois 60601
312.886.2359, 312.353.5693 (TTY)

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

POSTING MEMBER RIGHTS AND RESPONSIBILITIES
All contracted providers must display in a highly visible and prominent place, a statement of member’s rights and responsibilities. This statement must be posted and made available in languages consistent with the demographics of the population(s) served. This statement can either be Beacon’s statement or a comparable statement consistent with the provider’s state license requirements.

INFORMING MEMBERS OF THEIR RIGHTS AND RESPONSIBILITIES
Providers are responsible for informing members of their rights and respecting these rights. In addition to a posted statement of member rights, providers are also required to:

• Distribute and review a written copy of Member Rights and Responsibilities at the initiation of every new treatment episode and include in the member’s medical record signed documentation of this review.
• Inform members that Beacon does not restrict the ability of contracted providers to communicate openly with Plan members regarding all treatment options available to them including medication treatment regardless of benefit coverage limitations.
• Inform members that Beacon does not offer any financial incentives to its contracted provider community for limiting, denying, or not delivering medically necessary treatment to Plan members.
• Inform members that clinicians working at Beacon do not receive any financial incentives to limit or deny any medically necessary care.

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

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

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

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

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

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

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

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

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

HUMANA-CARESOURCE™ HEALTH PLAN MEMBER ELIGIBILITY
Possession of a health plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check member eligibility frequently.

The following resources are available to assist in eligibility verification:
TABLE 2-1: MEMBER ELIGIBILITY VERIFICATION TOOLS

<table>
<thead>
<tr>
<th>Online</th>
<th>Electronic Data Interchange (EDI)</th>
<th>Via Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon’s eServices</td>
<td>Providers with EDI capability can utilize the 270/271 EDI transaction with Beacon. To set up an EDI connection, view the companion guide then contract <a href="mailto:edi.operations@beaconhs.com">edi.operations@beaconhs.com</a>.</td>
<td>888.210.2018 Beacon’s integrated voice recognition (IVR);</td>
</tr>
</tbody>
</table>

Providers may also use the CareSource secure Provider Portal online to check Member eligibility, or call Provider Services.

Provider Services: 1.855.852.7005

Provider Portal: https://providerportal.caresource.com/KY
Click on “Member Eligibility” on the left, which is the first tab.
- Log on to www.caresource.com/KY and select Provider Portal from the menu options.
- Using our secure Provider Portal, you can check Humana – CareSource™ Member eligibility up to 24 months after the date of service. You can search by date of service plus any one of the following: Member name and date of birth, case number, Medicaid (MMIS) number, or Humana – CareSource™ Member ID number. You can submit multiple Member ID numbers in a single request.
- Call our automated Member eligibility verification system at 1.855.852.7005 from any touch-tone phone and follow the appropriate menu options to reach our automated Member-eligibility verification system. The automated system, available 24 hours a day, will prompt you to enter the Member ID number and the month of service to check eligibility.

In order to maintain compliance with HIPAA and all other federal and state confidentiality/privacy requirements, providers must have their practice or organizational TIN, NPI, as well as member’s full name, Plan ID and date of birth, when verifying eligibility through eServices and through Beacon’s IVR.

The Beacon Clinical Department may also assist the provider in verifying the member’s enrollment in the Humana – CareSource™ plan when authorizing services. Due to the implementation of the privacy act, Beacon requires the provider to have ready specific identifying information (provider ID#, member full name and date of birth) to avoid inadvertent disclosure of member sensitive health information.

Please Note: Member eligibility information on eServices and through IVR is updated every night. Eligibility information obtained by phone is accurate as of the day and time it is provided by Beacon. Beacon cannot anticipate, and is not responsible for, retroactive changes or disenrollments reported at a later date. Providers should check eligibility frequently.
3.1 QM & I Program Overview
   Provider Role
   Quality Monitoring

3.2 Treatment Records
   Treatment Record Reviews
   Treatment Record Standards
   Performance Standards and Measures
   Practice Guidelines
   Outcome Measurement
   Transitioning Members From One Behavioral Health Provider to Another
   Follow Up After Mental Health Hospitalization
   Reportable Incidents and Events

3.3 Reportable Incidents and Events - Overview
   Fraud and Abuse
   Federal False Claims Act
   Summary of Provisions
   Penalties
   Qui Tam (Whistleblower) Provisions
   Non-Retaliation and Anti-Discrimination
   Reduced Penalties
   Complaints
   Grievances and Appeal of Grievance Resolution
3.1 QM & I Program Overview

### TABLE 3-1: PROGRAM OVERVIEW

<table>
<thead>
<tr>
<th>Program Description</th>
<th>Program Principles</th>
<th>Program Goals and Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon administers, on behalf of the health plan, a Quality Management and Improvement (QM &amp; I) program whose goal is to continually monitor and improve the quality and effectiveness of behavioral health services delivered to members. Beacon’s QM &amp; I Program integrates the principles of continuous quality improvement (CQI) throughout our organization and the provider network.</td>
<td>• Continually evaluate the effectiveness of services delivered to health plan members; • Identify areas for targeted improvements; • Develop QI action plans to address improvement needs; and • Continually monitor the effectiveness of changes implemented, over time.</td>
<td>• Improve the health care status of members; • Enhance continuity and coordination among behavioral health care providers and between behavioral healthcare and physical health care providers; • Establish effective and cost efficient disease management programs, including preventive and screening programs, to decrease incidence and prevalence of behavioral health disorders; • Ensure members receive timely and satisfactory service from Beacon and network providers; • Maintain positive and collaborative working relationships with network practitioners and ensure provider satisfaction with Beacon services; and • Responsibly contain health care costs.</td>
</tr>
</tbody>
</table>

### PROVIDER ROLE
Humana – CareSource™ and Beacon employ a collaborative model of continuous QM & I, in which provider and member participation is actively sought and encouraged. Humana – CareSource™ and Beacon require each provider to have its own internal QM & I Program to continually assess quality of care, access to care and compliance with medical necessity criteria.

To participate in Beacon’s Provider Advisory Council, email provider.relations@beaconhs.com. Members, who wish to participate in the Member Advisory Council, should contact the Member Services Department.

### QUALITY MONITORING
Beacon monitors provider activity and utilizes the data generated to assess provider performance related to quality initiatives and specific core performance indicators. Findings related to provider compliance with performance standards and measures are also used in credentialing and recredentialing activities, benchmarking, and to identify individual provider and network-wide improvement initiatives. Humana – CareSource™ and Beacon’s quality monitoring activities include, but are not limited to:

- Site visits;
- Treatment record reviews;
- Satisfaction surveys;
- Internal monitoring of: timeliness and accuracy of claims payment; Provider compliance with
performance standards including but not limited to:

- Timeliness of ambulatory follow up after behavioral health hospitalization;
- Discharge Planning Activities;
- Communication with member PCPs, other behavioral health providers, government and community agencies;
- Tracking of adverse incidents, complaints, grievances and appeals; and
- Other quality improvement activities.

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

A record of each provider’s adverse incidents and any complaints, grievances or appeals pertaining to the provider, is maintained in the provider’s credentialing file, and may be used by Beacon and Humana – CareSource™ in profiling, recredentialing and network (re)procurement activities and decisions.

3.2 Treatment Records

TREATMENT RECORD REVIEWS
Beacon reviews member charts and utilizes data generated to monitor and measure provider performance in relation to the Treatment Record Standards and specific quality initiatives established each year. The following elements are evaluated in addition to any Kentucky specific regulatory requirements around chart review for special services such as IMPACT Plus etc.

- Use of screening tools for diagnostic assessment of substance use, adolescent depression and ADHD;
- Continuity and coordination with primary care providers and other treaters;
- Explanation of member rights and responsibilities;
- Inclusion of all applicable required medical record elements as required by the Commonwealth of Kentucky as identified in administrative regulations (KAR) and service manuals, and NCQA, and
- Allergies and adverse reactions; medications; physical exam; evidence of advance directives

Humana – CareSource™ and Beacon may conduct chart reviews onsite at a provider facility, or may ask a provider to copy and send specified sections of a member’s medical record to Beacon. Any questions that a provider may have regarding Beacon’s access to the Plan member information should be directed to Beacon’s privacy officer, Donna Zeh at donna.zeh@beaconhs.com.

HIPAA regulations permit providers to disclose information without patient authorization for the following reasons: “oversight of the health care system, including quality assurance activities.” Beacon
chart reviews fall within this area of allowable disclosure.

**TREATMENT RECORD STANDARDS**

To ensure that the appropriate clinical information is maintained within the member’s treatment record, providers must follow the documentation requirements below, based upon NCQA standards. All documentation must be clear and legible.

**TABLE 3-2: TREATMENT DOCUMENTATION STANDARDS**

<table>
<thead>
<tr>
<th>Member Identification Information</th>
<th>The treatment record contains the following member information:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Member name and health plan ID # on every page;</td>
</tr>
<tr>
<td></td>
<td>• Member’s address;</td>
</tr>
<tr>
<td></td>
<td>• Employer or school;</td>
</tr>
<tr>
<td></td>
<td>• Home, work, and cellular (if applicable) telephone # ;</td>
</tr>
<tr>
<td></td>
<td>• Marital/legal status;</td>
</tr>
<tr>
<td></td>
<td>• Appropriate consent forms; and</td>
</tr>
<tr>
<td></td>
<td>• Guardianship information, if applicable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Informed Member Consent for Treatment</th>
<th>The treatment record contains signed consents for the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Implementation of the proposed treatment plan;</td>
</tr>
<tr>
<td></td>
<td>• Any prescribed medications;</td>
</tr>
<tr>
<td></td>
<td>• Consent forms related to interagency communications;</td>
</tr>
<tr>
<td></td>
<td>• Individual consent forms for release of information to the member’s PCP and other behavioral health providers, if applicable; each release of information to a new party (other than Beacon or the Plan) requires its own signed consent form;</td>
</tr>
<tr>
<td></td>
<td>• Consent to release information to the payer or MCO (In doing so, the provider is communicating to the member that treatment progress and attendance will be shared with the payer.);</td>
</tr>
<tr>
<td></td>
<td>• For adolescents, ages 12–17, the treatment record contains consent to discuss behavioral health issues with their parents; and</td>
</tr>
<tr>
<td></td>
<td>• Signed document indicating review of patient’s rights and responsibilities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication Information</th>
<th>Treatment records contain medication logs clearly documenting the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• All medications prescribed;</td>
</tr>
<tr>
<td></td>
<td>• Dosage of each medication;</td>
</tr>
<tr>
<td></td>
<td>• Dates of initial prescriptions;</td>
</tr>
<tr>
<td></td>
<td>• Information regarding allergies and adverse reactions are clearly noted; and</td>
</tr>
<tr>
<td></td>
<td>• Lack of known allergies and sensitivities to substances are clearly noted.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical and Psychiatric History</th>
<th>Treatment record contains the member’s medical and psychiatric history including:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Previous dates of treatment;</td>
</tr>
<tr>
<td></td>
<td>• Names of providers;</td>
</tr>
</tbody>
</table>
• Therapeutic interventions;
• Effectiveness of previous interventions;
• Sources of clinical information;
• Relevant family information;
• Results of relevant laboratory tests; and
• Previous consultation and evaluation reports.

Documentation of Advance Directives

Substance use Information
Documentation for any member 12 years and older of past and present use of the following:
• Cigarettes;
• Alcohol; and Illicit, prescribed, and over-the-counter drugs.

Adolescent Depression Information
Documentation for any member 13-18 years was screened for depression
• If yes, was a suicide assessment conducted; and
• Was the family involved with treatment?

ADHD Information
Documentation the members aged 6-12 were assessed for ADHD
• Was family involved with treatment; and
• Is there evidence of the member receiving psychopharmacological treatment?

Diagnostic Information
• Risk management issues (e.g. imminent risk of harm, suicidal ideation/intent, elopement potential) are prominently documented and updated according to provider procedures;
• All relevant medical conditions are clearly documented, and updated as appropriate;
• Member’s presenting problems and the psychological and social conditions that affect their medical and psychiatric status;

A complete mental status evaluation is included in the treatment record, which documents the member’s:
  a. Affect;
  b. Speech;
  c. Mood;
  d. Thought control, including memory;
  e. Judgment;
  f. Insight;
  g. Attention/concentration;
  h. Impulse control;
  i. Initial diagnostic evaluation and DSM IV diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information; and
  j. Diagnoses updated at least quarterly.

Treatment Planning
The treatment record contains clear documentation of the following:
• Initial and updated treatment plans consistent with the member’s diagnoses, goals and progress;
• Objective and measurable goals with clearly defined time frames for achieving goals or resolving the identified problems;
• Treatment interventions utilized and their consistency with stated treatment goals and objectives;
• Member, family and/or guardian’s involvement in treatment
planning, treatment plan meetings and discharge planning; and
• Copy of Outpatient Review Form(s) submitted, if applicable.

Treatment Documentation

The treatment record contains clear documentation of the following:
• Ongoing progress notes that document the member’s progress towards goals, as well as their strengths and limitations in achieving said goals and objectives;
• Referrals to diversionary levels of care and services if the member requires increased interventions resulting from homicidity, suicidality or the inability to function on a day-to-day basis;
• Referrals and/or member participation in preventive and self-help services (e.g. stress management, relapse prevention, Alcoholics Anonymous, etc.) is included in the treatment record; and
• Member’s response to medications and somatic therapies.

Coordination and Continuity of Care

The treatment record contains clear documentation of the following:
• Documentation of communication and coordination between behavioral health providers, primary care physicians, ancillary providers, and health care facilities. (See Behavioral Health – PCP Communication Protocol later in this chapter, and download Behavioral Health – PCP Communication Form); and
• Dates of follow-up appointments, discharge plans and referrals to new providers.

Additional Information for Outpatient Treatment Records

These elements are required for the outpatient medical record:
• Telephone intake/request for treatment;
• Face sheet;
• Termination and/or transfer summary, if applicable; and
• The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan, and updates) should include the following treating clinician information:
  a. Clinician’s name
  b. Professional degree
  c. Licensure
  d. NPI or Beacon Identification number, if applicable
  e. Clinician signatures with dates.

Additional Information for Inpatient and Diversionary Levels of Care

These elements are required for inpatient medical records:
• Referral information (ESP evaluation);
• Admission history and physical condition;
• Admission evaluations;
• Medication records;
• Consultations;
• Laboratory and X-ray reports; and
• Discharge summary and Discharge Review Form.

Information for Children and Adolescents

A complete developmental history must include the following information:
• Physical, including immunizations;
• Psychological;
• Social;
• Intellectual;
• Academic; and
• Prenatal and perinatal events are noted.
To ensure a consistent level-of-care within the provider network, and a consistent framework for evaluating the effectiveness of care, Beacon has developed specific provider performance standards and measures. Behavioral health providers are expected to adhere to the performance standards for each level-of-care they provide to members, which include but are not limited to:

- Communication with PCPs and other providers treating shared members; and
- Availability of routine, urgent and emergent appointments (See Chapter 4).

**PRACTICE GUIDELINES**
Beacon and the Humana – CareSource™ promote delivery of behavioral health treatment based on scientifically proven methods. We have researched and adopted evidenced based guidelines for treating the most prevalent behavioral health diagnoses, including guidelines for ADHD, substance use disorders, and child/adolescent depression and posted links to these on our website. We strongly encourage providers to use these guidelines and to consider these guidelines whenever they may promote positive outcomes for clients. Beacon monitors provider utilization of guidelines through the use of claim, pharmacy and utilization data.

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

**OUTCOME MEASUREMENT**
Beacon strongly encourages and supports providers in the use of outcome measurement tools for all members. Outcome data is used to identify potentially high-risk members who may need intensive behavioral health, medical, and/or social care management interventions. Humana – CareSource™ requires that providers document attempts to communicate with member primary care providers, with member consent. Provider are expected to submit quarterly (monthly if applicable) reports to PCP on member treatment and progress.

Beacon receives aggregate data by provider including demographic information and clinical and functional status without member-specific clinical information.

**TABLE 3-3: COMMUNICATION BETWEEN BEHAVIORAL HEALTH PROVIDERS AND OTHER TREATERS**

<table>
<thead>
<tr>
<th>Communication between Outpatient Behavioral Health Providers and PCPs, Other Treaters</th>
<th>Communication between Inpatient / Diversionary Providers and PCPs, Other Outpatient Treaters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient behavioral health providers are expected to communicate with the member’s PCP and other OP behavioral health providers if applicable, as follows:</td>
<td>With the member’s informed consent, acute care facilities should contact the PCP by phone and/or by fax, within 24 hours of a member’s admission to treatment. Inpatient and diversionary providers must also alert the PCP 24 hours prior to a pending discharge, and must fax or mail the following member information to the PCP within 3 days post-discharge:</td>
</tr>
<tr>
<td>• Notice of commencement of outpatient treatment within 4 visits or 2 weeks, whichever occurs first;</td>
<td>• Date of Discharge;</td>
</tr>
<tr>
<td>• Updates at least quarterly during the course of treatment;</td>
<td>• Diagnosis;</td>
</tr>
<tr>
<td>• Notice of initiation and any subsequent modification of psychotropic medications; and</td>
<td>• Medications;</td>
</tr>
<tr>
<td>• Notice of treatment termination within 2 weeks.</td>
<td>• Discharge plan; and</td>
</tr>
<tr>
<td>Behavioral health providers may use Beacon’s Authorization for Behavioral Health Provider and PCP to Share Information and the Behavioral Health-PCP Communication Form available for initial</td>
<td>• Aftercare services for each type,</td>
</tr>
</tbody>
</table>
communication and subsequent updates, in Appendix B, or their own form that includes the following information:

- Presenting problem/reason for admission;
- Date of admission;
- Admitting diagnosis;
- Preliminary treatment plan;
- Currently prescribed medications;
- Proposed discharge plan; and
- Behavioral health provider contact name and telephone number.

Request for PCP response by fax or mail within 3 business days of the request to include the following health information:

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

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

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

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

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**TRANSITIONING MEMBERS FROM ONE BEHAVIORAL HEALTH PROVIDERS TO ANOTHER**

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

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

**FOLLOW UP AFTER MENTAL HEALTH HOSPITALIZATION**

All inpatient providers are required to coordinate after care appointments with community based providers prior to the member’s discharge. Beacon’s UM staff can assist providers in determining if the member is actively engaged in treatment with a behavioral health provider and assist with referrals to
ensure that members are discharged with a scheduled appointment. Members discharged from inpatient levels of care are scheduled for follow up appointments within 7 days of discharge from an acute care setting. Providers are responsible for seeing members within that timeframe and for outreaching members who miss their appointments within 24 hours of the missed appointment to reschedule. Beacon’s care managers and aftercare coordinators assist in this process by sending reminders to members; working to remove barriers that may prevent a member from keeping his or her discharge appointment and coordinating with treating providers. Network providers are expected to aid in this process as much as possible to ensure that members have the supports they need to maintain placement in the community and to prevent unnecessary readmissions.

REPORTABLE INCIDENTS AND EVENTS
Beacon requires that all providers report adverse incidents, other reportable incidents and sentinel events involving the Humana – CareSource™ members to Beacon as follows:

Download Adverse Incident Report Form
Click here for phone numbers

<table>
<thead>
<tr>
<th>Incident / Event Description:</th>
<th>Adverse Incidents</th>
<th>Sentinel Events</th>
<th>Other Reportable Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>An adverse incident is an occurrence that represents actual or potential serious harm to the wellbeing of a health plan member who is currently receiving or has been recently discharged from behavioral health services.</td>
<td></td>
<td>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.</td>
<td>An “other reportable incident” is any incident that occurs within a provider site at any level-of-care, which does not immediately place a health plan member at risk but warrants serious concern.</td>
</tr>
<tr>
<td>Incidents/Events Include the Following:</td>
<td>• All medico-legal or non-medico-legal deaths;</td>
<td>• All medico-legal deaths;</td>
<td>• Any non-medico-legal death;</td>
</tr>
<tr>
<td></td>
<td>• Any AWA involving a member who does not meet the criteria above;</td>
<td>• Any medico-legal death is any death required to be reported to the Medical Examiner or in which the Medical Examiner takes jurisdiction;</td>
<td>• Any absence without authorization from a facility involving a member who does not meet the criteria for a sentinel event as described above;</td>
</tr>
<tr>
<td></td>
<td>• Any injury while in a 24-hour program that could or did result in transportation to an acute care hospital for medical treatment or hospitalization;</td>
<td>• 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;</td>
<td>• Any physical assault or alleged physical assault</td>
</tr>
<tr>
<td></td>
<td>• Any sexual assault or alleged sexual assault;</td>
<td>• Any serious injury resulting in</td>
<td>•</td>
</tr>
<tr>
<td></td>
<td>• Any physical assault or alleged physical assault by a staff person or another patient;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Download Adverse Incident Report Form
Click here for phone numbers
against a member;
• Any medication error or suicide attempt that requires medical attention beyond general first aid procedures;
• Any unscheduled event that results in the temporary evacuation of a program or facility (e.g. fire resulting in response by fire department);
• Any unscheduled event that results in the evacuation of a program or facility whereby regular operations will not be in effect by the end of the business day and may result in the need for finding alternative placement options for member.

hospitalization for medical treatment;
• A serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is subsequently medically admitted;
• Any medication error or suicide attempt that requires medical attention beyond general first aid procedures;
• Any sexual assault or alleged sexual assault;
• Any physical assault or alleged physical assault by a staff person against a member; and
• Any unscheduled event that results in the evacuation of a program or facility whereby regular operations will not be in effect by the end of the business day and may result in the need for finding alternative placement options for member.

by or against a member that does not meet the criteria of a sentinel event;
• Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization;
• A serious injury, defined as any injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted; and
• Any unscheduled event that results in the temporary evacuation of a program or facility such as a small fire that requires fire department response. Data regarding critical incidents is gathered in the aggregate and trended on a quarterly basis for the purpose of identifying opportunities for quality improvement.
3.3 Reportable Incidents and Events – Overview

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

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

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

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

**Examples of Member Fraud and Abuse:** Under/unreported income, household membership (spouse/absent parent), out of state residence, third party liability or narcotic use/sales/distribution. This list is not inclusive of all examples of potential member fraud.
Beacon continuously monitors potential fraud and abuse by providers and members, as well as member representatives. Beacon reports suspected fraud and abuse to the health plan in order to initiate the appropriate investigation. The Plan will then report suspected fraud or abuse in writing to the correct authorities.

**FEDERAL FALSE CLAIMS ACT**

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

**SUMMARY OF PROVISIONS**

The FCA imposes civil liability on any person who knowingly:

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

**PENALTIES**

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

**QUI TAM (WHISTLEBLOWER) PROVISIONS**

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

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

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

**NON-RETELATION AND ANTI-DISCRIMINATION**

Anyone initiating a qui tam case may not be discriminated or retaliated against in any manner by their employer. The employee is authorized under the FCA to initiate court proceedings for any job-related losses resulting from any such discrimination or retaliation.
REDUCED PENALTIES
The FCA includes a provision that reduces the penalties for providers who promptly self-disclose a suspected FCA violation. The Office of Inspector General self-disclosure protocol allows providers to conduct their own investigations, take appropriate corrective measures, calculate damages and submit the findings that involve more serious problems than just simple errors to the agency.

If any member or provider becomes aware of any potential fraud by a member or provider, please contact us at 877.380.9729 and ask to speak to the Compliance Officer.

COMPLAINTS
Providers with complaints or concerns should contact Beacon at the number provided below and ask to speak with the clinical manager for Humana – CareSource™. All provider complaints are thoroughly researched by Beacon and resolutions proposed within 20 business days.

If a Humana – CareSource™ member complains or expresses concern regarding Beacon’s procedures or services, Plan procedures, covered benefits or services, or any aspect of the member’s care received from providers, they should be directed to call Beacon’s ombudsperson at 877.380.9729 (or TTY at 866.727.9441).

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

Humana – CareSource™ will review and provide a timely response and resolution of all grievances that are submitted by members, authorized member representative (AMR), and/or providers. Every grievance is thoroughly investigated, and receives fair consideration and timely determination.

Providers may register their own grievances and may also register grievances on a member’s behalf. Members, or their guardian or representative on the member’s behalf, may also register grievances. Grievances should be sent to:

Humana – CareSource™
Grievance and Appeals Specialist
P.O. Box 4760
Louisville, KY 40204

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

For both urgent and non-urgent grievances, the resolution letter informs the member or member’s representative to contact Humana – CareSource™’s Ombudsperson in the event that they are dissatisfied with Humana – CareSource™’s resolution.

Member and provider concerns about a denial of requested clinical service, adverse utilization management decision, or an adverse action, are not handled as grievances. See UM Reconsiderations and Appeals in Chapter 4, Utilization Management.
CHAPTER 4

Care Management and Utilization Management

4.1 Care Management

4.2 Utilization Management

4.3 Medical Necessity

4.4 Level-of-Care Criteria (LOCC)

4.5 Utilization Management Terms and Definitions
   Authorization Procedures and Requirements
   Member Eligibility Verification

4.6 Emergency Services
   Definition
   Emergency Screening and Evaluation
   Beacon Clinician Availability
   Disagreement Between Beacon and Attending Physician

4.7 Authorization Requirements
   Outpatient Treatment (Initial Encounters)
   Inpatient Services
   Return of Inadequate or Incomplete Treatment Requests
   Notice of Inpatient/Diversionary Approval or Denial
   Termination of Outpatient Care
   Decision and Notification Timeframes
4.1 Care Management

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

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

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

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

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

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

ICM and Care Coordination are voluntary programs and member consent is required for participation. For further information on how to refer a member to care management services, please contact the Beacon Health Strategies at 877.380.9729.

4.2 Utilization Management

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

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

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

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

4.3 Medical Necessity

All requests for authorization are reviewed by Beacon clinicians based on the information provided, according to the definition of medical necessity that is outlined in the Kentucky Administrative Regulations. 907 KAR 3:130 defines medical necessity in the following way:
Medical necessity means a covered benefit is: Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; Clinically appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice; Provided for medical reasons rather than primarily for the convenience of the individual, the individual’s caregiver, or the health care provider, or for cosmetic reasons; Provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided; Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 U.S.C. 1396d(r) and 42 CFR Part 441 Subpart B for individuals under twenty-one (21) years of age; and Provided in accordance with 42 CFR 440.230.”

4.4 Level-of-Care Criteria (LOCC)

Beacon’s LOCC, are the basis for all medical necessity determinations; accessible through eServices, includes Beacon’s specific LOCC for Kentucky for each level-of-care. Providers can also Contact Us to request a printed copy of Beacon’s LOCC.

Beacon’s LOCC were developed from the comparison of national, scientific and evidence-based criteria sets, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), Substance use and Behavioral health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). They are reviewed and updated annually or more often as needed to incorporate new treatment applications and technologies that are adopted as generally accepted professional medical practice.

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

4.5 Utilization Management Terms and Definitions

The definitions below describe utilization review including the types of the authorization requests and UM determinations as used to guide Beacon’s UM reviews and decision-making. All determinations are based upon review of the information provided and available to Beacon at the time.
<table>
<thead>
<tr>
<th>TABLE 4-1: UM TERMS AND DEFINITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adverse Determination:</strong> A decision to deny, terminate; or modify (an approval of fewer days, units or another level-of-care other than was requested, which the practitioner does not agree with) an admission, continued inpatient stay, or the availability of any other behavioral health care service, for</td>
</tr>
<tr>
<td>a. failure to meet the requirements for coverage based on medical necessity,</td>
</tr>
<tr>
<td>b. appropriateness of health care setting and level-of-care effectiveness, or</td>
</tr>
<tr>
<td>c. Health plan benefits.</td>
</tr>
<tr>
<td><strong>Adverse Action:</strong> The following actions or inactions by Beacon or the provider organization:</td>
</tr>
<tr>
<td>1. Beacon’s denial, in whole or in part, of payment for a service failure to provide covered services in a timely manner in accordance with the waiting time standards;</td>
</tr>
<tr>
<td>2. Beacon’s denial or limited authorization of a requested service, including the determination that a requested service is not a covered service;</td>
</tr>
<tr>
<td>3. Beacon’s reduction, suspension, or termination of a previous authorization for a service;</td>
</tr>
<tr>
<td>4. Beacon’s denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including but not limited to denials based on the following:</td>
</tr>
<tr>
<td>a. Failure to follow prior authorization procedures</td>
</tr>
<tr>
<td>b. Failure to follow referral rules</td>
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<tr>
<td>c. Failure to file a timely claim</td>
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<tr>
<td>5. Beacon’s failure to act within the timeframes for making authorization decisions</td>
</tr>
<tr>
<td>6. Beacon’s failure to act within the timeframes for making appeal decisions.</td>
</tr>
<tr>
<td><strong>Non-Urgent Concurrent Review &amp; Decision</strong> Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments. A non-urgent concurrent decision may authorize or modify requested treatment over a period of time or a number of days or treatments, or deny requested treatment, in a non-acute treatment setting.</td>
</tr>
<tr>
<td><strong>Non-Urgent Pre-Service Review &amp; Decision</strong> Any case or service that must be approved before the member obtains care or services. A non urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment, in non-acute treatment setting.</td>
</tr>
<tr>
<td><strong>Post-Service Review &amp; Decision (Retrospective Decision)</strong> Any review for care or services that have already been received. A post-service decision would authorize, modify or deny payment for a completed course of treatment where a pre-service decision was not rendered, based on the information that would have been available at the time of a pre-service review.</td>
</tr>
</tbody>
</table>
AUTHORIZATION PROCEDURES AND REQUIREMENTS

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

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

MEMBER ELIGIBILITY VERIFICATION

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

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

DEFINITION
Emergency services are those physician and outpatient hospital services, procedures, and treatments, including psychiatric stabilization and medical detoxification from drugs or alcohol, needed to evaluate or stabilize an emergency medical condition. The definition of an emergency is listed in your PSA.

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

EMERGENCY SCREENING AND EVALUATION
Plan members must be screened for an emergency medical condition by a qualified behavioral health professional from the hospital emergency room, mobile crisis team, or by an emergency service program (ESP). This process allows members access to emergency services as quickly as possible and at the closest facility or by the closest crisis team.

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

BEACON CLINICIAN AVAILABILITY
All Beacon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures. Beacon clinicians are available 24 hours a day, 7 days a week, to take emergency calls from members, their guardians, and providers. If Beacon does not respond to a request for authorization call within 30 minutes, authorization for medically necessary treatment can be assumed and the reference number will be communicated to the requesting facility/provider by the Beacon UR clinician within four hours.

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

**OUTPATIENT TREATMENT (INITIAL ENCOUNTERS):**
Humana – CareSource™ members are allowed 12 initial therapy sessions without prior authorization. These sessions, called initial encounters or IEs, must be provided by contracted in-network providers, and are subject to meeting medical necessity criteria.

To ensure payment for services, providers are strongly encouraged to ask new patients if they have been treated by other therapists. Via eServices, providers can look up the number of IEs that have been billed to Beacon, however the member may have used additional visits that have not been billed. If the member has used some IEs elsewhere, the new provider is encouraged to contact Beacon before beginning treatment. These initial encounters are not renewed annually, rather are applied towards each member’s episode of care. An episode of care is defined as continuous treatment with no gap greater than six months. A member is considered new to outpatient treatment if the member has not been in outpatient treatment within the previous six month period as a Humana – CareSource™ member.

**The following services count against the member’s 12 IEs:**
1. Outpatient behavioral health, including individual and family therapy
2. Outpatient substance use services (covered for pregnant/post-partum women only)
3. Combined psychopharmacology and therapy visits (CPT Codes 90805 and 90807).

**The following services require no authorization and do not count against the member’s IEs.**
1. Medication management sessions (90862, 96372); and
2. Group therapy sessions (CPT code 90853); and
3. Collateral therapy (90887)

The following table outlines the authorization requirements for each service. Please refer to your contract for specific information about procedure and revenue codes that should be used for billing. Services that indicate “eRegister” will be authorized via Beacon’s eServices portal. Providers will be asked a series of clinical questions to support medical necessity for the service requested. If sufficient information is provided to support the request, the service will be authorized. If additional information is needed, the provider will be prompted to contact Beacon via phone to continue the request for authorization. While Beacon prefer providers to make requests via eServices, we will work with providers who do have technical or staffing barriers to requesting authorizations in this way.

**TABLE 4-2: OUTPATIENT SERVICES**

<table>
<thead>
<tr>
<th>Benefit/Service</th>
<th>Authorization Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication management</td>
<td>No authorization required for medication management, injections, collateral therapy, group counseling or evaluations.</td>
</tr>
<tr>
<td>Injection Administration</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Interview</td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td></td>
</tr>
<tr>
<td>Individual Therapy</td>
<td>All other services count towards a member’s 12 initial encounters. Electronic Outpatient Request Form (eORF) required before the 21th visit. Clinical information must support the frequency and intensity of the requested service. Additional units authorized will be based on the clinical information provided to Beacon. Forms can be submitted via fax to 781-994-7633.</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td></td>
</tr>
<tr>
<td>Family Therapy</td>
<td></td>
</tr>
<tr>
<td>Group Therapy</td>
<td></td>
</tr>
<tr>
<td>Collateral Services (under 21)</td>
<td></td>
</tr>
</tbody>
</table>

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TABLE 4-3: COMMUNITY BASED SERVICES

<table>
<thead>
<tr>
<th>Benefit/Service</th>
<th>Notification Requirement</th>
<th>Initial Authorization Parameters (All determinations based on medical necessity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Rehabilitation Services</td>
<td>eServices authorization within 2 weeks of initial date of service</td>
<td>Authorization as requested, up to 4 hours daily for initial 30 days. Request additional visits through eServices prior to 30th day of service for CSR.</td>
</tr>
<tr>
<td>(Adult and Child)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>Telephonic Prior Authorization</td>
<td>Initial authorization up to 6 hours days/per week; weekly telephonic CSR.</td>
</tr>
<tr>
<td>Targeted Case Management</td>
<td>eServices authorization within 2 weeks of initial date of service</td>
<td>Initial authorization up to 16 visits per month for initial 90 days. Request additional visits through eServices prior to 90th day of service for CSR.</td>
</tr>
<tr>
<td>Emergency Services/Mobile Crisis</td>
<td>No authorization required</td>
<td>No authorization required</td>
</tr>
<tr>
<td>Personal Care Services; Home Visit (WRAP):</td>
<td>eServices authorization within 2 weeks of initial date of service</td>
<td>Initial authorization, up to 16 units for initial 30 days. Request additional visits through eServices prior to the 30th day of service.</td>
</tr>
<tr>
<td>Community Psychiatric Support Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Authorization decisions are posted on eServices within the decision timeframes outlined below. Providers receive an email message alerting them that a determination has been made. Beacon also faxes authorization letters to providers upon request; however we strongly encourage providers to use eServices instead of receiving paper notices. Providers can opt out of receiving paper notices on Beacon’s eServices portal. All notices clearly specify the number of units (sessions) approved, the timeframe within which the authorization can be used, and explanation of any modifications or denials. All denials can be appealed according to the policies outlined in this Manual.

Authorization decisions are posted on eServices within the decision timeframes outlined below. Providers receive an email message alerting them that a determination has been made. Beacon also faxes authorization letters to providers upon request; however we strongly encourage providers to use eServices instead of receiving paper notices. Providers can opt out of receiving paper notices on Beacon’s eServices portal. All notices clearly specify the number of units (sessions) approved, the timeframe within which the authorization can be used, and explanation of any modifications or denials. All denials can be appealed according to the policies outlined in this Manual.

All forms can be found at beaconhealthstrategies.com under Provider

INPATIENT SERVICES
All inpatient services (including inpatient ECT) require telephonic prior authorization within 24 hours of admission. Providers should call Beacon at 877.380.9729 for all inpatient admissions, including detoxification that is provided on a psychiatric floor or in freestanding psychiatric facilities. All other requests for authorization for detoxification should be directed to Humana – CareSource™ 1.855.852.7005. Admissions to Crisis Stabilization Units (for children/adolescents only) do not require authorization until after the first 48 hours and are authorized for up to a maximum of 10 days. Beacon typically authorizes inpatient stays in 2-3 day increments, depending on medical necessity. Continued stay reviews require updated clinical information that demonstrates active treatment. Additional information about what is required during preservice and concurrent stay reviews is listed below.
TABLE 4-4: UM REVIEW REQUIREMENTS – INPATIENT AND DIVERSIONARY

<table>
<thead>
<tr>
<th>Pre-Service Review</th>
<th>Continued Stay (Concurrent) Review</th>
<th>Post-Service Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>The facility clinician making the request needs the following information for a pre-service review:</td>
<td>To conduct a continued stay review, call a Beacon UR clinician with the following required information:</td>
<td>Post-service reviews may be conducted for inpatient, diversionary or outpatient services rendered when necessary. To initiate a post-service review, call Beacon. If the treatment rendered meets criteria for a post-service review, the UR clinician will request clinical information from the provider including documentation of presenting symptoms and treatment plan via the member’s medical record. Beacon requires only those section(s) of the medical record needed to evaluate medical necessity and appropriateness of the admission, extension of stay, and the frequency or duration of service. A Beacon physician or psychologist advisor completes a clinical review of all available information, in order to render a decision.</td>
</tr>
<tr>
<td>• Member’s health plan Identification number;</td>
<td>• Member’s current diagnosis and treatment plan, including physician’s orders, special procedures, and medications;</td>
<td></td>
</tr>
<tr>
<td>• Member’s name, gender, date of birth, and city or town of residence;</td>
<td>• Description of the member’s response to treatment since the last concurrent review;</td>
<td></td>
</tr>
<tr>
<td>• Admitting facility name and date of admission;</td>
<td>• Member’s current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan;</td>
<td></td>
</tr>
<tr>
<td>• DSM IV diagnosis: All five axes are appropriate; Axis I and Axis V are required. (A provisional diagnosis is acceptable);</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Description of precipitating event and current symptoms requiring inpatient psychiatric care;</td>
<td>Report of any medical care beyond routine is required for coordination of benefits with health plan (Routine medical care is included in the per diem rate).</td>
<td></td>
</tr>
<tr>
<td>• Medication history;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Substance use history;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prior hospitalizations and psychiatric treatment;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Member’s and family’s general medical and social history; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommended treatment plan relating to admitting symptoms and the member’s anticipated response to treatment.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Authorization determinations are based on the clinical information available at the time the care was provided to the member.
Members must be notified of all pre-service and concurrent denial decisions. Members are notified by courier of all acute pre-service and concurrent denial decisions. For members in inpatient settings, the denial letter is delivered by courier to the member on the day the adverse determination is made, prior to discharge. The service is continued without liability to the member until the member has been notified of the adverse determination. The denial notification letter sent to the member or member’s guardian, practitioner, and/or provider includes the specific reason for the denial decision, the member’s presenting condition, diagnosis, and treatment interventions, the reason(s) why such information does not meet the medical necessity criteria, reference to the applicable benefit provision, guideline, protocol or criterion on which the denial decision was based, and specific alternative treatment option(s) offered by Beacon, if any. Based on state and/or federal statutes, an explanation of the member’s appeal rights and the appeals process is enclosed with all denial letters. Notice of inpatient authorization is mailed to the admitting facility. Providers can request additional copies of adverse determination letters by contacting Beacon.

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

NOTICE OF INPATIENT/DIVERSIONARY APPROVAL OR DENIAL
Verbal notification of approval is provided at the time of pre-service or continuing stay review. Notice of admission or continued stay approval is mailed to the member or member’s guardian and the requesting facility within the timeframes specified later in this chapter.

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

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

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

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

The timeframes below present Beacon’s internal timeframes for rendering a UM determination, and notifying members of such determination. All timeframes begin at the time of Beacon’s receipt of the request. Please note, the maximum timeframes may vary from those on the table below on a case-by-case basis in accordance with state, federal government, NCQA or URAC requirements that have been established for each line of business.
<table>
<thead>
<tr>
<th>TABLE 4-5: DECISION AND NOTIFICATION TIMEFRAMES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Decision</strong></td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td><strong>Pre-Service Review</strong></td>
</tr>
<tr>
<td>Initial Auth for Inpatient Behavioral Health Emergencies</td>
</tr>
<tr>
<td>Initial Auth for Non Emergent Inpatient Behavioral Health Services</td>
</tr>
<tr>
<td>Initial Auth for Other Urgent Behavioral Health Services</td>
</tr>
<tr>
<td>Initial Auth for Non Urgent Behavioral Health Services</td>
</tr>
<tr>
<td><strong>Concurrent Review</strong></td>
</tr>
<tr>
<td>Continued Auth for Inpatient and Other Urgent Behavioral Health Services</td>
</tr>
<tr>
<td>Continued Auth for Non Urgent Behavioral Health Services</td>
</tr>
<tr>
<td><strong>Post Service</strong></td>
</tr>
<tr>
<td>Authorization for Behavioral Health Services Already Rendered</td>
</tr>
</tbody>
</table>

When the specified timeframes for standard and expedited prior authorization requests expire before Beacon makes a decision, an adverse action notice will go out to the member on the date the timeframe expires.
CHAPTER 5

Clinical Reconsideration and Appeals

Request for Reconsideration of Adverse Determination

5.1 Provider Appeals

How to Submit a Provider Grievance or Appeal
Member Grievance, Appeals, and Fair Hearing Requests
REQUEST FOR RECONSIDERATION OF ADVERSE DETERMINATION

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

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

5.1 Provider Appeals

Provider Appeals and Grievance Procedures

You have the right to file a grievance or an appeal with Humana – CareSource™ regarding:

1. A Provider payment issue; or
2. A contractual issue.

If you do not agree with a decision of the processed claim, you will have two years from the date of service or discharge to file an appeal. If the claims appeal is not submitted in the required timeframe the claim will not be considered and the appeal will be denied. If the appeal is denied, Providers will be notified in writing. If the appeal is approved, payment will show on the Provider’s Explanation of Payment (EOP).

Humana ChoiceCare shall resolve a provider grievance or appeal within thirty (30) calendar days. Humana ChoiceCare may request a fourteen (14) day extension from you to resolve your grievance or appeal. We will extend the review of your grievance or appeal if you request the extension.

Please note: If you believe the claim processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. You do not need to file an appeal. Providers have 365 days from the date of service or discharge to submit a corrected claim.

HOW TO SUBMIT A PROVIDER GRIEVANCE OR APPEAL

Claims Appeals:
Providers can submit claims through our secure Provider Portal, or in writing:

Provider Portal: https://providerportal.caresource.com/KY

Under the Provider Portal, click on the “Claims Appeals” tab on the left

Writing: Use the “Provider Claim Appeal Request Form” located in this manual or on our website. Please include:

- The Member’s name and Humana – CareSource™ Member ID number
- The Provider’s name and ID number
- The code(s) and reason why the determination should be reconsidered
- If you are submitting a Timely Filing appeal, you must send proof of original receipt of the appeal by fax or Electronic Data Information (EDI) for reconsideration
• If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination.

**Mail:**
Humana – CareSource™
Attn: Provider Appeals
P.O. Box 823
Dayton, OH 45401
Fax: 937.531.2398

**MEMBER GRIEVANCE, APPEALS, AND FAIR HEARING REQUESTS**
Members have the right to file a grievance or appeal. They also have the right to request a State Hearing once they have exhausted their appeal rights. As a Humana – CareSource™ Provider we may contact you to obtain documentation when a Member has filed a grievance or appeal or has requested a State Hearing. State and Federal agencies require Humana – CareSource™ to comply with all requirements, which include aggressive resolution timeframes. Members are encouraged to call or write to Humana – CareSource™ to let us know of any complaints regarding Humana – CareSource™ or the health care services they receive. Members or legal guardians may file a grievance or appeal with Humana – CareSource™. Representative and providers, with the member’s written consent, may also file a grievance or appeal with Humana – CareSource™. Detailed grievance and appeal procedures are explained in the Member Handbook. Members, legal guardians, or Providers can contact Humana – CareSource™ at 1.855.852.7005 (TTY: 1.800.648.6056 or 711) to learn more about these procedures.

**Member Grievances**
Any time a Member informs us that they are dissatisfied with Humana – CareSource™, or one of our Providers, it is a grievance. A member has thirty (30) calendar days from the date of an event causing dissatisfaction to file a grievance orally or in writing with Humana – CareSource™. Humana – CareSource™ investigates all grievances. If the grievance is about a Provider, Humana – CareSource™ calls the Provider’s office to gather information for resolution. Humana – CareSource™ has five (5) working days of receipt of the grievance to notify the member that the grievance has been received and when resolution of the grievance is expected. An investigation and final resolution of a grievance shall be completed within thirty (30) days of the date the grievance is received by Humana – CareSource™.

**Member Appeals**
Members have the right to appeal an adverse action or decision made by Humana – CareSource™. An adverse action for the purpose of an appeal is:

- the denial or limited authorization of a requested service, including the type or level of service;
- the reduction, suspension, or termination of a previously authorized service;
- the denial, in whole or in part, of payment for a service;
- the failure of the Humana – CareSource™ to provide services in a timely manner, as defined by the Department or its designee; or
- the failure of the Humana – CareSource™ to complete the authorization request in a timely manner as defined in 42 CFR 438.408.

Members have the right to appeal the decisions or actions listed above if they contact Humana – CareSource™ within 30 calendar days of receiving the notice of adverse action. Any timely oral appeal must be followed by a written appeal that is signed by the enrollee within ten (10) calendar days. Within five (5) work days of receipt of an appeal, Humana – CareSource™ shall provide the member with written notice that the appeal has been received and the expected date of its resolution, unless an expedited resolution has been requested.

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

**State Fair Hearings**

Once Members have exhausted their appeal rights they can request a state fair hearing if Humana – CareSource™ makes a decision to deny, reduce, suspend or stop care for a Member. Members have 30 days from receiving Humana – CareSource™’s final decision to file a state fair hearing.

If Humana – CareSource™ proposes to reduce, suspend or terminate a service already approved, Members may request continuation of benefits until a state fair hearing is held; however, the Member may be liable for the cost. Members may request a state fair hearing through the Department for Medicaid Services. They can submit their request in writing, by fax, or in person to:

Kentucky Department for Medicaid Services  
Division of Administration and Financial Management  
275 East Main St., 6W-C  
Frankfort, KY 40621  
Fax number: 502.564.6917  
For questions, they can call them at 1.800.635.2570.

**How to Submit Appeals**

There are three ways to submit appeals: through our Provider Portal, by fax or in writing.

a) **Provider Portal**: https://providerportal.caresource.com/KY

b) **Fax**: 1.855.262.9793

c) **Writing**:  
Humana – CareSource™  
Attn: Provider Appeals - Clinical  
P.O. Box 823  
Dayton, OH 45401

**Administrative Appeal Process**

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

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

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

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

- **Second Level** administrative appeals for Plan members should be submitted in writing to the Chief Operations Officer at Beacon. A decision is made within 20 business days of receipt of appeal information and notification of decision is sent within three business days of appeal determination.
CHAPTER 6
Billing Transactions

6.1 General Claim Policies
Definition of “Clean Claim"
Electronic Billing Requirements
Provider Responsibility
Limited Use of Information
Prohibition of Billing Members
Beacon’s Right to Reject Claims
Recoupments and Adjustments by Beacon
Claim Turnaround Time
Coding
Modifiers
Time Limits for Filing Claims
Coordination of Benefits (COB)

6.2 Provider Education and Outreach
Summary
How the Program Works
Claim Inquiries and Resources
Electronic Media Options
Claim Transaction Overview
Paper Claim Transactions
Paper Resubmission
Paper Submission of 180-Day Waiver
Completion of the Waiver Request Form
Paper Request for Adjustment or Void
IMPACT Plus Claims

6.3 IMPACT Plus
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.

6.1 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 utilizing the services of a billing agency must ensure through legal contract (a copy of which must be made available to Beacon upon request) the responsibility of a billing service to report claim information as directed by the provider in compliance with all policies stated by Beacon.

**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. See Chapter 2, Prohibition on Billing Members for more information.

**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 and be billed in accordance with the National Uniform Billing Committee (NUBC) standards.

* All UB04 claims must include the 3-digit bill type code and billed in accordance with the National Uniform Billing Committee (NUBC) standards.

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 6-3 lists some HIPAA-compliant modifiers accepted by Beacon. Please see your Behavioral Health Services Agreement for Modifiers that you are included in your contract.

TABLE 6-1: MODIFIERS

<table>
<thead>
<tr>
<th>HIPAA Modifier</th>
<th>Modifier Description</th>
<th>HIPAA Modifier</th>
<th>Modifier Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AH</td>
<td>Clinical Psychologist</td>
<td>HR</td>
<td>Family/couple with client present</td>
</tr>
<tr>
<td>AJ</td>
<td>Clinical Social Worker</td>
<td>HS</td>
<td>Family/couple without client present</td>
</tr>
<tr>
<td>HA</td>
<td>Child/Adolescent program</td>
<td>HT</td>
<td>Multi-disciplinary team</td>
</tr>
<tr>
<td>HB</td>
<td>Adult program, non-geriatric</td>
<td>HU</td>
<td>Funded by child welfare agency</td>
</tr>
<tr>
<td>HC</td>
<td>Adult program, geriatric</td>
<td>HW</td>
<td>Funded by state behavioral health agency</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>HD</th>
<th>Pregnant/ parenting women's program</th>
<th>HX</th>
<th>Funded by county/ local agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>HE</td>
<td>Behavioral health program</td>
<td>SA</td>
<td>Nurse Practitioner (This modifier required when billing 90862 performed by a nurse practitioner.)</td>
</tr>
<tr>
<td>HF</td>
<td>Substance use program</td>
<td>SE</td>
<td>State and/or federally funded programs/services</td>
</tr>
<tr>
<td>HG</td>
<td>Opioid addiction treatment program</td>
<td>TD</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>HH</td>
<td>Integrated behavioral health/substance use program</td>
<td>TF</td>
<td>Intermediate level of care</td>
</tr>
<tr>
<td>HI</td>
<td>Integrated behavioral health and mental retardation/ developmental disabilities program</td>
<td>TG</td>
<td>Complex/ high level of care</td>
</tr>
<tr>
<td>HJ</td>
<td>Employee assistance program</td>
<td>TH</td>
<td>Obstetrics</td>
</tr>
<tr>
<td>HK</td>
<td>Specialized behavioral health programs for high-risk populations</td>
<td>TJ</td>
<td>Program group, child and/or adolescent</td>
</tr>
<tr>
<td>HL</td>
<td>Intern</td>
<td>TR</td>
<td>School-based individualized education program (IEP) services provided outside the public school district responsible for the student</td>
</tr>
<tr>
<td>HM</td>
<td>Less than bachelor degree level</td>
<td>UK</td>
<td>Service provided on behalf of the client to someone other than the client-collateral relationship</td>
</tr>
<tr>
<td>HN</td>
<td>Bachelor’s degree level</td>
<td>U3</td>
<td>Psychology Intern</td>
</tr>
<tr>
<td>HO</td>
<td>Master’s degree level</td>
<td>U4</td>
<td>Social Work Intern</td>
</tr>
<tr>
<td>HP</td>
<td>Doctoral level</td>
<td>U6</td>
<td>Psychiatrist (This modifier required when billing for 90862 provided by a psychiatrist)</td>
</tr>
<tr>
<td>HQ</td>
<td>Group setting</td>
<td>UD</td>
<td>Substance Abuse Service</td>
</tr>
</tbody>
</table>

**TIME LIMITS FOR FILING CLAIMS**

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

- Within **180** days of the dates of service on outpatient claims
- Within **180** days of the date of discharge on inpatient claims, or

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the **180**-day filing limit will deny unless submitted as a waiver or reconsideration request, as described in this chapter.

**COORDINATION OF BENEFITS (COB)**

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

- When it is determined that Beacon Health Strategies is the secondary payer, claims must be submitted with a copy of the primary insurance’s explanation of benefits report and received by Beacon within 60 days of the date on the EOB.
• Beacon Health Strategies reserves to right of recovery for all claims in which a primary payment was made prior to receiving cob information that deems Beacon the secondary payer. Beacon applies all recoupments and adjustments to future claims processed, and reports such recoupments and adjustments on the EOB.

6.2 Provider Education and Outreach

SUMMARY
In an effort to help providers that may be experiencing claims payment issues, Beacon runs quarterly reports identifying those providers 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% 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
Additional information is available through the following resources:

Online at http://www.beaconhealthstrategies.com/providers.html
• 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.

- **Beacon’s Main Telephone Numbers**
  Provider Relations 877.380.9729
  EDI 877.380.9729
  TTY 866.727.9441

**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 ID045:

- **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 6-2 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 6-2: CLAIM TRANSACTION OVERVIEW**

<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 eServices IVR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member Eligibility Verification</td>
<td>Y Y Y</td>
<td>• Completing any claim transaction; and&lt;br&gt;• Submitting clinical authorization requests</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Submit Standard Claim</td>
<td>Y Y N</td>
<td>Submitting a claim for authorized, covered services, within the timely filing limit</td>
<td>Within 180 days after the date of service</td>
<td>N/A</td>
</tr>
<tr>
<td>Resubmission of Denied Claim</td>
<td>Y Y N</td>
<td>Previous claim was denied for any reason except timely</td>
<td>Within 180 days after the date of service</td>
<td>• Claims denied for late filing may be</td>
</tr>
<tr>
<td>180-Day Waiver* (Request for waiver of timely filing limit)</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>A claim being submitted for the first time will be received by Beacon after the original 180-day filing limit, and must include evidence that one of the following conditions is met:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provider is eligible for reimbursement retroactively; or</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Member was enrolled in the plan retroactively; or</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Services were authorized retroactively.</td>
<td></td>
<td></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 of benefits or payment is required.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 180 days from the qualifying event</td>
<td></td>
<td></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>
<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>
<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>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Request for Reconsideration of Timely Filing Limit*</th>
<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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 180 days from the date of payment or nonpayment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future EOB shows “Reconsideration Approved” or “Reconsideration Denied” with denial reason.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Request to Void Payment</th>
<th>N</th>
<th>N</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Claim was paid to provider in error; and</td>
<td>N/A</td>
<td>Do NOT send a refund check to Beacon.</td>
<td></td>
</tr>
<tr>
<td>• Provider needs to return the entire paid amount to Beacon.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Request for Adjustment (Corrected Claims)</th>
<th>Y</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The amount paid to provider on a claim, was incorrect.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Positive request must be received</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Do NOT send a refund check to Beacon.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A Rec ID is</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Adjustment may be requested to correct:
  o Underpayment (positive request); or
  o Overpayment (negative request).

  by Beacon within 180 days from the date of original payment.

• No filing limit applies to negative requests.

• Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount and, if money is owed to the 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.

<table>
<thead>
<tr>
<th>Obtain Claim Status</th>
<th>N</th>
<th>Y</th>
<th>Y</th>
<th>Available 24/7 for all claim transactions submitted by provider.</th>
<th>N/A</th>
<th>Claim status is posted within 48 hours after receipt by Beacon.</th>
</tr>
</thead>
<tbody>
<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.

**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.

Paper claim submission must be done using the most current form version as designated by the Centers for Medicare and Medicaid Services (CMS), National Uniform Claim Committee (NUCC). We cannot accept handwritten claims or SuperBills.

Detailed instructions for completing each form type are available at the websites below.
- CMS 1500 Form Instructions
- UB-04 Form Instructions: www.nucc.org

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

Beacon does not accept claims transmitted by fax.

**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 6-2 for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.

- If the resubmitted claim is received by Beacon more than 180 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.
  - Submit the corrected claim with a copy of the EOB for the corresponding date of service; or

- **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 180 days after the date on the EOB. A claim package postmarked on the 180th day is not valid.**

- If the resubmitted claim is received by Beacon within 180 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 180-DAY WAIVER**

- See Table 6-2 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 180-Day Waiver Form
- Complete a 180-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 / Waivers   
  500 Unicorn Park Drive, Suite 401   
  Woburn, MA 01801-3393

**COMPLETION OF THE WAIVER REQUEST FORM**

To ensure proper resolution of your request, complete the 180-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 180-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 6-2 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 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 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”.

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

**IMPACT PLUS CLAIMS**
IMPACT Plus claims must be submitted with the following information in order to ensure proper payment and processing:

- Commonwealth of KY IMPACT Plus Program Tax ID (not individual rendering site Tax ID)
- Site name in box 32 of the CMS 1500 form
- Site DCBS or DBH number in box 32a of the CMS form
- DCBS and DBH numbers should include the following qualifier: 0B

### 6.3 IMPACT Plus

Beacon does not contract directly with IMPACT Plus providers. Instead, Beacon contracts directly with the State who holds contracts with IMPACT Plus providers throughout the region. IMPACT Plus services are available to Humana – CareSource™ members according to the eligibility criteria outlined in 907 KAR 3:030. Beacon is responsible for screening members for eligibility and for making medical necessity determinations for IMPACT Plus Services. Providers must submit applications for eligibility directly to Beacon via fax 781.994.7633 or eServices. Incomplete applications will not be accepted. Beacon utilizes the state IMPACT Plus application form.

Eligibility materials can be found on eServices or on the following Kentucky DBHDID link: [http://dbhdid.ky.gov/dbh/impactplusforms.asp](http://dbhdid.ky.gov/dbh/impactplusforms.asp). Eligibility packets must be signed by a behavioral health professional or a behavioral health professional under supervision. Documentation of clinical need must be sufficient to support the intensity of service provided under IMPACT Plus. Providers must follow the guidelines outlined in the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) IMPACT Plus User’s Manual for the provision and documentation of all IMPACT Plus Services.

Beacon will adhere to the maximum service limits outlined in the DBHDID IMPACT Plus User’s Manual. Covered services and authorization requirements are outlined in the table below.

<table>
<thead>
<tr>
<th>Benefits/Services</th>
<th>Cap Limit</th>
<th>Notification Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targeted Case Management</td>
<td>Minimum of 4 units per month minimum required.</td>
<td>Once approved for IMPACT Plus, the member will receive an initial authorization for all requested services up to the CAP limit with the exception of those services requiring prior authorization that are listed below. Collaborative Service Plans (CSP) which document medical necessity for requested services must be submitted to Beacon within 14 days of initial eligibility determination. Telephonic continued stay review is required for all services beyond the initial 30 days. Beacon’s UM/CM staff will review updates to the CSP when making...</td>
</tr>
<tr>
<td>Behavioral Health Evaluation</td>
<td>Max 5 hours per evaluation</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Child Support Services (professional and paraprofessional)</td>
<td>Max 16 units per day</td>
<td></td>
</tr>
<tr>
<td>Parent to Parent Services</td>
<td>Max 16 units per day</td>
<td></td>
</tr>
<tr>
<td>After School Program</td>
<td>Max 16 units per day</td>
<td></td>
</tr>
<tr>
<td>Service Type</td>
<td>Max Units/day/week</td>
<td>Notes</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Summer Program</td>
<td>Max 24 units per day</td>
<td>continued stay determinations to ensure active treatment and progress are being monitored.</td>
</tr>
<tr>
<td>Individual Therapy (including w/ MD)</td>
<td>Max of 16 units of 90884 and 90887 combined per day; Max of 48 units combined per week</td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>Max 5 hours per day</td>
<td></td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>Max 3 units per day; 9 units per week</td>
<td></td>
</tr>
<tr>
<td>Day Treatment</td>
<td>Max 7 units per day</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Foster Care</td>
<td>N/A</td>
<td>No authorization required for first 48 hours, then telephonic CSR</td>
</tr>
<tr>
<td>Therapeutic Group Residential</td>
<td>N/A</td>
<td>No authorization required for first 48 hours, then telephonic CSR</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td>Max of 10 consecutive units</td>
<td>No authorization required for first 48 hours, then telephonic CSR</td>
</tr>
</tbody>
</table>

Please also refer to the sections below, which are applicable to IMPACT Plus providers.

- **Members**
  - Section 1.9 Prohibition on Billing Members
  - Section 2.1 Members Benefits & Member-Related Policies

- **Quality Management**
  - Section 3.1 QM & I Program Overview
  - Section 3.2 Treatment Records

- **Utilization Management**
  - Section 4.2 Utilization Management
  - Section 4.3 Medical Necessity
  - Section 4.4 Level-of-Care Criteria (LOCC)
  - Section 4.5 Utilization Management Terms and Definitions
  - Section 4.7 Authorization Requirements

- **Grievance and Appeals**
  - Section 5.1 Provider Appeals

- **Claims**
  - Section 6.1 General Claim Policies

- **Provider Education**
  - Section 6.2 Provider Education and Outreach