beacon
health options
Colorado Partnerships

Provider Handbook

Revised September 2017

Section 1

GENERAL INFORMATION

WELCOME TO BEACON HEALTH OPTIONS HEALTH FIRST COLORADO NETWORK SERVING COLORADO HEALTH PARTNERSHIPS AND FOOTHILLS BEHAVIORAL HEALTH PARTNERS.

As a Beacon Health Options Health First Colorado Network provider, you join some of the most accomplished behavioral health care professionals in the country — people who share our commitment to making quality behavioral health care more accessible for our members. This handbook was developed to answer your questions about the Beacon Health Options Health First Colorado Network and about how we manage and coordinate the delivery of behavioral health care to Health First Colorado members. It includes compliance with Health First Colorado requirements, services, clinical guidelines, policies and procedures, member rights and responsibilities and provider resources. Following these guidelines will assist us in giving you timely treatment authorizations and claims reimbursement.

If you have any questions or comments while reading the handbook or at any other time, please call Provider Relations at our toll-free Provider Line, 1-800-804-5040.

Provider Relations Needs:	**1-800-804-5040**
Clinical Authorization Needs:	
Colorado Health Partnerships	1-800-804-5008
Foothills Behavioral Health Partners	1-866-245-1959
Claims Needs:	
Beacon's National Claims Department	1-1-800-888-3944

Thank you for your participation in our network and for serving our Members. We look forward to a long and rewarding relationship with you as we work together to provide high quality Member care.

ABOUT THE BEACON HEALTH OPTIONS HEALTH FIRST COLORADONETWORK

Beacon Health Options serves two separate Colorado partnerships, each of which is contracted by the Health First Colorado Community Behavioral Health Services Program as a Behavioral Health Organization (BHO). BHOs are tasked with managing Health First Colorado behavioral health benefits and funds on a regional basis. BHOs must comply with all federal and state regulations regarding administration of the Health First Colorado program and act as good stewards of Health

First Colorado funds.

These two partnerships include Colorado Health Partnerships (CHP) and Foothills Behavioral Health Partners (FBHPartners). Each partnership holds a contract with the Colorado Department of Health Care Policy and Financing for Health First Colorado funded behavioral health services, on a regional service area basis. Together the two BHOs working with Beacon Health Options encompass 48 counties and over 660,000Health First Colorado members throughout Colorado.

Members are assigned a BHO based on the county in which they obtain Health First Colorado eligibility. (NOTE: This may not be their county of current residence. You, as the provider, are responsible for determining the Member's county of eligibility). Each partnership is organized as a Colorado Limited Liability Company owned by Community Behavioral Health Centers local to the service area, and Beacon Health Options.

Colorado Health Partnerships (CHP) includes Mind Springs Health, The Center for Mental Health, Axis Health Systems, AspenPointe Health Services, Health Solutions, Southeast Mental Health Services, Solvista Health, San Luis Valley Community Mental Health Center, and Beacon Health Options.

CHP manages behavioral health services for members in the following counties:

Alamosa	Delta	Huerfano	Montezuma	Rio Grande
Archuleta	Dolores	Jackson	Montrose	Routt
Baca	Eagle	Kiowa	Otero	Saguache
Bent	El Paso	Lake	Ouray	San Juan
Chaffee	Fremont	La Plata	Park	San Miguel
Conejos	Garfield	Las Animas	Pitkin	Summit
Costilla	Grand	Mesa	Pueblo	Teller
Crowley	Gunnison	Mineral	Prowers	
Custer	Hinsdale	Moffat	Rio Blanco	

Foothills Behavioral Health Partners (FBHPartners) includes Jefferson Center for Mental Health, Mental Health Partners, and Beacon Health Options. FBHPartners manages behavioral health services for members in the following counties:

Boulder	Clear Creek	Jefferson
Broomfield	Gilpin	

Each of these BHOs may have specific requirements and additional information that can be found in the BHO specific addendum that accompanies this handbook.

The Colorado partnerships are based on a unique model pioneered in Colorado in 1995. These partnerships bring together the advanced information and managed care strengths of a national company with the full array of high quality local service providers who practice throughout Colorado. The backbone of this provider system consists of Community Behavioral Health Centers that are regionally based and have long, local histories and outstanding records of service to local communities and residents. Colorado is one of few states that have such a strong public mental health system and one that delivers services to members at convenient locations throughout the rural and frontier areas of our state. One of the benefits to Colorado of this partnership model, is that it strengthens and preserves Colorado's public behavioral health safety net.

By choosing to participate as a provider in the Beacon Health Options Health First Colorado Provider Network, you are assisting us in increasing capacity for quality services to Health First Colorado members.

REVALIDATION / INITIAL ENROLLMENT WITH THE COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

As of March 1st, 2017, the Colorado Department of Health Care Policy and Financing (HCPF) mandates that all providers (both facilities and individuals) must be Enrolled/ Revalidated with the State of Colorado in order to be reimbursed for services rendered to Health First Colorado members. All providers must be Enrolled/ Revalidated for all licensures, programs offered, NPIs and Tax IDs **all for each service location.** Failure to fully comply with this process **will result in non-payment of claims submitted to Beacon Health Options.**

It is the responsibility of the provider to ensure that all information regarding their offered services has been submitted and approved by HCPF. It is also the responsibility of the provider to ensure that all information that Beacon Health Options has on file is accurate, up to date, and approved by the State of Colorado.

For more information, please visit the Colorado Department of Health Care Policy and Financing's website at https://www.colorado.gov/hcpf/provider-enrollment or call 1-844-235-2387.

Section 2

CONTINUUM OF SERVICES

The Beacon Health Options' Health First Colorado Behavioral Health Services Program is designed to include a wide array of services that support therapeutic interventions at the level of intensity indicated by the strengths and needs of each unique person served. Most of these services are offered through our Community Mental Health Center (CMHC) providers. However, routine outpatient assessment, psychotherapy, psychological testing, and medication management services are also offered by our network of independent outpatient providers. Hospitalization and residential levels of care are offered by contracted network facilities and some CMHCs. The care delivery system has been developed to ensure that, from the moment they access services, Health First Colorado members are directed to the most appropriate level and type of behavioral health care, in geographically convenient locations. Behavioral Health Organization (BHO) providers, facilities and other treatment programs are screened against credentialing standards, qualifications in specialty areas, and managed care experience. Authorizations for payment of services are determined through the application of medical necessity criteria and use of clinical judgment.

CLINICAL SERVICES DESCRIPTIONS

• **Alternative Treatment Unit (ATU):** A 24-hour psychiatric treatment program that provides supervision and treatment in a structured environment, which may or may not be medically staffed twenty-four hours a day. ATU services are designed for members without acute medical conditions who require short-term care. Medical consultation must be available.

• **Crisis Outpatient Services:** Crisis outpatient services are provided in response to a crisis that results in acute destabilization of functioning and are focused on rapid restoration of functioning in the community. These services are provided in an outpatient office, home environment or other community setting. They are time-limited services and may include a wide variety of intensive individual, couples, family treatment and case management services.

• **Crisis Stabilization/Observation:** Crisis Stabilization Unit (CSU) services are available in many areas. These programs are designed to provide evaluation and stabilization for members in crisis and in need of intensive observation. Treatment interventions are focused on mobilizing support and resources so that the Member can be managed in a less restrictive setting. CSU services vary by provider and location, with a common goal of helping members in crisis receive services at the least restrictive level. CSUs are staffed by behavioral health professionals, who provide continuing assessment of treatment needs and will facilitate transition of care to higher levels of care such as inpatient treatment, if needed. CSU staff will also help members transition to lower levels of care during aftercare planning, which may include outpatient therapy and medication management, as examples.

• **Day Treatment for Children and Adolescents:** Day Treatment programs are designed for treatment of serious covered disorders that cause significant impairment in usual life/school activities. Day Treatment is a time-limited treatment program that offers academic services together with

therapeutically intense, multimodal, and structured clinical services.

• **Emergency Services:** Services used during a behavioral health emergency which are unscheduled and immediate, and needed to evaluate or stabilize an emergency condition.

Note that emergency room services for substance use disorders are not covered by the BHO and should be billed to Fee For Service Health First Colorado.

• **Evaluation/Assessment Services:** Diagnostic assessment of the member who presents for treatment to determine the member's needs and strengths and to recommend the appropriate level of care and focus of treatment.

• **Family Preservation Services:** Time-limited, in-home treatment to maintain the child in the home or to facilitate reunification of the child with the family.

• **Home Based Services:** Services, which can vary in intensity and duration, provided in the home to assess and stabilize a member's symptoms, and to maintain and/or improve a member's level of functioning.

• **Inpatient Hospitalization:** Treatment of a mental health condition requiring 24-hour supervision, observation and intervention, in a structured therapeutic medical environment with 24-hour nursing care. This is the most restrictive level of care and generally applies to those members who are experiencing mental health symptoms resulting in behaviors that cause significant danger to themselves or others, or cause the member to be significantly disabled and unable to meet their basic needs.

• **Intensive Case Management:** Services typically provided by Community Behavioral Health Center staff for coordination of services, support, advocacy and to assist members with the recovery process.

• **Medication Management and Medication Assisted Therapy:** Interventions by a psychiatrist or other professional with prescription authority that include: evaluation, administration and monitoring of medications prescribed for the treatment of a covered behavioral health disorder. Members may also spend time with a nurse or physician's assistant, who reviews symptoms and side effects, instructs the member in symptom management, administers injections, monitors oral medication, and/or performs other adjunctive services on behalf of the psychiatrist, e.g. for methadone and/or suboxone. Please call Beacon Health Options to discuss authorization requests for Substance Use Disorder (SUD) services at 1-800-804-5008.

• **Mobile Assessment:** An assessment of a member's treatment needs by a clinician who travels to the member's location in the community, including an emergency room.

• **Outpatient Hospital Based Laboratory Services:** Services and laboratory studies provided on an outpatient basis for evaluation or diagnostic purposes related to the member's behavioral health treatment or condition. Please note all laboratories must be CLIA certified.

• **Outpatient Treatment:** Least restrictive level of care in which the member participates in face- to-face assessment, counseling and routine case management services delivered in a behavioral health provider's office or other community setting.

• **Partial Hospitalization Program:** A structured, intensive, time-limited program designed to provide diagnosis and treatment for members who require more structure than is provided by outpatient therapy in order to continue to reside in the community.

• **Post-stabilization Services:** Services that are provided in relationship to an emergency medical condition and are provided after a member is stabilized in order to maintain the stabilized condition.

• **Psychological Testing:** Administration of standardized tests and assessment techniques by a licensed psychologist for the purpose of diagnosis or treatment of a covered mental health diagnosis. Psychological testing supplements standard clinical assessment and evaluation.

• **Psychosocial Rehabilitation:** A comprehensive array of services that supports the recovery of a person with a serious mental illness. Services focus on individualized assessment through application of an approved model, goal setting by the member, and direct skills training.

• **Residential Treatment:** 24-hour services, in approved programs, that provide extensive structure and individualized treatment for covered mental health diagnoses and significant associated deficits in functioning that results in the inability to live in the community.

• **Respite:** Respite care provides a planned break for families or members in dealing with long- term or severe mental illness. Respite care can be provided in a variety of settings either in the home or away from the home.

• **School-Based Intensive Outpatient Services:** Services that are designed for children at risk of school failure or are candidates for expulsion due to symptoms or behavior that results from a behavioral health diagnosis. They are typically identified by school personnel. Services include family, group, and individual psychotherapy, play therapy, parent support, classroom behavior consultation, mentoring, psychiatric and nursing services coordinated with school nurse. Services are school-based and integrated with the student's academic day.

• **Vocational Services:** Services for any member interested in pursuing educational or work opportunities. Services may include assessment, prevocational training, job training, supported employment, social skills training, coaching, and referral to related agencies.

SUBSTANCE USE DISORDERS SERVICES

As of January 1, 2014, our continuum of services expanded to include outpatient treatment for members with **Substance Use Disorders (SUD)**. This makes a more comprehensive array of services available to assist members in their recovery. The list below includes services that were added in January 2014. In treating a member with a covered substance use disorder, if there are additional **outpatient** services a member needs, please contact Beacon Health Options to request authorization at 1-800-804-5008. As a part of that benefit expansion, the following Outpatient services were added to the Health First Colorado Behavioral Health Services Program:

• **Evaluation/Assessment Services:** Diagnostic assessment of the member who presents for treatment to determine the member's needs and strengths and to recommend the appropriate level of care and focus of treatment.

• **Outpatient Treatment:** Least restrictive level of care in which the member participates in face- to-face assessment, counseling and routine case management services delivered in a behavioral health provider's office or other community setting. Individual and group therapy may be provided based on the assessment and needs of the member. Family therapy and medication management services are also available when medically necessary.

• **Patient education related to alcohol and/or drug screening results:** Verbal discussion with the member providing the results of positive screens focused on patterns of use, relapse prevention and progress towards recovery goals of the member.

• **Peer services**: Services provided to members by others with lived experience with substance use recovery and/or mental health treatment. Peers are trained to help members identify strengths, develop and work towards personal recovery goals and maintain hope during the recovery process. Skills for relapse prevention are also a focus of these services.

• **Medication Assisted Treatment:** Methadone or suboxone administration by a licensed facility to assist members with opioid addictions. Includes use of medications along with behavioral interventions such as group and individual therapy to assist members in an integrated treatment approach addressing medical and psychosocial needs of members as they recover.

• **Social Detoxification Services**: Services provided by non-medical facilities to oversee and assist members who experience withdrawal from alcohol and/or drugs. A safe environment is provided and staff members help keep members comfortable as they are in the process of detoxification.

The benefit for substance use disorders does not include any inpatient or residential treatment at this time.

The Office of Behavioral Health contracts with Managed Service Organizations (MSO) who contract with providers that would include these more intensive levels of care. For more information or if you would like to find information for the MSO in your county, please visit the following link: https://www.cbhc.org/find-help/find-addiction-services/

Substance use disorder services are available through the BHO based on covered diagnoses and medical necessity for the particular service. If a requested service does not meet medical necessity criteria, or is not a covered diagnosis for the BHO, then Health First Colorado cannot fund the treatment. In this event, it may be helpful for providers to be aware of other funding sources such as your regional Managed Service Organization, local department of human services or probation. These funding sources may be available for some members when treatment is not approved through Health First Colorado funding. Self-pay may be another option for members in these circumstances.

Providers are encouraged to submit their requests for authorization for review for services they feel are medically necessary so Beacon Health Options can review the request and make a determination regarding medical necessity. Providers should become familiar with the BHO covered diagnoses, medical necessity criteria, and billing and coding standards. Beacon Health Options does offer periodic provider trainings and informational sessions. You can learn more about these opportunities by calling 719-226-7788.

Services are provided by Community Mental Health Centers and facilities licensed by the Office of Behavioral Health that are a part of our independent network of outpatient providers.

Providers who are not part of the Beacon Health Options network for Health First Colorado members should contact the Provider Relations Department of Beacon Health Options for any inquiries regarding joining the network. Provider Relations can be reached at 1-800-804-5040. Current providers, in the Beacon Health Options network, should also contact Provider Relations to discuss approval for program additions such as substance use disorder treatment procedures to current contracts.

Section 3

PROVIDER ASSISTANCE & REFERRALS

For access to care and any other member related services, please call:

Provider Relations Needs:	1-800-804-5040
Clinical Authorization and Claims Needs:	
Colorado Health Partnerships(CHP)	1-800-804-5008
Foothills Behavioral Health Partners	1-866-245-1959

CLINICAL OPERATIONS DEPARTMENT

Clinical Care Managers (CCM) are available 24 hours a day, 7 days a week for:

- Pre-authorization for:
  - inpatient
  - Acute Treatment Units
  - Residential Treatment
  - and any higher level of care
- Utilization review
- Consultation
- Continued authorizations (concurrent reviews)
- Providers may also call the Clinical Operations Department to consult with a CCM regarding a member's treatment needs related to:
  - Medication management referral
  - Psychological testing (prior authorization required)
  - Aftercare (in preparation for program/facility discharge) with an outpatient therapist or structured program
  - Referral to a different level of care, including discharge

CLINICAL CUSTOMER SERVICE DEPARTMENT

Representatives are available from 8:00 a.m. to 5:00 p.m. (MT), Monday through Friday. They are responsible for:

- Verification of Health First Colorado eligibility
- Assistance with member referrals
- Questions related to outpatient authorizations

- Verification of automated authorizations through ProviderConnect
- Benefit explanations
- Prevention, Education, and Outreach referral information

Claims questions - our phone lines have options for you to reach representatives in our Claims Customer Service department so that you can speak with specialists ready to answer questions about claims submission and payment. You can also reach the Beacon National Claims Department at 1-800-888-3944.

NETWORK CREDENTIALING DEPARTMENT

Provider Relations staff are available from 8:00 a.m. to 5:00 p.m. (MST), Monday through Friday. You can reach them at 1-800- 804-5040. Provider Relations staff is responsible for:

- Colorado Client Assessment Record(CCAR)
- ProviderConnect training
- Network monitoring
- Network management
- Application status

OUTPATIENT AUTHORIZATIONS: PROVIDERCONNECT

Authorization must be made within 30 calendar days after the date of service for which you are requesting authorization. Outpatient providers are required to use the ProviderConnect system to authorize outpatient therapy. Authorization of outpatient services should be completed by using our online ProviderConnect system. ProviderConnect is conveniently available 24 hours a day, seven days a week, including holidays. If you need assistance setting up access to ProviderConnect, please contact the EDI Helpdesk at 1-888-247-9311.

Initial evaluation sessions for outpatient therapy do not require authorization for our contracted providers. This initial evaluation session will be paid, regardless of diagnosis, and allows you to assess the member's need, determine the mode of treatment (individual, family, group therapy, etc.). Once you have completed this session you can contact us via ProviderConnect to request authorization for ongoing sessions.

PROVIDERCONNECT

ProviderConnect provides an online alternative to telephonic requests for authorizations, giving providers a 24/7 available, easy-to-use tool for completing everyday service requests. The system will allow users to access the following features:

- Member eligibility status
- Claims search (for specific member(s) in order to view details of claim such as claim status, paid date, check number, etc.)

- Electronic claims submission (both batch and single claim)
- View and print correspondence including authorizations and provider summary vouchers
- Access your provider practice profile (lookup demographic information, validate and submit changes online)
- Submit inquiry to customer service (send a question to Beacon Health Options online and get a response in the manner you choose)
- Benefit status
- Register outpatient care
- Updating provider demographic data

PROVIDER AVAILABILITY FOR MEMBER ACCESS TO CARE

Federal regulations prohibit discrimination against Health First Colorado covered individuals. Any practice which selectively excludes members from available treatment services/appointments may be in violation of those regulations. A statement by your scheduler or voicemail that you are "not currently accepting Health First Colorado clients" constitutes discrimination.

All Beacon Health Options providers must have appointments available for Health First Colorado members as specified below, according to State/Federal regulation and the provider contract:

1. **Routine Access:** A routine appointment must be available within seven (7) business days of a member's request. Under the Health First Colorado provider contract, providers are required to **offer** a routine appointment within seven (7) business days. If a provider offers a member a routine appointment within seven business days and the member declines and chooses an appointment outside of seven business days, the access requirement is met. Members must be offered the same hours of availability as all other insurance members.

2. **Routine Outpatient Appointment Following an Inpatient or Residential Discharge:** A routine appointment must be available within seven (7) business days after discharge from an inpatient psychiatric hospitalization or residential facility.

3. **Urgent Access**: Urgent care (appointments) shall be available within twenty-four (24) hours from the initial identification of need.

   Urgent Definition: A request from a member or designated member representative for situations or circumstances for which there is the potential for placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy without treatment, OR potential for serious impairment to bodily functions without treatment, OR potential for serious dysfunction of any bodily organ or part without treatment. The appointment should be scheduled within 24 hours of the initial request.

4. **Emergency Access:** Emergency services shall be available by phone, including by TTY

accessibility, within fifteen (15) minutes of the initial contact, in person within one (1) hour of contact in urban and suburban areas, in person within two (2) hours of contact in rural and frontier areas.

Emergency Definition: Conditions, situations or circumstances for which there is the risk for placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy without treatment, OR for serious impairment to bodily functions without treatment, OR for serious dysfunction of any bodily organ or part without treatment.

A regional Community Mental Health Center (CMHC) emergency services team should be consulted prior to inpatient hospital admission or higher level of care. These teams provide assessments at most local emergency rooms. Independent network providers typically do not have emergency room privileges. Thus it is impractical to require independent providers to conduct emergency evaluations in hospital ERs.

5. **Inpatient and Residential Treatment post-discharge follow-up appointments**: Outpatient follow-up appointments are required within seven (7) business days after discharge from an inpatient psychiatric hospitalization. Outpatient follow-up appointments or equivalent post-discharge follow-up are required, documented in the discharge care plan, within seven (7) business days after discharge from a residential treatment facility.

6. **Hours of operation:** Providers who serve only Health First Colorado members shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees. Minimum hours of provider operation shall include covered service coverage from 8:00 a.m. to 5:00 p.m. Monday through Friday and emergency coverage 24 hours a day, seven (7) days a week. Providers are encouraged to offer flexible appointment times or after regular business hours' appointments to members whenever possible.

7. **Extended Hours of Operation:** Extended Hours of Operation and covered service coverage must be provided at least two (2) days per week at clinic treatment sites which should include a combination of additional morning, evening or weekend hours, to accommodate members who are unable to attend appointments during standard business hours.

8. **Evening and/or Weekend Support Services:** Members and families should have access to clinical staff over evenings and weekends, not just an answering service or referral service staff.

9. Ongoing mental health and substance use disorder services shall be scheduled and continually provided for within two (2) weeks from an initial assessment or intake appointment. Ongoing services include, but are not limited to:

    - Assignment to a therapist and individual/group therapy

10. **Routine outpatient appointments:** Following intake/initial assessment, routine outpatient appointments shall occur at least three (3) times within forty-five (45) days.

EXPECTATIONS OF PROVIDERS FOR EMERGENCY ACCESS:

In order to comply with emergency access standards under the provider's contract, our expectations for independent providers are:

1. If an independent provider is contacted by a member in crisis, the provider will conduct an assessment to determine whether the member's situation can be handled outside of the emergency room. This assessment should follow the standards as indicated in item 4, Emergency Access, above.

2. If the member goes directly to the ER, or if the provider determines the member in crisis is best assessed in the ER, the provider will be available to the CMHC emergency services team to provide background information, diagnosis and other pertinent details on the member in crisis. This will assist the CMHC emergency services clinician in conducting the member's evaluation, and may result in the most appropriate disposition for the member.

   Providers are required to give contact information to members on their voicemail to include one of the following: the provider's pager, the provider's cell phone number, or how to reach a covering clinician with whom the provider contracts to provide coverage when the treating provider is not reachable.

3. Quarterly test calls are performed at random by the Beacon Health Options quality improvement staff to monitor provider compliance with these standards. Should a provider receive a test call and not meet the access to care standards, a corrective action plan (CAP) may be requested. The CAP should include how the provider intends to correct any access to care discrepancies and how these will be avoided in the future. A provider's non-response to a requested CAP may result in network disenrollment.

No prior authorization is required for emergency services. Outpatient providers are expected to offer 24-hour personal emergency access to their members or have formal arrangements for emergency coverage by another practitioner. An answering service/machine which refers all callers to an emergency room, community mental health center, crisis or other agency is **not acceptable** unless the provider has established a formal contract for emergency coverage with the agency. In all cases, providers must obtain prior authorization for inpatient care by calling the Access to Care Line 24 hours a day, seven days a week, at 1-800-804-5008.

Waiting Room Time for Scheduled Member Appointments:

A Health First Colorado member who arrives on time for their scheduled appointment shall wait no longer than fifteen (15) minutes to begin their scheduled appointment. If the appointment does not

begin within fifteen (15) minutes, the member shall be offered the option of rescheduling for the next available appointment. Members shall be notified of the option to reschedule through a posted notice in the waiting area or by having the wait time policy reviewed with the member at the initiation of treatment.

Members who were scheduled for prescriber services should be provided an appointment date that does not cause a delay or gap in their prescribed medication regimen. Members indicating urgent or emergent concerns should be provided an appointment that meets the access standards for urgent/emergency requests.

HOW MEMBERS ACCESS BEHAVIORAL HEALTH CARE

A member can access behavioral health care in four ways:

1. A member, family member, provider, or advocate for the member can call Beacon Health Options toll-free, seven (7) days a week for emergency or non-emergency situations, clinical assessment, and referral to the most appropriate provider.
2. The member can call or walk into any one of the Colorado Community Mental Health Centers (CMHC) or contact a network provider office and receive a face-to-face clinical evaluation and request services.
3. The member can be referred by their primary care physician, social services caseworker, court system or other community agency through the access points described above.
4. The member can go to or be brought to any emergency room. A face-to-face evaluation may be arranged with an area crisis evaluator. The crisis evaluator participates in disposition recommendations.

REFERRALS TO NETWORK PROVIDERS

All care must be authorized with the Beacon Health Options Engagement Center. Outpatient prior authorization is not required but authorization must be obtained for certain services within thirty business days following the initial appointment. Please contact us for a list of what outpatient services require authorization. All other levels of care must be pre-authorized. If authorization is not obtained for non-emergency treatment, an administrative denial or reduction of claims payment may result.

OUTPATIENT SERVICES

The initial authorization will define the number of sessions of psychotherapy allowed by the

BHO in which the member maintains eligibility. Data is used to monitor utilization and the provider may be requested to provide telephonic or written clinical review upon reauthorization. Psychological testing requires a separate pre-authorization.

PRIMARY BEHAVIORAL HEALTH PROVIDER

The first outpatient network provider seen by the member is established as the Primary Behavioral Health Provider. The Primary Behavioral Health Provider is responsible for identifying any additional behavioral health services required by the member and conferring with the Beacon Health Options Engagement Center CCM for referrals for additional services if required. The Primary Behavioral Health Provider is **required** to coordinate all services being provided and to **document** that coordination.

COORDINATION OF BEHAVIORAL HEALTH AND PRIMARY CARE

All members should have a Primary Care Physician (PCP). The Beacon Health Options Engagement Center can assist members in finding a PCP. Coordination with the PCP is necessary to promote integrated care, particularly related to medication management. Coordination with primary care is the responsibility of the Primary Behavioral Health Provider.

FACILITIES/PROGRAMS

Facilities/programs receive referrals and authorizations from Beacon Health Options Engagement Center CCMs. Prior authorization is always required. Beacon Health Options CCMs are available 24 hours a day, 7 days a week for prior authorization.

EMERGENCY DEPARTMENTS

After initial emergency department triage, authorization for further inpatient evaluation and/or treatment must be obtained from a Beacon Health Options Engagement Center CCM. At most hospitals, an independent assessment by a CMHC crisis evaluator will be required to assist in diversion, crisis stabilization, and referral to follow-up.

ELIGIBILITY VERIFICATION

Health First Colorado eligibility should be confirmed before the first visit. Confirm the member's name, social security number, and Health First Colorado ID number, by examination of the current Health First Colorado card or by calling our toll-free number to verify eligibility. We recommend re-verifying eligibility at least once a month as eligibility is subject to change.

ALTERNATIVE OR ADDITIONAL SERVICES

Providers must call to refer a member to another provider for a second opinion, consultation services or a new level of care. At that time, a Beacon Health Options Clinical Care Manager will review the case.

AUTHORIZATION AND DENIAL OF SERVICES

A letter confirming authorization for all levels of care will be posted on ProviderConnect for providers to view and print. When there is a denial, limitation or termination of requested services or of currently authorized services, the member or legal guardian is also sent a notification letter. The letters contain instructions for filing an appeal. The BHO Office of Member and Family Affairs and the Ombudsman for Health First Colorado Managed Care are available to help a member with the appeal process.

COLLECTION OF CO-PAYMENTS/DEDUCTIBLES

Members covered through Health First Colorado are not subject to co-pays or deductibles. Collection of fees directly from a Health First Colorado member may result in termination as a participating provider. This includes charges for non-covered services, including missed appointments.

Section 4

UTILIZATION MANAGEMENT PROCEDURES

All authorization decisions are based on the determination of medical necessity for the requested service, and on the Level of Care Guidelines. Services may be authorized only for covered services and covered diagnoses per our contract with the Department of Healthcare Policy and Financing (HCPF).

Providers are expected to cooperate fully with Care Management and Medical staff to provide accurate and timely clinical information to assist with this process. This may include submission of verbal reports or written documentation (including treatment plans). All documentation needs to be submitted in English, even if records in the client's chart are kept in another language.

Participation in telephonic or face-to-face staffings may be required for complex cases. Clinical and Medical staff will make every effort to make decisions in a manner that allows providers to focus on the care of members, and will not ask for more information than is necessary to make an appropriate decision regarding medical necessity of the service in question.

What is Medical Necessity per the Health First Colorado Contract and how are authorizations decisions made?

1. "Medically Necessary" describes a service that, in a manner in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care:

    a. Is reasonably necessary for the diagnosis or treatment of a covered behavioral health disorder or to improve, stabilize or prevent deterioration of functioning resulting from such a disorder
    b. Is clinically appropriate in terms of type, frequency, extent, site and duration
    c. Is furnished in the most appropriate and least restrictive setting where services can be safely provided
    d. Cannot be omitted without adversely affecting the member's behavioral health and/or physical health conditions associated with the member's covered mental health diagnosis, or the quality of care rendered.

2. Clinical Criteria

    a. Clinical Criteria utilized for decision making include the definition of "medically necessary services," listed above and the Beacon Health Options Level of Care

Guidelines, comprised of admission criteria, exclusion criteria, continued stay criteria and discharge criteria for the specific level of care requested. Additional clinical information, such as CCAR rating scales, may also be used to supplement other clinical information used for decision making.

Utilization management (UM) is the responsibility of the Beacon Health Options Clinical and Medical Departments. Clinical Care Managers (CCM) perform clinical reviews and care management for all levels of care via telephonic discussions and review of written clinical records. The frequency of review varies with the intensity of the level of care being provided and the clinical needs of the member. All care provided to members must be authorized by Beacon Health Options. Member consent is not required for provider participation in UM activities except for those UM activities related to substance use disorder services, when it is specifically required by law (42 CFR, part 2).

Beacon Health Options CCMs are responsible for the following functions:

- To conduct reviews with treatment providers to verify medical necessity based on Behavioral Health Organization (BHO) treatment criteria at point of access, for continuing care, and aftercare.
- To ensure that the evaluation of the member includes pertinent psychosocial, medical and psychiatric/behavioral health information to support the diagnosis and impairments determined by the provider.
- To ensure that service plans are strengths-based, address the current problems represented by the diagnosis and impairments identified by the provider, are coordinated with other service delivery persons or agencies, and are consistent with the BHO's clinical criteria.
- To be a catalyst to encourage good coordination of care, prompting providers to involve all appropriate treatment team members in the delivery of integrated care designed to assist the member in overall health. To this end, to listen for needs that may be unrelated to the behavioral health authorization decision, but may be having a significant impact by creating barriers to discharge or contributing to re-admissions (e.g., physical health needs, housing, transportation, other waiver services.) When these needs are present, CCMs will assist in connecting the member and provider to the appropriate agency to assist with the member's needs (Regional Care Collaborative Organizations, (RCCO, Managed Service Organizations (MSOs, Community Centered Boards, Single Entry Point agencies (SEPs), and Non Emergent Medical Transportation agencies).
- To ensure that level-of-care and treatment decisions are based on medical appropriateness and necessity, as described in the clinical criteria and guidelines, and are designed to achieve desired member outcomes within an optimal time frame.
- To ensure that discharge planning begins at admission, that the planning involves the member, significant others and other representatives who will ensure implementation of the discharge plan, that clear and specific criteria for discharging members from treatment are established at the outset of treatment, that the plan is realistic and attainable, and that it is both understood by and agreed to by the member and family/significant others as appropriate.

- To provide consultation to treatment team members when needs of members are complex.

WHEN DOES THE CCM CONDUCT CARE MANAGEMENT FUNCTIONS?

- When the ProviderConnect system directs the provider-user to call the CCM.
- When a provider contacts the CCM for **initial** *or* **continuing authorization.**
- When there is a need to change the level of care being provided.
- When quality data related to any aspect of member care indicates the need for provider involvement to clarify or take action on identified patterns/trends.
- When clinical information provided causes concern regarding quality of care, inactive/non-efficient treatment, or any safety concerns for the member.
- When a member has had multiple admissions to higher levels of care
- When members/guardians, community agencies or providers request involvement or review of the care provided.

PROVIDER RESPONSIBILITIES IN UTILIZATION MANAGEMENT

Beacon Health Options contracted providers are required to:

- Complete a comprehensive assessment of the member at the start of treatment that clearly provides rationale for the diagnosis and the mix of services provided to the member.
- Provide accurate clinical information that is consistent with the member's written documentation in the chart, to support authorization requests.
- Keep track of authorizations and their use of authorized services to allow them to make timely requests for re-authorizations.
- Begin discharge planning at the time of admission, for all levels of care.
- Submit complete and accurate discharge and aftercare plans to Beacon Health Options and all related aftercare providers within 72 hours of discharge. Member care and quality treatment are significantly impacted following inpatient treatment without this data.
- For inpatient and residential levels of care, to complete a discharge plan for each member within 48 hours of admission and have this plan signed by the member and guardian/family member, as appropriate. This plan needs to be in the member's chart. For any plan not completed within 48 hours, the chart needs to contain documentation of the clinical reason why this was not possible.
- Provide services in the least restrictive environment possible for the member.
- Follow all documentation requirements, including updated and accurate written treatment plans that guide their services to Health First Colorado members.
- Provide clinical information verbally, when requested, to assist with an authorization decision.
- Provide a copy of the member's written treatment plan or treatment notes, when requested.
- Respond in a timely manner when clinical or medical staff reach out to them to confirm

information (clarify their authorization request, confirm member's start or end date of treatment, or other treatment details.)

- Request initial authorizations for outpatient services no more than 30 calendar days after the initial assessment for outpatient services, and prior to admission to inpatient, or higher level of care services.
- Request concurrent authorizations on the last covered day for higher level of care services, or no later than 30 calendar days after the date of service for outpatient services.
- Request authorization only for services they feel meet medical necessity guidelines.
- Follow the Uniform Service Coding Standards Manual guidelines in providing care at the approved place of service, by the appropriately qualified staff person. You may be able to find the latest version on the Colorado Official State website https://www.colorado.gov/pacific/hcpf/mental-health-rate-reform-0

OUTPATIENT CARE INITIAL AUTHORIZATION

1. Providers should complete an initial evaluation then obtain authorization for outpatient care via ProviderConnect no later than 30 calendar days after the initial evaluation. Initial evaluations do not require authorization for contracted providers and can be billed with a deferred diagnosis (R69) or no diagnosis (Z03.89) code, if needed.

2. A treatment plan is required for all outpatient services, and must include time limited and measurable objectives. It must be formulated with member or guardian input, and signed by the member and/or guardian. Providers are not routinely required to submit a treatment plan to receive initial authorizations, but should be prepared to submit the plan upon request, if needed.

3. **Network providers do not need prior authorization of evaluation or individual therapy sessions. *However*, other services typically require prior approval.** See the BHO specific addendum for more information. The authorization will indicate a specific provider and type(s) of service. Authorizations will also include start and end dates of the authorization, and the number of units authorized, so the provider will know when to request additional services.

4. Family therapy is conducted for the treatment of the identified member's covered diagnosis only and billed under this individual's Health First Colorado coverage. **Separate billing for other family members who participate in the family therapy sessions is not allowed**.

5. For contracted providers, medication management does not require authorization.

6. The Colorado Client Assessment Record (CCAR) (required by Colorado Department of Health and Human Services**) for treatment of covered mental health conditions only**, shall be submitted promptly after authorization has been obtained. See CCAR, Section 12, for a copy of these forms. Providers can fill out CCAR forms on the website at http://www.chneforms.com/ccar/login.cfm.

OUTPATIENT CARE CONTINUED AUTHORIZATION

1. If further care is requested and determined to be clinically indicated, subsequent authorization will be made through ProviderConnect. When written documentation is required, this can be uploaded into the ProviderConnect system.

2. Additional care may be authorized if clinically indicated, and a provider may request that the authorization be back dated up to 30 calendar days prior to the date of the request. Outpatient authorizations will not be back dated for more than 30 calendar days prior to the request date, whether by telephone, fax, or other submission method.

3. For providers treating a covered **mental health condition**, the provider is required to submit their written treatment plan to Beacon Health Options for Peer Advisor review once the member has completed 25 sessions of service (any combination of individual, family or group therapy).

4. **Substance Use Disorder (SUD) Services**: Providers treating members with substance use disorders should follow the guidelines below:

    a. **Medication Assisted Treatment (MAT):** Submit requests through ProviderConnect or by calling Beacon Health Options at (800) 804 5008 or (866) 245-1959. Information needed includes: member's Health First Colorado ID, diagnosis, procedure code requested and dates of service. After this information is provided, our staff will review and if any further information is needed we will discuss the request telephonically with you, or let you know if any written documentation is needed.

    b. **Social Detoxification Services**: Submit requests through Provider Connect or by calling Beacon Health Options at 1-800-804 5008 or 1-866-245-1959. Information needed includes member's Health First Colorado ID, diagnosis, procedure code requested and dates of service. After this information is provided, our staff will review and if any further information is needed we will discuss the request telephonically with you, or let you know if any written documentation is needed.

    c. **All other outpatient requests: Additional requests** (including individual counseling, group counseling, family therapy, medication management, case management, patient education after urine/drug screens, peer services or any other outpatient service other than Medication Assisted Treatment or Social Detoxification services) require the following:

        i. Providers should submit their written initial assessment, treatment plan and the SUD Service Re-Authorization Request Form (located at the end of this section) at the time of their request for authorization of additional sessions for treatment of substance use disorders.

5. Treatment plans may be requested any other time there is a need to review the medical

necessity of the services and the provider is requested to submit the plan. Providers are not to create a special treatment plan for the authorization request, but to submit the treatment plan they are documenting and keeping up to date as a part of the member's treatment record. When treating a covered mental health diagnosis, the provider may send the treatment plan to Beacon Health Options for review when they are within 30 days of exhausting all authorized units for a particular service and they feel that additional sessions will be needed. This can help the authorization process occur in a timely manner. For treatment of a covered substance use disorder, providers may submit their written initial assessment, treatment plan and SUD Service Re-Authorization Request Form when they are within 30 days of exhausting all authorized units for a particular service and they feel additional units will be needed.

6. The treatment plan will be reviewed by a Beacon Health Options Peer Advisor before sessions in excess of 25 will be authorized for mental health services, and the initial assessment, treatment plan and SUD Service Re-Authorization Request Form will be reviewed prior to authorizing additional units in excess of the initially authorized SUD services.

7. If the initial assessment, treatment plan/ form does not meet clinical criteria, a CCM will address the relevant issues with the provider and refer the case for review. Routine outpatient care will not be authorized on a retrospective basis (more than 30 calendar days after the date of service), except in cases of retroactive Health First Colorado eligibility.

HIGHER LEVEL OF CARE (INPATIENT, PARTIAL HOSPITAL, RESIDENTIAL, DAY TREATMENT AND INTENSIVE COMMUNITY BASED SERVICES) PRIOR AUTHORIZATION

Prior authorization is required for all inpatient, partial hospital, residential, day treatment and intensive community-based services. ***These services are not covered for treatment of substance use disorders.***

Beacon Health Options may require an independent assessment by a Community Mental Health Center (CMHC) Crisis Evaluator or Residential Treatment Center Liaison prior to admission. In most cases, the CCM will consult with the local CMHC for availability of diversion services prior to authorizing higher levels of care.

For inpatient care, providers must direct members to a Beacon Health Options contracted facility to ensure eligibility for hospitalization benefits. If a contracted facility is not available, Beacon Health Options will work with a willing non-contracted facility to insure timely admission of a member in need of inpatient care. Providers are to collaborate with Beacon Health Options Care Management and the CMHC evaluators to assist member in receiving treatment at a lower level of care if needed, to meet the requirement that Health First Colorado members receive treatment at the least restrictive level of care. Collaboration includes the provision of verbal or written treatment information to another provider, if indicated.

Inpatient care requires coordination of care with the CMHC for Health First Colorado

admissions, to obtain the best treatment benefit for each member and arrange appropriate aftercare services. Care should be coordinated by a social worker or member of the treatment team with firsthand knowledge of the member's symptoms and care. This should begin on the day of admission and occur routinely and regularly throughout the hospitalization.

Inpatient care providers must follow the Inpatient Treatment Guidelines at the end of this section.

HIGHER LEVEL OF CARE CONTINUED AUTHORIZATION IPATIENT, PARTIAL HOSPITALIZATION, RESIDENTIAL, DAY TREATMENT AND INTENSIVE COMMUNITY SERVICE

1. Pre-authorization of continuing higher levels of care requires a telephonic or written review between the provider and the Beacon Health Options CCM. Providers should follow the instructions of the CCM regarding the clinical information needed. Most authorizations will be completed via telephonic review, but occasionally, written documentation is needed to determine medical necessity.

2. Beacon Health Options requires active collaboration with regional CMHC care coordinators in discharge planning. Providers not participating in Care Coordination with CMHC staff members for discharge planning and care coordination may receive an administrative denial of services since this is a required function. CMHC staff often have relevant clinical information to provide which informs the treatment plan and needs to be included. Coordinating care includes timely return of phone calls and potential face to face meetings with CMHC staff members.

3. To evaluate the higher level of care request, the CCM will require detailed information concerning the member's need for continuing care (i.e., measurable treatment goals, and discharge plans, current condition, and any additional services). It is the responsibility of the hospital's designated case manager (social worker or UR representative) to call the Engagement Center for all scheduled reviews and continued authorization prior to expiration of the current authorization. Late requests may not be retroactively authorized and may be administratively denied.

HOSPITAL PROFESSIONAL CHARGES

Some facility contracts are all-inclusive. Some contracts may exclude telephonic reviews. Professional charges may be included in contract rates. It is the responsibility of the facility to negotiate reimbursement with the professional staff, and to be familiar with the requirements of their contract in regard to UM procedures.

EMERGENCY SERVICES

1. Emergency care is defined as a medical condition manifested by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

a. placing the patient's health in serious jeopardy
b. serious impairment to bodily functions
c. or serious dysfunction of any bodily organ or part.

2. **Emergency services do not require prior authorization.**

3. Documentation must accompany claims for emergency services in order to support covered diagnosis. This documentation will be reviewed on a retrospective basis, after the member has received care.

AUTHORIZATION WHEN LEVEL OF CARE CHANGES

1. Authorization of care does not extend from one level of care to another. CCMs must be notified immediately when a member is discharged from any level of care and a CCM must receive the discharge and aftercare plan in writing or via ProviderConnect.
2. Authorization for treatment at a new level will be based on the current clinical presentation, treatment plan and continuity-of-care concerns.
3. A new authorization will be required with any change in the level of care.
4. Any unused portions of prior-to-admission outpatient authorizations are null and void once an inpatient/partial hospital/alternative level of care case is opened.

ELECTROCONVULSIVE THERAPY (ECT)

All inpatient and outpatient ECT requires pre-authorization. ECT requests must be reviewed by the BHO Medical Director. Please contact the Clinical Department at 1-800-804-5008 to request a review for authorization.

PSYCHOLOGICAL TESTING (ALL TESTING REQUIRES PRE-AUTHORIZATION)

The use of psychological testing can be very beneficial when it provides information relevant to the treatment of a psychiatric condition in a timely manner. Rather than being considered a routine procedure in an individual's treatment, testing should be requested only when other interventions have not been successful in providing sufficient information with which to develop an appropriate treatment plan.

When psychological testing is necessary, it should be requested in order to address specific questions which may be useful in diagnostic clarification and subsequent treatment planning. Specific testing procedures selected by the psychologist should demonstrate a focused approach toward addressing the referral questions. "Standard psychological test batteries" are discouraged. **Educational testing** (e.g., learning disabilities assessments), **vocational testing, and testing conducted in order to rule out medical conditions** (e.g., many neuropsychological assessments) **are excluded benefits and will not be authorized.** Pre-authorization for up to one hour of screening may be obtained by calling the Clinical Department at 1-800-804-5008. All testing beyond one hour's screening requires pre-authorization based on submission of a Psychological Evaluation Request Form, located at the end of this section, prior to testing. If you are both the treating therapist and a licensed psychologist, complete both sides of the form and

mail or securely fax to the Beacon Health Options' Clinical Management Department at 719-538-1439. If you are the treating therapist, but not a licensed psychologist, please take these steps to ensure a correctly completed form:

- Call the Beacon Health Options Access to Care line at 1-800-804-5008 for assistance with referral to a network psychologist with the appropriate expertise.
- Complete Page 1 of the Request Form and securely fax/mail it to Beacon Health Options. After the evaluation is assigned to a provider, the testing psychologist may request a phone consultation to insure that he/she has as much clinical information as possible and understands your questions.
- The psychologist must complete Page 2 and mail or fax the form to Beacon Health Options for authorization:

Beacon Health Options
9925 Federal Drive, Suite 100
Colorado Springs, CO 80921

FAX: (719) 538-1439

***NOTE:** Authorization on inpatient psychological testing can be expedited by calling 1-800-804-5008. Most contracts include all professional fees. For reimbursement, all psychological testing must be preauthorized.

GUIDELINES:

- One unit of testing equals one hour for psychological testing
- Testing is only authorized for face-to-face administration of testing procedures by a psychologist or psychometrician working under the supervision of a psychologist (i.e., chart reviews and testing feedback sessions are not to be authorized as a psychological testing procedure).
- The use of self-administered objective inventories is encouraged prior to requesting more extensive testing. One hour can be authorized by Beacon Health Options for such screenings. The following is a list of the most frequently requested inventories:

  MMPI-2: Minnesota Multiphasic Personality Inventory-2 (Adult)
  MMPI-A: Minnesota Multiphasic Personality Inventory-Adolescent
  MCMI-II: Millon Clinical Multiaxial Inventory-II (Adult)
  MAPI: Millon Adolescent Personality Inventory
  MACI: Millon Adolescent Clinical Inventory
  PIC: Personality Inventory for Children

- When such inventories do not provide sufficient information, additional testing may be warranted. Authorization for **personality assessments** varies depending upon the nature of the questions being asked and the specific tests being proposed to address those questions. The following tests are the most often utilized for personality

assessment and the standard authorization allowed for each procedure is:

Rorschach Projective Technique, 1.5 hours
Apperception Technique (TAT, CAT, or Roberts), 1.0 hours
Projective Drawings (DAP or H-T-P or Kinetic Family Drawing), .5 hours
Beck Depression Inventory, 0.5 hours
Reynolds Depression Scales (Child, Adolescent, or Adult), 0.5 hours Sentence Completion or Incomplete Sentences Procedures, 0.5 hours Bender Visual-Motor Gestalt Test, 0.5 hours

- The use of intellectual assessments can be authorized only if they are being used to clarify a psychiatric diagnosis or to determine whether treatment might need to be modified because of a member's intellectual disability. Appropriate uses would be for assessment of psychosis, neuropsychological screening, and, in some instances, the assessment of attention deficit disorders. The most often requested procedures for intellectual assessments are the Wechsler Scales:

  WPPSI-R (preschool), 1.5 hours
  WISC-IV (children & adolescents), 1.5 hours
  WAIS-IV (adults), 1.5 hours

- **ATTENTION DEFICIT DISORDER ASSESSMENTS:** There is wide variation between practitioners in conducting these assessments. Focused evaluations can generally accomplish this assessment in one to three hours. Full, comprehensive, neuropsychological evaluations, which are often requested (sometimes from six to twelve hours), are not medically necessary to identify and diagnose Attention Deficit Disorder (ADD) or Attention Deficit /Hyperactivity Disorder(ADHD). The following are the most commonly used procedures for ADD/ADHD assessments.

  Rating scales (Parent's, Teacher's, Connors scales, etc.), 0.5 hours
  CBCL (Child Behavior Checklist), 0.5 hours
  Gordon Diagnostic System, 1.0 hours
  TOVA (Test of Variables of Attention), 1.0 hours
  WISC-IV (Wechsler Intelligence Scale for Children – IV), 1.5 hours

- **NEUROPSYCHOLOGICAL ASSESSMENTS:** Neuropsychological assessments will be authorized for individuals receiving mental health services only when treatment planning considerations warrant such an evaluation. Generally, neuropsychological evaluations can be completed within six hours.

GENERAL MEDICAL RECORD REQUIREMENTS

SEE SECTION 17 OF THIS HANDBOOK FOR DOCUMENTATION REQUIREMENTS

The State of Colorado requires the completion of the Colorado Client Assessment Record (CCAR) for treatment of all covered **mental health conditions**. Additionally, Beacon Health

Options has medical record requirements for members receiving services at any level of intensity:

1. **CCAR:** Form must be completed promptly after initial authorization is received, at discharge and once annually if the member is in treatment for 12 months or longer. Please submit the CCAR to Beacon Health Options promptly upon completion. (See Section 12 for instructions.)

2. **Coordination of Care:** All providers must coordinate care with any client's primary care medical provider (PCMP) and with other treatment providers, to include member's outpatient therapist or prescriber, RCCO's, SEP agencies, Community Centered Boards, as appropriate for each member. If a member does not have a PCMP, providers are to assist the member in locating one. Assistance is also available at the Beacon Health Options Engagement Center and may be obtained by calling 800-804-5008. Coordination of care is required and should be documented. A release of information is required for the coordination of care with other providers. See Section 8, Coordination of Care, within this Provider Handbook for further details. **Missed Appointments:** Providers are expected to contact members who unexpectedly miss an appointment within 24 hours of the missed appointment. The urgency of the contact is determined by the provider's assessment of risk potential related to the missed appointment. Actions are to be documented in the member's medical record.

3. **Discharge Plan:** Within 48 hours of admission to inpatient or residential care, the member's chart must include a written discharge plan, signed by the member and parent/guardian/family member as appropriate. If the plan is not completed within 48 hours, the chart must contain the clinical rationale for why it was not completed, and it should be completed as soon as clinically appropriate.

4. **Medical Record and Treatment Plan:**
    a. All documentation requirements in Section 17 must be contained in the member's medical record. Additionally, all member medical records must contain a comprehensive biopsychosocial assessment, measurable treatment goals, signed progress notes, and a discharge plan. The treatment plan should indicate involvement of a member's family/significant others when clinically indicated. If not clinically indicated, this should be noted as a part of the plan. Medical and psychological treatment documentation and progress notes must be current, dated and signed, and treatment plans must be updated regularly.
    b. The provider initiating treatment must formulate an initial treatment plan with input from the member. The treatment plan should describe the specific target problems or symptoms, and identify strengths and supportive resources, as well as the diagnosis, planned interventions at the level of care proposed and clear, time limited and measurable criteria for discharging the member from treatment that are agreed upon by member and provider. Discharge criteria may be modified as a member's circumstances change; modifications will be documented in the member's treatment plan. The treatment plan must be signed

by the member or the member's guardian. If the member refuses to sign, this too should be documented in the record.

c. Progress notes must reflect that treatment provided to the member at each session is tied to the goals of the treatment plan.
d. We require thorough documentation of regular communication with other providers, including physical health providers, and an integrated treatment plan.
e. Medical records are subject to quality of care and financial audits. Client consent is not necessary.

5. **Advanced Directives** It is the policy of Beacon Health Options to inform members of their right to make medical decisions in compliance with the Patient Self-Determination Act (s. 4206 s. 4751; Pub L No. 101-508) and the Colorado Medical Treatment Decision Act (CRS 15.18.103.) and to assist them in exercising this right. Notification is made through a description of The Acts in the Member Handbook.

   a. If a member requests additional information on The Acts from the provider, the member can be referred to the BHO Office of Member and Family Affairs, the Member Handbook, or the BHO website.
   b. For help writing an Advanced Directive, refer the member to her/his PCMP or to the Colorado Bar Association. In Colorado, Advanced Directives, as defined in the Patient Self-Determination Act, apply to medical/surgical procedures, not psychiatric conditions.
   c. Providers are encouraged to assist members to develop crisis plans that define the member's wishes in time of psychiatric crisis.
   d. Providers are required to ask members if they have an Advanced Directive and are encouraged to ask if they would like a copy placed in their mental health record. Providers must document in a prominent part of the individual's current medical record whether or not the individual has executed an advanced directive. If the member is incapacitated at the time of admission, the provider shall ask the family or significant other if the member has an Advanced Directive and shall give the family information about advanced directives. At such time as the member is able to understand the question, the provider must again ask if the member has an Advanced Directive and, if so, document that in the medical record.
   e. A provider may not condition a member's care or treatment on whether or not he/she has executed an Advanced Directive.
   f. Providers must inform members how to report a grievance to the appropriate state agency, if an Advanced Directive is not followed.

MENTAL HEALTH INPATIENT CARE REQUIREMENTS

These Mental Health Inpatient Care Requirements are for coordinating with our partner CMHCS for the clinical care provided by facilities to members. These requirements are not intended to cover the UM process between facilities and Beacon Health Options' Care Managers. Please review the Provider Handbook for the Beacon UM procedures and rules related to UM for Foothills Behavioral Health Partners and Colorado Health Partnerships.

Inpatient mental health treatment represents the most intensive level of psychiatric care. Multidisciplinary assessments and multimodal interventions are provided in a 24-hour secure and protected, medically staffed and psychiatrically supervised treatment environment. Twenty-four-hour skilled psychiatric nursing care, daily psychiatric/medical evaluation and management and a structured treatment milieu are required.

These services must be documented daily and appropriately in the treatment records and are subject to audit.

Inpatient treatment settings must provide all of these services at the appropriate intensity, frequency, and with a focus on initiating and sustaining active treatment from admission through discharge, with timely assessment and adjustment of medications, ensuring treatment participation, and collaborative and prompt communication with the associated CMHCs or other BHO representatives as well as outpatient treatment providers.

CLINICAL REQUIREMENTS: ASSESSMENT

- An initial visit with a psychiatrist, or other psychiatric practitioner with prescriptive authority (e.g., Physician Assistant, Nurse Practitioner, Resident Physician) and psychiatrist consultation, for evaluation and treatment planning within 24 hours of admission.
    - A comprehensive bio-psychosocial history including at a minimum:
        - History of presenting illness
        - Psychiatric history, substance use history
        - Medical history
        - Family history
        - Social history
        - Current medications
        - Allergies
    - Comprehensive review of systems
    - Full mental status examination
    - Initial psychiatric assessment/formulation including current Diagnostic and Statistical Manual based diagnoses
    - Risk assessment
    - Individualized overall assessment / formulation of key issues and recommended interventions.
    - Comprehensive, individualized, treatment plan including psychopharmacologic treatment plan when appropriate

CLINICAL REQUIREMENTS: SUBSEQUENT TREATMENT

A documented daily visit with an attending, licensed, prescribing psychiatric provider, to include:

- Collection and review of interim history
- Evaluation and documentation of the member's current mental status
- Assessment of the member's progress in relation to their presenting problems
- Justification of continued need for inpatient care
- Update of the treatment plan, including medication strategy

  - Progress note documentation as required in Section 17 of this handbook
- Other daily interventions.
  - Individual psychotherapeutic intervention focused on presenting problems (may be part of the prescriber visit)
  - Group/milieu activity
  - Safety planning as indicated
  - Discharge planning and coordination with CMHC or community provider receiving post discharge care of client (evidenced from first days of admission).

CLINICAL REQUIREMENTS: DISCHARGE

- Documentation of the discharge plan including follow-up appointments per handbook guidelines, discharge medications, and emergency contacts delivered to the patient in writing with a face–to-face review.
- Provision of a 30-day prescription for discharge medications with confirmation that the member has the resources to obtain medications or documentation that a new prescription is not required.
  - Any prescribed medications requiring pre-authorization in order to be filled must have the pre-authorization obtained by the hospital staff prior to the member being discharged.
- Transfer of certification to outpatient level of care with or without court ordered medications requires advance notification and discussion with receiving CMHC.
- The liaison can coordinate direct communication with the CMHC treatment team, and a treatment plan that bridges a Certified patient from inpatient to outpatient receiving team must be developed before discharge
- The prescriber's dictated discharge summary must be faxed to the outpatient provider within 72 hours of discharge. Quality **of care concerns related to poor aftercare communication and arrangement will be reported to the BHO.**

COORDINATION OF CARE REQUIREMENTS

The cycle of communication between the CMHC liaison/dc planner and a member of the clinical team familiar with the care of the member must be maintained from the date of admission through the date of discharge. The CMHC liaison/dc planner is the assigned staff for the capitated mental health center who will facilitate discharge and assist with aftercare planning.

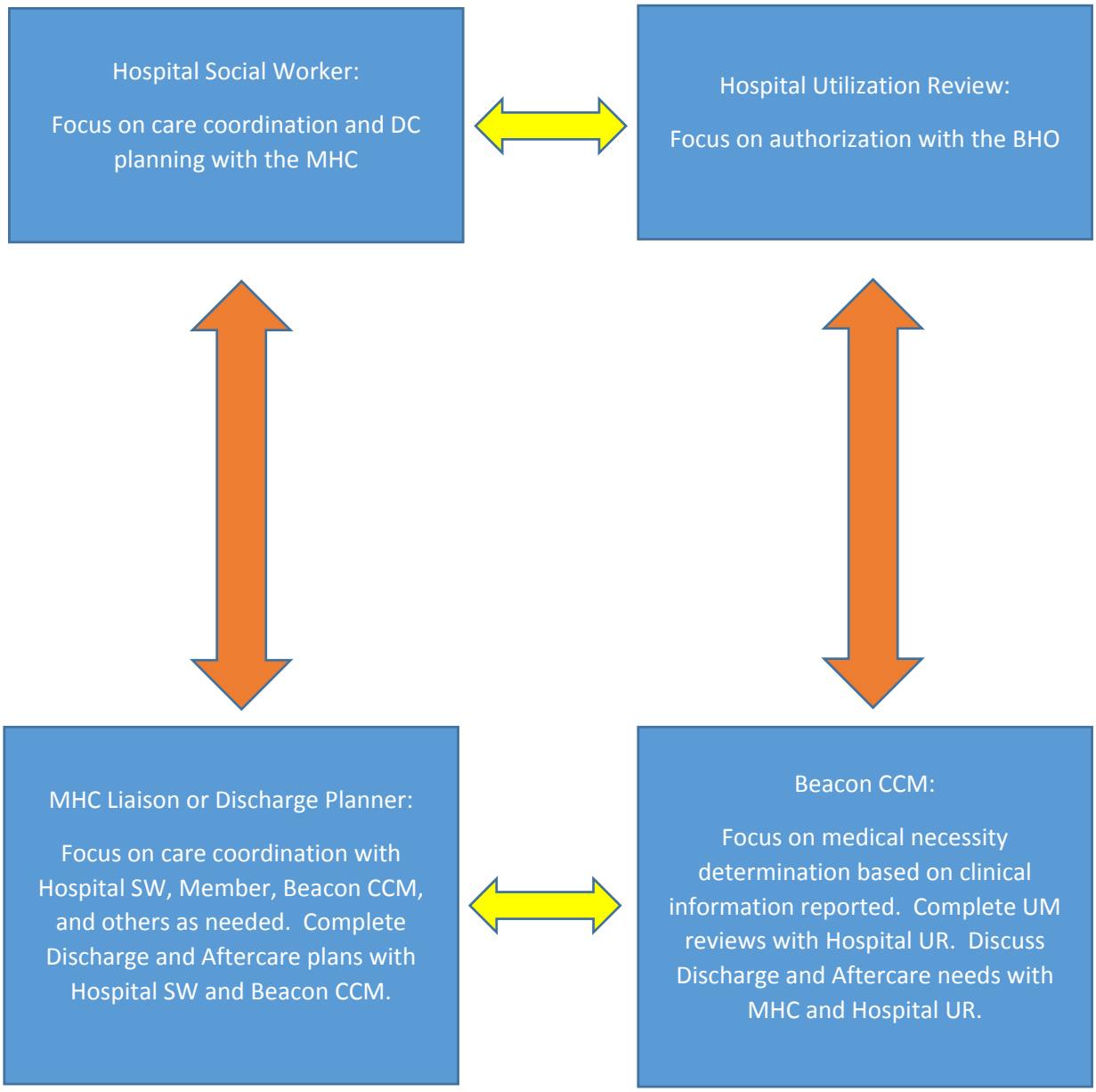
The communication needed between the hospital, the CMHC, and the BHO has defined purposes. Please see the chart on the following page which illustrates the purpose and method for coordination of care.

Coordination of care discussions include aftercare planning. If the hospital plans to recommend a step down to any level of care other than outpatient, it must involve a referral to the Beacon CCM managing the inpatient admission and discussion with the CMHC liaison/discharge lanner. The referral must occur prior to discharge to ensure a decision can be made prior to the

member discharge from inpatient care. Referrals for Partial Hospitalization, Intensive Outpatient, ATU, or other services should be made to Beacon Health Options at least two days prior to discharge to ensure a timely decision can be reached.

Additional Requirements include:

- Frequent coordination of care and unrestricted communication with the CMHC liaison/dc planner, including:
    - Contact by a practitioner involved with the member's care (i.e. an active representative of the treatment team such as the member's assigned social worker, therapist or prescriber)
- Communication with the inpatient liaison or other appropriate representative of the member's capitated Community Mental Health Center within 24 hours of admission
    - Exchange of Pertinent History including
        - Establishing connection
        - Discharge planning
- Updates by the attending MD or other treatment staff on progress, medications, family sessions/needs, aftercare referrals
- Examples of coordination of care:
    - Progress updates with a focus toward discharge (DC) readiness
    - Medication feedback or discussion of previous meds,
    - Development of Transition Plan to outpatient receiving team, especially for any patient on Certification with or without Court Ordered Medications.
    - Barriers to discharge (resource needs, family, placement),
    - Aftercare referrals to services other than Outpatient need to be given to Beacon CCM staff and discussed with the MHC liaison/DC planner.
- Contact at least 24 hours prior to DC to ensure aftercare plans are in place.
- The hospital must be responsive to the CMHC calls and return calls within 24 hours.
    - Face to face meetings with the member when requested by the CMHC liaison/DC Planner, to be facilitated by the hospital staff in a timely manner
    - Calls/emails from the CMHC liaison/dc planner returned within 24 hours or by the next business day


Hospital Social Worker:
Focus on care coordination and DC planning with the MHC
Hospital Utilization Review:
Focus on authorization with the BHO
MHC Liaison or Discharge Planner:
Focus on care coordination with Hospital SW, Member, Beacon CCM, and others as needed. Complete Discharge and Aftercare plans with Hospital SW and Beacon CCM.
Beacon CCM:
Focus on medical necessity determination based on clinical information reported. Complete UM reviews with Hospital UR. Discuss Discharge and Aftercare needs with MHC and Hospital UR.

HOSPITAL COMMUNICATES TO:

BHO: The BHO Clinical Care Manager (CCM) is the primary contact for the hospital's admission and UR staff. The CCM completes UM tasks for initial and ongoing review and authorization of services. The BHO MD is the only person involved in care who may deny inpatient services for clinical reasons.

CMHC: The mental health centers' liaisons, intensive case managers, or discharge planners (titles vary) are the primary contact for the hospital's social worker, therapist, or other clinical staff. The hospital contact with the CMHC must be a staff member who is involved in the member's care and/or treatment planning. The purpose of this communication is to relay vital information that the MHC may know that will help treatment. Typically, this includes medication information and history, baseline symptoms and functioning, treatment history, and planning for discharge to gather appointments and ensure needed resources and referrals are in place.

COMMUNITY MENTAL HEALTH CENTER:

The CMHC must be contacted prior to admission for assessment of the member or to arrange a courtesy evaluation. Failure to contact the capitated CMHC prior to admission may result in administrative denials for dates of service.

Following admission and throughout the stay, communication between the CMHC and the hospital social worker/therapist must be timely and relevant. Focus is on providing information about member history of medications, treatment, symptoms/baseline, and discharge planning. The communication can be initiated by the hospital or the CMHC.

This is not to be a reiteration of UM discussions such as with the BHO CCM. The purpose is preparation for discharge and related aftercare needs, with the CMHC providing often vital historical information to the treating provider

BHO:

The CCM (Clinical Care Manager) at Beacon will complete UM reviews at admission and during concurrent reviews for continued stay, based on Medical Necessity criteria.

The initial admission review will usually be with the MHC assessor, but may occasionally be with hospital or courtesy evaluators depending on the capitated MHC's workflow. Even if the initial review is with a courtesy evaluator or hospital assessor, the CMHC will be involved in the admission discussion. Hospitals who admit Health First Colorado member to an inpatient unit prior to pre-certifying care with Beacon may be administratively denied dates of service.

Continued stay reviews with be with the hospital UR staff. The UR staff hold the responsibility to call Beacon during their scheduled review time to complete timely reviews.

Section 5

MEMBER CHOICE OF PROVIDERS

Beacon Health Options has developed a large provider network for the Community Behavioral Health Services Program that is capable of providing the types of services needed by Members in convenient locations. Members and families can choose any Beacon Health Options Health First Colorado Network provider who is licensed, credentialed and enrolled with the Colorado Department of Health Care Policy and Financing for the necessary service(s). A Member may request that a provider be considered to join the relevant behavioral health organization. In cases of a member already in treatment with a provider at the time the member obtains Health First Colorado eligibility, for the purpose of continuity of care, the member's provider may request a Single Case Agreement and treatment may be continued. In cases involving special needs, Beacon Health Options may offer a Single Case Agreement to any other provider meeting the specialty or cultural requirement and who meets our credentialing and quality criteria.

Under certain circumstances members may request an out-of-network provider. These circumstances may include:

1) The service or type of provider the member needs is not available in our network

2) The network provider refuses to provide the treatment requested by the member on moral or religious grounds

3) The member's primary provider determines that going to a network provider would pose a risk to the member

4) The member has personal or social contact with the available network provider(s) that would make it inappropriate to pursue a treatment relationship

5) The State determines that other circumstances warrant out-of-network treatment.

Section 6

SECOND OPINION

Members/guardians/designated client representatives (DCR) have the right to a Second Opinion regarding a clinical decision of their treating provider, including recommendations about a member's diagnosis, need for treatment or the need for a specific service. A Second Opinion is available at no cost to the member. Providers are required to inform members and legal guardians of this right initially and any time the member/guardian/DCR expresses disagreement with a particular clinical decision or recommendation. The member/guardian /DCR may choose any network provider to obtain a Second Opinion, as long as the provider has the identified appropriate expertise and is able and willing to provide a Second Opinion. In some cases, the Behavioral Health Organization (BHO) will arrange for the member to obtain a Second Opinion from a provider outside the network, at no cost to the member[1]. (Note that disagreement with a BHO decision to deny a service request is handled through the Appeal Process (see Section 9) and not through a Second Opinion.)

A member/guardian/DCR may request assistance from the Behavioral Health Organization's Office of Member and Family Affairs (OMFA) in obtaining a referral to an appropriate provider for a Second Opinion. OMFA staff will also inform members of the right to a Second Opinion during the course of helping the member with any grievance concerning a provider's diagnosis or treatment recommendation.

If a member/guardian/DCR disagrees with a treating provider regarding a diagnosis or treatment recommendation, the member may seek a Second Opinion and transition their treatment to a different network provider.

If the member/guardian/DCR wishes to continue treatment with the first provider and the first and Second Opinions differ, the member/guardian/DCR may express their preference as to which opinion they wish to follow and may request assistance from OMFA in resolving the disagreement with the first provider. If the Second Opinion and recommendations are clinically acceptable to both the member and the treating provider, the recommendations are implemented. If not, the treating provider may choose to terminate treatment with the member and assist with a referral to another network provider. No provider is obligated to provide a diagnosis or treatment which he/she believes to be ineffective or inappropriate. If the member/guardian/DCR is not satisfied with the results of the Second Opinion, they may seek a third opinion at their own expense.

Any clinical decision, diagnosis, or treatment recommendation made by a provider is subject to the quality and medical review of the BHO in the process of authorization, payment and utilization review. A recommendation from a network provider is not a guarantee of medical necessity or authorization by the BHO.

[1] Code of Federal Regulations 42 CFR 438.206(b)(3).

For Colorado Health Partnerships contact the CHP Office of Member and Family Affairs at **1-800-804-5040.**

For Foothills Behavioral Health Partners, contact the FBHPartners Office of Member and Family Affairs at **303-432-5956 or 1-866-245-1959.**

Section 7

EPSDT AND CMHTA PROGRAM INFORMATION

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM

EPSDT is a special health care program for children and youth. It aims to ensure they receive preventive, dental, behavioral health, developmental and specialty services. With EPSDT, any medically necessary health care service is covered. A service may be covered even if it is not a Health First Colorado benefit; no arbitrary limitations on services are allowed. Any person enrolled in the Health First Colorado program can get EPSDT services if they are 20 years old or younger; this age group is automatically enrolled. All Health First Colorado providers can offer EPSDT services.

Regarding Co-Pays:

- Children 18 years old and younger are eligible for EPSDT, with no co-pay, for any covered service.
- Adults 19 and 20 years old are eligible for EPSDT, but may have a small co-pay for some services.
- Children in Department of Social and Human Services custody are eligible for ESPDT services with no co-pay, if they are 18 or younger. They may have some co-pays if they are 19 or 20.

EPSDT ASSESSMENT

EPSDT Assessment is conducted by Primary Care Medical Provider (PCMP) or Pediatricians to screen for mental health care and other health care issues.

EPSDT stands for:

Early**:** Find and assess problems early
Periodic**:** Check children's health at several ages
Screening**:** Check physical, mental, developmental, dental, hearing, vision and other health areas
Diagnostic**:** Do follow-up tests when a health risk or problem is found
Treatment**:** Correct, reduce or control health problems

Under EPSDT, children and youth can get all medically necessary care, such as:

- Well-child visits and teen check-ups
- Developmental evaluations
- Behavioral evaluations

- Immunizations (shots) and vaccines

- Lab tests, including lead poisoning testing
- Health and preventive education
- Vision services
- Dental services
- Hearing services

WELL – CHILD CHECK UPS

Well-child check-ups are regularly scheduled medical examinations that make sure a child or adolescent is healthy and meeting the expected developmental milestones. The provider can identify physical and behavioral health risks early and correct, reduce or control health problems. They also can ensure that a child gets necessary immunizations and screenings at the right ages. Well-child check-ups are more comprehensive than sports physicals. A child should get well-child check-ups at the following ages:

- 2-4 days after birth
- 1 month
- 2 months
- 4 months
- 6 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- Once per year from ages 3-20

MEDICAL NECESSITY FOR EPSDT

The term "medical necessity" means that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it:

- Is found to be an equally effective treatment among other less conservative or costlier treatment options, and
- Meets at least one of the following criteria:
    - The service will prevent, or is reasonably expected to prevent or diagnose, the onset of an illness, condition, primary disability, or secondary disability.
    - The service will, or is reasonably expected to cure, correct, reduce, or ameliorate the physical, mental, cognitive, or developmental effects of an illness, injury, or disability.
    - The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury, or disability.
    - The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living.

- Medical necessity may also be a course of treatment that includes mere observation or no treatment at all.

TREATMENT

Medically necessary health care services must be made available for the treatment of all physical and mental illnesses or conditions discovered by any screening or diagnostic procedure. Additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or ameliorate illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan.

To learn more about Colorado's EPSDT benefit, please call the Department of Health Care Policy and Financing at: (303) 866-6167, or go to their EPSDT web site: https://www.colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt , or call the BHO Office of Member and Family Affairs.

The State of Colorado also may provide the following through Healthy Communities and other programs:

- Educate all eligible members about the EPSDT Program.
- Describe the available benefits in greater detail.
- Help find a primary care physician or other medical providers as needed.
- Arrange for an appointment, if the member needs help.
- Communicate options for transportation assistance, if necessary.
- Follow-up on screening appointments. Follow-up includes assistance to reschedule the missed appointment.

EPSDT CARE PROVIDERS

EPSDT exams are performed by or under the supervision of a certified Medicaid physician, dentist or other provider who is qualified to provide medical services and is appropriately Revalidated/Enrolled for these services with the Colorado Department of Health Care Policy and Financing.

Behavioral health providers are required to:

- Assess new members to determine that EPSDT screenings have been occurring.
- Refer members to their PCMP, if screenings are not being conducted.
- Provide behavioral health assessment/treatment upon referral from a PCP who desires additional behavioral health services, in which medical necessity has been determined.
- Communicate with the PCMP regarding any pertinent findings/actions.
- Document all actions in the member's clinical record.

Because assessing physical health is an important component of providing comprehensive behavioral health care, we require all behavioral health providers to ensure that their Health First Colorado clients who are under age 21 have had an EPSDT well-child exam, according to the well-

child check-up schedule listed above. You must contact the member's PCMP or talk with the child's parent or guardian to determine if this has happened.

If the child or youth does not have a PCMP or has not been screened according to the recommended schedule, you should contact the Family Health Coordinators in your community to facilitate the screening process. A list of Family Health Coordinators can be found at: https://www.colorado.gov/pacific/hcpf/family-health-coordinator-list.

If additional assistance is needed, or if you have questions about EPSDT resources, you can call the Access to Care line and ask to speak with a care manager: 1-800-804-5008 (Colorado Health Partnerships) or 1-866-245-1959 (Foothills Behavioral Health Partners).

CHILD MENTAL HEALTH TREATMENT ACT

The Child Mental Health Treatment Act (CMHTA), also known as HB-1116 and SB-260, is a treatment resource for Colorado's children and families. The CMHTA was developed as an alternative to dependency and neglect determination by the courts when there is no abuse or neglect involved. CMHTA applies to all Colorado children, whether covered by Health First Colorado or not covered by Health First Colorado. The CMHTA includes a preservation and reunification program and provides residential, community-based and transitional care services for children and adolescents. The program is funded in part by Health First Colorado and tobacco fund dollars.

Children at risk of out of home placement are eligible for the program. The program provides timely access to an assessment and decision about placement for a child into the program. The program itself provides funding for non- Health First Colorado members, but requests under the law can also be used for Health First Colorado members. Medicaid eligible children with a covered diagnosis who show medical necessity will be funded through the BHO. To have an assessment under the CMHTA, parents or legal guardians should contact their local community behavioral health center or the BHO for more information.

For more information please go to http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251581518087.

Section 8

FACILITATING IMPROVED INTEGRATION OF SERVICES AND COORDINATION OF CARE

An integrated and well-coordinated system of care is necessary to ensure positive treatment outcomes for Health First Colorado members. Consequently, the Behavioral Health Organizations (BHOs) and Beacon Health Options require coordination of services for all of their members. The primary outpatient provider is responsible for care coordination. Member consent is required for coordination of care with other providers. Member consent is not required for coordination of care with the BHO and Beacon Health Options when the member is being treated for a covered mental health diagnosis; however, the member's consent is required when the treatment is for a covered Substance Use Disorder (SUD).

The responsibilities of network providers in coordination of care include:

- 24/7 emergency availability to clients and to emergency services staff, who may provide care to clients in a crisis.
- The provider must ensure that care coordination goals are member-centered and based on a thorough assessment of the member's behavioral health, substance use treatment and physical health treatment needs. The assessment should identify and document any physical condition that is worsened by or contributing to the member's behavioral health condition.
- The provider must include care coordination goals in the member's treatment plan.
- The provider must ensure the coordination of services and the exchange of relevant healthcare information between the member' Primary Care Medical Provider (PCMP) or a physician other than a PCP who is involved in the member's care, and the member's behavioral health service provider.
- The provider is responsible for documenting the contact information for the member's PCMP, and if the member does not have a PCMP, the behavioral health provider is responsible for assisting the member in obtaining a primary care provider through the area Regional Care Collaborative Organization (RCCO).
- Assisting members in finding a PCMP, Health First Colorado can provide a referral for members to their local RCCO looking for a PCMP. Health First Colorado can be contacted at 1-888-367-6557 or 1-303-839-2120 in the Denver metro area. Health First Colorado's website also provides information on how to obtain a PCMP: http://www.healthcolorado.net/
- The provider is responsible for collaborating with the RCCO care coordinator as appropriate and, as needed, referring the member to the appropriate agency/entity for complex care coordination needs, such as the Primary Care Medical Provider, medical home, Community Mental Health Center based regional Integrated Care Coordinator, or the Beacon Health Options Intensive Case Manager.
- The provider is responsible for coordination of services, with the Beacon Health Options Care Management Department, for member transitions to and from higher levels of care.
- This includes active and prompt response to requests for information and participation in

admission evaluation, case staffing, discharge planning, and utilization reviews, as required to facilitate continuity in treatment, efficiency in care, and timely processing of authorizations and claims.

- The provider is responsible for regular ongoing coordination of care and sharing of clinical observations between psychiatric prescribers and psychotherapists. Coordination of care may include the following but not be limited to these listed activities:
    - Psychotherapists referring to a prescriber for medication evaluation
    - Prescribers performing medication evaluations
    - Member consent for Care Coordination
    - Target symptoms and areas of concern
    - Medication prescribed
    - Documentation of regular ongoing coordination of care in the member's treatment record. Maintaining a current integrated treatment plan. Identifying, providing, arranging for, and coordinating with other social, legal, and human services that support the member and documentation of that coordination. See the list of human services agencies below for more detail.

COORDINATION WITH OTHER HUMAN SERVICES AGENCIES

Beacon Health Options and the BHOs have implemented procedures for coordinating behavioral health services with other services offered by other human service agencies including:

- County social services departments
- Child welfare agencies
- Residential child care facilities
- Organizations providing services to older adults
- Schools
- Criminal Justice systems
- Agencies providing substance use disorder services
- Agencies providing translation/interpretation services
- Agencies providing services to deaf and hard of hearing members
- And any other agencies providing human services to Health First Colorado recipients in need of behavioral health care

Please see the BHO Specific Provider Handbook Addendum, or reach out to the Vice President of Transformation, for assistance with recurring service integration challenges at 800-804-5040.

Section 9

Reviews, Reconsiderations and Appeals

Colorado Health Partnerships and Foothills Behavioral Health Partners are Colorado Behavioral Health Organizations (BHO) contracted with the Colorado Department of Health Care Policy and Financing (HCPF) to manage Health First Colorado behavioral health benefits through the Colorado Community Behavioral Health Services Program, and have delegated their utilization management programs to Beacon Health Options. Each of these BHOs has an Office of Member and Family Affairs (OMFA) that is available to assist members in exercising their rights to appeal.

All authorization determinations are made within timeframes required by Health First Colorado standards. As the Beacon Health Options Engagement Center is also accredited by the Utilization Review Accreditation Commission (URAC), its timeframes meet the more stringent of the two standards, where they differ from one another. All notifications for authorizations and denials also comply with both Health First Colorado and URAC standards, as does the content of Notice of Adverse Benefit Determination letters. For requirements concerning initial and continued stay authorization of all levels of care, please refer to Section 4, Utilization Management Procedures. At the time of any review, a BHO Medical Director or Peer Reviewer may deny authorization based on the diagnosis, the service requested, or medical necessity criteria. In addition, when a BHO Medical Director or Peer Reviewer is reviewing a case, a provider may be asked to participate in a phone call to discuss the service, or to provide a written copy of the member's treatment plan. Clinical Care Managers or any other staff members do not have the authority to deny a service. Denials may only be issued by a BHO Medical Director or Peer Reviewer. If a service is determined not to be a BHO covered service or a diagnosis is determined not to be a BHO covered diagnosis, the service or diagnosis may still be available to the member under Health First Colorado, but not through the BHO. In addition, there may be other funding sources for particular services, depending on the member's situation. For assistance please contact the BHO's Office of Member and Family Affairs.

When a request for service is in whole or in part denied, providers may be asked by members to assist in the Health First Colorado appeal process. The State of Colorado Health First Colorado contract allows for an appeal process for its members who are denied any request for covered behavioral health services as well as under other circumstances referred to as Adverse Benefit Determinations and is defined at the end of this section. The following information identifies the process for the Health First Colorado member to access his/her appeal rights. The provider is granted Reconsideration rights but the right to appeal is available only to the member, the member's guardian, or the member's Designated Client Representative (DCR). The provider may represent the member in all levels of appeal with the member's written consent, if they are designated in writing as the member's DCR.

CONTACTING THE BHO OFFICES OF MEMBER AND FAMILY AFFAIRS AND BEACON HEALTH OPTIONS

To obtain assistance for a member to exercise his/her appeal rights:

For **Colorado Health Partnerships** contact the CHP Office of Member and Family Affairs at **1-800-804-5040 ext., 361-483.**

For **Foothills Behavioral Health Partners,** contact the FBHPartners Office of Member and Family Affairs at **303-432-5956 or 1-866-245-1959.**

CLINICAL GUIDELINES

Clinical services are authorized based upon diagnosis, service requested, medical necessity criteria, and the application of established treatment guidelines. Medical necessity criteria are defined by the BHO and aligned with the Health First Colorado contract established by the HCPF. Treatment guidelines are adopted and revised by each BHO with input from members and families. Guidelines are developed using national standards, published research, expert opinions and local "best" practices. Treatment guidelines are periodically reviewed and revised to reflect the growing knowledge of best practice standards. These guidelines are made available at no cost, at:

Colorado Health Partnerships – http://www.coloradohealthpartnerships.com

Foothills Behavioral Health Partners - http://www.fbhpartners.com

CLINICAL PEER REVIEW PROCESSES

When a Clinical Care Manager receives a request for authorization and there is any question as to whether the information provided meets criteria for authorization, the case is referred for a Clinical Peer Review with the BHO medical staff. The BHO medical staff consists of a psychiatrist Medical Director for all 24-hour levels of care and a clinical psychologist Peer Advisor for specific non-urgent, outpatient levels of care. Medical staff will conduct a Clinical Peer Review before denying any service request. A Clinical Peer Review consists of a decision based on review of all available clinical information by an appropriately licensed behavioral health professional (physician or clinical psychologist).

At the completion of a Clinical Peer Review, the BHO Peer Reviewer will inform the provider/facility if services will be authorized or denied. A denial of authorization becomes effective at the completion of this review, unless otherwise specified by the BHO Peer Reviewer. If a decision is made to deny authorization, written Notice of Adverse Benefit Determination of this decision will be mailed to the member and provider/facility within the earlier of one (1) business day or three (3) calendar days.

PROVIDER'S REQUEST FOR RECONSIDERATION (PEER TO PEER REVIEW)

Following a clinical denial, a Reconsideration Peer to Peer Review can be requested by the provider **if the provider can offer clinically significant information that was not available to the Peer Reviewer at the time of an adverse determination.** Preferably, this request will be made within 24 hours of a denial. A request for Reconsideration Peer to Peer Review should be made telephonically to a Beacon Health Options Clinical Care Manager (CCM) via the Access to Care line (1-800-804-5008). The Clinical Care Manager will then give the provider instructions on how to complete the review. A Clinical Peer Reviewer will be available within one business day to complete the review. The re-decision to authorize or deny the request for services will be made at the completion of the Peer to Peer Review. If the denial of the requested services is upheld at the time of the Peer to Peer Review, the provider will be notified verbally. Both the provider and the member will also receive written notification of the decision. Upon conclusion of the Reconsideration, any further review must be made through the process of a formal appeal.

A formal appeal can only be initiated by the member/guardian/DCR. The member may name the provider as his/her DCR but must do so in writing.

RETROSPECTIVE AUTHORIZATION PROCESS

Requests for retrospective authorization will be considered in the following circumstances:

- Member is made Health First Colorado eligible retroactively
- Member's condition at the time of initiation of treatment made it impossible for the provider/facility to obtain enough identifying information to determine Health First Colorado eligibility via the Health First Colorado Web Portal

Providers are expected to check the Health First Colorado Web Portal for Health First Colorado eligibility prior to admission of presumed medically indigent patients. In addition, for members who have Health First Colorado at admission to a service often have frequent changes to Health First Colorado eligibility. Therefore, **it is recommended that eligibility is checked prior to each outpatient service, and frequently throughout any higher level of care service to ensure payment.** Authorizations are dependent upon eligibility. If a member becomes ineligible for Health First Colorado, **claims for those dates of service cannot be paid**.

Requesting a Retrospective Review

Providers have ninety (90) calendar days from the first day of non-authorized services, or from the date of the member's notice confirming retroactive Health First Colorado eligibility, to request a retrospective review. Note that BHO responsibility for payment of services does not extend greater than 90 days prior to the date of the eligibility determination. For consideration of payment for services more than 90 days prior to the date eligibility is finally determined, please contact Health First Colorado.

To obtain consideration, the provider/facility must submit a written request including documentation supporting the basis for the request. A retrospective review determination requires the submission of the medical records covering the span of the request, which will be considered

complete and final at the time of submission of the request for retrospective review. Beacon Health Options will make determinations on a retrospective request within 30 calendar days. If the request is approved, then dates of service retroactively authorized may cover all or only part of a given episode of care depending upon a determination of medical necessity throughout the episode. For any dates of services that are not authorized, a Notice of Adverse Benefit Determination letter will be sent to the provider and the member/guardian. The member/guardian/DCR may appeal a denial of payment for all or any part of the episode of care. The provider may appeal only if designated in writing to appeal on the member's behalf or if designated by the member as the member's DCR.

MEMBER'S REQUEST OF AN APPEAL

A member/guardian/DCR may file an appeal for any of the adverse benefit determinations listed in the definition at the end of this section. In most cases, appeals (standard or a quick appeal; see definition at end of this section) must be filed by the member/guardian/DCR within 600 calendar days of the date of a Notice of Adverse Benefit Determination. However, if a member is appealing an adverse benefit determination to reduce, suspend or terminate a previously authorized service AND the member wants to continue the service during the appeal, the appeal must be filed within 10 days of the Notice of adverse benefit determination or by the date that the adverse benefit determination would take effect, whichever is later. Also, the services must have been ordered by an authorized provider; the original period covered by the original authorization must not have expired, and the member must ask that services be continued during the appeal. Appeals received outside of required timeframes will not be processed. (See section below, **HOW LONG WILL PREVIOUSLY AUTHORIZED SERVICES CONTINUE WHEN AN ADVERSE BENEFIT DETERMINATION IS APPEALED?)**

The appeal request may be verbal but **must** be followed up in writing in order to complete the appeal. The BHO's Office of Member and Family Affairs is available to assist members with this appeal process, including helping a member put their appeal in writing. The appeal request must be submitted to the Grievance and Appeals Coordinator, Beacon Health Options, 9925 Federal Drive, Suite 100, Colorado Springs, Colorado 80921, by fax to 719-538-1433, or telephonically at 800-804-5040 for CHP, or 866-245-1959 for FBHPartners. A psychiatric physician who was not involved in the initial denial will re-evaluate the original decision based on information received in the appeal letter, any subsequent information the member/guardian/DCR may provide, and on the original clinical documentation. For a standard appeal, a determination will be made and resolution mailed to the member within 10 working days of the receipt of the appeal. In the case of a quick appeal, determination and notification will be made within 3 calendar days (72 hours) of the receipt of the appeal.

MEMBER'S REQUEST FOR A STATE FAIR HEARING

A member/guardian/DCR may also file a request for a State Fair Hearing in writing to review any Health First Colorado adverse benefit determination as listed in the definitions at the end of this section. A State Fair Hearing can only be requested after all appeal options have been completed.

The Member/Guardian/DCR must ask for the State Fair Hearing within 120 calendar days from the date of the appeal decision letter sent by Beacon Health Options. If, however, the adverse benefit determination involves a reduction, suspension or termination of a previously authorized service AND the member wants the service continued during the State Fair Hearing, the member must request the State Fair Hearing within ten (10) days of the Notice of Adverse Benefit Determination letter or by the date the adverse benefit determination would take effect, whichever is later. The member must also ask that the services be continued during the State Fair Hearing process. If, prior to receiving an unfavorable decision from the BHO on the member's appeal AND the member wants to continue previously authorized services during the State Fair Hearing, the member/guardian/DCR may request a State Fair Hearing within 10 days of the BHO's decision on the appeal. (See section below**, HOW LONG WILL PREVIOUSLY AUTHORIZED SERVICES CONTINUE WHEN AN ADVERSE BENEFIT DETERMINATION IS APPEALED?)**

A member may represent him/herself or use legal counsel, a relative, a friend, the Health First Colorado Ombudsman or other spokesperson at the hearing. The member or his/her authorized representative shall be entitled to examine the complete case file and any other documents to be used at the hearing at a reasonable time before the hearing or during the hearing. Documents and information that are confidential as a matter of law shall be exempt from this requirement unless they are to be offered as evidence during the hearing. Conference telephone hearings may be offered as an alternative to face-to-face hearings. All applicable provisions of the face-to-face hearing shall apply to telephone hearings. The hearing shall be private unless the applicant or recipient requests, on the record, that the hearing be open to the public. If the member/member's guardian/DCR is not fluent in English or has a language difficulty, the court will arrange to have present at the hearing a qualified interpreter who will be sworn to translate correctly. An Administrative Law Judge decision is the final decision in the member's appeal process. To initiate this process, the member/guardian/DCR can contact the Office of Administrative Courts at 1525 Sherman Street, 4th Floor, Denver, CO 80203, 303-866-5626, fax 303-866-5909.

Assistance with this process is available for member/member's guardian/designated representative from the BHO Office of Member and Family Affairs at the numbers above, or from the Ombudsman for Health First Colorado Managed Care at 1-877-435-7123, (TTY: 1-888-876-8864) 303 E 17th Street, Denver, CO, 80203, e-mail: help123@maximus.com.

HOW LONG WILL PREVIOUSLY AUTHORIZAED SERVICES CONTINUE WHEN AN ADVERSE BENEFIT DETERMINATION IS APPEALED?

If the member/guardian/DCR has requested that previously authorized services continue during an appeal, services will continue only until **one** of the following occurs:

- The member withdraws the appeal
- 10 days pass after the BHO mails its decision on the appeal and the decision is against the member UNLESS the member, within the 10 day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached
- A State Fair Hearing officer makes a decision that is adverse to the Member
- Or, the time period covered by the original authorization ends.

Member Responsibility for Services Furnished while an Appeal or State Fair Hearing is Pending

If the BHO's decision on a member's appeal is adverse to the member, and the member has not filed for a State Fair Hearing, , the BHO may recover the cost of the services furnished to the member while the appeal is pending, if the reason why the services were furnished was solely because of the requirements listed above. (This does not apply if the member received services because of medical necessity.) Similarly, if the State Fair Hearing decision is adverse to the member and services were furnished while the Hearing was pending, the BHO may recover the cost if the service furnished solely because of the requirements listed above.

BHO Responsibility for Services Furnished while the Appeal is Pending

If the BHO's decision on a member's appeal upholds the member's appeal and the member has not filed for a State Fair Hearing, the BHO must pay for the services that were furnished while the appeal is pending, if the reason why the services were furnished was solely because of the requirements listed above. Similarly, if the State Fair Hearing decision upholds the member's appeal and services were furnished while the Hearing was pending, the BHO must pay for the services that were furnished solely because of the requirements listed above. If the services were not provided, the BHO must provide the services as quickly as possible.

An Example of Termination, Suspension or Reduction of a Previously Authorized Service

An example of termination, suspension or reduction of a previously authorized service would be when the BHO authorizes 30 days of residential treatment, but terminates the services after 15 days, and the termination is not due to a change in Health First Colorado eligibility.

DEFINITIONS

Adverse Benefit Determination

An appeal or State Fair Hearing may be filed for events categorized as adverse benefit determinations. Adverse benefit determinations include:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously authorized service.
3. Denial of payment for a service, in whole or in part.
4. Failure of the BHO to provide a service in a timely manner.
5. Failure of the BHO to act within approved timeframes for grievances or appeals.
6. Denial of a request by a member in a rural area to obtain treatment outside of the Beacon Health Options Health First Colorado Provider Network.

Clinical Peer Review

This process involves a review of clinical information provided verbally or in writing by an appropriately qualified and licensed BHO Peer Reviewer.

Peer-to-Peer Review

This process involves telephonic discussion of pertinent clinical information by a provider and an appropriately qualified and licensed BHO Medical Director or Peer Reviewer. The Peer Reviewer has the authority to deny authorization should the member not have a covered diagnosis or not meet medical necessity criteria for the service being requested.

Standard Appeal

A member may appeal any adverse benefit determination, as defined above. The standard appeal process is the most often requested appeal and is initiated when the denial of services does NOT jeopardize the life or health of the member. The standard appeal must be completed within a 10 working day timeframe. When this determination is made, notification will be mailed to the member. This process can be used for any prospective, concurrent or retrospective appeal.

Quick Appeal

When a denial of services may jeopardize the life or health of a member, a quick appeal process may be requested. The quick appeal is to insure a more timely decision than the ten (10) working day standard appeal process. The quick appeal occurs most frequently at higher levels of care (i.e., inpatient requests, ATU requests etc). In the case of a quick appeal, determination will be made and a resolution letter mailed to the member within three (3) calendar days (72 hours) of the request for appeal.

Section 10

NETWORK CREDENTIALING

The Network Credentialing and Provider Relations Departments are responsible for monitoring all administrative aspects of the provider network. This includes, but is not limited to, provider credentialing and re-credentialing, provider status changes and updates, geographic and specialty access, training, and provider relations activities.

Beacon Health Options' program for credentialing and re-credentialing providers is designed to comply with the National Committee for Quality Assurance (NCQA) standards for the credentialing of behavioral health providers. This program will be described below as it applies to Health First Colorado participating providers.

If you are interested in becoming a provider for the Behavioral Health Organization (BHO) that administers the Colorado Community Behavioral Health Services Program, please email the Provider Relations Department, their email is listed below, to request a current pre-application form. Please submit the completed and detailed form along with your resume to the Colorado Provider Relations email. Please note that there are pre-requirements in place which include:

- An active license with the state of Colorado
- Current malpractice insurance
- And approval from the Colorado Department of Health Care Policy and Financing for Enrollment/Revalidation as a Medicaid provider
    - All licensures, tax IDs, NPI, and services offered **must** be approved for **each** service location in order to be eligible to receive reimbursement for services rendered to Health First Colorado members.

For facilities interested in Health First Colorado participation, please include a staff roster and specific information about the program(s) the facility offers on the pre-application form. Please note that both the facility **and** all staff must be approved for Enrollment/Revalidation as a Medicaid provider for all licensures, tax IDs, NPIs for **each** service location as well. Please review the remainder of this section for information about our credentialing criteria.

Provider Relations:	**1-800-804-5040**
Fax	719-538-1433
Email	COProviderRelations@BeaconHealthOptions.com

CREDENTIALING

All providers who participate in the Beacon Health Options Health First Colorado Network must be credentialed according to Beacon Health Options' standards and policies. Among these requirements is Primary Source Verification (see Glossary) of the following information:

- Current valid license to practice as an independent behavioral healthcare practitioner at the highest level certified or approved by the state.
- Clinical privileges in good standing at the institution designated by the practitioner as the primary admitting facility, as applicable.
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline, or licensure.
- Board certification, if designated on the application.
- Current, adequate malpractice insurance.
- History of professional liability claims which result in settlements or judgments paid by or on behalf of the practitioner.
- Specialized training for non-traditional practitioners.

Beacon Health Options also requires:

- A copy of a current DEA Certificate, as applicable
- Work history
- Information from the State Board of Licensure and the National Practitioner Data Bank
- Information about sanctions or limitations on licensure from the appropriate state
- Medicare and/or Health First Colorado sanctions.

Beacon Health Options performs verification of the following elements to meet the State of Colorado's Health First Colorado requirements for providers:

- Background investigation through the Colorado Bureau of Investigation; and
- Background investigation through the Background Investigation Unit Colorado Department of Human Services (TRAILS).

As part of the credentialing process, Beacon Health Options may conduct a structured site visit of provider offices. This site visit includes an evaluation using Beacon Health Options' standards and includes evaluation of the provider's clinical record-keeping practices to ensure conformity with Beacon Health Options' standards.

It is the responsibility of the provider to give current information to our Network Credentialing Department within the timeline defined below for the provider to maintain network status. When Network Credentialing receives the new information, they will update the data system and add the documentation to the provider's file. **Failure to submit current copies of expired items will result in suspension or termination from the network.**

PROVIDER CONTRACT REQUIREMENTS

1. **Providers must notify the BHO within 24 hours upon the occurrence of any of the following:**

- Adverse incidents regarding members'
  - Attempted suicide requiring medical care
  - Suicide
  - Homicide
  - Suspected neglect or abuse of members
  - Incidents that may attract media attention
  - (See Section 14 Quality Management for more information.)
- Revocation, suspension, restriction, termination, or relinquishment of any of the licenses, authorizations, or accreditation's whether voluntary or involuntary.
- Any legal action pending for professional negligence or alleged malpractice.
- Any indictment, arrest, or conviction for felony charges or for any criminal charge.
- Any lapse or material change in professional liability insurance coverage.
- Revocation, suspension, restriction, termination or relinquishment of medical staff membership or clinical privileges at any healthcare facility.
- Any alleged professional misconduct or ethical violations reported to state licensing boards, professional organizations or the National Practitioners Data Bank.

Failure to report any of the above within the specified time frame will result in immediate suspension from the network with possible termination.

2. Appointment Availability and Access Standards

Beacon Health Options contracted providers are required to meet all access standards as stated in the Health First Colorado regulations. Specific information for routine access will be gathered during the initial authorization process for outpatient care. Beacon Health Options conducts quarterly quality activities to assure compliance with these standards. These activities may include random contacts to providers to measure timeframes for Routine and Emergent appointment access.

The access/availability timeframes required in the Health First Colorado regulations are as follows:

- **Emergent Access**: Members in a crisis must be contacted by phone within 15 minutes of initial member request. A face-to-face evaluation must be conducted within 1 hour of initial contact in urban areas and within 2 hours in rural areas. Providers are required to have coverage for after-hours emergencies; it is not an acceptable practice for a phone message to refer clients directly to an emergency room in a crisis. If members are referred to an emergency room or crisis center following a crisis evaluation, the provider must be available by phone 24 hours a day, 7 days a week to offer information and consultation to the emergency services provider.
- **Urgent Access**: Members must be offered an appointment that is within 24 hours of initial contact.
- **Routine Access**: Members must be offered an initial appointment that is within 7 business days of the member's request.

Inpatient and Residential Treatment post-discharge follow-up appointments: Outpatient follow-up appointments are required within seven (7) business days after discharge from an inpatient psychiatric hospitalization. Outpatient follow-up appointments or equivalent post-discharge follow-up are required, documented in the discharge care plan, within seven (7) business days after discharge from a residential treatment facility.

Waiting Room Time for Scheduled Member Appointments: A Health First Colorado member who arrives on time for their scheduled appointment shall wait no longer than fifteen minutes to begin their scheduled appointment. If the appointment does not begin within 15 minutes, the member shall be offered the option of rescheduling for the next available appointment. Members shall be notified of the option to reschedule through a posted notice in the waiting area or by reviewing the wait time policy with the member at the initiation of treatment.

Members who were scheduled for prescriber services should be provided an appointment date that does not cause a delay or gap in their prescribed medication regimen. Members indicating urgent or emergent concerns should be provided an appointment that meets the access standards for urgent/emergency requests.

If you have questions about these timeframes, please contact the BHO Director of Quality Management.

3. **Recredentialing**

Beacon Health Options requires that practitioners and organizational providers undergo recredentialing every three (3) years. Recredentialing begins approximately six months prior to the expiration of the 3-year cycle. Providers are sent a recredentialing application that must be completed in its entirety, signed, and returned to Beacon Health Options as soon as possible, with all requested verifications attached. Failure to complete the application in its entirety, including failure to submit all requested verifications and failure to respond to requests for additional information, in the time frame specified, may result in disenrollment from all lines of business and may require providers to reapply to all lines of business. It is the responsibility of the provider to ensure that all necessary materials have been submitted to Beacon Health Options.

Credentialing information that is subject to change must be re-verified from primary sources during the recredentialing process. The practitioner must attest to any limits on his/her ability to perform essential functions of the position and attest to absence of current illegal drug use (in accordance with applicable legal requirements such as the Americans with Disabilities Act).

Providers may undergo a structured site review to ensure conformity with Beacon Health Options' standards. This review includes an evaluation of clinical record keeping practices at each site.

LOCAL CREDENTIALING COMMITTEE

Both Colorado Health Partnerships (CHP) and Foothills Behavioral Health Partners (FBHPartners) conduct a Local Credentialing Committee. The Local Credentialing Committee (LCC) is comprised of representatives of all major clinical disciplines. The LCC functions as an advisory body to the National Credentialing Committee (NCC). Files for credentialing and re-credentialing are first reviewed by the LCC; recommendations are forwarded to the NCC regarding the network participation in Beacon Health Options Health First Colorado Provider Network. This committee is also responsible for reviewing all provider pre-applications for providers seeking to join the CHP or FBHPartners networks.

NATIONAL CREDENTIALING COMMITTEE

Beacon Health Options' National Credentialing Committee (NCC) is made up of representatives of all major clinical disciplines, participating providers, and representatives of major departments including the National Network Management and Quality Management departments. The NCC has decision-making authority for all credentialing matters including approvals and denials for network participation during initial credentialing and re-credentialing. The NCC also makes decisions regarding provider sanctions. The NCC reports its activities to Beacon Health Options' Corporate Quality Improvement Committee (CQIC) which provides oversight.

CHANGE OF STATUS OR ADDRESS

Providers are responsible for updating and ensuring their demographic information is current via ProviderConnect. If technical issues are experienced when attempting to make updates via the ProviderConnect portal, please contact the EDI Helpdesk at 1-888-247-9311.

Failure to notify Network Credentialing of changes in a timely manner may result in delay in payment of claims or change in network status to include suspension or termination from the network.

Ensure that all information on ProviderConnect is current and that any new practice affiliations, changes in address or licensure, and facility or program involvement is updated, as needed. Remember to include all important information:

- Your name and name(s) of practice, facility, program
- Tax identification number and billing information
- Street address(es), city, state and zip
- Telephone number(s)
- Copies of new or updated licenses or authorizations
- Copies of cover sheets for updated liability coverage

PROVIDER TERMINATIONS, SANCTIONS AND APPEALS

Voluntary: If a provider chooses to terminate from the network, a written request must be submitted to Provider Relations. Please be sure to include effective date of disenrollment, reason for disenrollment request and the specific lines of business that will need to be disenrolled. Provider Relations will acknowledge receipt of the request, coordinate member related services with the clinical department, and notify the provider of the final termination date. Per Health First Colorado policy, providers will be placed in a "pending disenrollment" status for 90 days after the disenrollment effective date, as specified by the provider. This 90-day period serves as a set period of time for providers to transfer and members currently in their care into the care of other in network provider(s).

Involuntary: Non-adherence to performance standards or criteria, substandard performance, unethical practices, and breaches in professional code of conduct may result in termination from the provider network. Critical areas monitored include:

- professional and ethical conduct
- adherence to contract stipulations
- professional liability claims/disposition involving direct member care
- patterns of practice contrary to Beacon Health Options' procedural standards
- patterns of service delivery
- billing fraud
- due process
- violation of state/federal laws
- reporting of all sentinel events

If performance standards are suspect, Beacon Health Options will contact the provider by phone, or by authorized mail, to alert the provider to the issue(s) and will review the appropriate documentation in compliance with due process/fundamental fairness procedures. A full description for Beacon Health Options' sanctioning policies and procedures can be obtained on written request from Network Credentialing.

APPEALS

Providers who are terminated from the network or are otherwise sanctioned have the right to appeal. Such appeals are heard by the National Provider Appeals Committee (PAC), which is comprised of representatives of all major disciplines, Beacon Health Options participating providers, and representatives of certain Beacon Health Options' departments, including Network Management, Clinical Operations and Quality Management. Members of the PAC must not have participated in the National Credentialing Committee decision under review in which a provider was terminated. Providers who have been sanctioned by the National Credentialing Committee, based on a peer review of a quality of care concern have the right to a fair hearing, if such a hearing is requested within 30 days. Sanctioned or terminated providers are notified about the procedure for requesting the fair hearing at the time they are notified about the adverse action. Providers sanctioned by the National Credentialing Committee for reasons other than quality of care concerns must submit their appeal in writing within 30 days. Providers eligible for written appeals will be notified of their appeal rights at the time they are notified about the adverse action. Filing an appeal

will not stay the sanctions imposed by the National Credentialing Committee.

NOTE: Providers who are convicted of crimes involving sexual misconduct or the violation of a member's civil rights, or who are the subject of malpractice judgements or settlements or licensure actions involving sexual misconduct or violations of a member's civil rights, are excluded from any further network participation. The National Credentialing Committee must approve any exceptions to this policy.

Section 11

BENEFIT EXCEPTIONS

PRESCRIPTION DRUGS

The BHO will not be responsible for the cost of prescription drugs, including those received in the emergency room.

Health First Colorado has a Preferred Drug List (PDL) for many Health First Colorado members who need prescription medication. The PDL is a list of drugs that do not need prior approval by the state. Drugs that are not on this list do need approval from the State. Health First Colorado members get their mental health medications in one of two ways:

1. For Health First Colorado only members, medications are provided through the state Fee for Service prescription program. The PDL currently includes some medications for Attention Deficit Hyperactive Disorder (ADHD), depression, and psychotic disorders. People with serious mental illness can still get the medications they need, even if their medications are not on the PDL. The state has a process for members to obtain prescriptions not on the PDL.

2. If a Health First Colorado eligible member also has Medicare (dual eligibility), he or she must enroll in a Medicare Part D plan. Medicare Part D covers certain medications members may need. If the Part D plan will not pay for certain classes of drugs, then Health First Colorado will pay. Benzodiazepines are an example of mental health drugs not covered by Medicare Part D.

RESIDENTIAL TREATMENT

The BHO covers medically necessary use of mental health residential treatment for minors who have a covered mental health diagnosis where the need for residential treatment derives from the covered diagnosis, and who are not in the custody of the Department of Social Services or the Department of Youth Corrections. **Residential treatment is not a covered service for members diagnosed only with a Substance Use Disorder (SUD).**

RECIPIENT CO-PAYMENTS

The BHO and its contracted provider network will not assess any charges to Health First Colorado recipients for covered services. This includes co-payments. **Balance billing is also not allowed.** Members receiving treatment for SUD covered diagnoses should have a signed copy of the Release of Information form on file before providers reach out to the BHO for authorization or coordination of care. Members receiving SUD services who do not feel comfortable allowing their providers to bill Health First Colorado may work with their provider to find other funding sources for the treatment, including member self-pay, if the member chooses this option.

EXCLUSIONS FROM THE HEALTH FIRST COLORADO BEHAVIORAL HEALTH SERVICES PROGRAM

The following Health First Colorado populations are specifically excluded by the Behavioral Health Services for receiving behavioral health services via Health First Colorado:

Program:

1. Qualified Medicare Beneficiaries Only
2. Undocumented Aliens (who are entitled to emergency services)
3. Members with Presumptive Eligibility
4. Program of All-inclusive Care for the Elderly (PACE)
5. Members with QMB Health First Colorado only

Benefits Exclusions and Limitations:

1. Treatment of the underlying condition of organic mental disorders associated with permanent brain dysfunction.
2. Treatment of the underlying condition of mental retardation or pervasive developmental disorder or autism.
3. Treatment for obesity, or weight loss not associated with anorexia nervosa or bulimia except as part of an overall treatment plan.
4. Test or procedures conducted to rule out medical conditions.
5. Medical care, supplies or service required for concomitant medical problems.
6. Care which is predominantly custodial or domiciliary in nature.
7. Speech therapy.
8. Stand-alone smoking cessation programs, unless adjunctive to a comprehensive treatment plan.
9. Treatment for chronic pain, unless of predominantly psychological origin.
10. Inpatient treatment for conditions which are often described as sexual addiction, compulsive gambling, co-dependency, or adult children of alcoholics, or non-abusing family members.
11. Structured sexual therapy programs including sexual offender treatment.
12. Nutritionally-based therapies.
13. Health care services, treatment and/or supplies which are deemed to be experimental by the BHO's Medical Director, or investigational, or mainly for research or not in keeping with national standards of practice, including, but not limited to: crystal healing therapy, Rolfing, regressive therapy, megavitamin therapy, rebirthing therapy and aversion treatment.
14. Ancillary services such as sleep therapy, employment counseling, training and/or educational therapy for learning disabilities, or other educational services. Educational testing will only be considered if pre-authorized by Beacon Health Options.
15. Discrete services and treatments which are for personal growth, development, or professional authorization (e.g., training analysis).
16. Discrete services and treatments which are required under law to be provided by the school system for children.
17. Services that are court-ordered but not deemed medically necessary.
18. Electroconvulsive therapy (ECT), unless pre-authorized.
19. Psychological testing, including neuropsychological testing, unless pre-authorized.

20. Therapy for behaviors considered to be normal for the development stage.
21. Inpatient medical detox services or any services higher than ASAM Level I or outpatient services the treatment of Substance Use Disorders

There are no limitations of benefits for the Health First Colorado Behavioral Health Program offered by the BHOs.

Section 12

COLORADO CLIENT ASSESSMENT RECORD (CCAR)

The Colorado Client Assessment Record (CCAR) is a state-required form that must be completed for all members receiving behavioral health treatment. CCAR forms are not required if the only service being provided is for treatment of a covered substance use diagnosis. The CCAR form is used to capture demographic, administrative, clinical, and outcome data. It is a clinical instrument designed to assess the behavioral health status of a consumer in treatment. The tool can be used to identify current clinical issues facing the member and to measure progress during treatment.

The CCAR consists of an administrative section and an outcomes section:

- The administrative section contains questions related to a member's characteristics (e.g., social security number, date of birth, gender, etc.)
- The outcomes section contains questions related to a member's daily functioning on 25 clinical domains.

Providers are required by contract to complete a "full" CCAR for every publicly funded client at admission, annually, at discharge, and when there is a change in client status (e.g., change in payer source, admission to inpatient psychiatric hospital, change in living arrangement, etc). Completion of a "full" CCAR means populating all of the fields completely (for example, the complete social security number, the complete first and last name, etc.).

Outpatient psychotherapy providers must complete a CCAR at admission and discharge from treatment, and at least annually for members who are not discharged from treatment within one year. Medication providers must complete a CCAR only if there is no treating psychotherapist. In addition, a CCAR must be completed by a hospital upon a psychiatric hospitalization and discharge.

The CCAR form must be completed online (see instructions below).

ACCESSING THE CCAR FORM ONLINE

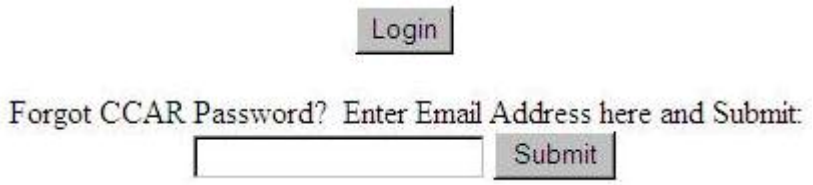
The online CCAR form can be accessed at http://www.chneforms.com/ccar/

When you click on the link provided, the login/password page of the CCAR application will open. Your login will be the email address you have given Beacon Health Options Provider Relations staff. If you have not given Beacon Health Options your email address, please add/update that information via ProviderConnect at https://www.valueoptions.com/pc/eProvider/providerLogin.do. Providers cannot use this application without a valid email address. A password will be assigned to you and is given at

random and cannot be changed.

For facilities, only one password/email address combination can be assigned at one time to one facility.

Providers without a password must use the text box at the bottom of the login page called "Forgot CCAR Password?" This function will only work if an email has been loaded into your provider file.



Enter your email address and click the Submit button. At that point, you will be emailed your password information with which you can then go back and login to the CCAR application.

WHO NEEDS TO SEND IN A CCAR FORM AND WHEN

The first provider (outpatient therapist) to obtain an authorization for the member is the provider responsible for submitting the CCAR. For example, if an outpatient therapist has an authorization to see the member, and a second therapist gets another authorization for group therapy after the first outpatient therapist, the first outpatient therapist is responsible for completing the CCAR form. For outpatient therapists, an admission CCAR, annual update CCAR, and a discharge CCAR are required.

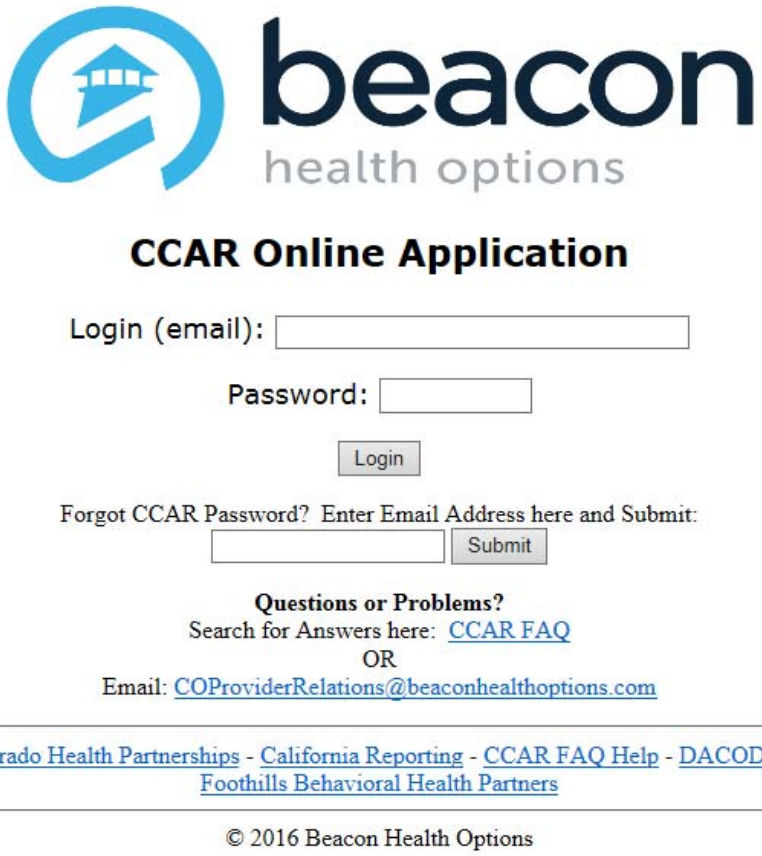
Although an authorization is not necessary for medication management services, a prescriber is required to submit a CCAR if there is no treating psychotherapist.

If a member in treatment is admitted to a hospital, the hospital will fill out an update CCAR form. If an update CCAR form is needed, that facility will not need to send in a discharge CCAR form. The only time a hospital (or other level of care higher than outpatient) will send in an admit CCAR is when the member is not in any other type of treatment. If an admit CCAR is needed (select Type of Update 03, Psychiatric Hospital Admission), so is a discharge CCAR (select Type of Update 07, Psychiatric Hospital Discharge).

When completing CCARs, it is important to ensure that the first date of contact and the date of the first appointment fields are completed. This information assists in determining if State standards for routine access are being met.

FREQUENTLY ASKED QUESTIONS (FAQ)

At the bottom of the CCAR login screen there is a link to the CCAR Frequently Asked Questions (FAQ) that also allows you to search for questions concerning CCAR forms.



TECHNICAL SUPPORT

For technical support, please contact Provider Relations Department at 1-800- 804-5040 or send an email to: COproviderrelations@BeaconHealthOptions.com

Section 13

CLAIMS BILLING INFORMATION

Claims Procedures & E-Commerce Initiative
E-Commerce Initiative
Claims Submission Guidelines
Health First Colorado (Medicaid) Retroactivity
Incomplete Claims are not Complete Claims
Paper Claim Submission Address
Required Claim Elements
Requests for Additional Information
Claims Processing
Provider Summary Vouchers
Coordination of Benefits
Overpayment Recovery
Requests for Review
Claims Disputes
Claims Appeal Process
Adjustments and Reversal Requests
Resubmissions
Claims Billing Audits
Audit Appeals
Reporting Fraud, Waste and Abuse

Resource Documents

- **EDI Resource Document – E-Support Services for ProviderConnect and Electronic Claims (PDF)**
- **Provider Summary Voucher Form Sample (PDF)**
- **Revised CMS 1500 Form Version 02/12 (Sample) (PDF)**
- **Tips for Completing the CMS 1500 (PDF)**
- **UB04 Claim (PDF)**
- **Tips for Completing the UB04 (PDF)**

Beacon Health Options Colorado will be processing all claims for Colorado Health Partnerships and Foothills Behavioral Health Partners, both of which are Behavioral Health Organizations (BHOs) contracted with the state of Colorado for the Health First Colorado (Medicaid) Community Mental

Health Services Program. For answers to questions about Billing for Professional and Facility/Program Services, call Beacon Health Options: **1-800-804-5008.**

CLAIMS PROCEDURE AND E-COMMERCE INITIATIVE

E-COMMERCE INITIATIVE

Beacon maintains claims processing procedures designed to comply with the requirements of client plans, government-sponsored health benefit programs, and applicable state laws, rules, and/or regulations.

Providers in the Beacon network are strongly recommended to electronically submit all claims.

To electronically submit claims, Beacon's *providers* are strongly encouraged to use ProviderConnect, or one of the electronic claims resources detailed further in the section titled "Electronic Resources." These resources will expedite claims processing and assist *participating providers* to conduct certain claim submission and other routine transactions. Electronic claim submission is also accepted through clearinghouses. When using the services of a clearinghouse, providers must reference Beacon's Payer ID, **FHC &Affiliates**, to ensure Beacon receives those claims. The provider must also register for online services and submit the Intermediary Authorization Form to be linked with the clearinghouse.

Another option for providers for electronic claim submission is to install Beacon's EDI Claims Link for Windows Software on their computer(s).

For information on these resources, please refer to the Beacon Health Options website.

CLAIMS SUBMISSION GUIDELINES

Unless otherwise identified in the provider agreement, *providers* must file or submit claims within ninety (90) calendar days from the date of service, or where applicable, from date of determination by the primary payer. Claims received after the above noted ninety (90) day time period after the date of service may be denied due to lack of timely filing. Claims must match the *authorization* or *certification* or *notification* applicable to *covered services* for which the claim applies to avoid potential delays or denial in processing. To electronically submit claims, Beacon Health Options providers are required to use *ProviderConnect* or one of the electronic claims resources detailed further in the section titled "Electronic Resources," to conduct claim submission. These resources will expedite claims processing.

In accordance with Senate Bill 10-16-106.3., Beacon Health Options will pay, deny or settle all electronically received health insurance claims within 30 days after initial receipt. Additionally, all claims received via hard-copy will be paid, denied or settled within 45 days after initial receipt.

In cases where Beacon Health Options fails to pay clean claims in the time frames referenced in the above paragraph, a penalty in the amount of 10% of the total amount ultimately allowed on the claim will be paid.

Providers should not submit claims in their name for services that were provided by a physician's assistant, nurse practitioner, psychological assistant, intern or another clinician. In facility or program settings, supervising clinicians should not submit claims in their name for services that were provided by a resident, intern or psychological assistant.

Separate claim forms must be submitted for each member for whom the provider bills and it must contain all of the required data elements. Each billing line should be limited to one date of service and one procedure code.

When billing for CPT codes that include timed services in the code description (e.g., 90832; 90833; 90834; 90836; 90837; 90838; 90839 and appropriate Evaluation and Management codes, the actual time spent must clearly be documented within the *member's* treatment record. This time should be documented indicating a session's start and stop times (e.g., 9:00-9:50).

The service location **must** be submitted on all claims, and it **must not** be a Post Office Box number. Beacon Health Options will use this address information in conjunction with the NPI to select the appropriate provider record for processing the claim on our system as well as to verify the provider's Medicaid enrollment status (or revalidation) with the Colorado Department of Health Care Policy and Financing

Providers should submit claims consistent with national and industry standards. To ensure adherence to these standards, Beacon Health Options relies on claims edits and investigative analysis processes to identify claims that are not in accordance to national and industry standards and therefore were paid in error. The claims edits and investigative analysis processes include CMS's National Correct Coding Initiative (NCCI), which consists of:

- Procedure-to-Procedure edits that define pairs of HCPCS/CPT codes that should not be reported together.
- Medically Unlikely Edits (MUE) or units-of-service edits. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct and therefore needs to be supported by medical records.
- Other Edits for Improperly Coded Claims – regulatory or level of care requirements for correct coding.

Examples of claims edits can include but are not limited to the following:

- Invalid procedure and/or diagnosis codes
- Invalid code for place of service
- Invalid or inappropriate modifier for a code
- State-specific edits to support Medicaid requirements
- Diagnosis codes that do not support the procedure
- Add-on codes reported without a primary procedure code
- Charges not supported by documentation based on review of medical records
- Claims from suspected fraudulent activities of providers and members that warrant additional review and consideration

- Services provided by a sanctioned provider or provider whose license has been revoked or restricted
- Incorrect fee schedule applied
- Duplicate claims paid in error
- No authorization on file for a service that requires prior authorization

All billings by the provider are considered final unless adjustments or a request for review is received by Beacon Health Options within the time period identified in the provider agreement, or if no time period is identified in the *provider agreement* within sixty (60) calendar days from the date indicated on the *Explanation of Benefits* (*EOB*). Payment for *covered services* is based upon *authorization*, certification or notification (as applicable), coverage under the *member's* benefit plan and the *member's* eligibility at the time of service.

HEALTH FIRST COLORADO RETRO ELIGIBILITY

The State of Colorado approves Health First Colorado (Colorado's Medicaid Program) retro-active eligibility for 3 months (90 days) prior to application approval. Providers must submit retro-active requests for authorization and claims payment with county or state load letter to consider any payment. Providers should continue to verify eligibility on the State of Colorado web portal to verify any coverage. Beacon Health Options will accept retro-active authorization requests for up to 120 days after the member becomes eligible.

INCOMPLETE CLAIMS ARE NOT CLEAN CLAIMS

In accordance with Senate Bill 10-16-106.3 Beacon Health Options will notify the provider within 30 calendar days if the resolution of a claim requires additional information. As indicated in this section the provider will be given a full explanation of what additional information is needed.

Claims with invalid or incomplete information will be **denied** with an Explanation of Benefit advising the provider of the incorrect or invalid information. Effective January 1st, 2018, Beacon Health Options will be rejecting "Not Clean Claims" via 277CA for electronic claims or a letter for paper claims instead of processing and denying with the notices provided via EOBs. Claims that are not clean will not be uploaded in to the Beacon Health Options system.

The provider is required to submit a "corrected" claim to Beacon Health Options providing the updated information for payment consideration. Corrected claims received more than 60 calendar days from the date on the Provider Summary Voucher may not be considered for payment.

If Beacon Health Options is unable to locate a member's Health First Colorado ID provided on the claim form, the claim will be denied with an Explanation of Payment indicating the member is "unknown". If possible, Beacon Health Options will indicate the member's name in the patient account number field, shown on your Provider Summary Voucher. The necessary corrections should be made and a new claim submitted for consideration. Please be sure to send all requested information within the account- specific timely filing guidelines.

PAPER CLAIMS SUBMISSION ADDRESS

Beacon Health Options
ATTN: Health First Colorado Claims
P. O. Box 1850
Hicksville, NY 11802-1850

REQUIRED CLAIM ELEMENTS

Claims for covered services rendered to members should be submitted using UB-04 or CMS-1500 forms, or their respective electronic equivalent or successor forms, with all applicable fields completed and all elements/information required by Beacon Health Options included. The following lists capture the Beacon Health Options required claim fields to make a clean claim for the UB04 and CMS-1500.

Tips for Completing the UB04 (CMS-1450) Claim Form

FAILURE TO PROVIDE VALID INFORMATION MATCHING THE INSURED'S ID CARD COULD RESULT IN A REJECTION OF YOUR CLAIM.

Field	Field description	Field type	Instructions
1	Facility name, Address, Telephone Number, and Country Code	Required	This field contains the complete Servicing address (the address where the services are being performed/rendered) and telephone and/or fax number. This must be a street address. Please enter this to match the name and address submitted to Beacon Health Options on your credentialing documents.
2	Pay-to Name and Address	Conditional	This field contains the address to which payment should be sent if different from the information in Field 1. Please be sure this matches what you submitted on your credentialing documents.

3a	Patient Control Number	Conditional	Complete this field with the patient account number assigned by the provider that allows for the retrieval of individual patient financial records. If completed, this number will be included on the Provider's Summary Voucher.
3b	Medical / Health Record Number	Conditional	In this field, report the patient's medical record number as assigned by the provider.
4	Type of Bill	Required	This field is for reporting the type of bill for the purposes of third party processing of the claim such as inpatient or outpatient. The first digit is a leading zero. The second digit is the type of facility. The third digit classifies the type of care being billed. The fourth digit indicates the sequence of the bill for a specific episode of care.

Field	**Field description**	**Field type**	**Instructions**
5	Federal Tax Number	Required	Enter the number assigned by the federal government for tax reporting purposes. This may be either the Tax Identification Number (TIN) or the Employer Identification Number (EIN).
6	Statement Covers Period "From" and "Through"	Required	Use this field to report the beginning and end dates of service for the period reflected on the claim in MMDDYY format.
7	Reserved for Assignment by the NUBC	Not Required	N/A
8a	Patient Identifier	Required	This field is for the patient's identification number.
8b	Patient Name	Required	This field is for the patient's last, middle initial, and first name.

9a	Patient Address	Required	This field is for entering the patient's street address. Please comply with US Postal service guidelines for all addresses
9b	(unlabeled field)	Required	This field is for entering the patient's city.
9c	(unlabeled field)	Required	This field is for entering the patient's state code as defined by the US Postal Service.
9d	(unlabeled field)	Required	This field is for entering the patient's ZIP code.
9e	(unlabeled field)	Required	This field is for entering the patient's Country Code.
10	Patient Birth date	Required	This field includes the patient's complete date of birth using the eight-digit format (MMDDCCYY).
11	Sex	Required	Use this field to identify the sex of the patient.

Field	**Field description**	**Field type**	**Instructions**
12	Admission Date / Start of Care Date	Required	Enter the date care begins. For inpatient care, it is the date of admission. For all other services, it is the date care is initiated.
13	Admission Hour	Conditional	Required for some accounts including all Medicaid claims. Enter the hour in which the patient is admitted for inpatient or outpatient care. **NOTE**: Enter using Military Standard Time (00 – 23) in top-of-the-hour times only.
14	Priority (Type) of Admission/Visit	Required	Enter the appropriate code for the priority of the admission or visit. See valid codes at the end of this section.

15	Source of Referral for Admission or Visit	Required	This field contains a code that identifies the point of patient origin for this admission or visit. See valid codes at the end of this section.
16	Discharge Hour	Conditional	This field is used for reporting the hour the patient is discharged from inpatient care. **NOTE**: Enter using Military Standard Time (00 – 23) in top-of-the-hour times only.

Field	**Field description**	**Field type**	**Instructions**
17	Patient Discharge Status	Required	Use this field to report the status of the patient upon discharge – required for institutional claims. See valid codes at the end of this section.
18 – 28	Condition Codes	Conditional	Use these fields to report conditions or events related to the bill that may affect the processing of it.
29	Accident State	Conditional	When appropriate, assign the two digit abbreviation of the state in which an accident occurred.
30	Reserved for Assignment by the NUBC	Not Required	N/A
31 – 34	Occurrence Codes and Dates	Conditional	The occurrence code and the date fields associated with it define a significant event associated with the bill that affects processing by the payer (e.g., accident, employment related, etc.).
35 – 36	Occurrence Span Codes and Dates	Conditional	This field is for reporting the beginning and end dates of the specific event related to the bill.

37	Reserved for Assignment by the NUBC	Not Required	N/A
38	Responsible Party Name and Address	Required	This field is for reporting the name and address of the person responsible for the bill.
39 - 41	Value Codes and Amounts	Required	These fields contain the codes and related dollar amounts to identify the monetary data for processing claims. This field is qualified by all payers.

Field	**Field description**	**Field type**	**Instructions**
42	Revenue code	Required	Use this field to report the appropriate *HIPAA* compliant numeric code corresponding to each narrative description or standard abbreviation that identifies a specific accommodation and/or ancillary service.
43	Revenue Description	Optional	This field contains a narrative description or standard abbreviation for each revenue code category reported on this claim. .
44	HCPCS / Rate / HIPPS Code	Conditional	This field is used to report the appropriate HCPCS codes for ancillary services, the accommodation rate for bills for inpatient services, and the Health Insurance Prospective Payment System rate codes for specific patient groups that are the basis for payment under a prospective payment system.
45	Service Date	Conditional	Indicates the date the outpatient service was rendered using the six-digit format (MMDDYY).
46	Service Units	Required	In this field, units such as pints of blood used, miles traveled and the number of inpatient days are reported.

47	Total Charges	Required	This field reports the total charges – covered and non-covered – related to the current billing period.
48	Non-Covered Charges	Conditional	This field indicates charges that are non-covered charges by the payer as related to the revenue code.
49	Reserved for Assignment by the NUBC	Not Required	N/A

Field	**Field description**	**Field type**	**Instructions**
50a, b, c	Payer Name	Required	If more than one payer is responsible for this claim, enter the name(s) of primary, secondary and tertiary payers as applicable. Provider should list multiple payers in priority sequence according to the priority the provider expects to receive payment from these payers.
51a, b, c	Health Plan Identification Number	Required	This field includes the identification number of the health insurance plan that covers the patient and from which payment is expected.
52a, b, c	Release of Information Certification Indicator	Required	Enter the appropriate code denoting whether the provider has on file a signed statement from the patient or the patient's legal representative to release information. Refer to Attachment B for valid codes.
53a, b, c	Assignment of Benefits Certification Indicator	Required	Enter the appropriate code to indicate whether the provider has a signed form authorizing the third party insurer to pay the provider directly for the service rendered.

54a, b, c	Prior Payments	Conditional	Enter any prior payment amounts the facility has received toward payment of this bill for the payer indicated in Field 50 lines a, b, c.
55a, b, c	Estimated Amount Due	Not required	Enter the estimated amount due from the payer indicated in Field 50 lines a, b, c.
56	National Provider Identifier – Billing Provider	Required	This field is for reporting the unique provider identifier assigned to the provider.

Field	**Field description**	**Field type**	**Instructions**
57	Other Provider Identifier – Billing Provider	Not Required	The unique provider identifier assigned by the health plan is reported in this field.
58a, b, c	Insured's Name (last, first name, middle initial)	Required	The name of the individual who carries the insurance benefit is reported in this field. Enter the last name, first name and middle initial. THIS MUST MATCH THE NAME ON THE *MEMBER*'S IDENTIFICATION CARD
59a, b, c	Patient's Relationship to Insured	Required	Enter the applicable code that indicates the relationship of the patient to the insured.
60a, b, c	Insured's Unique Identification	Required	This is the unique number the health plan assigns to the insured individual. THIS MUST MATCH THE ID ON THE *MEMBER*'S IDENTIFICATION CARD.

61a, b, c	Group Name	Required	Enter the group or plan name of the primary, secondary and tertiary payer through which the coverage is provided to the member.
62a, b, c	Insurance Group Number	Conditional	Enter the plan or group number for the primary, secondary and tertiary payer through which the coverage is provided to the member.
63a, b, c	Treatment *Authorization* Codes	Conditional	Enter the *authorization* number assigned by the payer indicated in Field 50, if known. This indicates the treatment has been preauthorized.
64a, b, c	Document Control Number	Not Required from the Provider	This number is assigned by the health plan to the bill for their internal control. Also used to indicate the DCN on any claim adjustment being requested.

Field	**Field description**	**Field type**	**Instructions**
65a, b, c	Employer Name (of the Insured)	Conditional	Enter the name of primary employer that provides the coverage for the insured indicated in Field 58.
66	*Diagnosis* and Procedure Code Qualifier (*ICD* Version Indicator)	Required	This qualifier is used to indicate the version of *ICD*-10-CM being used. A "0" is required in this field for the *UB-04*.
67	Principal *Diagnosis Code*	Required	Enter the valid *ICD*-10-CM *diagnosis code* that describes the principal *diagnosis* to the highest level of specificity for services rendered.

a - q	Other *Diagnosis Codes* / Present on Admission Indicator (POA)	Conditional	This field is for reporting all *diagnosis codes* in addition to the principal *diagnosis* that coexist, develop after admission, or impact the treatment of the patient or the length of stay. The *ICD*-10 completed to its fullest character must be used. The present on admission (POA) indicator applies to *diagnosis codes* (e.g., principal, secondary and E codes) for inpatient claims to general acute-care hospitals or other facilities, as required by law or regulation for public health reporting. It is the eighth digit attached to the corresponding *diagnosis code*.
68	Reserved for Assignment by the NUBC	Not Required	N/A

Field	**Field description**	**Field type**	**Instructions**
69	Admitting *Diagnosis*	Required	Enter a valid *ICD*-10-CM *diagnosis code* that describes the *diagnosis* of the patient at the time of admission.
70 a – c	Patient's Reason for *Visit*	Conditional	The *ICD*-10-CM codes that report the reason for the patient's outpatient *visit* is reported here.
71	Prospective Payment System (PPS) Code	Not required	This code identifies the DRG based on the grouper software and is required only when the provider is under contract with a health plan using DRG codes.
72	External Cause of Injury (ECI) Code	Not Required	In the case of external causes of injuries, poisonings, or adverse effects, the appropriate *ICD*-10-CM *diagnosis code* is reported in this field.
73	Reserved for Assignment by the	Not Required	N/A

	NUBC		
74	Principal Procedure Code and Date	Conditional	This field contains the *ICD*-10-CM code for the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date on which the principal procedure was performed.
74 a – e	Other Procedure Codes and Dates	Conditional	This field allows reporting up to five *ICD*-10-CM procedure codes to identify the significant procedure performed during the billing period and the related dates.
75	Reserved for Assignment by the NUBC	Not Required	N/A

Field	**Field description**	**Field type**	**Instructions**
76	Attending Provider Names and Identifiers	Required	This field is for reporting the name and identifier of the provider with the responsibility for the care provided on the claim.
77	Operating Physician Name and Identifiers	Conditional	Report the name and identification number of the physician responsible for performing surgical procedure in this field.
78 – 79	Other Provider Names and Identifiers	Conditional	This field is used for reporting the names and identification numbers of individuals that correspond to the provider type category.
80	Remarks	Not Required	This field is used to report additional information necessary to process the claim.

81 a – d	Code – Code	Conditional	This field is used to report codes that overflow other fields and for externally maintained codes NUBC has approved for the institutional data set. Taxonomy codes should be reported in these fields using a qualifier of B3.

UB04 (CMS-1450) REFERENCE MATERIAL[1]

Type of Bill Codes (Field 4)

This is a three-digit code; each digit is defined below.

First Digit – Leading Zero	
0XXX	

Second Digit – Type of Facility	**Description of Second Digit**
01XX	Hospital

02XX	Skilled Nursing
03XX	Home Health Facility
04XX	Religious Non-medical Health Care Institutions (RNHCI) – Hospital Inpatient
05XX	Reserved for National Assignment by the NUBC
06XX	Intermediate Care (not used for Medicare)
07XX	Clinic (Requires Special Reporting for the Third Digit)
08XX	Special Facility or ASC Surgery (Requires Special Reporting for the Third Digit)
09XX	Reserved for National Assignment by the NUBC

Third Digit – Bill Classification	**Description of Third Digit Except for Clinics and Special Facilities**
0X**1**X	Inpatient (Including Medicare Part A)

0X**2**X	Inpatient (Medicare Part B Only) (Includes HHA *Visits* Under a Part B Plan of Treatment)
0X**3**X	Outpatient (Includes HHA *Visits* Under a Part A Plan of Treatment Including DME Under Part A)
0X**4**X	Laboratory Services Provided to Non-Patients, or Home Health Not Under a Plan of Treatment
0X**5**X	Intermediate Care Level 1
0X**6**X	Intermediate Care Level II
0X**7**X	Reserved for National Assignment by NUBC
0X**8**X	Swing Beds
0X**9**X	Reserved for National Assignment by NUBC

Third Digit – Bill Classification	**Description of Third Digit Classification for Clinics Only**
0X**1**X	Rural Health Clinic
0X**2**X	Clinic – Hospital Based or Independent Renal Dialysis Center
0X**3**X	Freestanding
0X**4**X	ORF
0X**5**X	CORF
0X**6**X	CMHC
0X**7**X	Federally Qualified Health Center (FQHC)
0X**8**X	Licensed Freestanding Emergency Medical Facility
0X**9**X	Other

Third Digit – Bill Classification	**Description of Third Digit Classification for Special Facility Only**
0X**1**X	Hospice (Non-hospital based)
0X**2**X	Hospice (Hospital based)
0X**3**X	Ambulatory Surgery Center
0X**4**X	Freestanding Birthing Center
0X**5**X	Critical Access Hospital
0X**6**X	Residential Facility (Not used for Medicare)
0X**7**X	Reserved for National Assignment by NUBC

0X**8**X	Reserved for National Assignment by NUBC
0X**9**X	Special Facility - Other (Not used for Medicare)

Fourth Digit – Frequency of the Bill	Description of Fourth Digit Frequency of the Bill
0XX**0**	Nonpayment / Zero Claim
0XX**1**	Admit through Discharge Claim
0XX**2**	Interim – First Claim
0XX**3**	Interim – Continuing Claim (Not valid for Medicare PPS Claims)
0XX**4**	Interim – Last Claim (Not valid for Medicare Inpatient Hospital PPS Claims)
0XX**5**	Late Charges Only Claim
0XX**6**	Reserved for National Assignment by NUBC
0XX**7**	Replacement of Prior Claim
0XX**8**	Void / Cancel of a Prior Claim
0XX**9**	Final Claim for a Home Health PPS Episode

[1] Ingenix® *Uniform Billing Editor, March, 2015*

Sex Codes (Field 11)

Code	Definition
M	Male
F	Female
U	Unknown

Type of Admission Codes (Field 14)

Code	Definition
1	*Emergency*
2	*Urgent*
3	Elective
4	Newborn
5	Trauma
6 – 8	Reserved for National Assignment
9	Information Not Available

Source of Admission Codes Except Newborns (Field 15)

Code	Definition
1	Nonhealthcare Facility Point of Origin
2	Clinic or Physician's Office
3	Reserved for assignment by the NUBC
4	Transfer From a Hospital (Different Facility)
5	Transfer from a Skilled Nursing Facility or Intermediate Care Facility or Assisted Living Facility
6	Transfer from Another Health Care Facility
7	Reserved for assignment by the NUBC
8	Court/Law Enforcement
9	Information Not Available
A	Reserved for assignment by the NUBC
B	Reserved for assignment by the NUBC
C	Reserved for assignment by the NUBC
D	Transfer from One Distinct Unit of the Hospital to Another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer
E	Transfer from Ambulatory Surgery Center
F	Transfer from Hospice Facility
G – Z	Reserved for National Assignment

Additional Source of Admission Codes for Newborns (Field 15)

Code	Definition
1 – 4	Discontinued
5	Born Inside this Hospital
6	Born Outside this Hospital
7 – 9	Reserved for National Assignment

Patient Status (Field 17)

Code	Definition
01	Discharged to Home or Self-Care (Routine Discharge)
02	Discharged / Transferred to a Short-Term General Hospital for Inpatient Care
03	Discharged / Transferred to a SNF with Medicare Certification in Anticipation of Skilled Care
04	Discharged / Transferred to a Facility That Provides Custodial or Supportive Care
05	Discharged / Transferred to a Designated Cancer Center or Children's Hospital

Code	Definition
06	Discharged / Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care
07	Left Against Medical Advice or Discontinued Care
08	Reserved for Assignment by the NUBC
09	Admitted as an Inpatient to This Hospital
10 – 19	Reserved for Assignment by the NUBC
20	Expired
21	Discharged / Transferred to Court / Law Enforcement
22 - 29	Reserved for Assignment by the NUBC
30	Still a Patient
31-39	Reserved for Assignment by the NUBC
40	Expired at Home
41	Expired in a Medical Facility such as a Hospital, SNF, ICF or Free-Standing Hospice
42	Expired, Place Unknown
43	Discharged / Transferred to a Federal Health Care Facility
44 – 49	Reserved for Assignment by the NUBC
50	Discharged to Hospice, Home
51	Discharged to Hospice, Medical Facility (Certified) Providing Hospice *Level of Care*
52 – 60	Reserved for Assignment by the NUBC

61	Discharged / Transferred Within This Institution to a Hospital Based Medicare Approved Swing Bed
62	Discharged / Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital
63	Discharged / Transferred to a Medicare Certified Long Term Care Hospital (LTCH)
64	Discharged / Transferred to a Nursing Facility Certified Under Medicaid but Not Certified Under Medicare
65	Discharged / Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
66	Discharged / Transferred to a Critical Access Hospital
67 – 68	Reserved for Assignment by the NUBC
69	Discharged / Transferred to a Designated disaster Alternative Care Site
70	Discharged / Transferred to Another Type of Healthcare Institution Not Defined Elsewhere in this Code List
71 – 80	Reserved for Assignment by the NUBC
81	Discharge to Home or Self-Care with a Planned Acute Care hospital Inpatient Readmission
82	Discharged / Transferred to a Short-Term General Hospital for Inpatient Care with a Planned Acute Care hospital Inpatient

Code	**Definition**
	Readmission
83	Discharged /Transferred to a Skilled Nursing Facility with Medicare Certification with a Planned Acute Care hospital Inpatient Readmission
84	Discharged /Transferred to a Facility that Provides Custodial of Supportive Care with a Planned Acute Care hospital Inpatient Readmission
85	Discharged /Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care hospital Inpatient Readmission
86	Discharged /Transferred to Home Under Care of Organized Home Health Service Organization with a Planned Acute Care hospital Inpatient Readmission
87	Discharged /Transferred to Court / Law Enforcement with a Planned Acute Care hospital Inpatient Readmission

88	Discharged /Transferred to a Federal Health Care Facility with a Planned Acute Care hospital Inpatient Readmission
89	Discharged /Transferred to a Hospital-based Medicare Approved Swing Bed with a Planned Acute Care hospital Inpatient Readmission
90	Discharged /Transferred to an Inpatient Rehabilitation Facility Including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care hospital Inpatient Readmission
91	Discharged /Transferred to a Medicare Certified Long-term Care Hospital with a Planned Acute Care hospital Inpatient Readmission
92	Discharged /Transferred to a Nursing Facility Certified under Medicaid but not Certified under Medicare with a Planned Acute Care hospital Inpatient Readmission
93	Discharged /Transferred to a Psychiatric Hospital or Psychiatric Distinct Part unit of a Hospital with a Planned Acute Care hospital Inpatient Readmission
94	Discharged /Transferred to a Critical Access Hospital with a Planned Acute Care hospital Inpatient Readmission
95	Discharged /Transferred to Another Type of Healthcare Institution Not Defined Elsewhere in this Code List with a Planned Acute Care hospital Inpatient Readmission

Release of Information Indicator Codes (Field 52)

Code	Definition
I	Informed consent to release medical information for conditions or diagnoses regulated by federal statutes
Y	Yes, provider has a signed statement permitting release of medical billing data related to a claim

Member's Relationship to the Insured Codes for UB04 Only (Field 59, 837I, version 5010)

Code	Definition
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

Valid Taxonomy Codes

100000000X	BH & SOCSERV PROVIDERS
101YA0400X	BH & SOCIAL SERVICE, COUNSELOR, ADDICTION (SUBSTAN
101YM0800X	BH & SOCIAL SERVICE, COUNSELOR, MH
101YP1600X	BH & SOCIAL SERVICE, COUNSELOR, PASTORAL
101YP2500X	BH & SOCIAL SERVICE, COUNSELOR, PROFESSIONAL
101YS0200X	BH & SOCIAL SERVICE, COUNSELOR, SCHOOL
101Y00000X	BH & SOCIAL SERVICE, COUNSELOR
103GC0700X	BH & SOCIAL SERVICE, NEUROPSYCHOLOGIST, CLINICAL
103G00000X	BH & SOCIAL SERVICE, NEUROPSYCHOLOGIST
103TA0400X	BH & SOCIAL SERVICE, PSYCHOLOGIST, ADDICTION (SUBS
103TA0700X	BH & SOCIAL SERVICE, PSYCHOLOGIST, ADULT DEVELOPME
103TB0200X	BH & SOCIAL SERVICE, PSYCHOLOGIST, BEHAVIORAL
103TC0700X	BH & SOCIAL SERVICE, PSYCHOLOGIST, CLINICAL
103TC1900X	BH & SOCIAL SERVICE, PSYCHOLOGIST, COUNSELING
103TC2200X	BH & SOCIAL SERVICE, PSYCHOLOGIST, CHILD, YOUTH &
103TE1000X	BH & SOCIAL SERVICE, PSYCHOLOGIST, EDUCATIONAL
103TE1100X	BH & SOCIAL SERVICE, PSYCHOLOGIST, EXERCISE & SPOR
103TF0000X	BH & SOCIAL SERVICE, PSYCHOLOGIST, FAMILY
103TF0200X	BH & SOCIAL SERVICE, PSYCHOLOGIST, FORENSIC
103TH0100X	BH & SOCIAL SERVICE, PSYCHOLOGIST, HEALTH
103TM1700X	BH & SOCIAL SERVICE, PSYCHOLOGIST, MEN & MASCULINI

103TM1800X	BH & SOCIAL SERVICE, PSYCHOLOGIST, MENTAL RETARDAT
103TP0814X	BH & SOCIAL SERVICE, PSYCHOLOGIST, PSYCHOANALYSIS
103TP2700X	BH & SOCIAL SERVICE, PSYCHOLOGIST, PSYCHOTHERAPY
103TP2701X	BH & SOCIAL SERVICE, PSYCHOLOGIST, PSYCHOTHERAPY,

103TR0400X	BH & SOCIAL SERVICE, PSYCHOLOGIST, REHABILITATION
103TS0200X	BH & SOCIAL SERVICE, PSYCHOLOGIST, SCHOOL
103TW0100X	BH & SOCIAL SERVICE, PSYCHOLOGIST, WOMEN
103T00000X	BH & SOCIAL SERVICE, PSYCHOLOGIST
1041C0700X	BH & SOCIAL SERVICE, SOCIAL WORKER, CLINICAL
1041S0200X	BH & SOCIAL SERVICE, SOCIAL WORKER, SCHOOL
104100000X	BH & SOCIAL SERVICE, SOCIAL WORKER
106H00000X	BH & SOCIAL SERVICE, MARRIAGE & FAMILY THERAPIST
160000000X	NURSING SERVICE
163WA0400X	NURSING SERVICE, RN, ADDICTION (SUBSTANCE USE DISO
163WA2000X	NURSING SERVICE, RN, ADMINISTRATOR
163WC0200X	NURSING SERVICE, RN, CRITICAL CARE MEDICINE
163WC0400X	NURSING SERVICE, RN, CASE MANAGEMENT
163WC1400X	NURSING SERVICE, RN, COLLEGE HEALTH
163WC1500X	NURSING SERVICE, RN, COMMUNITY HEALTH
163WC1600X	NURSING SERVICE, RN, CONTINUING EDUCATION/STAFF DE
163WC2100X	NURSING SERVICE, RN, CONTINENCE CARE
163WC3500X	NURSING SERVICE, RN, CARDIAC REHABILITATION
163WD0400X	NURSING SERVICE, RN, DIABETES EDUCATOR
163WD1100X	NURSING SERVICE, RN, DIALYSIS, PERITONEAL
163WE0003X	NURSING SERVICE, RN, EMERGENCY
163WE0900X	NURSING SERVICE, RN, ENTEROSTOMAL THERAPY
163WF0300X	NURSING SERVICE, RN, FLIGHT
163WG0000X	NURSING SERVICE, RN, GENERAL PRACTICE
163WG0100X	NURSING SERVICE, RN, GASTROENTEROLOGY
163WG0600X	NURSING SERVICE, RN, GERONTOLOGY
163WH0200X	NURSING SERVICE, RN, HOME HEALTH
163WH0500X	NURSING SERVICE, RN, HEMODIALYSIS
163WH1000X	NURSING SERVICE, RN, HOSPICE
163WI0500X	NURSING SERVICE, RN, INFUSION THERAPY
163WI0600X	NURSING SERVICE, RN, INFECTION CONTROL
163WL0100X	NURSING SERVICE, RN, LACTATION CONSULTANT

163WM0102X	NURSING SERVICE, RN, MATERNAL NEWBORN
163WM0705X	NURSING SERVICE, RN, MEDICAL-SURGICAL
163WM1400X	NURSING SERVICE, RN, NURSE MASSAGE THERAPIST (NMT)
163WN0002X	NURSING SERVICE, RN, NEONATAL INTENSIVE CARE
163WN0003X	NURSING SERVICE, RN, NEONATAL, LOW-RISK
163WN0300X	NURSING SERVICE, RN, NEPHROLOGY
163WN0800X	NURSING SERVICE, RN, NEUROSCIENCE
163WN1003X	NURSING SERVICE, RN, NUTRITION SUPPORT
163WP0000X	NURSING SERVICE, RN, PAIN MANAGEMENT
163WP0200X	NURSING SERVICE, RN, PEDIATRICS
163WP0218X	NURSING SERVICE, RN, PEDIATRIC ONCOLOGY
163WP0807X	NURSING SERVICE, RN, PSYCH/MH, CHILD & ADOLESCENT
163WP0808X	NURSING SERVICE, RN, PSYCH/MH
163WP0809X	NURSING SERVICE, RN, PSYCH/MH, ADULT
163WP1700X	NURSING SERVICE, RN, PERINATAL
163WP2201X	NURSING SERVICE, RN, AMB CARE
163WR0400X	NURSING SERVICE, RN, REHABILITATION

163WR1000X	NURSING SERVICE, RN, REPRODUCTIVE ENDOCRINOLOGY/IN
163WS0121X	NURSING SERVICE, RN, PLASTIC SURGERY
163WS0200X	NURSING SERVICE, RN, SCHOOL
163WU0100X	NURSING SERVICE, RN, UROLOGY
163WW0000X	NURSING SERVICE, RN, WOUND CARE
163WW0101X	NURSING SERVICE, RN, WOMEN'S HC, AMB
163WX0002X	NURSING SERVICE, RN, OBSTETRIC, HIGH-RISK
163WX0003X	NURSING SERVICE, RN, OBSTETRIC, INPATIENT
163WX0106X	NURSING SERVICE, RN, OCCUPATIONAL HEALTH
163WX0200X	NURSING SERVICE, RN, ONCOLOGY
163WX0601X	NURSING SERVICE, RN, OTORHINOLARYNGOLOGY & HEAD-NE
163WX0800X	NURSING SERVICE, RN, ORTHOPEDIC
163WX1100X	NURSING SERVICE, RN, OPHTHALMIC
163WX1500X	NURSING SERVICE, RN, OSTOMY CARE
163W00000X	NURSING SERVICE, RN
164W00000X	NURSING SERVICE, LICENSED PRACTICAL NURSE
164X00000X	NURSING SERVICE, LICENSED VOCATIONAL NURSE
167G00000X	NURSING SERVICE, LICENSED PSYCHIATRIC TECHNICIAN
190000000X	GROUP

193200000X	GROUP, MULTI-SPECIALTY
193400000X	GROUP, SINGLE SPECIALTY
207LA0401X	PHYSICIAN, ANESTHESIOLOGY, ADDICTION MEDICINE
207LC0200X	PHYSICIAN, ANESTHESIOLOGY, CRITICAL CARE MEDICINE
207PE0004X	PHYSICIAN, EMERGENCY MEDICINE, EMERGENCY MEDICAL S
207PP0204X	PHYSICIAN, EMERGENCY MEDICINE, PEDIATRIC EMERGENCY
207P00000X	PHYSICIAN, EMERGENCY MEDICINE
207QA0401X	PHYSICIAN, FAMILY PRACTICE, ADDICTION MEDICINE
207RA0401X	PHYSICIAN, INTERNAL MEDICINE, ADDICTION MEDICINE
2080P0006X	PHYSICIAN, PEDIATRICS, DEVELOPMENTAL BEHAVIORAL
2084A0401X	PHYSICIAN, PSYCH & NEUR, ADDICTION MEDICINE
2084F0202X	PHYSICIAN, PSYCH & NEUR, FORENSIC PSYCHIATRY
2084N0600X	PHYSICIAN, PSYCH & NEUR, CLINICAL NEUROPHYSIOLOGY
2084P0005X	PHYSICIAN, PSYCH & NEUR, NEURODEVELOPMENTAL DISABI
2084P0800X	PHYSICIAN, PSYCH & NEUR, PSYCHIATRY
2084P0802X	PHYSICIAN, PSYCH & NEUR, ADDICTION PSYCHIATRY
2084P0804X	PHYSICIAN, PSYCH & NEUR, CHILD & ADOLESCENT PSYCHI
2084P0805X	PHYSICIAN, PSYCH & NEUR, GERIATRIC PSYCHIATRY
220000000X	RESP, REHAB, & REST SERVICE PROVIDERS
221700000X	RESP, REHAB, & REST SERVICE, ART THERAPIST
225A00000X	RESP, REHAB, & REST SERVICE, MUSIC THERAPIST
225400000X	RESP, REHAB, & REST SERVICE, REHABILITATION PRACTI
225600000X	RESP, REHAB, & REST SERVICE, DANCE THERAPIST
225800000X	RESP, REHAB, & REST SERVICE, RECREATION THERAPIST
226300000X	RESP, REHAB, & REST SERVICE, KINESIOTHERAPIST
250000000X	AGENCIES
251B00000X	AGENCIES, CASE MANAGEMENT
251C00000X	AGENCIES, DAY TRAINING, DEVELOPMENTALLY DISABLED S
251E00000X	AGENCIES, HOME HEALTH
251F00000X	AGENCIES, HOME INFUSION

251G00000X	AGENCIES, HOSPICE CARE, COMMUNITY BASED
251J00000X	AGENCIES, NURSING CARE
251K00000X	AGENCIES, PUBLIC HEALTH OR WELFARE

260000000X	AMB HC FACILITIES
261QA1903X	AMB HC FACILITIES, CLINIC/CENTER, AMB SURGICAL
261QC0050X	AMB HC FACILITIES, CLINIC/CENTER, CRITICAL ACCESS
261QC1500X	AMB HC FACILITIES, CLINIC/CENTER, COMMUNITY HEALTH
261QC1800X	AMB HC FACILITIES, CLINIC/CENTER, CORPORATE HEALTH
261QD1600X	AMB HC FACILITIES, CLINIC/CENTER, DEVELOPMENTAL DI
261QE0002X	AMB HC FACILITIES, CLINIC/CENTER, EMERGENCY CARE
261QF0400X	AMB HC FACILITIES, CLINIC/CENTER, FEDERALLY QUALIF
261QH0100X	AMB HC FACILITIES, CLINIC/CENTER, HEALTH
261QM0801X	AMB HC FACILITIES, CLINIC/CENTER, MH (INCLUDING CO
261QM0850X	AMB HC FACILITIES, CLINIC/CENTER, ADULT MH
261QM0855X	AMB HC FACILITIES, CLINIC/CENTER, ADOLESCENT AND C
261QM1300X	AMB HC FACILITIES, CLINIC/CENTER, MULTI-SPECIALTY
261QM2800X	AMB HC FACILITIES, CLINIC/CENTER, METHADONE CLINIC
261QP0904X	AMB HC FACILITIES, CLINIC/CENTER, PUBLIC HEALTH, F
261QP0905X	AMB HC FACILITIES, CLINIC/CENTER, PUBLIC HEALTH, S
261QR0400X	AMB HC FACILITIES, CLINIC/CENTER, REHABILITATION
261QR0401X	AMB HC FACILITIES, CLINIC/CENTER, REHABILITATION,
261QR0405X	AMB HC FACILITIES, CLINIC/CENTER, REHABILITATION,
261QR1300X	AMB HC FACILITIES, CLINIC/CENTER, RURAL HEALTH
261Q00000X	AMB HC FACILITIES, CLINIC/CENTER
270000000X	HOSPITAL UNITS
273R00000X	HOSPITAL UNITS, PSYCHIATRIC UNIT
273Y00000X	HOSPITAL UNITS, REHABILITATION UNIT
276400000X	HOSPITAL UNITS, REHABILITATION, SUBSTANCE USE DISO
280000000X	HOSPITALS
282NC0060X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL, CRITICAL A
282NC2000X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL, CHILDREN
282NR1301X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL, RURAL
282NW0100X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL, WOMEN
282N00000X	HOSPITALS, GENERAL ACUTE CARE HOSPITAL
283Q00000X	HOSPITALS, PSYCHIATRIC HOSPITAL
283XC2000X	HOSPITALS, REHABILITATION HOSPITAL, CHILDREN
283X00000X	HOSPITALS, REHABILITATION HOSPITAL
284300000X	HOSPITALS, SPECIAL HOSPITAL
290000000X	LABORATORIES
291U00000X	LABORATORIES, CLINICAL MEDICAL LABORATORY

293D00000X	LABORATORIES, PHYSIOLOGICAL LABORATORY
310000000X	NURS & CUST CARE FACILITIES
3104A0625X	NURS & CUST CARE FACILITIES, ASSISTED LIVING FACIL
3104A0630X	NURS & CUST CARE FACILITIES, ASSISTED LIVING FACIL
310400000X	NURS & CUST CARE FACILITIES, ASSISTED LIVING FACIL
310500000X	NURS & CUST CARE FACILITIES, INTERMEDIATE CARE FAC
311ZA0620X	NURS & CUST CARE FACILITIES, CUSTODIAL CARE FACILI
311Z00000X	NURS & CUST CARE FACILITIES, CUSTODIAL CARE FACILI
311500000X	NURS & CUST CARE FACILITIES, ALZHEIMER CENTER (DEM
313M00000X	NURS & CUST CARE FACILITIES, NURSING FACILITY/INTE
3140N1450X	NURS & CUST CARE FACILITIES, SKILLED NURSING FACIL
314000000X	NURS & CUST CARE FACILITIES, SKILLED NURSING FACIL
315D00000X	NURS & CUST CARE FACILITIES, HOSPICE, INPATIENT
315P00000X	NURS & CUST CARE FACILITIES, INTERMEDIATE CARE FAC
320000000X	RTC FACILITIES
320800000X	RTC FACILITIES, COMMUNITY BASED RTC FACILITY, MENT
320900000X	RTC FACILITIES, COMMUNITY BASED RESIDENTIAL TREATM
322D00000X	RTC FACILITIES, RTC FACILITY, EMOTIONALLY DISTURBE
323P00000X	RTC FACILITIES, PSYCHIATRIC RTC FACILITY
3245S0500X	RTC FACILITIES, SA REHABILITATION FACILITY, SA TRE
324500000X	RTC FACILITIES, SA REHABILITATION FACILITY
32600000X	RTC FACILITIES, RTC FACILITY, MENTAL RETARDATION A
330000000X	SUPPLIERS
340000000X	TRANSPORTATION SERVICES
3416A0800X	TRANSPORTATION SERVICES, AMBULANCE, AIR TRANSPORT
3416L0300X	TRANSPORTATION SERVICES, AMBULANCE, LAND TRANSPORT
3416S0300X	TRANSPORTATION SERVICES, AMBULANCE, WATER TRANSPOR
341600000X	TRANSPORTATION SERVICES, AMBULANCE
343800000X	TRANSPORTATION SERVICES, SECURED MEDICAL TRANSPORT
343900000X	TRANSPORTATION SERVICES, NON-EMERGENCY MEDICAL TRA
344600000X	TRANSPORTATION SERVICES, TAXI
347B00000X	TRANSPORTATION SERVICES, BUS
347C00000X	TRANSPORTATION SERVICES, PRIVATE VEHICLE

347D00000X	TRANSPORTATION SERVICES, TRAIN
347E00000X	TRANSPORTATION SERVICES, TRANSPORTATION BROKER
360000000X	PA & APN PROVIDERS
363AM0700X	PA & APN PROVIDERS, PA, MEDICAL
363A00000X	PA & APN PROVIDERS, PA
363LA2100X	PA & APN PROVIDERS, APN, ACUTE CARE
363LC1500X	PA & APN PROVIDERS, APN, COMMUNITY HEALTH
363LP0808X	PA & APN PROVIDERS, APN, PSYCH/MH
363L00000X	PA & APN PROVIDERS, APN
364SA2200X	PA & APN PROVIDERS, CLIN NURSE SPEC, ADULT HEALTH
364SC1501X	PA & APN PROVIDERS, CLIN NURSE SPEC, COMMUNITY HEA
364SP0807X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, CHI
364SP0808X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH
364SP0809X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, ADU
364SP0810X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, CHI
364SP0811X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, CHR
364SP0812X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, COM
364SP0813X	PA & APN PROVIDERS, CLIN NURSE SPEC, PSYCH/MH, GER
364SR0400X	PA & APN PROVIDERS, CLIN NURSE SPEC, REHABILITATIO
364S00000X	PA & APN PROVIDERS, CLIN NURSE SPEC
367500000X	PA & APN PROVIDERS, NURSE ANESTHETIST, CERTIFIED R
380000000X	RESPITE CARE FACILITY
385HR2050X	RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE
385HR2055X	RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE,
385HR2060X	RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE,
385HR2065X	RESPITE CARE FACILITY, RESPITE CARE, RESPITE CARE,
385H00000X	RESPITE CARE FACILITY, RESPITE CARE

Tips for Completing the CMS-1500 Version 02/12 Claim Form

FAILURE TO PROVIDE VALID INFORMATION MATCHING THE INSURED'S ID CARD COULD RESULT IN A REJECTION OF YOUR CLAIM.


HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12
PICA
PICA
CARRIER

Enter in the white, open carrier area the name and address of the payer to whom this claim is being sent. Enter the name and address information in the following format:

1st Line – Name
2nd Line – First line of address
3rd Line – Second line of address, if necessary
4th Line – City, State (2 characters) and ZIP Code

Field Number	Field Description	Data Type	Instructions
Member Information (Fields 1-13)			
1	Coverage	Optional	Show the type of health insurance coverage applicable to this claim by checking the appropriate box (i.e., if a Medicare claim is being filed, check the Medicare box).
1a	Insured's ID number	Required	List the Insured's identification number here. THIS MUST MATCH THE ID ON THE INSURED'S IDENTIFICATION CARD. Verify that the identification number corresponds to the insured listed in item 4. The patient and the insured are not always the same person. Some payers assign unique identification numbers to each enrollee or *dependent* and require the number of the enrollee or *dependent* receiving services (the patient) instead of the insured's number in this item.

2	Patient's name	Required	Enter the patient's last name, first name, and middle initial, if any. NOTE: If the patient has a last name suffix (e.g., Jr, Sr) enter it after the last name, but before the first name. Do not include any professional titles. Do not use any punctuation in this field.

Field Number	**Field Description**	**Data Type**	**Instructions**
3	Patient's birth date and gender	Required	Enter the patient's birth date and sex. Use the eight digit format (MM|DD|CCYY) format for date of birth. Enter an X in the correct box to indicate the sex of the patient. Only one box can be marked. If the gender is unknown, leave blank.
4	Insured's name	Required	Enter the insured's full last name, first name and middle initial. If the insured has a last name suffix (e.g., Jr, Sr) enter it after the last name, but before the first name. THIS MUST MATCH THE NAME ON THE INSURED'S IDENTIFICATION CARD
5	Patient's address, city, state, zip code and telephone number	Required	Enter the patient's mailing address and telephone number. On the first line, enter the street address (apartment number or Post Office Box number); the second line, the city and state; the third line, the ZIP code and phone number. NOTE: Do not use commas, periods, or other punctuation in the address (i.e., 123 North Main Street 101 instead of 123 N. Main Street, #101). When entering a nine-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.
6	Patient's relationship to the insured	Required	Check the appropriate box for the patient's relationship to the insured when item 4 is completed. Remember that the patient's relationship to the insured is not always "self".

7	Insured's address, city, state, zip code and telephone number	Required	Enter the insured's address (apartment/PO box number, street, city, state, zip code and telephone number with area code). When the address is the same as the patient's enter the word "same". Complete this item only when items 4 and 11 are completed. NOTE: Do not use commas, periods, or other punctuation in the address (i.e., 123 North Main Street 101 instead of 123 N. Main Street, #101). When entering a nine-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.

Field Number	**Field Description**	**Data Type**	**Instructions**
8	Reserved for NUCC use	N/A	
9	Other insured's name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the name (last name, first name, middle initial) of the person who is insured under other payer.
9a	Other insured's policy or group number	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's policy or group number or the insured's identification number.
9b	Reserved for NUCC use	N/A	
9c	Reserved for NUCC use	N/A	
9d	Other insured's insurance plan name or program name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's insurance company or program name.

10a - c	Is the patient's condition related to: • Employment? • Auto accident? • Other accident?	Required	Place an "X" in the box indicating whether or not the condition for which the patient is being treated is related to current or previous employment, an automobile accident or any other accident. Enter an "X" in either the YES or NO box for each question. NOTE: The state postal code must be shown if "yes" is marked in 10b for "auto accident". Any item marked yes indicates there may be other applicable insurance coverage that would be primary such as automobile liability insurance. Primary insurance information must then be shown in item 11.
10d	Claim Codes (Designated by NUCC)	Not required	Not required by Beacon Health Options. Please leave blank.
11	Insured's Policy, Group or FECA number	Optional	Enter the Insured's policy or group number as it appears on the insured's health care identification card.

Field Number	**Field Description**	**Data Type**	**Instructions**
11a	Insured's date of birth and sex	Conditional	Required if the patient is not the insured. Enter the insured's eight-digit birth date in the MMDDCCYY format and sex if different from item 3.
11b	Other Claim ID (Designated by NUCC)	Conditional	Not required by Beacon Health Options. Please leave blank.
11c	Insurance plan name or program name	Conditional	Enter the insured's insurance company or program name.
11d	Is there another health benefit plan?	Required	Place an "X" in the box indicating whether there may be other insurance involved in the reimbursement of this claim. If "yes" complete items 9, 9a and 9b.

12	Patient's or authorized person's signature (Medicaid/other information release)	Required	The patient *must* sign and date the claim *if* authorizing the release of medical information. If "signature on file" is indicated, the provider *must* maintain a signed release form or *CMS*-1500 (formerly HCFA 1500). The patient's signature authorizes release of medical information necessary to process the claim.
13	Insured's or authorized person's signature	Required	The signature in this item authorizes payment of benefits to the physician or supplier. Signature on file, SOF, is acceptable.
Provider of Service or Supplier Information (Fields 14-33)			
14	Date of current illness, injury or pregnancy	Not required	Not applicable.
15	Other Date	Not required	Not applicable.
16	Dates patient unable to work in current occupation	Not Required	Required if the patient is eligible for disability or worker's compensation benefits due to this illness. Enter the "From" and "To" dates the patient was unable to work in MMDDYY or MMDDCCYY format.
17	Name of referring physician or other source	Not Required	Enter the name of the referring physician or other source if applicable.

Field Number	**Field Description**	**Data Type**	**Instructions**

17a	ID number of referring physician	Conditional	The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. (This qualifier is used for Supervising Provider only.) 5010A1 Instructions: The NUCC defines the following qualifiers used in 5010A1: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.) The non-*NPI* ID number of the referring, ordering, or supervising provider refers to the unique identifier of the professional or to the provider designated *taxonomy* code. This field allows for the entry of 2 characters in the qualifier field and 17 characters in the Other ID# field.
17b	*NPI*	Required	Enter the *NPI* of the referring or ordering physician listed in item 17.
18	Hospitalization dates related to current services	Conditional	Required if this claim includes charges for services rendered during an inpatient admission. Enter dates in MMDDYY format.
19	Additional Claim Information (Designated by NUCC)	Not Required	Beacon Health Options does not require completion of this field.

20	Outside lab/charges	Not Required	Beacon Health Options does not require completion of this field.

Field Number	**Field Description**	**Data Type**	**Instructions**
21.1-4	*Diagnosis* or nature of illness or injury	Required	Enter the applicable *ICD* indicator to identify which version of *ICD* codes is being reported. 9 *ICD*-9-CM (service dates through 9/30/15) 0 *ICD*-10-CM (service dates beginning 10/1/15) Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's *diagnosis* and/or condition. List no more than 12 *ICD*-9-CM or *ICD*-10-CM *diagnosis codes*. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.
22	Medicaid resubmission code/original reference number	Optional	List the original reference (claim) number for resubmitted claims.
23	Prior *authorization* number	Not required	Not applicable.
24a	Dates of service	Required	Enter "From" and "To" dates of service in MMDDYY or MMDDCCYY format. Line items can include no more than two dates of service for the same procedure code. Grouping is allowed only for services on consecutive days. The number of days must correspond to the number of units in 24G.
24b	Place of service	Required	Enter the appropriate place of service code from the list of *HIPAA* compliant codes. Below on page 19.
24c	EMG	Not required	Emergency Indicator not applicable.

24d	Procedures, services or supplies *CPT*/HCPCS	Required	Enter a valid *CPT* or HCPCS code for each service rendered.

Field Number	**Field Description**	**Data Type**	**Instructions**
24d	Modifier	Conditional	Modifiers are required where applicable for Medicaid plans. Enter a valid *CPT* or HCPCS code modifier for each service entered. ** **HIPAA: Billing Code Modifiers** * When submitting a *CPT* or HCPC code with a modifier, it is critical that the modifier be placed in its appropriate order. *HIPAA* allows up to four (4) modifiers to be used. The order of the modifiers has a particular meaning. The order of the modifiers is found below: **Modifier ONE**: This field is dedicated for modifiers that affect or define the service (i.e., TG modifier to identify a 'complex high *level of care*') **Modifier TWO**: This field is dedicated for modifiers that identify pricing (i.e., HA modifier to identify 'child/adolescent' or HN modifier to identify 'bachelors level') **Modifier THREE & FOUR**: These fields are dedicated for modifiers that identify statistics (e.g., HV 'funded by State Addictions Agency')

			If you have any questions regarding the placement of Modifiers, please contact your Regional Provider Relations office for instructions.
24e	*Diagnosis* pointer	Conditional	Enter the *diagnosis code* reference number as shown in item 21 to relate the date of service and the procedures performed to the primary *diagnosis*. Enter only one reference number per line. *Do not* enter the *diagnosis code*. (Electronic claims will allow up to four reference numbers per line.)
24f	Charges	Required	Enter the provider's billed charges for each service.
24g	Days or units	Required	Enter the appropriate number of units or days that correspond to the "From" and "To" dates indicated in Field 24a.

Field Number	Field Description	Data Type	Instructions
24h	EPSDT family plan	Not Required	If service was rendered as part of or in response to an EPSDT panel, mark an "X" in this block.
24i	ID Qual.	Not Required	If the provider does not have an *NPI*, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an *NPI* and will need to report non-*NPI* identifiers on their claim forms. The qualifiers will indicate the non-*NPI* number being reported.
24j	Rendering Provider ID. #	Required	Enter the NPI in the un-shaded area of the field.
25	Federal Tax ID number and type: • Social Security Number or • Employer Identification Number	Required	Enter the nine-digit Employee Identification Number (EIN) or Social Security Number under which payment for services is to be made for reporting earnings to the IRS. Enter an "X" in the appropriate box that identifies the type of ID number used for services rendered. Do not enter hyphens with numbers. Enter numbers left justified in the field.
26	Patient's account number	Optional	Enter the unique number assigned by the provider for the patient. If entered, the patient account number will be returned to the provider on the *Provider Summary Voucher*.
27	Accept assignment?	Required	Enter an "X" in the appropriate box. Required for Government claims (e.g., Medicaid)

Field Number	Field Description	Data Type	Instructions
28	Total charge	Required	Enter the total charge for this claim. This is the total of all charges for each service noted in Field 24f.
29	Amount paid	Conditional	Enter the total amount paid by the patient for services billed on this claim.
30	Reserved for NUCC Use	NA	

31	Signature of physician or supplier including degrees or credentials	Required	Signature of physician or supplier including degree(s) or credentials and date of signature. NOTE: The person rendering care *must* sign and indicate licensure level.
32	Name and address of facility where services were rendered	Required	Enter name and address where services are rendered. This must be a street address not a P.O. Box.
32a	a. *NPI*#	Not Required	Enter the *NPI* of the service facility. Only report a Service Facility Location *NPI* when the *NPI* is different from the Billing Provider *NPI*.
32b	b. Other ID#	Not Required	Not Applicable
33	Physician's/supplier's billing: name, address, zip code and phone number	Required	Enter the appropriate billing information.
33a	*NPI*#	Required	Enter the *NPI* of the billing provider or group.
33b	Other ID#	Not Required	NA

Place of Service Codes (Field 24B)

NOT ALL PLACE OF SERVICE CODES ARE USED BY BEACON HEALTH OPTIONS

Place of Service Code(s)	**Place of Service Name**	**Place of Service Description**
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).

11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, *diagnosis*, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.

Place of Service Code(s)	**Place of Service Name**	**Place of Service Description**
21	Inpatient Hospital	A facility, other than a psychiatric facility, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency *diagnosis* and treatment of illness or injury is provided.

26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the *level of care* or treatment available in a hospital.

Place of Service Code(s)	**Place of Service Name**	**Place of Service Description**
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective October 1, 2003)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the *diagnosis* and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the *diagnosis* and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient *visits* to a hospital-based or hospital-affiliated facility.

Place of Service Code(s)	Place of Service Name	Place of Service Description
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the *level of care* or treatment available in a hospital or SNF.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and *psychological testing*. (effective October 1, 2003)

Place of Service Code(s)	Place of Service Name	Place of Service Description
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service not identified above.

**All data elements noted as required must be provided, but they must also be current and match what the member has on file. If the member's ID on the claim is illegible, or does not match what the client has provided to us, we may not be able to determine the claimant. We strongly recommend that you obtain a copy of the member's ID card, and validate that it is current at the time of each visit.

**There are times when supporting information is required to approve payment; if supporting documentation is not included, the claim may not be considered clean.

**Claims that are not submitted on a CMS 1500 2012-02 or a UB04 often will not contain the information we need to consider the claim clean and will cause the claim to take a longer processing time. Claims submitted on old claim forms may be returned or denied.

**Electronically submitted claims must also be in a HIPAA 5010 compliant format and conform to the Beacon Health Options companion guide to be considered clean.

In addition, the claim should be free from defect or impropriety (including lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment. If additional information is required, the participating provider will forward information reasonably requested for the purpose of consideration and in obtaining necessary information relating to coordination of benefits, subrogation, and verification of coverage, and health status.

Guidance on completion of UB-04 and CMS-1500 forms, or their electronic equivalents, is available on the 'Provider' section of the website and within this handbook.

For paper claims, the use of scanning by means of Optical Character Recognition (OCR) technology allows for a more automated process of capturing information. The following elements are required to take advantage of this automated process. If the provider does not follow the guidelines, claims will still be processed; however manual intervention will be required which may delay claims processing.

Tips for completing paper claims:

- Use machine print
- Use original red claim forms
- Use black ink
- Print claim data within the defined boxes on the claim form
- Use all capital letters
- Use a laser printer for best results
- Use correction tape for corrections
- Submit any notes on 8 ½" x 11" paper
- Use an eight-digit date format (e.g., 10212015)
- Use a fixed width font (Courier, for example)

REQUESTS FOR ADDITIONAL INFORMATION

To maintain in-network status and upon request by Beacon Health Options, or its authorized designee, providers must promptly furnish requested documentation or information related to and/or in support of claims submitted. Failure to do so may result in a change in network participation status from active to inactive. Inactive providers are ineligible to receive referrals or payment as a provider for covered services rendered to members.

CLAIMS PROCESSING

Beacon Health Options, will process complete and accurate claims submitted by providers for covered services rendered to members in accordance with normal claims processing policies and procedures, the payment terms included in the provider agreement, and applicable state and/or federal laws, rules and/or regulations, with respect to timeliness of claims processing.

Normal claims processing procedures may include, without limitation, the use of automated systems which compare claims submitted with diagnosis codes and/or procedure codes and associated billing or revenue codes. Automated systems may include edits that result in an adjustment of the payment to the provider for covered services or in a request for submission of treatment records.

Provider agrees that no payment is due for covered services or claims submitted unless the covered services are clearly and accurately documented in the treatment record prior to submission of the claim.

Reimbursement for covered services provided in an inpatient facility, inpatient rehabilitation or residential setting/level of care will be at the contracted reimbursement rate in effect on the date of admission.

Payment for services rendered to members is impacted by the terms in the provider agreement, the member's eligibility at the time of the service, whether the services were covered services, if the services were medically necessary, compliance with any preauthorization/certification/ notification requirements, member expenses, timely submission of the claim, claims processing procedures, overpayment recovery, and/or coordination of benefits activities.

Note: Regardless of any provision to the contrary, providers acknowledge and agree that the payment rates in the provider agreement extend and apply to covered services rendered to members of benefit plans administered in whole or in part by Beacon Health Options.

PROVIDER SUMMARY VOUCHERS

Provider Summary Vouchers (PSVs) or remittance advices are the documents that identify the amount(s) paid. Providers should access PSVs through ProviderConnect or request copies of PSVs via facsimile through Beacon Health Options' automated PSV faxback service at 866-409-5958. Accessing PSVs electronically is a transaction subject to the e-commerce initiative. Additional information regarding access to PSVs is available via the 'Provider' section of the BHO the websites.

COORDINATION OF BENEFITS

Some members may have health benefits coverage from more than one source. In these instances, benefit coverage is coordinated between primary and secondary payers.

Providers should obtain information from members as to whether the member has health benefits coverage from more than one source, and if so, provide this information to Beacon Health Options.

By Federal mandate, providers must exhaust all other insurance coverage and payment prior to billing Health First Colorado for covered services. To the extent not otherwise required by applicable laws or regulations, providers agree that in no event will payment from primary and secondary payers for covered services rendered to members exceed the rate specified in the provider agreement.

Providers must submit a copy of the EOB through ProviderConnect that includes the primary payer's determination when submitting claims to Beacon Health Options. The services included in the claim submitted to Beacon Health Options should match the services included in the primary payer EOB.

Authorization, certification or notification requirements under the member's benefit plan still apply in coordination of benefits situations.

NOTE: Some benefit plans require that the member update at designated time periods (e.g., annually) other health benefit coverage information. Claims may be denied in the event the member fails to provide the required other coverage updates.

OVERPAYMENT RECOVERY

Providers should routinely review claims and payments in an effort to assure that they code correctly and have not received any overpayments. Beacon will notify providers and providers of overpayments identified by Beacon, clients and/or government agencies, and/or their respective designees. Overpayments include, but are not limited to:

- Claims paid in error
- Claims allowed/paid greater than billed
- Inpatient claim charges equal to the allowed amounts
- Duplicate payments
- Payments made for individuals whose benefit coverage is or was terminated
- Payments made for services in excess of applicable benefit limitations
- Payments made in excess of amounts due in instances of third party liability and/or coordination of benefits
- Claims submitted contrary to national and industry standards such as the CMS National Correct Coding Initiative (NCCI) and medically unlikely edits (MUE) described in the Claims Submission Guidelines

Subject to the terms of the provider agreement and applicable state and/or federal laws and/or regulations, Beacon or its designee will pursue recovery of overpayments through:

- Adjustment of the claim or claims in question creating a negative balance reflected on the PSV (claims remittance)
- Written notice of the overpayment and request for repayment of the claims identified as overpaid

Failure to respond to any written notice of and/or request for repayment of identified overpayments in the time period identified in the notice/request is deemed approval and agreement with the overpayment; thereafter, Beacon will adjust the claim or claims in question creating a negative balance. Any negative balance created will be offset against future claims payments until the negative balance is zeroed out and the full amount of the overpayment is recovered. Beacon may use automated processes for claims adjustments in the overpayment recovery process.

In those instances, in which there is an outstanding negative balance as a result of claims adjustments for overpayments for more than ninety (90) calendar days, Beacon Health Options reserves the right to issue a demand for re-payment. Should a provider fail to respond and/or provide amounts demanded within the thirty (30) calendar days of the date of the demand letter, Beacon Health Options will pursue all available legal and equitable remedies, including without limitation placing the outstanding overpayment amount (negative balance) into collections.

If the provider disagrees with an overpayment recovery and/or request for re-payment of an overpayment, the provider may submit a request for additional review from Beacon Health Options in writing such that the written request for review is received by Beacon Health Options on or before the date identified in the notice of overpayment recovery or request for re-payment of an overpayment. Please attach a copy of your written demand or request letter to your request for review and include the following information; provider's name, identification number and contact information, member name, and number, a clear identification of the disputed items to include the date of service and the reason the disputed overpayments are being contested.

If you choose to remit a check to cover an overpayment, please mail it to the address below:

Beacon Health Options
240 Corporate Blvd
Norfolk, VA 23502
ATTN: Finance Department

REQUESTS FOR REVIEW

Providers may request review of a Beacon Health Options claims determination. All requests for review must be submitted in writing or made telephonically to the address and/or telephone number on the member's identification card within sixty (60) calendar days or the time period specified in the provider agreement (if any) from the date of Beacon Health Options' original claim determination.

Requests for review received beyond the above noted time period will not be reviewed and are considered 'expired.'

CLAIMS DISPUTES

Providers must exhaust all administrative processes concerning unresolved claims disputes pursuant to the terms of the provider agreement, and more specifically any dispute resolution provisions, prior to pursuing any legal or equitable action.

CLAIMS APPEAL PROCESS

If you feel Beacon Health Options has made an incorrect payment or processing decision on a claim, you may file a claim appeal by writing a letter to Beacon Health Options and provide the reason you believe the claim should be reprocessed. In the letter be sure to include the member's name and ID number, date(s) of service, service, and provider's name. Your letter and supporting documentation should be sent to the following address:

Beacon Health Options
ATTN: Health First Colorado Claims Appeals
P. O. Box 1347
Latham, NY 12110

All appeals must be filed within 60 days of the date of the provider summary voucher (EOB) in which the claim was included.

Adjustments and Reversal Requests may be requested by calling Customer Service or by Submitting adjustment and reversal requests on-line using ProviderConnect

PROVIDERCONNECT RESOURCES

Direct Claims Submissions User Guide

- https://www.beaconhealthoptions.com/wp-content/uploads/2016/11/Direct-Claim-Submission-Guide.pdf

Guide to Changing or Reprocessing Professional Claims Online

- https://www.beaconhealthoptions.com/pdf/compliance/Guide_to_Changing_or_Reprocessing_Professional_Claims_Online.pdf

RESUBMISSIONS

Incomplete Claims

1. Claims may be "zero-paid" by Beacon Health Options in the case of incorrect or incomplete required data elements.
2. Beacon Health Options will notify the provider via the Provider Summary Voucher, of those data elements requiring completion or correction. The required data elements and other claim submission requirements are outlined in Sections D1 and D2 of this manual. Electronic Media Claims (EMC) submission guidelines are contained in the Beacon Health Options EDI Specifications Manual.

Re-submissions

1. Claims that are "zero paid" due to incorrect or incomplete required data elements must be resubmitted for payment consideration within sixty (60) days from the date on the Provider Summary Voucher.
2. Providers may resubmit corrected claims by mail or EMC.
3. Corrected claims should have a clear indication on the claim that the claim is a "Corrected Claim"

CLAIMS BILLING AUDITS

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

- members
- external referrals from state, federal and other regulatory agencies
- internal staff
- data analysis and
- whistleblowers.

Beacon Health Options also conducts random audits.

Beacon Health Options conducts the majority of its audits by reviewing records providers either scan or mail to Beacon Health Options, but in some instances on-site audits are performed as well. Record review audits, or discovery audits, entail requesting an initial sample[1] of records from the provider to compare against claims submission records. Following the review of the initial sample, Beacon Health Options may request additional records and pursue a full/comprehensive audit. Records reviewed may include, but are not limited to:

[1] Unless otherwise required by a specific client or a government agency, Beacon Health Options utilizes the Office of Inspector General's (OIG) Random Sample Determination Tool (RAT-STATS) to select a random and statistically valid sample of eligible records.

- Financial
- administrative,
- current and past staff rosters,
- and treatment records.

For the purposes of Beacon Health Options' audits, the 'treatment record' includes, but is not limited to:

- progress notes,
- medication prescriptions and monitoring,
- documentation of counseling sessions,
- the modalities and frequency of treatment furnished,
- and results of clinical tests.

It may also include summaries of the:

- diagnosis
- functional status
- treatment plan
- symptoms
- prognosis
- and progress to date.

providers must supply copies of requested documents to Beacon Health Options within the required time. The required time will vary based on the number of records requested but will not be less than ten (10) business days when providers are asked to either scan or mail records to Beacon Health Options. For the purpose of on-site audits, providers must make records available to Beacon Health Options staff during the audit. providers are required to sign a form certifying all requested records and documentation were submitted or made available for the audit. Beacon Health Options will not accept additional or missing documentation and/or records once this form is signed, including for the purposes of a request for appeal. Beacon Health Options will not reimburse providers for copying fees related to providing documents and/or treatment records requested in the course of a claims billing audit, unless otherwise specifically required by applicable state or federal law, rule or regulation.

In the course of an audit, documents and records provided are compared against the claims submitted by the provider. Claims must be supported by adequate documentation of the treatment and services rendered. **Providers' strict adherence to these guidelines is required.** A member's treatment record must include the following core elements:

- member name
- date of service
- rendering provider signature and/or rendering provider name and credentials
- diagnosis code

- start and stop times (e.g., 9:00 to 9:50),
- time-based CPT codes
- and service code to substantiate the billed services.

Documentation must also meet the requirements outlined in Provider Handbook Section: Treatment Record Standards & Guidelines. Beacon Health Options coordinates claims billing audits with appropriate Beacon Health Options clinical representatives when necessary. The lack of proper documentation for services rendered could result in denial of payment, or, if payment has already been issued, a request for refund.

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

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

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

AUDIT APPEALS

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

- a copy of the audit report of findings letter
- the provider's name and identification number
- contact information
- identification of the claims at issue, including the name or names of the members, dates of service, and an explanation of the reason/basis for the dispute.

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

The provider's appeal will be presented to Beacon Health Options' National Compliance – Program Integrity Subcommittee within forty-five (45) days of receiving the provider's request for appeal. The subcommittee is comprised of Beacon Health Options employees who have not been involved in reaching the prior findings. The Subcommittee will review the provider's appeal documentation, discuss the facts of the case, as well as any applicable contractual, state or federal statutes. The Beacon Health Options staff member/auditor who completed the provider's audit will present his/her audit findings to the subcommittee but will not vote on the appeal itself. The subcommittee will uphold, overturn, uphold in-part, or pend the appeal for more information. Once a vote is taken, it will be documented and communicated to the provider within ten (10) business days of the subcommittee's meeting. If additional time is needed to complete the appeal, Beacon Health Options will submit a letter of extension to the provider requesting any additional information required of the provider and estimating a time of completion. If repayments or a corrective action plan (CAP) are required, the provider must submit the required repayments or CAP within ten (10) business days of receiving the subcommittee's findings letter, unless an installment payment plan is approved.

Beacon Health Options will take appropriate legal and administrative action in the event a provider fails to supply requested documentation and member records or fails to cooperate with a Beacon Health Options investigation or corrective action plan. Beacon Health Options may also seek termination of the provider agreement and/or actions to recover amounts previously paid on claims involved in the investigation or requests for records. Beacon Health Options will report any suspicion or knowledge of fraud, waste or abuse to the appropriate authorities or regulatory agency as required or when appropriate.

REPORTING FRAUD WASTE AND ABUSE

Providers should report fraud, waste and abuse, or suspicious activity thereof, such as inappropriate billing practices (e.g., billing for services not rendered, use of CPT codes not documented in the treatment record, etc.). Reports and questions may be made in writing to Beacon

Health Options at the address below or by calling the Beacon Health Options Ethics Hotline at 888-293-3027.

Beacon Health Options, Inc.
National Headquarters
Attn: Program Integrity Department
240 Corporate Boulevard
Norfolk, VA 23502

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Section 14

QUALITY MANAGEMENT

Beacon Health Options supports the quality management programs of Colorado Health Partnerships and Foothills Behavioral Health Partners, both of which are Behavioral Health Organizations (BHOs) contracted with the state of Colorado for the Health First Colorado Community Behavioral Health Services Program. Each of the BHO's Quality Management Programs (QM) monitors and evaluates quality across the entire range of behavioral health services provided to Health First Colorado members. The BHO's QM programs are intended to ensure that the structure and processes in place lead to desired outcomes for members.

The scope of the QM Programs includes:

- Clinical Services/Utilization Management (UM) Programs
- Care Process and Outcome Measurement/Monitoring for Members in Treatment
- Clinical Treatment Record Evaluation
- Service Availability and Access to Care
- Quality of Care and Patient Safety/Adverse Incident Evaluation
- Program Integrity/Fraud and Abuse
- Compliance with all applicable Federal and State regulations in the delivery of services to members
- Performance Improvement Activities/Projects

Several of the above activities and processes above are described in greater detail in other sections of the Provider Handbook.

For more information or to ask questions about specific BHO's Quality Management Programs, contact the Director of Quality Management for the BHO located in your area. More information about individual BHO Quality Management Programs can be obtained by referencing the BHO specific provider addendum reference guides and the respective BHO websites.

REPORTING ADVERSE INCIDENTS (VARIANCES/SENTINEL EVENTS)

To manage care effectively and assure the safety of members, the BHOs and Beacon Health Options investigate and review adverse incidents that have resulted in harm or potential harm to a member or significant other participating in treatment. Providers are required to complete a report on the following adverse incidents, to be submitted to Beacon Health Options:

- Attempted or completed suicide or homicide at any level of treatment
- Death by any cause while in psychiatric treatment
- Allegations of sexual or physical abuse or neglect in treatment
- Assaults with physical harm in which the member is the initiator or victim

- Absence without leave, AMA, or missing and considered a danger to self and/or others; and/or endangered and unable to care for self
- Accidental injuries in a facility or provider office
- Medication errors/Adverse drug reactions
- Other variances inconsistent with appropriate clinical care

Providers are expected to report incidents on an Adverse Incident Report Form, which can be downloaded from the "provider forms" tab on the BHO website, within 24 hours of the occurrence for sentinel events (e.g., unexpected deaths, suicides, homicides), and within 48 hours for all other incidents. Please fax this completed form to Beacon Health Options Quality Management Department at (719) 538-1456. Depending upon the type of incident and the circumstances, you may be contacted for further information or a review of the incident.

BEHAVIORAL HEALTH ORGANIZATION QUALITY PROGRAM

The objective of the BHO and Beacon Health Options Provider Quality Program (PQP) is to assess and improve the quality and effectiveness of care delivered to Colorado Health First Colorado members. The program is designed to quantify provider performance so data can be used to recognize quality care, identify provider and facility best practices, improve provider network services, and identify areas for continuing education. Measures of performance and outcome as well as practitioner practice patterns are reviewed.

Other areas reviewed may include treatment record documentation, compliments, grievances/member satisfaction, and quality of care and utilization patterns. Providers will receive formal, written feedback on their performance every three years.

QUALITY OF CARE

The BHOs have a joint Quality of Care Committee that oversees the investigation and resolution of all quality of care issues. Please contact the BHO Quality Management Department to report any quality of care issues identified in the provision of services to members by downloading the Adverse Incident/Quality of Care Report Form found on the "provider forms" tab of the BHO website. Please fax this completed form to Beacon Health Options Quality Management Department at (719) 538-1456.

Potential quality of care indicators monitored by the BHOs and Beacon Health Options include the following types of quality of care issues:

- Provider inappropriate/unprofessional behavior
- Clinical practice-related issues
- Access to care-related issues
- Attitude and service-related issues

Providers are required to respond to Quality of Care inquiries, assist with investigations, provide corrective action plans when requested, and report on progress toward addressing concerns through corrective actions as requested.

TREATMENT RECORD AUDITS

Beacon Health Options, on behalf of the BHOs, may request treatment records for documentation reviews, quality of care reviews, state Health First Colorado audits or reviews verifying that services billed are documented in member's treatment record and include all required elements. As a Beacon Health Options provider, you are expected to comply with all requests for member treatment records as specified in your contract (Section 2, Compliance with Beacon Health Options Policies and Programs).

CONFIDENTIALITY

To support quality management responsibilities for oversight of member care, the BHOs and Beacon Health Options have in place strict confidentiality policies and procedures regarding the protection and disclosure of member information. These policies and procedures ensure that all protected health information (PHI) providers submit is maintained on a confidential basis in accordance with all applicable regulatory (e.g. HIPAA, 42 CFR Part 2) and accreditation requirements. The BHOs and Beacon Health Options ensure that all such information obtained is used solely for the purposes of utilization management, quality management, disease management, discharge planning, case management, and claims payment. In addition, Beacon Health Options maintains information systems to collect, maintain, and analyze information that incorporate adequate safeguards to ensure the confidentiality and security of PHI received, as well as a plan for secure storage, maintenance, tracking, and destruction of member-identifiable clinical information.

BHO and Beacon Health Options staff engaged in quality improvement activities maintain the confidentiality of the information used in such activities. All written reports, records or any work product or communication related to quality improvement activities are considered privileged and confidential information, except when specific reference is necessary to meet the goals of the QM program. Reference to individual providers or members is redacted to safeguard the person's identity. Confidential information used in QM activities may include but is not limited to:

- Protected Health Information (PHI)
- Certification of behavioral health treatment
- Claims processing information
- Utilization review
- Peer review
- Response to congressional inquiries (made at the request of the member)
- Appeals
- Quality assurance

CONSENTS TO DISCLOSE SUBSTANCE USE DISORDER INFORMATION CONSENTS TO DISCLOSE SUBSTANCE USE DISORDER INFORMATION

For each member receiving Substance Use Services, the providers shall obtain a release of information, compliant with 42 C.F.R. § 2.31, authorizing the provider to disclose information related to the member and his or her receipt of Substance Use Services to the relevant BHO for claims payment purposes. Such consent shall additionally authorize the re-disclosure of such

information by the BHO to the Department of Health Care Policy and Financing (the "Department"), as required by and for the purposes set forth in the BHOs' contracts with the Department. Providers shall retain and maintain each such consent for a period of at least six (6) years from the last effective date of such consent. If a member refuses to sign such a consent, providers shall document their efforts to obtain such a consent and shall notify the BHO prior to billing for the provision of Substance Use Services for such members.

Providers and delegated entities are expected to safeguard the confidentiality of treatment record information related to both active and past clients. Participating provider contracts are explicit in regard to treatment record confidentiality requirements.

Section 15

OFFICE OF MEMBER AND FAMILY AFFAIRS (OMFA)

Each of the Behavioral Health Organizations (BHO) has an Office of Member and Family Affairs (OMFA). Beacon Health Options provides support and works closely with the OMFAs. The two BHOs, Colorado Health Partnerships and Foothills Behavioral Health Partners, each contract with the state of Colorado for the Health First Colorado Community Behavioral Health Services Program. The BHOs and Beacon Health Options comply with all federal and state regulations to protect member rights, educate members about their behavioral health services, and promote recovery and resilience.

As a Beacon Health Options Provider, you must be knowledgeable about and uphold Health First Colorado member's rights. Per Federal Regulations, Colorado Regulations, and BHO and Beacon Health Options policies, Health First Colorado members are entitled to be treated with dignity and respect, to learn about their Health First Colorado benefits, receive information in a format that they understand, have access to a BHO-approved grievance process, and have their rights and responsibilities upheld.

As a Beacon Health Options provider, you are required to:

- Prominently post member rights statements in waiting areas or hand each Health First Colorado client a copy at intake (found in the Section 15 of the Provider Manual; English and Spanish versions are available).
- Inform members about behavioral health and substance use disorder services that are available to the client as a Health First Colorado member.
- Post information about access to care standards and wait times. This includes the member's ability to reschedule his or her appointment should in-office wait times be outside the standard.
- Prominently post information about the Ombudsman for Health First Colorado Managed Care or hand each Health First Colorado client a copy at intake (found in the Section 15 of the Provider Manual in English and Spanish).
- Inform members of their right to file a grievance or appeal an action.
- Provide BHO Member information in Spanish. The BHO OMFA offices can provide you with Spanish language materials. OMFA contact information is provided at the end of this section.
- Offer interpreter services for members who are Deaf, hard of hearing, have communication disabilities or have limited English proficiency. If you have a client who is deaf or does not speak English, or their family member is deaf or does not speak English, our contract requires that interpreter services be provided at no cost to the member. Contact Beacon

Health Options if you need an interpreter for a client or family member or assistance with a referral to a provider who is fluent in the member's language.
- Inform members about the role of the BHO and the BHO's duties as a contractor for the Department of Health Care Policy and Financing.

OMFA provides support and advocacy to Health First Colorado members. At Colorado Health Partnerships the OMFA is administered both at the BHO and local community behavioral health center level. At Foothills Behavioral Health Partners the OMFA is administered by the BHO. Whether administered at the BHO or at the community behavioral health center, the OMFA is driven by a belief that people can and do recover from mental illness and substance use disorders and people can achieve success in their lives, despite having a behavioral health diagnosis.

OMFA staff are located at the BHO offices and at your local community behavioral health center. You can find up-to-date contact information at the respective BHO websites.

OMFA staff:

- Handle grievances, including: complaint resolution, assisting members with filing grievances and advocating for members.
- Assist members with filing an appeal and support members through the appeal process.
- Help members /families understand their rights and responsibilities and work to uphold those rights.
- Assist members with finding a provider who can offer a second opinion.
- Provide members/families with information about community resources that will help them with their recovery.
- Help members and family members understand and access their benefits.
- Identify local concerns of members, family members, providers and stakeholders.
- Help members/families have a voice in the behavioral health system by getting involved in committees and advisory boards.

OMFA staff may also provide:

- Member Handbooks, wellness brochures and tip sheets.
- Educational presentations on a variety of topics including recovery, symptom management, and wellness maintenance.
- Training in crisis planning. A crisis plan is a tool that teaches people who have a mental health diagnosis or substance use disorder how to plan ahead to avoid triggers and relapse, and to develop strategies to maintain wellness.
- Information about peer specialists, client-run programs, and support groups.
- Many Health First Colorado members benefit from peer support and client-run programs. OMFA may employ trained peer specialists in addition to maintaining a data base of client-run and self-help programs.

MEMBER AND FAMILY INPUT

The two BHOs and Beacon Health Options seek member and family input into the design of our programs and services.

Members and family members have an opportunity to:

- Participate in focus groups and member surveys
- Serve on member advisory committees and forums
- Participate in survey design and administration

Any Health First Colorado member is eligible to participate. Providers should refer interested members to the appropriate OMFA listed at the end of this section.

MYSTRENGTH.COM

CHP supports members who are interested in using on-line wellness tools, specifically MyStrength.com. MyStrength.com is a web and mobile self-help resource that gives consumers additional tools to manage their anxiety and depression. It can be used alone, or in conjunction with clinical services, so it offers access to those individuals who are not quite ready to commit to more traditional clinical services. It can help individuals to not only manage their symptoms, but to create wellness in their lives. The digital format complements traditional treatment, expands access, and can improve outcomes in a cost effective manner. CHP will educate Members and providers about how to use this tool.

Goals of the myStrength.com website align with our shared vision and include:

- Expanding access to care
- Extending evidenced-based models to a broader audience
- Reducing stigma/offering hope because users can connect with others who are dealing with anxiety and depression.
- Accelerating/extending treatment for those who need support between appointments, or who want more services than are typically approved.
- Improving outcomes – preliminary research shows improved outcomes for those consistently using the program.
- Providing a consumer-driven model as users have access to others who are experiencing depression, anxiety.

CULTURAL COMPETENCE

Beacon Health Options providers are required to provide culturally appropriate care. Providers are expected to incorporate the member's culture and cultural attributes into their care, when appropriate. The OMFA staff conducts provider trainings on cultural issues. To learn more about the trainings, or to get a copy of the BHO Cultural Competence Plan log onto our website at:

Colorado Health Partnerships – http://www.coloradohealthpartnerships.com

Foothills Behavioral Health Partners - http://www.fbhpartners.com

COMMUNITY RESOURCES

The OMFA offices maintain a list of resources in the community that can help Health First Colorado members. Resources include food banks, spiritual groups, daycare services, primary care information, dental benefits, and many others. To obtain information on resources that might be available to your clients, please call the OMFA office in your area.

ACHIEVE SOLUTIONS

Achieve Solutions®, Beacon Health Options' award winning website, is a resource where you can find behavioral health information and tools for your clients. The website contains several self-assessments, tools to assist members in understanding their diagnosis, and over 10,000 articles and educational materials for both behavioral health and physical health disorders.

OMFA ASSISTANCE TO MEMBERS WISHING TO FILE A GRIEVANCE OR APPEAL

Appealing a Notice of Action

The BHO's have a separate process for grievances and a separate process for "actions." Health First Colorado actions are defined below and are handled through the Appeals process, which is described in detail in Section 9. Please refer to Section 9 - Reviews, Reconsiderations, and Appeals.

Actions

An appeal may be filed for events categorized as Actions. Actions are defined as:

1. The denial or limited authorization of a requested service, including the type or level of service.
2. The reduction, suspension, or termination of a previously authorized service.
3. Denial of payment for a service, in whole or in part.
4. Failure of the BHO to provide a service in a timely manner.
5. Failure of the BHO to act within approved timeframes for grievances or appeals
6. Denial of a request by a member in a rural area to obtain treatment outside of the Beacon Health Options Health First Colorado Provider Network.

Section 9 - Reviews, Reconsiderations, and Appeals provides a detailed description of the appeals process.

GRIEVANCES UNRELATED TO AUTHORIZATION OR DENIAL OF AUTHORIZATION

The two BHO OMFAs and Beacon Health Options offer a Member grievance resolution process which are compliant with state and federal regulations. Members, family members and other interested parties can file complaints about any issues related to the behavioral health care they

receive from the BHOs, Beacon Health Options or our providers. A grievance is defined as any oral or written expression of dissatisfaction about any matter related to their behavioral health services (other than an action). Examples include:

- Access to Care
- Customer Service
- Failure to respect a member's rights
- Financial/Billing issues
- Non-covered benefits
- BHO failure to follow its appeal process.

Grievances can be filed over the phone, in person, or in writing at any time. At CHP, grievances are filed with OMFA, the Beacon Health Options Grievance Coordinator, the Client Advocate at a community behavioral health center or the Ombudsman. At FBHP, grievances are filed with the FBHP OMFA Client and Family Advocate based at the local community behavioral health center or with the FBHP Grievance Coordinator.

Any interested party can file a grievance on behalf of the member, including: a provider, the member's legal guardian, or an independent advocate. If the grievance is filed by someone other than the member or legal guardian, the member or legal guardian must appoint them to act as a

Designated Client Representative (DCR). The member will be contacted to obtain permission to investigate and resolve the grievance, sign a DCR form and sign releases of information.

Providers do not need a Release of Information (ROI) signed by the member or guardian to share information with the BHO OMFA staff for purposes of grievance resolution when this information involves *only mental health information.* However, if the grievance resolution requires sharing information that reveals that the member *has received a substance use disorder diagnosis, been evaluated for substance use disorders, been referred for substance use disorder services, or sought or obtained treatment for substance use disorders,* then the member or guardian must sign a Part 2 compliant ROI form before information can be shared with the BHO OMFA staff for grievance resolution. This form can be found in the quality section, section 14, under Release of Information.

Filing a grievance will not restrict or compromise the member's access to behavioral health services.

The Office of Member and Family Affairs helps members with the grievance process. Staff from OMFA will:

- Explain the grievance and resolution process.
- Investigate the grievance by contacting agencies and others to gather information.
- Provide a resolution to the grievance.
- Provide support to the member during the process.

ADMINISTRATIVE GRIEVANCE REVIEW

If the member is dissatisfied with the resolution, the member, guardian, or DCR can file an oral or written request to have the decision reviewed by the Department of Health Care Policy and Financing. Requests for review of a decision should be sent to:

Department of Health Care Policy and Financing
(800) 221-3943

This is the final step in the administrative grievance process and the decision of the Department is final.

COMPLIMENTS

Our providers and staff also want to know what we are doing well. If you have a compliment, please contact the Grievance Coordinator. The compliment will be forwarded to the appropriate person and will be logged in our data base.

OMBUDSMAN FOR HEALTH FIRST COLORADO MANAGED CARE

The Ombudsman for Health First Colorado Managed Care is an independent program that provides assistance with grievances and with appeals of actions for Health First Colorado eligible members who are receiving behavioral health services. The member, or anyone who has filed a grievance on behalf of a member, can get help with any portion of the grievance or appeal process. The Ombudsman can be reached by calling:

The Ombudsman for Health First Colorado Managed Care
877-435-7123 or 303-830-3560

Providers are required to post information about the Ombudsman for Health First Colorado Managed Care or to give it to the member at intake. Posters in English and Spanish can be found attached to this section.

CONTACTING THE BHO OFFICES OF MEMBER AND FAMILY AFFAIRS AND BEACON HEALTH OPTIONS

To receive answers to your questions about the member grievance process, get copies of educational or member materials, or learn how a client can participate on an advisory committee:

For Colorado Health Partnerships and Beacon Health Options contact the CHP Office of Member and Family Affairs at **1-800-804-5040.**

For Foothills Behavioral Health Partners, contact the FBHPartners Office of Member and Family Affairs at **303-432-5951 or 1-866-245-1959.**

Section 16

TRANSPORTATION

TRANSPORTATION ARRANGEMENTS

Fee for Service Health First Colorado pays for transportation in some instances when alternative transportation is unavailable, however, it is not a covered benefit under the Behavioral Health Organizations (BHO) CHP and FBHPartners. Providers should refer members seeking transportation assistance to the member's county Department of Social/Human Services Office, to the local community behavioral health center Member/Family Advocate's Office, or to the BHO Office of Member and Family Affairs. BHO OMFAs are listed below:

For **Colorado Health Partnerships** contact the CHP Office of Member and Family Affairs at **1-800-804-5040 ext 361-483**

For **Foothills Behavioral Health Partners,** contact the FBHPartners Office of Member and Family Affairs at **303-432-5956 or 1-866-245-1959.**

Section 17

MEDICAL RECORD DOCUMENTATION STANDARD

Beacon Health Options has specific documentation standards that must be adhered to by all providers.

These standards incorporate all federal and state Health First Colorado documentation requirements as well as good professional practice. They are intended to insure the highest quality of care, reduce medical errors, and achieve full compliance with federal, state, and Beacon Health Options audit requirements.

All providers must maintain a comprehensive medical record for each member served. At a minimum, the medical record substantiates the diagnosis, the medical necessity of care, the quality of care, the progress of care, and the claims submitted for reimbursement.

While network Community Mental Health Centers follow the applicable Division of Behavioral Health regulations regarding medical records (2 CCR 502-2 and 2 CCR 502-1), all Beacon Health Options providers must meet the following minimum standards for their own medical records.

General Requirements:

- Each record includes the member's identification including but not limited to:
  - age
  - date of birth
  - gender
  - address
  - employer or school
  - home and work telephone numbers
  - emergency contacts
  - marital/legal status
  - and financial information
- Each record includes appropriate consent forms and guardianship information.
- Each record contains a statement as to whether or not a member over age 18 has an Advanced Directive (AD) and contains a statement that you provided AD information if requested.
- Each record contains a statement as to whether or not a member under age 21 has had a well-child exam (Early Periodic Screening Diagnosis and Treatment requirement) in the last year and results of the exam if related to the mental health condition, or a referral to a Primary Care Physician if no recent exam has occurred.

- Each record contains a copy of Health First Colorado client rights and responsibilities signed by the member.
- Each record contains a copy of the member's signed acknowledgement that s/he received your Notice of Privacy Practices.
- Each record contains a copy of your professional disclosure form signed by the client.
- Each record contains a copy of any release of information (to PCP or other parties as indicated) signed by the member, or a statement that member refused to sign. Releases must meet all HIPAA and42 CRF Part 2 requirements,
- Each record contains an assessment of transportation needs and documentation that the provider helped to arrange transportation when necessary.

Each record includes an individual bio-psychosocial assessment (e.g., presenting problems; medical history, physical health status, and relevant medical conditions. current medications, allergies, retardation or organic brain disorders; identified strengths; relevant psychological, emotional, behavioral, cultural and social conditions affecting the member and family; past or present history of abuse; legal involvement; psychiatric history; relevant family information; past and present use of alcohol and other substances).

  - For children and adolescents, the assessment includes a developmental history (e.g., physical, psychological, social, intellectual and academic).
  - For older adults, the assessment includes issues specific to that population, such as hearing and/or vision loss, strength, mobility and aging issues.
- Each record includes a mental status examination documenting the member's presentation/appearance, affect and mood, speech, cognitive/intellectual functioning, thought content/process, judgment, insight, attention/concentration, memory, impulse control, and danger to self and others.
  - Each record includes a clinical formulation describing the reasoning and justification for the diagnosis, and a current Diagnostic and Statistical Manual (DSM) diagnosis based on psychiatric, psychological, substance use or medical condition. The formulation includes sufficient description of the criteria per the current DSM to support the diagnosis. Any subsequent changes in diagnosis must be similarly documented and explained.
  - The documented diagnosis is consistent with the presenting problems, history, mental status examination and/or other assessment data in the record.

Service/Treatment Plan:

Each record includes an individualized treatment/service plan containing behaviorally measurable goals and objectives, the desired discharge criteria, the provider's intended therapeutic interventions, frequencies and modalities, and estimated timelines for goal attainment/problem resolution.

- The treatment/service plan is consistent with the member's diagnosis and needs as identified in the assessment.
- There is documented evidence in a progress note that the member (and parent/guardian, if applicable) participates in the development of, understands, and agrees with the treatment/service plan and any significant revisions/updates.
- The treatment/service plan must include specific criteria for discharging the member from treatment that are agreed upon by the member and provider. Discharge criteria may be

modified as a member's circumstances change; modifications will be documented in the member's treatment plan.
- The treatment plan addresses coordination of care with other relevant providers.
- The treatment/service plan is reviewed by the client and provider at least every 6 months or when a major change in the member's condition or service needs occurs. The plan is revised as necessary. For members involuntarily receiving services pursuant to Section 27-65- 101 *et seq*., CRS, the plan must be reviewed monthly. The treatment plan for substance use diagnoses is completed every 45 days in accordance with OBH standards. The member or guardian must sign the treatment plan. If they refuse, this fact must be documented clearly in a progress note.

Progress Notes:

- Each record includes a progress note for each encounter which describes the goal/objective being addressed during the session, the member's efforts in achieving treatment/service plan goals/ objectives, and the treatment interventions used by the provider to assist the member.
- Each progress note includes information relevant to the claim for payment, including date, start time, duration or end time, CPT code, place of service, diagnosis being treated, persons present, and provider signature with credentials and date signed.
- Case management notes reflect the name and agency of person contacted, start time and duration, and the content of each contact.
- Progress notes document an ongoing assessment of member safety (e.g., dangerous to self or others) and substance use/abuse issues, if applicable, and how these have been addressed.
- For members who become homicidal, suicidal or unable to conduct activities of daily living, the record documents prompt referral to the appropriate level of care.
- Each record documents attempts at outreach for persons who unexpectedly miss scheduled appointments.

Miscellaneous:

- As applicable, each record includes results of laboratory tests, psychological testing, and consultation reports.
- As applicable, each record indicates what medications have been prescribed, the dosages of each, the dates of initial prescription or refills, prescriber information, and informed consent for medication.
- Each record documents preventive and recovery-focused services as appropriate, such as relapse prevention, wellness programs, lifestyle changes, and referrals to community resources.
- Each record documents continuity and coordination of care between the Care Coordinator (Primary Clinician), consultants, ancillary providers and health care institution/providers, and other community services agencies.
- Each record documents the date(s) of follow-up appointments or, as appropriate, discharge plans and summary.
- All entries are dated.
- All entries include the legible identity of the rendering provider's name, professional degree and identification number, if applicable.

- All entries are legible to someone other than the writer, and written/typed in black or blue ink.
- Each page contains the member's name and Health First Colorado ID.

A documentation training webinar and sample forms are available on the BHO websites or from the Beacon Health Options Quality Department.

For assistance with documentation requirements, Beacon Health Options offers providers the ability to contact Provider Relations with any questions or to assist with any difficulties providers may be experiencing. Provider Relations can be reached at 800-804-5040.

Section 18

COMPLIANCE / PROGRAM INTEGRITY OVERVIEW

COMPLIANCE AND ANTI – FRAUD PLAN

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

FALSE CLAIMS ACT

The Federal False Claims Act, 31 U.S.C. § 3729, et seq., establishes liability for those who knowingly submit a false claim to the government, cause another person or entity to submit false claims to the government, or knowingly make a false record or statement to get a false claim paid by the government.

Those found liable under the False Claims Act must pay a civil penalty of not less than $5,500 and no more than $11,000 for each false claim, plus three times the amount of the government's damages resulting from the false claims. Penalties may be slightly decreased if self-reporting standards are met.

The Health First Colorado False Claims Act, Colorado Revised Statutes § 25.5-4-304 et seq., further enables the state to recover money at the state level related to the Colorado Medical Assistance Act. The penalties associated with a violation of the Health First Colorado False Claims Act automatically increase to equal the civil penalties allowed under the Federal False Claims Act.

Please review the relevant federal and state regulations for the most current and specific information.

EXCLUSION SCREENINGS

Providers shall maintain full participation status in the Health First Colorado Community Mental Health Services Program. This includes the provider, all provider employed and contracted health care practitioners, health care providers, and health care facilities, and those other employees, contracted individuals and entities who will provide services to members, including without limitation, mental health and/or substance abuse, utilization review, medical social work and/or other administrative services.

Providers shall not have any employees, agents, management staff, or persons with ownership or control interest whom have been convicted of criminal offenses related to their involvement in Health First Colorado, Medicare, or social service programs under Title XX of the Social Security Act.

Providers shall not employ or contract with individuals or entities who have been disbarred, suspended or otherwise excluded from participation in any government sponsored health care program, including without limitation the Health First Colorado program or the federal Medicare program. Providers shall, prior to hire or contracting, and at least monthly thereafter, screen all of their employees and contractors against the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals to determine whether they have been excluded from participation in Health First Colorado.

Providers shall notify Beacon Health Options immediately in the event that the provider, or any individuals or entities employed or contracted by the provider, is debarred, suspended or otherwise excluded from participation in any government sponsored health care program; including if the provider, any person who has an ownership or control interest in the provider, or who is a managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Health First Colorado or the Title XX services program.

CLAIMS BILLING AUDITS

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

- members
- external referrals from state, federal and other regulatory agencies
- internal staff
- data analysis
- whistleblowers
- and others who express a concern about potential fraud, waste or abuse.

Beacon Health Options also conducts random audits.

Beacon Health Options conducts the majority of its audits by reviewing records providers either scan or mail to Beacon Health Options, but in some instances on-site audits are performed as well. Record review audits entail requesting an initial sample of records from the provider to compare against claims submission records. Following the review of the initial sample, Beacon Health Options may request additional records and pursue a full/comprehensive audit. Records reviewed may include, but are not limited to, Financial, administrative, current and past staff rosters, and treatment records.

For the purposes of Beacon Health Options audits, the 'treatment record' includes, but is not limited to:

- progress notes
- medication prescriptions and monitoring
- documentation of treatment sessions the modalities and frequency of treatment furnished
- and results of clinical tests.

It may also include summaries of the:

- Diagnosis
- functional status
- treatment plan
- symptoms
- prognosis
- and progress to date.

Providers must supply copies of requested documents to Beacon Health Options within the required timeframe. The required timeframe will vary based on the number of records requested but will not be less than ten (10) business days when providers are asked to either scan or mail records to Beacon Health Options. For the purpose of on-site audits, providers must make records available to Beacon Health Options staff during the audit. Providers are required to sign a form certifying all requested records and documentation were submitted or made available for the audit. Beacon Health Options will not accept additional or missing documentation and/or records once this form is signed, including for the purposes of a request for appeal. Beacon Health Options will not reimburse providers for copying fees related to the providing of documents and/or treatment records requested in the course of a claims billing audit, unless otherwise specifically required by applicable state or federal law, rule or regulation.

In the course of an audit, documents and records provided are compared against the claims submitted by the provider. Claims must be supported by adequate documentation of the treatment and services rendered. Providers' strict adherence to these guidelines is required. A member's treatment record must include the following core elements:

- member name
- date of service
- rendering provider signature and/or rendering provider name and credentials
- diagnosis code

- start and stop times, e.g. 9:00 to 9:50 (time-based CPT codes)
- and service code to substantiate the billed services.

Documentation must also meet the requirements outlined in the provider handbook section: Treatment Record Standards & Guidelines, as well the Colorado Department of Health Care Policy & Financing's (HCPF) Uniform Service Coding Standards Manual (USCSM). Beacon Health Options coordinates claims billing audits with appropriate Beacon Health Options clinical representatives when necessary. The lack of proper documentation for services rendered could result in denial of payment, or, if payment has already been issued, a request for refund.

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

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

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

later fails to follow through, the *provider* may be re-addressed by the *NCC* and involuntarily disenrolled for breach of contract.

APPEAL

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

- a copy of the audit report of findings letter
- the provider's name and identification number
- contact information
- identification of the claims at issue, including the name or names of the members, dates of service, and an explanation of the reason/basis for the dispute.

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

The provider's appeal will be presented to Beacon Health Options' National Compliance – Program Integrity Subcommittee within forty-five (45) days of receiving the provider's request for appeal. The subcommittee is comprised of Beacon Health Options employees who have not been involved in reaching the prior findings. The subcommittee will review the provider's appeal documentation, discuss the facts of the case, as well as any applicable contractual, state or federal statutes. The Beacon Health Options staff member/auditor who completed the provider's audit will present his/her audit findings to the subcommittee but will not vote on the appeal itself. The subcommittee will uphold, overturn, uphold in-part, or pend the appeal for more information. Once a vote is taken, it will be documented and communicated to the provider within ten (10) business days of the subcommittee's meeting. If additional time is needed to complete the appeal, Beacon Health Options will submit a letter of extension to the provider requesting any additional information required of the provider and estimating a time of completion. If repayments or a corrective action plan (CAP) are required, the provider must submit the required repayments or CAP within ten (10) business days of receiving the subcommittee's findings letter, unless an installment payment plan is approved.

Beacon Health Options will take appropriate legal and administrative action in the event a provider fails to supply requested documentation and member records or fails to cooperate with a Beacon Health Options investigation or corrective action plan. Beacon Health Options may also seek termination of the provider agreement and/or actions to recover amounts previously paid on claims involved in the investigation or requests for records. Beacon Health Options will report any suspicion or knowledge of fraud, waste or abuse to the appropriate authorities or regulatory agency as required or when appropriate.

REPORTING FRAUD, WASTE, AND ABUSE

Providers should report fraud, waste and abuse, or suspicious activity thereof, such as inappropriate billing practices (e.g., billing for services not rendered, use of CPT codes not documented in the treatment record, etc.). Reports and questions may be made in writing to Beacon Health Options at the address below, by emailing

Program.IntegrityReferrals@BeaconHealthOptions.com or by calling the Beacon Health Options Ethics Hotline at 1-888-293-3027.

Beacon Health Options, Inc.
Corporate Headquarters
240 Corporate Boulevard, Suite 100
Norfolk, VA 23502
ATTN: Compliance Department

Suspected fraud, waste and abuse may also be reported directly to:

Behavioral Health Organizations

- Colorado Health Partnerships (CHP)
  CHP Compliance – 1-800-804-5040
- Foothills Behavioral Health Partners
  Corporate Compliance Hotline – 303-432-5985

Colorado Department of Health Care Policy & Financing

- Phone: 855-375-2500
- Email: ReportProviderFraud@hcpf.state.co.us
- Fax: 303-866-4411
- Mail:
  Department of Health Care Policy and Financing
  Attn: Program Integrity Section
  1570 Grant Street
  Denver, Colorado 80213
- https://www.colorado.gov/pacific/hcpf/how-report-suspected-fraud

Health First Colorado Fraud Control Unit

- Phone: 720-508-6696
- Email: MFCU.Investigations@state.co.us
- http://www.coloradoattorneygeneral.gov/departments/criminal_justice/Health First Colorado_fraud_control_unit

CONFIDENTIALITY, PRIVACY AND SECURITY OF IDENTIFIABLE HEALTH INFORMATION

Providers are:

- expected to comply with applicable federal and state privacy, confidentiality and security laws, rules and/or regulations, including without limitation the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules and regulations promulgated thereunder, and 42 C.F.R. Part 2
- and,are responsible for meeting their obligations under these laws, rules and regulations, by implementing such activities as monitoring changes in the laws, implementing appropriate mitigation and corrective actions, and timely distribution of notices to patients(members), government agencies and the media when applicable. In the event that Beacon Health Options receives a complaint or becomes aware of a potential violation or breach of an obligation to secure or protect member information, Beacon Health Options will notify the provider/participating provider, and request that the provider/participating provider respond to the allegation and implement corrective action when appropriate. Participating providers must respond to such requests and implement corrective action as indicated in communications from Beacon Health Options.

Providers and their business associates interacting with Beacon Health Options staff should make every effort to keep protected health information secure. If provider does not use email encryption, Beacon Health Options recommends sending protected health information to Beacon Health Options through an inquiry in ProviderConnect or by secure fax.

Section 19

FBHPARTNERS SPECIFIC INFORMATION

FBHPartners is committed to two quality initiatives in which providers must participate. The first is intended to increase access to psychiatrist's services in the BHO's five (5) county service area by facilitating referrals from network providers to the medical staff at Jefferson Center for Mental Health (Jefferson Center) and The Mental Health Partners (MHP). The second, our Screening and Referral Policy and Procedures, is intended to advance care coordination and health integration within FBHPartners service area.

Improving Access to Psychiatric Services (addendum to Section 3):

FBHPartners (FBHP) has in place a procedure for network providers serving members who are eligible to FBHPartners that facilitates referral to psychiatric prescribers employed by JCMH and MHP. When an FBHPartners' member requires a psychiatric/medication referral the provider should implement the following procedure:

1. Complete the Medication Evaluation Referral Form (MERF) found on the FBHP website at www.FBHPartners.com, Provider Section, Forms Section;
2. Ensure that the packet of information, as outlined on the MERF form, is complete and available; and
3. Fax the request form to the Beacon Health Options Service Center at 719-538-1439. Beacon Health Options and the serving community mental health center will facilitate the referral from there.

Behavioral and Physical Health Screening and Referral (addendum to Section 8):

FBHPartners requests that all behavioral health providers implement a program of behavioral health and physical health screening and referral at all access points across FBHPartners care system, including substance use disorder (SUD) and mental health providers and integrated physical health sites. The purpose is to ensure Members, no matter the FBHPartners setting, receive access to a consistent set of screening, assessment, and referral service protocols for SUD, depression, anxiety, trauma and physical health care access.

FBHPartners provides a set of recommended screening instruments, with well-established reliability for risk of alcohol and drug abuse, depression, anxiety and trauma (see FBHPartners website www.fbhpartners.com for the policy and recommended instruments). All behavioral health providers should have in place procedures for screening at the initial assessment.

1. For SUD providers the procedures include screening for depression, anxiety and trauma, along with the SUD assessment.

2. For mental health providers the procedures include screening for alcohol and drug abuse and trauma along with the MH assessment.
3. SUD and mental health providers, co-located/integrated within a PCMP office or FQHC, should work closely with the health care provider to implement procedures for behavioral health screening, including depression, anxiety, alcohol and drug abuse and trauma, in particular for high-risk Members with severe mental illness or Members with a SUD with intravenous mode of administration of drugs, who are pregnant or postpartum.
4. Behavioral health providers should screen for physical health care access at initial contact, including Member identification of their PCP and last non-emergent physical health care visit.
5. All behavioral health providers, in particular the partner mental health centers and large SUD facility providers, should have in place clear protocols/procedures for receipt of screening referrals from PCMP offices or FQHCs as well as procedures for coordinating with those offices.