Section 1
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NHP/Beacon Partnership

Neighborhood Health Plan (NHP) has contracted with Beacon Health Strategies LLC (Beacon), a Beacon Health Options company, to manage the delivery of mental health and substance use services for all NHP members. NHP delegates these areas of responsibility to Beacon:

- Claims processing and claims payment
- Member rights and responsibilities
- Member connections
- Provider contracting and credentialing
- Quality management and improvement
- Service authorization
- Utilization management/case management

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 provider services agreement with Beacon.

This 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 Sections 1–4. Detailed information regarding clinical processes, including authorizations, utilization review, case management, reconsiderations and appeals are found in Sections 5 and 6. Section 7 covers billing transactions and Beacon’s level-of-care criteria are presented in Sections 8–14, accessible only through eServices or by calling Beacon. More information is provided in “Appendix A: Beacon Forms.”

The Manual is posted on Beacon’s and NHP’s websites, www.beaconhealthoptions.com, www.nhp.org, and on Beacon’s eServices; only the version on eServices includes Beacon’s level-of-care criteria. Providers may request a printed copy by calling Beacon at 1-800-414-2820.

Updates to the manual as permitted by the provider services agreement are posted on Beacon’s and NHP’s 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 days’ notice unless the change is mandated sooner by state or federal requirements.

MassHealth

NHP has four MassHealth plans:
- MassHealth CommonHealth
- MassHealth Standard
- MassHealth Family Assistance
- MassHealth CarePlus

NHP’s plan coverage aligns with the MassHealth contractual coverage for these member groups. MassHealth Essential and MassHealth Basic plans terminated 12/31/13.

Commercial

NHP’s commercial plans include NHP Business Choice (including NHP Care) and NHP Prime. NHP Prime plans are merged market ACA-certified and available to groups of all sizes—large group and merged marked (small group and non-group). All NHP commercial plans meet minimum creditable coverage guidelines that have been established by the Massachusetts Department of Insurance (DOI).

Beacon Health Options

Beacon Health Strategies LLC (Beacon), a Beacon Health Options company, is a limited liability, managed behavioral health care company. Established in 1996, Beacon’s mission is to partner with NHP and contracted providers to improve the delivery of behavioral healthcare for the members we serve.

Beacon Health Options

Tel. 800-414-2820
TDD/TTY 781-994-7660
Hours Mon.– Fri. 8 a.m.– 6 p.m.,
Clinical Hours
Beacon’s clinical staff is available 24/7.
Behavioral Health Provider Manual

Introduction

NHP/Beacon Behavioral Health Program

The NHP/Beacon mental health and substance use program provides members with access to a full continuum of mental health and substance use services through Beacon’s 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 NHP members receive timely access to clinically appropriate behavioral health care services, NHP and Beacon believe that quality clinical services can achieve improved outcomes for our members.

Commonwealth of Massachusetts: Children’s Behavioral Health Initiative

The Children’s Behavioral Health Initiative (CBHI) is an undertaking of the Executive Office of Health and Human Services and MassHealth, along with the Massachusetts Managed Care Entities, to implement a behavioral health system of care targeted at the needs of children in the Commonwealth. It encompasses:

- Improved education and outreach to MassHealth members, providers, members of the public, and private and state agency staff who come into contact with MassHealth members for early periodic screening, diagnosis and treatment (EPSDT) services
- Implementation of standardized behavioral health screening as a part of EPSDT “well-child” visit
- Improved and standardized behavioral health assessments for eligible members who use behavioral health services
- The development of an information-technology system known as the virtual gateway, to track assessments, treatment planning and treatment delivery
- A requirement to seek federal approval to cover several new or improved community-based services.

Beacon and NHP are full and active participants in CBHI. All behavioral health services created under CBHI are contracted with Beacon and available to serve NHP MassHealth members under age 21; some CBHI services are available to all Medicaid youth.

For more information on the court order, and the elements of the state’s remedy plan, please visit the Children’s Behavioral Health Initiative website and Beacon’s CBHI web page.

More Information

- To get more information from Beacon:
- Return to the “Provider Tools” page of this website for detailed information about working with Beacon, frequently asked questions, clinical articles and practice guidelines, and links to additional resources.
- Call IVR at 1-888-210-2018 to check member eligibility, number of visits available and applicable copayments, confirm authorization, and get claim status.
- Log on to eServices to check member eligibility and number of visits available, submit claims and authorization requests, view claims and authorization status, view/print claim reports, update practice information, and use other
electronic tools for communication and transactions with Beacon.

- Email provider.relations@beaconhs.com.
  For other Beacon contact information, visit www.beaconhealthoptions.com or call 1-800-414-2820.

For benefit and other administrative information pertaining to medical/surgical care, visit www.nhp.org or call NHP at 1-800-462-5449.
## Section 2
Provider Participation in Beacon's Behavioral Health Services Network

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**Network Operations**

Beacon’s Network Operations Department, with Provider Relations, is responsible for procurement and administrative management of Beacon’s behavioral health provider network. As such, their role includes contracting, credentialing and provider relations functions. Representatives are easily reached by emailing provider.relations@beaconhs.com, or by phone Monday–Thursday 8:30 a.m. to 6:00 p.m., and Friday 8:30 a.m. to 5:00 p.m. Visit www.beaconhealthoptions.com for contact information.

**Contracting and Maintaining Network Participation**

A “participating provider” is an individual practitioner, private group practice, licensed outpatient agency, or facility that has been credentialed by Beacon and has signed a provider services agreement (PSA) with Beacon. Participating providers agree to provide mental health and/or substance abuse services to members, to accept reimbursement directly from Beacon according to Beacon Health Options NHP fee schedule, 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, they may notify the member of their termination, but in all cases Beacon will always notify members when their provider has been terminated.

**Electronic Tools**

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

- **Interactive voice recognition (IVR)** is available for selected transactions by telephone at 1-888-210-2018.
- **EServices**, Beacon’s secure web portal for providers, can be used to complete almost all transactions and is accessible through www.beaconhealthoptions.com.
- **Electronic Data Interchange (EDI)** is available for claim submission and eligibility verification directly by provider or via an intermediary.

These tools are described in the following sections.

**Interactive Voice Recognition (IVR)**

Interactive voice recognition (IVR) is available to providers as an alternative to eServices. It provides accurate, up-to-date information by telephone, enabling providers to:

- Verify member eligibility, benefits and copayment
- Check number of visits available
- Check claim status
- Confirm an authorization
- IVR is free, easy to use, available 24/7, and requires only a telephone. To access IVR, call 1-888-210-2018 toll-free.

**EServices**

Beacon’s secure web portal supports all provider transactions, while saving providers’ time, postage expense and billing fees and reducing paper waste. eServices is completely free to contracted providers and no software is needed. Use eServices to:

- Verify member eligibility & benefit
- View authorization status
- Update practice information
- Check number of visits available
- Submit claims

**Electronic Transactions and Communication with Beacon**

Beacon’s website, www.beaconhealthoptions.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.
- Upload EDI claims to Beacon
- View claims status
- EDI acknowledgment and submission reports
- Submit authorization requests
- Pend authorization requests for internal approval
- View EDI upload history
- Access Beacon's level-of-care criteria & provider manual

Providers can access eServices 24/7. Many fields are automatically populated to minimize errors and improve claim approval rates on first submission. Claim status is available within two hours of electronic submission, all transactions generate printable confirmation, and transaction history is stored for future reference.

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

Click here 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.

### Electronic Data Interchange (EDI)

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.

Providers can submit EDI claims directly to Beacon, or through a billing intermediary. For information about testing and set-up for EDI, download [Beacon’s 837 & 835 Companion Guides](#).

For technical and business related questions, email edi.operations@beaconhs.com. To submit EDI claims through an intermediary, contact the intermediary for assistance. If using Emdeon, use [Beacon’s Emdeon Payer ID and Beacon’s NHP ID](#).

### Email

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

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

### Communication of Member Information

In keeping with HIPAA requirements, providers are reminded that personal health information (PHI) should not be communicated via 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.

### Appointment Access Standards

The Division of Insurance (DOI), MassHealth, and the Health Connector monitor accessibility of appointments within our network, based on the following standards:
Inpatient and 24-hour diversionary service must schedule an aftercare follow-up prior to a member’s discharge; the appointment date must be within the following time frames:

<table>
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<th>Type of Care</th>
<th>Appointment Must Be Offered:</th>
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<tr>
<td>Non-24 hour diversionary</td>
<td>Within 2 calendar days</td>
</tr>
<tr>
<td>Psychopharmacology Services/</td>
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<tr>
<td>Medication Management</td>
<td>Within 14 calendar days</td>
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<tr>
<td>All other outpatient services</td>
<td>Within 7 calendar days</td>
</tr>
<tr>
<td>Intensive care coordination (ICC)</td>
<td>Within 3 calendar days</td>
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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 begin 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.

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

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

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

Providers are encouraged to check the database regularly, to ensure that the information about their practice is up-to-date. For the following practice changes and access limitations, the provider’s obligation to notify Beacon is fulfilled by updating information in eServices:

- Changes or limitations in appointment access for the practice or any clinician, including but not limited to:
  - 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
  - Is temporarily or permanently unable to meet Beacon standards for appointment access
  - Change in address or telephone number of any service
  - Addition or departure of any professional staff
  - Change in linguistic capability, specialty or program
  - Discontinuation of any covered service listed in Exhibit A of provider’s PSA
  - Change in licensure or accreditation of provider or any of its professional staff

Notice of the practice changes and access limitations listed above can also be submitted to Beacon by emailing provider.relations@beaconhs.com.
The following additional examples also require notification but cannot be communicated via eServices. Please email provider.relations@beaconhs.com or call the Provider Relations Department at 781-994-7556.

- Change in designated account administrator for the provider’s eServices accounts; and
- Merger, change in ownership, or change of tax identification number. (As specified in the PSA Beacon is not required to accept assignment of the PSA to another entity.)

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

### Beacon’s Provider Database

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

- Quarterly reporting to NHP for mandatory DOI, MassHealth, and Health Connector reporting requirements
- Monthly reporting to NHP for updating provider directories
- Identifying and referring members to providers who are appropriate and have available services to meet their individual needs and preferences
- Network monitoring to ensure member access to a full continuum of services across the entire geographic service area
- Network monitoring to ensure compliance with quality and performance standards including appointment access standards.

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 Beacon staff 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.

To use Locate-a-Provider, go to www.beaconhealthoptions.com.

### Adding Sites, Services, and Programs

The PSA is specific to the services for which the provider originally contracted with Beacon. To add a site, service or program not previously included in the PSA, the provider should notify Beacon in writing (email to provider.relations@beaconhs.com is acceptable) of the location and capabilities of the new site, service or program. Beacon will determine whether the site, service or program meets an identified geographic, cultural/linguistic and/or specialty need in our network and will notify the provider of its determination.

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

### Provider Credentialing and Recredentialing

Beacon conducts a rigorous credentialing process for network providers based on CMS (Centers for Medicare & Medicaid Services) and NCQA (National Committee for Quality Assurance) 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 time frame. 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 application(s), please email provider.relations@beaconhs.com.

Individual Practitioner Credentialing
Beacon individually credentials the following categories of clinicians in private solo or group practice settings:

- Psychiatrist
- Physician certified in Addiction Medicine
- Psychologist
- Licensed Clinical Social Workers
- Master’s Level Clinical Nurse Specialists/Psychiatric Nurses
- Licensed Mental Health Counselors
- Licensed Marriage and Family Therapists
- Other behavioral healthcare specialists who are Master’s level or above and who are licensed, certified, or registered by the state in which they practice.

To be credentialed by Beacon, practitioners must be licensed and/or certified in accordance with state 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 have the opportunity to submit additional, clarifying information. Discrepancies and/or unmet criteria may disqualify the practitioner for network participation.

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

Organizational Credentialing
Beacon credentials and recredits facilities and licensed outpatient agencies as organizations. Facilities that must be credentialed by Beacon as organizations include:

- Licensed outpatient clinics and agencies including hospital-based clinics
- Freestanding Inpatient Mental Health facilities, freestanding and within general hospital
- Inpatient Mental Health units at general hospitals
- Inpatient Detoxification facilities
- CBHI programs
  - Therapeutic Mentoring
  - In-Home Therapy/In-Home Behavioral Services
  - Family Support and Training (Family Partners)
  - Intensive care coordination (ICC)
- Other diversionary mental health and substance abuse services including:
  - Partial hospitalization
  - Day Treatment
  - Intensive outpatient
  - Community-based Acute Treatment
  - Community Support Services for Substance use

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 (TJC), (formerly the Joint Commission on Accreditation of Healthcare Organizations), Council on Accreditation of Services for Family and Children (COA), Council on Accreditation of Rehabilitation Facilities (CARF), or Det Norske Veritas (DNV), such accreditation must be in force and in good standing at the time of credentialing or recredentialing of the facility. If the facility is not accredited by one of these accreditation organizations, Beacon 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. Master’s level mental health counselors are approved to function in all contracted hospital-based, agency/clinic-based and other facility services sites. Behavioral health program eligibility criteria include the following:

- Master’s degree or above in a mental health field (including but not restricted to counseling, family therapy, psychology, etc.) from an accredited college or university
- An employee or contractor within a hospital or mental health clinic licensed in the Commonwealth of Massachusetts, and which meets all applicable federal, state and local laws and regulations
- Supervised in the provision of services by a licensed independent clinical social worker, a licensed psychologist, a licensed master’s level clinical nurse specialist, or licensed psychiatrist meeting the contractor’s credentialing requirements
- Is covered by the hospital or mental health/substance abuse agency’s professional liability coverage at a minimum of $1,000,000/$3,000,000
- Absence of Medicare/Medicaid sanctions

The Contractor shall use, and shall require its Providers to use, the OIG List of Excluded Individuals Entities (LEIE) upon initial hiring or contracting and on an ongoing monthly basis to screen employees and contractors, including providers and subcontractors, to determine if any such individuals or entities are excluded from participation in federal health care programs. The Contractor shall notify EOHHS of any discovered exclusion of an employee or contractor. Once the facility has been approved for credentialing and contracted with Beacon to serve NHP members, all licensed or certified behavioral health professionals listed may treat members in the facility setting.

**CANS Certification**

In addition to the criteria noted, clinicians—including private and facility-based practitioners—who provide behavioral health assessment and treatment to MassHealth members under age 21 must be trained and certified in the use of CANS. Recertification will be required every two years. If you have questions, email mass.cans@umassmed.edu or call the University of Massachusetts CANS Training Program at 508-857-1116.

Providers must enter the CANS assessments into EOHHS’ Virtual Gateway. All providers must have a Virtual Gateway account and a high speed Internet or satellite Internet connection to access the CANS IT system.

Providers must obtain member consent to enter the information gathered using the CANS Tool and the determination whether or not the assessed member is suffering from a Serious Emotional Disturbance (SED) into the IT system. If consent is not obtained, providers are still required to enter the SED determination.

**Recredentialing**

All practitioners and organizational providers are reviewed for recredentialing within 24 months of their last credentialing approval date. They must continue to meet Beacon’s established credentialing criteria and quality of care standards for continued participation in Beacon’s behavioral health provider network. Failure to comply with recredentialing requirements, including timelines, may result in removal from the network.

**Prohibition on Billing Members**

NHP members may not be billed for any covered service or any balance after reimbursement by Beacon except for any applicable copayment, coinsurance and/or deductible.

**Commercial Members**

Providers may provide and obtain payment for non-covered services only from eligible Commercial members and only if the provider has obtained prior written acknowledgment from the member that such services are not covered and the member will be financially responsible.
**MassHealth Members**

Providers may not charge members for any service:

- That is not a medically necessary MCO or non-MCO Covered Service;

- For which other MCO-covered services or non-MCO covered service may be available to meet the member’s needs, or

- Where the Provider did not explain the above-listed items, that the Enrollee will be liable to pay the Provider for the provision of any such services. The Provider shall be required to document compliance with this provision.

Providers may not charge MassHealth 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.

**Additional Regulations**

According to 211 CMR 52.12(11), “[n]othing in 211 CMR 52.12 shall be construed to preclude a carrier from requiring a health care provider to hold confidential specific compensation terms.

According to 211 CMR 52.12(12), “[n]othing in 211 CMR 52.12 shall be construed to restrict or limit the rights of health benefit plans to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers.”
# Section 3
Members, Benefits, and Member-related Policies

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Mental Health and Substance Abuse Benefits

NHP offers benefit programs for MassHealth, QHP and Commercial enrollees. The following levels of care are covered (unless noted), provided that services are medically necessary and delivered by contracted network providers:

- Clinical Stabilization Services (CSS) for Substance Use Disorders (Level III.5)
- Acute Treatment Services (ATS) for Substance Use Disorders—Medically monitored (Level III Detox)
- Inpatient Mental Health
- Outpatient (OP) Mental Health Treatment
- Outpatient (OP) Substance Abuse Treatment
- Crisis Stabilization Unit (CSU)
- Partial Hospital Program (PHP)
- Intensive Outpatient Program (IOP)
- Ambulatory Detoxification
- Community Support
- Emergency Services
- Psychological and Neuropsychological Testing
- CBHI Services (MassHealth enrollees)
- Autism Services

Initial Encounters

Members are allowed initial therapy sessions without prior authorization. These sessions, called initial encounters (IEs), must be provided by contracted in-network providers, and are subject to meeting medical necessity criteria.

IEs are counted per member regardless of the number of providers seen. To ensure payment for services, providers are strongly encouraged to ask new patients if they have been treated by other therapists. Through eServices and IVR, 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 obtain authorization before beginning treatment.

Outpatient Benefit Summary

MASSHEALTH MEMBERS

- Twelve (12) IEs per member per calendar year
- Copayments do not apply

COMMERCIAL MEMBERS

- The first eight (8) therapy sessions require no prior authorization; member ID cards show specific copayment amount.
- IEs are administered on a plan year basis. Plan years vary for Commercial members, depending on group and individual contract dates and may begin and end during any annual cycle.
- Copayments are subject to change each plan year.
- Member cost-sharing can be verified on eServices. (See Chapter 2 “Provider Participation in Beacon’s Behavioral Health Options Network” for more information).

Outpatient Benefits

Access

NHP members may access outpatient mental health and substance use services by self-referring to a network provider, by calling Beacon, or by referral through acute or emergency room encounters. Members may also access outpatient care by referral from their PCPs; however, a PCP referral is never required for behavioral health services.
Both outpatient mental health and substance use services count against the member’s IEs.

Evaluation and Management Services (E & M) require no authorization and do not count toward the member’s IEs.

The initial evaluation by a psycho pharmacist (medication management) does require authorization. Extended visits for outpatient psychotherapy do require authorization. Therefore, psychotherapy codes and psychotherapy add-on codes do count against the member’s IEs.

Diagnostic evaluation codes do require authorization and do count towards the member’s IEs.

Group therapy sessions do not require authorization and do not count towards the member’s IEs.

Benefits do not include payment for health care services that are not medically necessary.

Neither Beacon nor NHP are responsible for the costs of investigational drugs or devices or the costs of non-health care services, such as the costs of managing research or the costs of collecting data that is useful for the research project but not necessary for the enrollee’s care.

Authorization is required for all services except emergency services. (See Chapter 5 “Utilization Management and Case Management” for authorization procedures.)

MassHealth, QHP and Commercial Members

- Both outpatient mental health and substance use services count against the member’s IEs.
- Evaluation and Management Services (E & M) require no authorization and do not count toward the member’s IEs.
- The initial evaluation by a psycho pharmacist (medication management) does require authorization. Extended visits for outpatient psychotherapy do require authorization. Therefore, psychotherapy codes and psychotherapy add-on codes do count against the member’s IEs.
- Diagnostic evaluation codes do require authorization and do count towards the member’s IEs.
- Group therapy sessions do not require authorization and do not count towards the member’s IEs.

Additional Benefit Information

- Benefits do not include payment for health care services that are not medically necessary.
- Neither Beacon nor NHP are responsible for the costs of investigational drugs or devices or the costs of non-health care services, such as the costs of managing research or the costs of collecting data that is useful for the research project but not necessary for the enrollee’s care.
- Authorization is required for all services except emergency services. (See Chapter 5 “Utilization Management and Case Management” for authorization procedures.)

Member Rights and Responsibilities

Member Rights

NHP and Beacon are family committed to ensuring that members are active and informed participants in the planning and treatment phases of their mental health and substance use services. 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 NHP 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 mental health or substance use health care provider to appeal on their behalf according to the same procedures.

**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 NHP regarding any of the following:

- 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 4 “Quality Management and Improvement Program”

**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 reached at 1-800-414-2820 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.

**Member Responsibilities**
Members of NHP agree to do the following:

- Choose a primary care practitioner (PCP) and site for the coordination of all medical care. Members may change PCPs at any time by contacting NHP.
- Carry the NHP 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 NHP 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 one of the statements listed below, based on facility licensure.
**Department of Public Health (DPH) -licensed facilities**

Network facilities whose licenses are issued by DPH are required to post DPH’s statement of human rights within the facility prominently, consistent with the primary language of the facility’s membership.

**All other network facilities**

Facilities not licensed by DPH must visibly post a statement approved by their Board of Directors incorporating DPH’s statement of human rights. All hospitals that provide behavioral health inpatient services must have a human rights protocol that is consistent with DMH requirements (104 CMR 27.00) including a human rights officer and human rights committee.

**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 NHP members regarding all treatment options available to them, including medication treatment regardless of benefit overage 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 NHP members.

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

**Nondiscrimination Policy and Regulations**

In signing the Beacon PSA, providers agree to treat NHP members without discrimination. Providers may not refuse to accept and treat an NHP 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, preexisting 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 NHP 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.

M.G.L. c. 151B, s. 4, cl. 10 prohibits discrimination against any individual who is a member of federal, state, or local public assistance, including medical assistance or unemployment compensation, solely because the individual is such a member. Accordingly, except as specifically permitted or required by regulations relative to institutional providers, no provider shall deny any medical service to a member eligible for such service unless the provider would at the same time and under similar circumstances, deny the same service to a person who is not a member of public assistance (e.g., no new members are being accepted, or the provider does not furnish the desired service to any member).

A provider shall not specify a particular setting for the provision of services to a member that is not also specified for nonmembers in similar circumstances.
No provider shall engage in any practice, with respect to any NHP member, that constitutes unlawful discrimination under any other state or federal law or regulation, including but not limited to, practices that violate the provisions of 45 CMR Part 80 (relative to discrimination on account of race, color, or national origin), 45 CMR Part 84 (relative to discrimination against handicapped persons), and 45 CMR Part 90 (relative to age discrimination). In addition, providers shall not discriminate based on a member’s 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.

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

It is our joint goal to ensure that all members receive 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 sign-up 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
- Quality Improvement 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
- 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, the provider should explain the purpose and benefit of communication to the member’s PCP and other relevant providers. (See Chapter 4 “Quality Management and Improvement Program.”)

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 on the 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 specific 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

Beacon collaborates with NHP 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 NHP medical, social, and disease management programs and accepts referrals for behavioral health case management from NHP. 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 NHP. Beacon will assist behavioral health providers or members interested in obtaining any of this information by referring them to NHP’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 case management protocols require Beacon to provide any NHP member with assessment and referral to an appropriate treatment source. It is Beacon’s policy to follow Federal and Commonwealth Information laws and guidelines concerning the confidentiality of HIV-related information.

NHP Member Eligibility

NHP Member Cards

**MassHealth members**

NHP MassHealth members are issued two cards: an NHP membership card and a MassHealth membership card. NHP Commercial members are issued one card, the NHP membership card. Neither card is dated, nor are they returned when a member becomes ineligible. Therefore, the presence of a card does not ensure that a person is currently enrolled or eligible with NHP.

An NHP MassHealth member card contains the following information:

- Member’s name
- NHP identification number
- Primary care provider
- Copayment amount (if applicable)
- MassHealth ID or Plan Type

**Commercial and QHP Members**

NHP Commercial members are issued one card, the NHP membership card.

A NHP Commercial Plan member card contains the following information:

- Member’s name
- Plan ID
- Copayment amount

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

**Member Eligibility Verification**

Member eligibility changes occur frequently. To facilitate reimbursement for services, providers are strongly advised to verify a NHP member’s eligibility upon admission to treatment and on each subsequent date of service.

The following resources are available to assist in eligibility verification:

- **Online**
  - Beacon’s eServices (See Chapter 2 “Provider Participation in Beacon’s Behavioral Health Services Network” for more information)
  - MassHealth Eligibility Verification System (EVS) for both MassHealth members. Providers will need a username and password. Go to www.mass.gov/masshealth/newmmis to register.
  - **Electronic Data Interchange (EDI)—**Providers with EDI capability can use the 270/271 EDI transaction with Beacon. To set up an EDI connection, view the Companion Guide then email edi.operations@beaconhs.com.
  - **By telephone**—Beacon’s integrated voice recognition (IVR) at 1-888-210-2018; and for MassHealth automated voice response (AVR) at 1-800-554-0042

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, NHP 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 NHP 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.

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.
Section 4
Quality Management and Improvement Program

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Overview

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

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

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

- Improve the health care status of members
- Enhance continuity and coordination among behavioral health care providers and between behavioral 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.
- Responsibly contain health care costs.

Provider Role

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

To participate in Beacon’s Provider 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. Beacon’s quality monitoring activities include, but are not limited to:

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

On a periodic basis, Beacon’s QM & I Department aggregates and trends all data collected and presents the results to the Service Quality Committee (SQC) for review. The SQC may recommend initia-
tives 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 in profiling, recredentialing and network (re)procurement activities and decisions.

**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:

- Use of screening tools for diagnostic assessment of substance use
- 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 listed below
- Allergies and adverse reactions; medications; physical exam

Beacon may conduct chart reviews on-site 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 NHP member information should be directed to Beacon's privacy officer, at Compliance@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. (See Chapter 3 “Confidentiality of Member Information.”)

**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.

**Member Identification Information**

The treatment record contains the following member information:

- Member name and NHP identification number on every page
- Member’s address
- Employer or school
- Home and work telephone number
- Marital/legal status
- Appropriate consent forms
- Guardianship information, if applicable

**Informed Member Consent for Treatment**

The treatment record contains signed consents for the following:

- Implementation of the proposed treatment plan
- Any prescribed medications
- Consent forms related to interagency communications
- 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 NHP) requires its own signed consent form.
- 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.)
- For adolescents aged 12–17, the treatment record contains consent to discuss substance abuse issues with their parents.
For Mass Health members under age 21, member or guardian consent to enter into the MassHealth Virtual Gateway; information gathered using the CANS Tool and the provider’s determination as to whether the assessed member is or is not suffering from a Serious Emotional Disturbance (SED).

Signed document indicating review of member’s rights and responsibilities

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

**Medical and Psychiatric History**
Treatment record contains the member’s medical and psychiatric history including:
- Previous dates of treatment
- Names of providers
- Therapeutic interventions
- Effectiveness of previous intervention
- Sources of clinical information
- Relevant family information
- Results of relevant laboratory tests
- Previous consultation and evaluation reports

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

**Diagnostic Information**
- Risk management issues (e.g., imminent risk of harm, suicidal ideation/intent, elopement potential) are prominently documented and updated according to provider procedures
- All relevant medical conditions are clearly documented, and updated as appropriate
- 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:
  - Affect
  - Speech
  - Mood
  - Thought control, including memory
  - Judgment
  - Insight
  - Attention/concentration
  - Impulse control
  - Initial diagnostic evaluation and DSM or appropriate ICD diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information
  - Diagnoses updated at least quarterly

**Treatment Planning**
The treatment record contains clear documentation of the following:
- Evidence of the use of an Outcomes tool as required
- 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 (as appropriate) in treatment planning, treatment plan meetings and discharge planning
- 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 his/her 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 homicidality, 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
- Member's response to medications and somatic therapies

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

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

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**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)
- Dates of follow-up appointments, discharge plans and referrals to new providers

**Additional Information for Outpatient Treatment Records**
All of the above noted elements are required for the outpatient medical record, with the addition of the following:
- Telephone intake/request for treatment
- Face sheet
- Termination and/or transfer summary, if applicable
- The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan, and updates) include the following treating clinician information:
  - Clinician's name
  - Professional degree
  - Licensure NPI or Beacon Identification number, if applicable
  - Clinician signatures with dates

**Additional Information for Inpatient and Diversionary Levels of Care**
All of the above noted elements are required for inpatient medical records, with the addition of the following:
- Referral information (ESP evaluation)
- Admission history and physical condition
- Admission evaluations
Additional Documentation Requirements for Records Pertaining to Inpatient Services for MassHealth Members

All records pertaining to inpatient services must include the following:

- Member’s name
- Name of attending physician
- Name of the member’s physician
- Date of admission, date of application for and authorization of MassHealth benefits if application is made after admission

- Care Plan
- Initial and subsequent continued stay review dates
- Verification that attending physician believes continued stay is necessary including:
  - Reason for continued stay
  - Care plan for continued stay
- Other supporting material believed appropriate to be included in the record by the Contractor’s Utilization Management staff

Additional Information for Children and Adolescents

For MassHealth members under age 21, documentation that a Child Adolescent Needs and Strengths (CANS) tool has been completed in an outpatient, inpatient or community-based acute treatment (CBAT) setting is required (See “Outcome Measurement,” next section). A complete developmental history must include the following developmental information:

- Physical, including immunizations
- Psychological

- Social
- Intellectual
- Academic
- Prenatal and perinatal events are noted

Performance Standards and Measures

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

- Seven- and 30-day ambulatory care rates: Inpatient facilities are responsible for scheduling a follow-up outpatient appointment within seven days of every member discharge
- Fourteen-day medication monitoring
- Communication with PCPs and other providers treating shared members
- Availability of routine, urgent and emergent appointments (See Chapter 2 “Provider Participation in Beacon’s Behavioral Health Options Network.”)

Practice Guidelines

Beacon and NHP 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. (See “Clinical Resources” on the “Provider Tools” web page.) 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 comments about providers’ experience with any other guidelines. To provide feedback, or to request paper copies of the Practice Guidelines adopted by Beacon, contact Beacon.

**Outcome Measurement**

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

MassHealth requires a uniform behavioral health assessment process that includes a comprehensive needs assessment employing the Child and Adolescent Needs and Strengths (CANS) tool for all MassHealth members under age 21 receiving specific levels of care. The mandate to use the CANS tool is consistent with the Commonwealth’s plan under the Children’s Behavioral Health Initiative established in 2009, to more reliably identify the behavioral health needs of MassHealth members under age 21.

For MassHealth members over the age of 21, we require providers to utilize an Outcomes tool to aid in guiding, assisting, and informing providers during the treatment process while facilitating communication between clients and their practitioners. While an Outcomes Tool is not required for Commercial members, we encourage its use however; the use of an outcomes tool is required for GIC Commercial members. Please find a list of Outcomes Tools on Beacon’s website at www.beaconhealthoptions.com.

**The Child and Adolescent Needs and Strengths Tool (CANS)**

The CANS tool provides a standardized way to organize information gathered during the comprehensive clinical evaluation that is part of a behavioral health assessment. The CANS is intended to be used as a treatment decision support tool for behavioral health providers.

Behavioral health clinicians must be trained and certified in the use of CANS and recertification is required every two years. Questions about CANS training and certification should be directed to the CANS training group at mass.cans@umassmed.edu or 508-857-1116.

There are two forms of the Massachusetts CANS:

- “CANS Birth through Four” is used until a child’s fifth birthday
- “CANS Five through Twenty” is used from the child’s fifth birthday until the adolescent’s 21st birthday

The state requirement to use CANS extends to all Beacon-contracted providers who provide behavioral health assessment and treatment to MassHealth members under age 21, for outpatient therapy, in-home therapy, and intensive care coordination. The aforementioned providers are required to use the CANS as part of an initial behavioral health assessment and must update it at least every 90 days. When a member is treated by more than one behavioral health provider, each provider is required to use the CANS. Inpatient providers are required to use CANS as part of the discharge planning process for 24-hour care, including:

- Psychiatric inpatient hospitalization
- Community-based acute treatment.

Providers enter the CANS assessments via the EOHHS Virtual Gateway. All providers must have a Virtual Gateway account and a high speed Internet or satellite Internet connection to access the CANS IT system.

Providers must obtain member consent to enter into the MassHealth Virtual Gateway; information gathered using the CANS Tool and the provider’s determination as to whether the assessed member
is or is not suffering from a Serious Emotional Disturbance (SED). If consent is not obtained, providers are still required to enter the SED determination.

Continuity and Coordination of Care

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

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

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

Educate Members and Obtain Member Consent

Providers are expected to educate members about the benefits of care coordination and encourage them to grant consent for their clinical and environmental information to be shared among treaters. Notification requirements in this section can be fulfilled only with the member’s consent. (See Chapter 3, “Members and Member Related Policies” for information about member consent.)

Communication between Outpatient Behavioral Health Providers and PCPs, Other Treaters

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

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

Behavioral health providers may use Beacon’s Authorization for Behavioral Health Provider and PCP to Share Information Form and the Behavioral Health PCP Communication Form available for initial communication and subsequent updates, in “Appendix A,” or their own form that includes the following information:

- Presenting problem/reason for admission
- Date of admission
- Admitting diagnosis
- Preliminary treatment plan
- Currently prescribed medications
- Proposed discharge plan
- Behavioral health provider contact name and telephone number
- Request for PCP response by fax or mail within three business days of the request to include the following health information:
  - Status of immunizations
  - Date of last visit
  - Dates and reasons for any and all hospitalizations
  - Ongoing medical illness
» Current medications
» Adverse medication reactions, including sensitivity and allergies
» History of psychopharmacological trials
» Any other medically relevant information

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

Transitioning Members from One Behavioral Health Provider to Another

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

Routine outpatient behavioral health treatment by an out-of-network provider is not an authorized service covered by Beacon. Members may be eligible for transitional care within 30 days after joining NHP, 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.

Communication between Inpatient/Diversionary Providers and PCPs, Other Outpatient Treaters

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

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

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.

Reportable Incidents and Events

Beacon requires that all providers report adverse incidents, other reportable incidents and sentinel events involving NHP members to Beacon on the same day as the incident or event occurs, by phone and by fax. Data regarding critical incidents is analyzed and trended on a quarterly basis for the purpose of identifying opportunities for quality improvement.

Providers should direct all such reports to their Beacon clinical manager or UR clinician by phone. Beacon’s Clinical Department is available 24 hours a day, and providers must call, regardless of the hour, to report such incidents. Providers should be prepared to present all relevant information related to the nature of the incident, the parties involved (names and telephone numbers) and the member’s current condition.

In addition, providers are required to fax a copy of the Adverse Incident Report Form (for adverse and other reportable incidents and sentinel events) to Beacon’s quality manager at 781-994-7642.

Incident and event reports should not be emailed unless the provider is using a secure messaging system.

- For the Adverse Incident Report Form, go to www.beaconhealthoptions.com.

- For phone numbers, go to www.beaconhealthoptions.com.
**Sentinel Events/Adverse Incidents**

An occurrence that represents actual or potential serious harm to the wellbeing of an NHP member who is currently receiving or has been recently discharged from behavioral health services.

Inpatient and acute service providers are required to report sentinel events and adverse incidents to their assigned Beacon UR clinician on the same day that the incident occurs. Beacon’s Clinical Department is available 24 hours a day and providers must call, regardless of the hour, to report such incidents.

Providers should be prepared to present all relevant information related to the nature of the incident, the parties involved (names and telephone numbers) and the member’s current condition.

Sentinel Events/Adverse Incidents occurring within or on the grounds of a behavioral health facility that either results in death of the member or immediately jeopardizes the safety of a member receiving services in any level-of-care includes:

- **Medicolegal Deaths**: Any death required to be reported to the Medical Examiner or in which the Medical Examiner takes jurisdiction (i.e. Unexplained or Violent Death)

- **Unanticipated death occurring in any setting** (e.g., suicide, homicide, unexpected death by medical cause that is potentially related to behavioral health condition or treatment (e.g. medication toxicity, cardiac arrest due to psychotropic, lethal drug interactions).

- **Any abduction or absence without authorization (AWA) involving a member who is under the age of 18 or who was admitted or committed pursuant to State Laws and who is at high risk of harm to self or others.**

- **Any serious injury resulting urgent/emergent interventions such as a 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

- **Significant sexual behavior with other patients or staff, whether consensual or not, while in behavioral health treatment setting.**

- **Serious adverse reaction to treatment including medication errors requiring urgent or emergent medical treatment in response (e.g. neuroleptic malignant syndrome, tardive dyskinesia, other serious drug reaction)**

- **Medication error that requires medical attention beyond general first aid procedures.**

- **Physical assault or alleged physical assault by a staff person against a member.**

- **Violent/Assaultive behavior with physical harm to self or others (e.g., attempted murder, physical assault) and requiring urgent or emergent medical intervention**

- **Unscheduled event that results in the evacuation of a program or facility whereby regular operations will not be in effect by the end of the business day and may result in the need for finding alternative placement options for members.**

- **Suicide attempt at a behavioral health facility resulting in serious injury requiring medical admission.**

- **Injuries (e.g. accidents) in a behavioral health treatment setting that require urgent or emergent treatment**

- **Property damage, including that which occurs secondary to the setting of a fire, due to the intentional actions of a Beacon member while in a behavioral health treatment setting**

- **Human Rights Violations (e.g. neglect, exploitation)**

- **Any violation or alleged violation of the Department of Mental Health restraint and seclusion regulations**

- **Any unscheduled event that results in the evacuation of a program or facility**

- **Serious threat of damage to EOHHS facility**
- Serious threat of harm to EOHHS personnel
- Other occurrences representing actual or potential serious harm to a member not listed above (e.g. staff misconduct).

**Other Reportable Incidents**

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

Providers are required to report all “other reportable incidents” to their Beacon UR clinician or clinical manager for NHP on the same day that the incident occurs. Providers may access Beacon’s Clinical Department 24 hours a day, and must notify Beacon after hours when necessary to remain in compliance with this requirement.

Other Reportable Incidents include:

- Non-medicolegal deaths
- Suicide Attempt at a behavioral health facility not requiring medical admission
- Any absence without authorization from a facility involving a member who does not meet the criteria for a sentinel event / adverse incident as described above and/or elopements from a behavioral health treatment setting when the patient is considered or alleged to be a danger to self or others.
- Any physical assault or alleged physical assault by or against a member that does not meet the criteria of a sentinel event/ adverse incident.
- Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization.
  - A Serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted.
- Any unscheduled incident that results in the temporary evacuation of a program or facility such as a small fire that requires fire department response.
- Member fall unrelated to a physical altercation on a behavioral health unit.
- A medical incident resulting in admission to a medical unit or facility
- Any possession or use of contraband to include illegal or dangerous substances or tools (i.e. alcohol/drugs, weapons, or other non-permitted substances or tools)
- Self-injurious behavior exhibited by a member while at a behavioral health facility.
- Illegal behavior exhibited by a member while at a behavioral health facility defined as illegal by state, federal or local law (i.e. selling illegal substances, prostitution, or public nudity).

**Reporting Method**

- Beacon’s Clinical Department is available 24 hours a day.
- Providers must call, regardless of the hour, to report such incidents.
- Providers should direct all such reports to their Beacon clinical manager or UR clinician by phone.
- In addition, providers are required to fax a copy of the Adverse Incident Report Form (for adverse and other reportable incidents and sentinel events) to Beacon’s Ombudsperson at 1-800-414-2820 or by TTY at 1-866-727-9441. All adverse incidents are forwarded to the health plan for notification as well.
- Incident and event reports should not be emailed unless the provider is using a secure messaging system.

**Provide the Following:**

Providers should be prepared to present:

- All relevant information related to the nature of the incident
- The parties involved (names and telephone numbers)
- The member’s current condition
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
- Upcoding 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
- 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 NHP in order to initiate the appropriate investigation. NHP 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:

- Presents (or causes to be presented) to the federal government a false or fraudulent claim for payment or approval
- Uses (or causes to be used) a false record or statement to get a claim paid by the federal government
- Conspires with others to get a false or fraudulent claim paid by the federal government
- 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-retaliati*on and Anti-discriminat*ion**

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 call us at 781-994-7500 and ask for the Compliance Officer.

If any member or provider becomes aware of any potential fraud by a member or provider, please call us at 1-800-414-2820 and ask for the Compliance Officer.

**Complaints**

Providers with complaints or concerns should contact Beacon at 800-414-2820 (TTY 866-727-9441) and ask to speak with the clinical manager for NHP. All provider complaints are thoroughly researched by Beacon and resolutions proposed within 20 business days.

If an NHP members complains or expresses concerns regarding Beacon’s procedures or services, NHP 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 800-414-2720 or TTY at 866-727-9441.

**Grievances and Appeal of Grievance Resolution**

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

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.

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

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

Member and provider concerns about a denial of requested clinical service, adverse utilization management decision, or an adverse action, are not handled as grievances. (See “Request for Reconsideration of Adverse Determination” in Chapter 6 “Utilization Management.”)
Section 5
Utilization Management and Case Management

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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, case 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 criteria (medical necessity).
- Financial incentives based on an individual UM clinician’s number of adverse determinations or denials of payment are prohibited.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

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

Medical Necessity

All requests for authorization are reviewed by Beacon clinicians based on the information provided, according to the following definition of medical necessity.

Medically necessary services are health care and services that:

- Are calculated to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a disability, or result in illness or infirmity; and
- For which there is no comparable medical service or site of service available or suitable for the member requesting the service that is more conservative and less costly; and

This definition applies to all levels of care and all instances of Beacon’s utilization review.

Level-of-Care Criteria

Beacon’s level-of-care criteria (LOCC), are the basis for all medical necessity determinations; Chapters 8–14 of this manual, accessible through eServices, present Beacon’s specific LOCC for NHP for each level-of-care. Providers can also contact Beacon 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 Mental 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 Programming Scientific Review Committee (SRC) reviews all new treatment applications and technologies and then presents the information to the Provider Advisory Council for review and recommendations.

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 needs and characteristics of the local service delivery system are taken into consideration.

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.
**Adverse Determination: Commercial & QHP Members**

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 failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level-of-care effectiveness, or NHP benefit.

**Adverse Action: MassHealth Members**

The following actions or inactions by Beacon or the provider organization:

- 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
- Beacon's denial or limited authorization of a requested service, including the determination that a requested service is not a covered service
- Beacon's reduction, suspension, or termination of a previous authorization for a service
- 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:
  - Failure to follow prior authorization procedures
  - Failure to follow referral rules
  - Failure to file a timely claim
- Beacon's failure to act within the time frames for making authorization decisions
- Beacon's failure to act within the time frames for making appeal decisions

**Non-urgent Concurrent Review and Decision**

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.

**Non-urgent Preservice Review and Decision**

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.

**Post-service Review and Decision (formerly called “Retrospective Decision”)**

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 preservice decision was not rendered, based on the information that would have been available at the time of a preservice review.

**Urgent Care Request and Decision**

Any request for care or treatment for which application of the normal time period for a non-urgent care decision:

- Could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, based on a prudent layperson’s judgment, or
- In the opinion of a practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is requested.

**Urgent Concurrent Review Decision**

Any review for a requested extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments in an acute treatment setting, when a member’s condition meets the definition of urgent care, above.

**Urgent Preservice Decision**

Formerly known as a precertification decision, any case or service that must be approved before a member obtains care or services in an inpatient setting, for a member whose condition meets the definition of urgent care above. An urgent preservice decision may authorize or modify requested treatment over a period of time or number of days or treatments,
or deny requested treatment in an acute treatment setting.

**Services Requiring Authorization**

For MassHealth, QHP and Commercial members, the following services require Beacon’s prior authorization:
- Inpatient services\(^1\)
- Diversionary services
- Extended outpatient sessions\(^2,3\)
- Day treatment
- Psychological and neuropsychological testing
- Out-of-network services\(^4\)
- CBHI Services

\(^1\)Emergency services do not require preservice authorization; however, facilities must notify Beacon of the emergency treatment and/or admission within 24 hours. (See “Emergency Services,” later in this chapter.)

\(^2\)E&M services never require authorization. However, the initial evaluation by a psychopharmacologist (medication management) will require authorization. Extended visits for outpatient psychotherapy do require authorization.

\(^3\)Group therapy (90853) never requires authorization.

\(^4\)Out-of-network service is not a covered benefit. It may be authorized in some circumstances where needed care is not available within the network.

**Authorization Procedures and Requirements**

This section describes the processes for obtaining authorization for inpatient, 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 time frames, are not followed.

**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 an NHP 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. (For instructions for verifying member eligibility, see Chapter 3 “Members, Benefits, and Member-related Policies.”)

*Member eligibility can change, and possession of an NHP member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check Beacon’s eServices or call IVR at 888-210-2108.*

**Emergency Services**

**Definition**

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

The definition of an emergency medical condition is:

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

Emergency care will not be denied, however subsequent days do require preservice 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 NHP. 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
MassHealth mandates that Emergency Service Providers (ESPs) perform an emergency screening for all MassHealth and enrollees requiring inpatient admission. If there are extenuating circumstances, and the ESP cannot evaluate the member in a timely manner (within one hour from telephone notification or member’s arrival to the site), Beacon will allow a qualified clinician from a hospital emergency room or other evaluation site to provide the emergency evaluation for MassHealth members. This process allows members to access emergency services as quickly as possible and at the closest facility or by the closest crisis team. All ESPs are contracted providers for Beacon.

After the emergency evaluation is completed, the ESP or facility clinician should call Beacon to complete a clinical review, if admission to a level of care that requires precertification is needed.

The ESP 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.

For commercial members it is not required that an ESP provide an evaluation for members requiring inpatient admission but the service is a covered benefit or commercial members.

Beacon Clinician Availability
All Beacon clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage, and referral procedures. Beacon clinicians are available 24 hours a day, seven days a week, to take emergency calls from members, their guardians, and providers. If Beacon does not respond to the 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 benefit.

Inpatient and Diversionary Services
Initial Assessment
Beacon requires a face-to-face evaluation for all members who require admission to acute services. To the maximum extent feasible, all members must be screened by a qualified behavioral health professional or at the nearest emergency room prior to admission to:
- Inpatient mental health
- Partial hospitalization
- Intensive outpatient program (IOP)
- Crisis Stabilization Bed

The purpose of this initial assessment is to determine whether a member meets level of-care criteria for the identified behavioral health treatment.

Pre-service Review
Following the assessment and verification of the member’s eligibility for NHP benefits, hospital clinical staff, or other providers wishing to provide or arrange for inpatient care, are required to call Beacon prior to the admitting a covered NHP member to an inpatient unit on a non-emergency basis. The facility clinician making the request needs the following information for a preservice review:
Notice of Inpatient/Diversionary Approval or Denial

Verbal notification of approval is provided at the time of preservice or continuing stay review. For an admission, the evaluator then locates a bed in a network facility and communicates Beacon’s approval to the admitting unit. Notice of admission or continued stay approval is mailed to the member or member’s guardian and the requesting facility within the time frames 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. All denial decisions are made by a Beacon physician or psychologist advisor. The UR clinician and/or Beacon physician advisor offers the treating provider the opportunity to seek reconsideration.

Members must be notified of all preservice and concurrent denial decisions. For members in inpatient settings, the denial letter is delivered via telefax 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.

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.

- Member’s NHP Identification number
- Member’s name, gender, date of birth, and city or town of residence
- Admitting facility name and date of admission
- DSM or appropriate ICD diagnosis. (A provisional diagnosis is acceptable.)
- Description of precipitating event and current symptoms requiring inpatient psychiatric care
- Medication history
- Substance abuse history
- Prior hospitalizations and psychiatric treatment
- Member’s and family’s general medical and social history
- Recommended treatment plan relating to admitting symptoms and the member’s anticipated response to treatment

Continued Stay (Concurrent) Review

Continuation beyond the previously authorized length of stay requires review and approval by Beacon prior to expiration of the existing authorization. To conduct a continued stay review, call a Beacon UR clinician with the following required information:

- Member’s current diagnosis and treatment plan, including physician’s orders, special procedures, and medications
- Description of the member’s response to treatment since the last concurrent review
- Member’s current mental status, discharge plan, and discharge criteria, including actions taken to implement the discharge plan
- Report of any medical care beyond routine is required for coordination of benefits with NH. (Routine medical care is included in the per diem rate.)
for TDD/TTY capability, in established prevalent languages, (“Babel card”).

Notice of inpatient authorization is mailed to the admitting facility.

**Transfer between Facilities**

Providers must request approval from Beacon prior to transferring members. The member must meet Beacon’s admission criteria for the receiving facility prior to transfer. Without preservice authorization for the receiving facility, elapsed days will not be reimbursed or considered for appeal.

**Other Services Requiring Pre-service Approval**

- Electroconvulsive therapy during an inpatient stay and in outpatient settings
- Continued/extended outpatient visits after member has exhausted his or her initial visits. (See next section and eServices.)
- Inpatient and outpatient services with out-of-network providers. Out-of-network care is not a covered benefit, but may be approved in certain circumstances: Call Beacon.

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**Outpatient Services**

Outpatient behavioral health treatment is an essential component of a comprehensive health care delivery system. All NHP members are covered for outpatient behavioral health services, provided that the authorization procedures described in this chapter are followed.

See Chapter 3 ‘Members, Benefit , and Member-related Policies’ for more information about outpatient benefits including copayments and initial encounters (IEs) available to members without authorization. Member benefits can also be found on eServices with other eligibility information.

**Authorization Not Required for Initial Encounters (IEs)**

As presented in Chapter 3, MassHealth members are allowed 12 initial encounters (IEs) per calendar year without authorization. Commercial members are allowed eight (8) initial encounters per member's plan year.

**Other Exemptions from Authorization**

- Group therapy (CPT code 90853) does not require authorization and does not count towards the member’s IEs.
- E & M Services do not require authorization and do not count toward the member’s IEs. Note however that combined psychotherapy and psychotherapy add-on codes do count towards the member’s IEs. Additionally, the psychopharmacologist’s initial evaluation will need a prior authorization if there are no IEs.

**Extended Outpatient Authorization**

If a provider wishes to begin or continue treatment after a member has exhausted his or her IEs, or to continue treatment beyond completion of an existing outpatient authorization, he or she must submit an Electronic Outpatient Review Form (EORF) through Beacon's eServices. The extended authorization request should be submitted approximately two weeks before the additional visits are scheduled.

**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 level-of-care criteria documented in Chapters 8-14 (accessible through eServices) to determine whether the service meets medical necessity for continuing outpatient care.
**Return of Inadequate or Incomplete Treatment Requests**

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

**Notice of Outpatient Authorization Determination**

Beacon’s outpatient authorization decisions are posted on eServices, whether approved, modified or denied, within the decision time frame specified below. Providers receive an email message, alerting them that a determination has been made.

Beacon also faxes an authorization letter to the provider if requested. However, Beacon strongly encourages providers to opt out of receiving paper notices and to rely on eServices instead; log on to eServices to opt out of receiving paper notices.

Both electronic and paper notices specify the number of units (sessions) approved, the time frame within which the authorized visits may be used, and an explanation of any modifications made by Beacon.

**Outpatient Denials**

Denials for extended outpatient services may be appealed by the member or provider and are subject to the reconsideration process outlined in Chapter 6.

**Post-service Review**

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.

Authorization determination is based on the clinical information available at the time the care was provided to the member.

**Decision and Notification Time Frames**

Beacon is required by the state, federal government, NCQA and 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 time frames below present Beacon’s internal time frames for rendering a UM determination, and notifying members of such determination. All time frames begin at the time of Beacon’s receipt of the request. Please note: the maximum time frames 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.
**Decision and Notification Time Frames:**
**MassHealth**

<table>
<thead>
<tr>
<th>Request</th>
<th>Type of Decision</th>
<th>Decision Time frame</th>
<th>Verbal Notification</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-service</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Authorization for Inpatient Behavioral Health Emergencies</td>
<td>Expedited</td>
<td>Within 30 minutes</td>
<td>Within 30 minutes</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Initial Authorization for Non-emergent Inpatient Behavioral Health Services</td>
<td>Expedited</td>
<td>Within 2 hours</td>
<td>Within 2 hours</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Initial Authorization for Other Urgent Behavioral Health Services</td>
<td>Urgent</td>
<td>Within 72 hours</td>
<td>Within 72 hours</td>
<td>Within 72 hours</td>
</tr>
<tr>
<td>Initial Authorization for Non-urgent Behavioral Health Services</td>
<td>Standard</td>
<td>Within 7 calendar days</td>
<td>Within 7 calendar days</td>
<td>Within 7 calendar days</td>
</tr>
<tr>
<td><strong>Concurrent Review</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continued Authorization for Inpatient and Other Urgent Behavioral Health Services</td>
<td>Urgent/ Expedited</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Continued Authorization for Non-urgent Behavioral Health Services</td>
<td>Non-urgent/ Standard</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
</tr>
<tr>
<td><strong>Post-service</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorization for Behavioral Health Services Already Rendered</td>
<td>Non-urgent/ Standard</td>
<td>Within 7 calendar Days</td>
<td>Within 7 calendar days</td>
<td>Within 7 calendar days</td>
</tr>
</tbody>
</table>

Per the Commonwealth of Massachusetts, Executive Office of Health & Human Services contract with contracted Managed Care Organizations, based on 42 CFR Part 438, MassHealth members, member representatives or providers have the right to request an extension for up to 14 calendar days. The determination will be issued as expeditiously as the member’s health requires but, no later than the date the extension expires.

When the specified time frames 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 time frame expires.
**Decision and Notification Time frames: Commonwealth Care**

<table>
<thead>
<tr>
<th>Request Type</th>
<th>Determination Approval</th>
<th>Verbal Notification</th>
<th>Written Notification</th>
<th>Determination Denial</th>
<th>Verbal Notification</th>
<th>Written Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-service</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 1 business day</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Non-urgent/Standard</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 1 business day</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td><strong>Concurrent Review</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent/expedited</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Non-urgent/Standard</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 1 business day</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td><strong>Post-service</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-urgent/Standard</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
<td>Within 14 Calendar Days</td>
</tr>
</tbody>
</table>

**Case Management**

Beacon’s Intensive Case Management (ICM) Program is designed to ensure the coordination of care for children and adults at significant clinical risk due to behavioral health conditions and psychosocial factors. The program includes assessment, care planning, advocacy and linkage to necessary support and services. Individualized care plans are developed in collaboration with members and their health care teams aimed at improving a member’s overall functioning. Beacon case management is provided by licensed behavioral health clinicians.

Referrals for ICM are taken from inpatient facilities, outpatient providers, health plan representatives, PCPs, state agencies, members and their families.

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

- Member has a prior history of acute psychiatric, or substance abuse admissions authorized by Beacon; with a readmission within a 60 day period
- First inpatient hospitalization following a potentially 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 comorbid medical condition that when combined with psychiatric and/or substance abuse issues could result in exacerbation of fragile medical status
- Adolescent or adult that is currently pregnant, or within a 90 day postpartum 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 who are receiving acute behavioral health and/or substance use treatment services at the same time
Other, complex, extenuating circumstances where the ICM team determines the benefit of inclusion beyond standard criteria

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

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

ICM and Care Coordination are voluntary programs, and member consent is required for participation. For further information on how to refer a member to case management services, please contact Beacon at 1-800-414-2820.
Section 6
Clinical Reconsideration and Appeals

- Request for Reconsideration of Adverse Determination ........................................ 6-2
- Clinical Appeal Processes ......................................................................................... 6-2
- Administrative Appeal Process .................................................................................. 6-7
Behavioral Health Provider Manual

Clinical Reconsideration and Appeals

**Request for Reconsideration of Adverse Determination**

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

A peer review conversation may be requested at any time by the treating provider, and may occur prior to or after an adverse determination, upon request for a reconsideration. Beacon UR clinicians and physician advisors (PAs) are available daily to discuss denial cases by phone at 1-800-414-2820.

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

**Clinical Appeal Processes**

**Overview**

A Commercial, QHP or MassHealth member and/or the member’s appeal representative or provider (acting on behalf of the member) may appeal an adverse action/adverse determination. Both clinical and administrative denials may be appealed. Appeals may be filed either verbally, in person, or in writing.

Appeal policies are made available to members and/or their appeal representatives as enclosures in all denial letters, and upon request.

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

**Peer Review**

For all acute and diversionary levels of care, adverse determinations are rendered by board-eligible or board-certified psychiatrists of the same or similar specialty as the services being denied.

A peer review conversation may also be requested at any time by the Treating Provider, and it may occur prior to an adverse determination or after, upon request for a reconsideration.

**Urgency of Appeal Processing**

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

**Designation of Authorized Member Representative (AMR)**

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

**Appeal Process Detail**

This section contains detailed information about the appeal process for Commonwealth Care and MassHealth members, in two tables:

- Table 1: Expedited Clinical Appeals
- Table 2: Standard Clinical Appeals

Each table illustrates:

- How to initiate an appeal
- AMR requirements
- Resolution and notification time frames for expedited and standard clinical appeals, at the first, second, and external review levels.
Table 1: Expedited Clinical Appeals

<table>
<thead>
<tr>
<th>MassHealth</th>
<th>Level 1 Appeal</th>
<th>Level 2 Appeal</th>
<th>External Review</th>
</tr>
</thead>
</table>
| Members, their legal guardian, or their appeal representative (AMR) have up to 30 calendar days after receiving notice of an adverse action in which to file an appeal. If the member designates an AMR to act on their behalf, Beacon will attempt to obtain a signed and dated Designation of Appeal Representative Form. Every attempt will be made to have this form completed prior to the deadline for resolving the appeal. All expedited internal appeals will be processed by Beacon even if we have not received the Designation of Members, their legal guardian, or their appeal representative (AMR) have up to 30 calendar days after receiving notice of an adverse action in which to file an appeal. If the member designates an AMR to act on their behalf, Beacon will attempt to obtain a signed and dated Designation of Appeal Representative Form. Every attempt will be made to have this form completed prior to the deadline for resolving the appeal. All expedited internal appeals will be processed by Beacon even if we have not received the Designation of Members, their legal guardian, or their appeal representative (AMR) have up to 30 calendar days after receiving notice of an adverse action in which to file an appeal.

The provider may act as the member’s appeal representative. However, the provider must still submit a signed authorized Designation of Appeal Representative Form (AMR) to Beacon as documentation that the member did in fact authorize the provider to file an Expedited Internal Appeal on the member’s behalf. However, Beacon may not delay or dismiss an Expedited appeal if the signed form is not submitted.

A Beacon Physician Advisor, who was not involved in the initial decision, reviews all available information and attempts to speak with the member’s attending physician.

Decision is made within 72 hours of initial request.

Throughout the course of an appeal, the member shall continue to receive services without liability for services previously authorized by Beacon, until he/she is notified of the appeal determination. Members must submit appeal request within the specified timeframe of the Adverse Action in order to continue services without liability.

Members, their legal guardian, or AMRs who remain aggrieved by an expedited internal appeal decision, have the option to request, an external review from the Executive Office of Health and Human Services, Office of Medicaid’s Board of Hearings (BOH).

Beacon will provide the BOH with all documentation relating to the expedited internal appeal.

Members or their AMR must make this request to BOH within 20 days after the expedited internal appeal decision, but within 10 days if they wish to receive continuing services without liability.

Members or their AMR must complete the Request for Fair Hearing Form, included with the expedited internal appeal decision notification, and submit to BOH.
### Contact Information
Appeal requests can be made by calling Beacon’s Appeals Coordinator at 1-800-414-2820.
*NHP in lieu of Beacon may review the appeal request at the member or AMR’s request.

### Contact Information
Members or their AMR should contact the Beacon Appeals Coordinator for assistance in making the request to BOH at 1-800-414-2820.

**Board Of Hearings**  
Office of Medicaid  
100 Hancock Street, 6th Floor  
Quincy, MA 02171  
1-800-655-0338 or 617-847-1200  
Fax: 617-847-1204

### Commercial & QHP

| Members, their legal guardian, or AMR have up to 180 days to file an appeal after notification of Beacon’s adverse determination.  
The provider may act as the member’s appeal representative. However, the provider must still submit a signed authorized Designation of Appeal Representative Form (AMR) to Beacon as documentation that the member did in fact authorize the provider to file an Expedited Internal Appeal on the member’s behalf. However, Beacon may not delay or dismiss an Expedited appeal if the signed form is not submitted.  
A Beacon Physician Advisor, who was has not been involved in the initial decision, reviews all available information and attempts to speak with member’s attending physician.  
A decision is made within 72 hours of initial request.  
Throughout the course of an appeal for services previously authorized by Beacon, the member shall continue to receive services without liability until notification of the appeal resolution, provided the appeal is filed on a timely basis.  
| N/A  
| Members, their legal guardian, or AMRs who remain aggrieved by an expedited internal appeal decision, have the option to request an external review from through an External Review Agency (ERA) assigned by the Health Policy Commission, Office of Patient Protection (OPP).  
Any request for an expedited external review shall be in writing, from a physician, stating that the delay in providing or continuation of health care services that are the subject of the adverse determination, would pose an immediate threat to your health. You have the right to request continuation of service throughout the appeal process from OPP but must do so within two business days of receipt of the adverse determination letter. You do not have to complete all levels of internal appeal before requesting an expedited external appeal, this may be done at the same time an internal expedited appeal is requested with Beacon. The external review panel will send final written outcome of an expedited external review within 72 hours of the request for the review.  

### Contact Information
Appeal requests can be made by calling Beacon’s Appeals Coordinator at 1-800-414-2820.
*NHP in lieu of Beacon may review the appeal request at the member or AMR’s request.

### Contact Information
Members or their AMR should contact the Beacon Appeals Coordinator for assistance in making the request to the Office of Patient Protection (OPP) at 1-800-414-2820. Members or their AMR may also contact OPP directly.  
Call 1-800-436-7757 or go to www.statema.us/hpc/opp to obtain the forms and additional instructions for the external review. (There is a fee of $25 per appeal, with maximum fees of $75 per year.)
### Table 2: Standard Clinical Appeals

<table>
<thead>
<tr>
<th>MassHealth</th>
<th>Level 1 Appeal</th>
<th>Level 2 Appeal</th>
<th>External Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members, their legal guardian, or their appeal representative (AMR) have up to 30 calendar days after receiving notice of an adverse action in which to file an appeal. When the member is designating an appeal representative to appeal on his/her behalf, the member must complete and return a signed and dated Designation of Appeal Representative Form prior to the deadline for resolving the appeal (30 calendar days). The Designation of Appeal Representative Form is required even if the provider is acting as the authorized representative. Failure to do so prior to the appeal due date will result in dismissal of the appeal. However, verbal and written communication can only occur with the member or their legal guardian until such time as the form is received. If an individual other than the member or their legal guardian requests the standard first level appeal, the member must complete and return the Designation of Appeal Representative Form prior to the deadline for resolving the appeal. Failure to do so will result in the dismissal of the appeal and notice of dismissal to the member only. A Beacon physician advisor, not involved in the initial decision, will review available information and attempt to contact the member's attending physician/provider. Resolution and notification will be provided within 30 calendar days of the appeal request. If the appeal requires review of medical records (post service situations), the member's or AMR's signature is required on an Authorization to Release Medical Information Form authorizing the release of medical and treatment information relevant to the appeal. If the medical record with Authorization to Release Medical Information Form is not received prior to the deadline for resolving the appeal, a resolution will be rendered based on the information available. Throughout the course of an appeal, the member may continue to receive services without liability for services previously authorized by Beacon, until he/she is notified of the appeal determination. Explain the member may be held liable for payment of continuing services if the appeal is not deemed in his/her favor. MassHealth members must submit appeal request within ten days of the Adverse Action in order to continue services without liability.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the event that Beacon's standard first level appeal decision upholds the initial determination, the member has the right to initiate a second level appeal with NHPBeacon or waive his/her right to a second level appeal and file an appeal with the Executive Office of Health and Human Services, Office of Medicaid's Board of Hearings (BOH). When the member is designating an appeal representative to appeal on their behalf, the member must complete and return a signed and dated Designation of Appeal Representative Form prior to the deadline for resolving the appeal. Failure to do so will result in dismissal of the appeal.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MassHealth members or their AMR should contact Beacon's Appeals Coordinator for help in making a request for external appeal with BOH. Beacon will provide BOH with all documentation relating to the standard first and/or second level appeal. MassHealth members or their AMR must submit requests to BOH within 30 days from Beacon's the standard first or second level appeal decision notification, but within 10 days if they wish to receive continuing services without liability. MassLanguage re: members may be held liable to pay back MH for continuing services if the appeal is not resolved in their favor. MassHealth members or their AMR must complete the Request for Fair Hearing Form included with all levels of appeal decisions, and submit to BOH. External Review Agency will review the case if the member is not satisfied with the second level hearing.</td>
<td></td>
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</tr>
</tbody>
</table>

MassHealth members or their AMR should contact Beacon's Appeals Coordinator for help in making a request for external appeal with BOH. Beacon will provide BOH with all documentation relating to the standard first and/or second level appeal. MassHealth members or their AMR must submit requests to BOH within 30 days from Beacon's the standard first or second level appeal decision notification, but within 10 days if they wish to receive continuing services without liability. MassLanguage re: members may be held liable to pay back MH for continuing services if the appeal is not resolved in their favor. MassHealth members or their AMR must complete the Request for Fair Hearing Form included with all levels of appeal decisions, and submit to BOH. External Review Agency will review the case if the member is not satisfied with the second level hearing.
The provider must submit medical chart for review. If the chart is not received within 20 days of initial letter, a reminder letter is sent, giving additional 15 days. If chart is not received, a decision is made, based on available information.

<table>
<thead>
<tr>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal requests can be made by calling Beacon's Appeals Coordinator at 1-800-414-2820 or in writing to Appeals Coordinator.</td>
</tr>
<tr>
<td>Beacon Health Options</td>
</tr>
<tr>
<td>500 Unicorn Park Drive</td>
</tr>
<tr>
<td>Suite 103</td>
</tr>
<tr>
<td>Woburn, MA 01801</td>
</tr>
</tbody>
</table>

*NHP in lieu of Beacon may review the appeal request at the member or AMR’s request.

<table>
<thead>
<tr>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal requests can be made by calling NHPBeacon's Appeal/Grievances Coordinator at 1-800-462-5449 or in writing to Member Appeal/Grievances Coordinator.</td>
</tr>
<tr>
<td>Neighborhood Health Plan</td>
</tr>
<tr>
<td>253 Summer Street</td>
</tr>
<tr>
<td>Boston, MA 02210</td>
</tr>
</tbody>
</table>

Commercial & QHP

Commercial members, their legal guardian, or AMR have up to 180 days to file an appeal after notification of Beacon’s adverse determination.

A Beacon physician advisor, not involved in the initial decision, will review available information and attempt to contact the member’s attending physician/provider. Resolution and notification will be provided within 30 calendar days of the appeal request.

If the appeal requires review of medical records (post service situations), the member’s or AMR’s signature is required on an Authorization to Release Medical Information Form authorizing the release of medical and treatment information relevant to the appeal. The Designation of Appeal Form is required even if the provider is acting as the authorized representative.

If the medical record with Authorization to Release Medical Information Form is not received prior to the deadline for resolving the appeal, a resolution will be rendered based on the information available.

Throughout the course of an appeal for services previously authorized by Beacon, the member shall continue to receive services without liability until notification of the appeal resolution, provided the appeal is filed on a timely basis.

N/A

In the event that Beacon's Standard First Level Appeal decision upholds the adverse determination, the member may request an external review with the Health Policy Commission, Office of Patient Protection (OPP).

Commercial members or their AMR must file a request in writing with the OPP within four (4) months of Beacon’s First Level Appeal Adverse Determination.

Any requests seeking continuation of coverage during appeal review must be received by OPP within two business days of receipt of Beacon's first level appeal adverse determination.
### Contact Information

**Appeal requests can be made by calling Beacon’s Appeals Coordinator at 1-800-414-2820 or in writing to Appeals Coordinator**  
Beacon Health Options  
500 Unicorn Park Drive  
Suite 103  
Woburn, MA 01801  
* NHP in lieu of Beacon may review the appeal request at the member or AMR’s request.

**Contact Information**  
Members or their AMR should contact the Beacon Appeals Coordinator for assistance in making the request to OPP at 1-800-414-2820; however, members or their AMRs may contact the Office of Patient Protection (OPP) directly at 1-800-436-7757 or visit [http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/patient-protection](http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/patient-protection) to obtain the forms and additional instructions for the external review. (There is a fee of $25 that is paid by Beacon Health Options, with maximum fees of $75 per year.)

### 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 both commercial and Medicaid 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 both commercial and Medicaid 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.
Section 7
Billing Transactions

General Claim Policies ............................................................. 7-2

Electronic Submission of Claims ....................................... 7-2

Reconsideration of Timely Filing Requests .......................... 7-10
This chapter presents all information needed to submit claims to Beacon. Beacon strongly encourages providers to rely on electronic submission, either through EDI or eServices, in order to achieve the highest success rate of first-submission claims.

**General Claim Policies**

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

- The required edits, minimum submission standards, signature certification form, authorizing agreement and certification form, data specifications, as outlined in this P&P Manual must be fulfilled and maintained by all providers and billing agencies submitting EMC to Beacon.

- 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.

- 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.

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

- Providers are not permitted to bill NHP members under any circumstances for covered services rendered, excluding copayments when appropriate. (See “Prohibition on Billing Members” in Chapter 2 “Provider Participation in Beacon’s Behavioral Health Services Network.”)

**Time Limit for Filing Claims**

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

- Within 60 days of the dates of service on outpatient claims
- Within 60 days of the date of discharge on inpatient claims, or
- Within 60 days from the last date on an interim bill on an inpatient claim

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the 60-day filing limit will deny unless submitted with a valid and approved Waiver Request Form (see 60-day Waiver Policy later in this chapter).

All clean claims will be adjudicated within thirty (30) days from the date that Beacon receives the claim.

**Definition: Clean Claims**

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 or is missing any required substantiating documentation of particular circumstance requiring special treatment that prevents timely payments from being made on the claim.

Clean claims may be submitted electronically, through EDI or eServices, as described in the following sections. While paper claims are discouraged, instructions for submitting on paper are also included in this chapter.

**Electronic Submission of Claims**

Beacon strongly encourages providers to rely on electronic submission in order to realize the following advantages:

- Expedited processing, allowing provider to view claim status within hours of submission,
- Increased accuracy of submissions, increasing approval rates for providers
- Automated tracking and better control flow
- Reduction in errors that lead to resubmission
- Improved reporting

Beacon offers two electronic methods for submitting claims, EDI and eServices, described below.

**Electronic Data Interchange (EDI)**

EDI supports electronic submission of claim batches in HIPAA-compliant 837P format for professional services and 837I format for institutional services, through Electronic Data Interchange (EDI). Providers may submit claims using EDI/837 format directly to Beacon or through a billing intermediary.

If using Emdeon as the billing intermediary, two IDs must be included in the 837 file or adjudication:
- Beacon’s payor ID is 43324.
- Beacon’s NHP ID is 001.

Beacon requires testing for all submitters, including providers and/or their billing intermediaries, prior to submission of 837P and 837I transactions. After testing is successfully completed, providers and/or their billing intermediaries submit 837 claim transaction files by direct Internet connection via Beacon’s secure EDI Gateway which is a secure web server.

To use Beacon’s EDI Gateway, submitters need an Internet connection and a browser that supports 128-bit encryption, such as Internet Explorer 5.5 or higher. A Login ID, Password & URL for the EDI Gateway will be provided during the testing and certification process.

When the claims in the 837 file are adjudicated, the explanation of benefits (EOB) remittance report can be downloaded from the EDI gateway in the HIPAA 835 transaction format. Claim status and EOB reports are also available through eServices; claim status is also accessible telephonically through Beacon’s IVR (See Chapter 2 “Provider Participation in Beacon’s Behavioral Health Services Network.”)

Providers interested in submitting EDI claims using the HIPAA-compliant 837 transaction, should download and review the 837 companion guide, then email Beacon at edi.operations@beaconhs.com for setup and testing.

**Additional EDI Resources**

- Read About EDI
- Read/Download EDI Companion Guides

**Submitting Claims on eServices**

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. For more information about using eServices, see Chapter 2 “Provider Participation in Beacon’s Behavioral Health Services Network.”

**Paper Claims**

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. Beacon discourages paper claim submission.

Mail paper claims to:

Beacon Health Options
NHP Claims Department
500 Unicorn Park Drive, Suite 103
Woburn, MA 01801-3393

Claim status and EOB information are available in eServices regardless of how a claim was submitted. Claim status is also available through IVR.

Beacon requires the Physician/Practitioner’s name and NPI number in box 24j.

All providers are required to record the name, site ID and address of the facility where services were rendered in Box 32 on the CMS 1500 claim form. If the facility name, site ID or address is not identified, a Beacon Claim Specialist will choose the “primary” site as the default.

Beacon requires the Attending NPI in box 76.

**Bill Type Codes**

All inpatient UB04 claims must include the three-digit bill type codes in Box 4.
**Discharge Status Codes**

All inpatient UB04 claims must include one of the following discharge status codes in Box 17:

- **01** Discharged to Home / Self Care
- **02** Discharged/Transferred to another Acute Hospital
- **03** Discharged/Transferred to Skilled Nursing Facility
- **04** Discharged/Transferred to Intermediate Care Facility
- **05** Discharged/Transferred to another Facility
- **06** Discharged/Transferred to Home/ Home Health Agency
- **07** Left against Medical Advice or Discontinued Care
- **08** Discharged/Transferred Home/IV Therapy
- **09** Admitted as Inpatient to this Hospital
- **20** Expired
- **30** Still a Patient

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

**Interim Billing & Date Ranges**

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

The date range on an inpatient claim that is 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 prior authorization letters for correct date ranges.

**Resubmission Policy & Procedures**

Claims that have previously denied may be resubmitted to Beacon in the following manner:

- If the original denied claim to be resubmitted was received by Beacon within 60 days from the date of service, the corrected claim may be resubmitted as an original.
- A corrected and legible photocopy is also acceptable.
- If the original denied claim to be resubmitted was received by Beacon more than 60 days from the date of service, the following procedures apply.
  - 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.

**Electronic Resubmission**

Denied claims can be resubmitted most efficiently by one of the following electronic methods:

- **EDI**—Follow the instructions in the EDI companion guide for correct placement of REC. ID number; or
- **EServices**—Claims can be automatically resubmitted by clicking “resubmit” next to the denied claim line in the search result screen. The REC. ID is auto-populated and the user edits the data element that caused the denial. Claims can also be re-keyed; enter “yes” in the field indicating a resubmission/adjustment, then enter the REC. ID where indicated.

**Paper Resubmission**

The entire claim 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 claim lines along with resubmitted claim lines.

Beacon requires that the corrected claim (or a corrected and legible photocopy) be resubmitted in one of the following ways:

- Submit the corrected claim with a copy of the EOB for the corresponding date of service; or
Completion of the 60-day Waiver Request Form

Providers are required to complete one 60-day Waiver Request Form per claim, as accurately and legibly as possible, including:

- **Provider Name**—Enter the name of the provider who provided the service(s).
- **Provider ID Number**—Enter the provider ID Number of the provider who provided the service(s).
- **Member Name**—Enter the Member’s name.
- **NHP Member ID Number**—Enter the NHP Member ID Number.
- **Contact Person**—Enter the name of the person whom Beacon should contact if there are any questions regarding this request.
- **Telephone Number**—Enter the telephone number of the contact person.
- **Reason for Waiver**—Place an “X” on all the line(s) that describe why the waiver is requested.
- **Provider Signature**—A 60-day waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. Beacon will not accept “Signature on file.”
- **Date**—Indicate the date that the form was signed.

Beacon’s Waiver Decision

Beacon’s determination regarding the 60-day waiver request is reflected on a future EOB: If the request is approved for waiver of the 60-day filing limit, the claim appears adjudicated; if the waiver request is denied, the reason for denial appears. (See Appendix for denial codes.) Note that approval of a 60-day waiver request only means that the timely filing requirement has been overridden; approval does not guarantee payment of the associated claim. Each claim will pay or deny based upon normal adjudication logic.

Contact Beacon’s Claims Department with any questions.
Recoupments and Adjustments by Beacon

Beacon reserves the right to recoup money from providers due to errors in billing and/or payment. In that event, Beacon applies all recoupments and adjustments to future claims processed, and report such recoupments and adjustments on the EOB with Beacon’s record identification number (REC.ID) and the provider’s patient account number. Please do NOT send a refund check to Beacon.

Provider Request for Adjustment or Void

If the Explanation of Benefits (EOB) for a Beacon claim shows that a provider has been incorrectly paid, the provider must request an adjustment or void, as appropriate:

- Adjustment requests are filed to increase or decrease the original amount paid on a claim. Claims that have been denied cannot be adjusted but may be resubmitted. Adjustment requests can be filed electronically.
- Void requests are filed to refund the entire original payment on a claim, to Beacon. Void requests can only be sent via the paper adjustment process.

If an adjustment appears on an EOB and is not correct, another adjustment request may be submitted using the Beacon REC.ID from the previous adjustment.

Adjustment/void requests are not applicable for claims that have been denied. (See previous section on claim resubmission).

Underpayment (Positive Request)

Positive adjustment requests (when Beacon has underpaid the provider) must be submitted within 60 Days from the date of payment as shown on the EOB.

Overpayment (Negative Request)

If an EOB shows that Beacon overpaid the provider on a single claim, the provider must submit an adjustment request to Beacon. The provider should not send a refund check. Beacon will investigate the need for an adjustment and if a reduction in payment is warranted, Beacon will reduce the next payment to the provider and this adjustment will be reflected in the provider’s next EOB. If money is owed to Beacon, the 60-day filing limitation is not applicable.

Do not send a refund check to Beacon.

Electronic Adjustment Requests

Adjustments to claims payments can be done electronically, by submitting the paid claims with the REC.ID number via the following methods:

- EDI—Follow the instructions in the EDI companion guide for correct placement of REC.ID number.
- EServices—Claims can be automatically resubmitted through the claims search function by clicking “resubmit” next to the denied claim line in your search result screen. The system will automatically populate your REC.ID and will give you a chance to edit the data element that was causing the denial. Claims can also be reentered and the REC.ID can be manually entered after “yes” is entered in the resubmission/adjustment field.

Paper Adjustment Requests

When submitting an adjustment request, attach a copy of the original claim form and the EOB that reflects the payment to the adjustment form. Void requests must be submitted using the Adjustment/Void Request Form only. Do not attach a copy of the claim that is to be voided.

Adjustments to payment amounts can be done in one of the following manners:

- Complete the Adjustment/Void Request Form per the instructions below.
- Attach copy of the EOB on which the claim was paid an incorrect amount.
- Prepare the claim based on your requested final payment, with all required elements; place the REC.ID in box 19 of the CMS 1500 claim form, or box 64 of the UB04 form.
- Send the form, documentation and claim to:

Beacon Health Options
Claim Departments—60-day Waivers
500 Unicorn Park Drive, Suite 103
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. A copy of the original claim must be attached to the request.

- **Provider Name**—Enter the name of the provider to whom the payment was made.

- **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.

- **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.

- **NHP Member Identification Number**—Enter the NHP 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.

- **Beacon Record ID Number**—Enter the record ID number as listed on the EOB.

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

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

- **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.

- **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.”

- **Date**—List the date that the form is signed.

The provider must send Beacon the original adjustment/void request, along with a copy of the EOB on which the claim was paid. For an adjustment, include a copy of the newly adjusted claim form with the Adjustment/Void Request Form. Submit completed forms to:

Beacon Health Options
Claims Department—
Adjustment Void/Request
500 Unicorn Park Drive, Suite 103
Woburn, MA 01801-3393

Reconsideration of Timely Filing Requests

In the event that a claim falls outside of all time frames for resubmission and adjustment described above, providers may request a reconsideration of the applicable filing limits (See resubmission and adjustment sections in this chapter).

To request reconsideration, submit the claim(s) to Beacon with a cover letter and all supporting documentation. The outcome of the reconsideration will be communicated as a message of “Reconsideration Approved” or “Reconsideration Denied” on your provider EOB.

Please note that in some circumstances it is possible to have determination of “Reconsideration Approved” that still results in a claim denial. The reconsideration process decides only if the timely filing limit will be overridden; all other billing/authorization requirements and adjudication logic still apply.

Coding

Providers are required to submit HIPAA compliant coding on all electronic and paper claim submissions; this includes HIPAA compliant revenue, CPT, HCPCS and ICD9 codes. Claims submitted without HIPAA compliant coding will be denied for payment. Providers should refer to their exhibit A for a complete listing of contracted, reimbursable procedure codes.

Modifiers

Modifiers are used to make up specific code sets that are applied to identify services for correct payment. On the CMS 1500 claim form place the modifier code in Box 24d. On the UB04 claim form place the modifier code in Box 49 or beside the HCPCS code in Box 44. The modifier reflects the discipline and
licensure status of the treating practitioner. Please refer to your provider’s fee schedule for applicable modifier.

**Medication Management**

All providers must use the appropriate E & M code when billing for a medication management session. In addition, one of the following modifiers is required to indicate the licensure level of the practitioner who provided the service:

- U6 - For licensed physician
- SA - For licensed RNCS

**Diagnosis Codes**

Beacon accepts only ICD diagnosis codes listing approved by CMS and HIPAA. Providers must record the appropriate primary diagnosis code in Box 21 on the CMS 1500 claim form and in Box 67 on the UB04 claim form. In order to be considered for payment all claims must have a Primary ICD diagnosis in the range of 290 to 319. All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.

**Coordination of Benefits**

In accordance with The National Association of Insurance Commissioners (NAIC) regulations, Beacon coordinates benefits for mental 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 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 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 has TPL and COB specialists to address any specific questions regarding these types of claims.

Providers should use the **TPL Indicator Form** to notify EOHHS of the potential existence of other health insurance coverage and to include a copy of the enrollee’s health insurance card with the TPL Indicator Form whenever possible.

The **TPL Indicator Form** can be found on the Beacon website, “Provider Tools Page.”

**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**

- **EServices**—Providers can check claim status 24/7 via eServices, regardless of how claims were submitted.

- Interactive Voice Response: 888-210-2018—Available 24 hours a day. You will need your:
  - Tax ID
  - Member ID
  - Date of birth
Date of service

- Claims Hotline—888-249-0478
- Hours of operation:
  8:30 a.m.–5:30 p.m. Monday–Thursday
  and 9:00 a.m.–5:00 p.m. Friday.

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**Appendix A: Beacon Forms**

- Adverse Incident Reports Form
- Adjustment/Void Request Form
  (for paid claims only)
- Authorizations for Beacon Health Options to Release Confidential Information
- Authorizations for Beacon Health Options to Release Confidential Information to Beacon
- Authorization for BH and PCP providers to Share Confidential Information
- Claim Inquiry Form
- CMS 1500 Standard Form
- Combined MCO Outpatient Review Form
- EDI Transitions—Billing Intermediary Authorization Form
- EDI Transactions—Trading Partner Setup Form
- Family Stabilization Team Discharge Request
- Family Stabilization Team Extension Request
- Home Based Therapy Appointment Form
- In Home Therapy Extension Request Form
- In Home Therapy Discharge Form
- Intensive Case Management—Initial Intake and Referral
- Primary Care Professional/Behavioral Health Communication Form
- Provider Directory Questionnaire
- Provider Credentialing Rights
- Psychological Testing Form