Beacon Health Options of California, Inc.

Provider Handbook

Overview

Welcome to the Beacon Health Options of California, Inc. (Beacon of California) network of participating providers. This handbook is an extension of the provider agreement and includes requirements for doing business with Beacon of California, including policies and procedures for individual providers, affiliates, group practices, programs and facilities. It provides important information regarding the managed care features incorporated in the Beacon of California provider agreements and reflects the policies and procedures that are applicable to our Knox-Keene product lines.

Beacon of California is a wholly owned subsidiary of Beacon Health Option, Inc. (Beacon) and a health care service plan licensed under the Knox-Keene Act to provide Mental Health or Substance Use Disorder or Mental Disorder (MHSUD) and Employee Assistance Program (EAP) services to commercial clients and health plans. Beacon of California also provides administrative services to Beacon's administrative service only (ASO) clients. As a Knox-Keene Plan, Beacon of California is regulated by the California Department of Managed Health Care (DMHC). Where there is conflict between Beacon requirements and Knox-Keene regulations, this handbook will reflect the Knox-Keene regulations for Beacon of California business, if more stringent.

Together, the Beacon of California provider agreement, addenda, and the handbook outline the requirements and procedures applicable to providers in the Beacon of California networks. Information specific to participating providers in the EAP network can be found in the EAP Provider Handbook.

Beacon of California also maintains a web site at www.beaconhealthoptionsca.com. Beacon maintains a separate handbook for requirements and information regarding the Beacon agreement. Therefore, in addition to careful review of the information provided in this handbook, it is important to be familiar with the requirements provided at www.beaconhealthoptions.com.

Beacon of California may, by notice, amend or change any or all provisions of the handbook by providing 45 business days prior written notice to providers unless the amendment is material and not made in order to comply with a change in state or federal law or accreditation standards. Refer to your Beacon of California participating agreement for information related to handbook or agreement amendments. To the extent that there is an inconsistency between the handbook and the provider agreement, Beacon of California reserves the right to interpret such inconsistency. Beacon of California's interpretation shall be final and binding.

Contact Information

Administrative Appeal	To request an administrative appeal, call the toll-free number included in the administrative denial letter received.
Adverse Incident	Report all adverse incidents to the Clinical Care Manager with whom the provider conducts reviews.
Changing your Provider Profile (e.g. Name, address)	To change or update your Provider Profile (e.g. address), the preferred method is through the "Update Demographic Information" option in ProviderConnect. Providers without access to ProviderConnect can call the National Provider Services Line at 800-397-1630 Monday through Friday 8 a.m. – 8 p.m. Eastern Time. NOTE: Updating a Tax ID requires an accompanying W-9 form, which can be uploaded as an attachment in ProviderConnect. A copy of the W-9 form is available at www.beaconhealthoptions.com.
Claims	For general claim inquiries, please call 800-888-3944. For technical questions related to direct claim submission via ProviderConnect or using Beacon's EDI Claims Link software, please contact the EDI Help Desk at: **Telephone:** 888-247-9311 from 8 a.m. – 6 p.m. Eastern Time **Fax:** 866-698-6032 **E-mail:** e-supportservices@beaconhealthoptions.com For providers who are unable to submit a claim electronically, paper claims should be sent to: Beacon Health Options, Inc. P.O. Box 1852 Hicksville, NY 11802
Clinical Appeals	To request a clinical appeal on a member's behalf, call the toll-free number included in the adverse determination letter received.
Complaints/Grievances	To file a complaint/grievance, call the toll-free number on the back of the member's identification card to speak to Customer Service.
Credentialing	To obtain information pertaining to network participation status, contact the National Provider Services Line at 800-397-1630 from 8 a.m. – 8 p.m. Eastern Time Monday through Friday. To send supporting documentation such as malpractice or insurance cover sheets, please fax to 866-612-7795.

Fraud and Abuse	Report questionable billing practices or suspected fraud to: Beacon Health Options, Inc. ATTN: SIU 1400 Crossways Blvd., Ste. 101 Chesapeake, VA 23320 siu@beaconhealthoptions.com National Provider Services Line at 800-397-1630 from 8 a.m. – 8 p.m. Eastern Time Monday through Friday.
Member Benefits, Eligibility, and Authorizations	For questions about member eligibility or benefits, providers can submit an inquiry via ProviderConnect by selecting the "Eligibility and Benefits" option. For questions about authorization status, providers can select the "Review an Authorization" option via ProviderConnect. For additional questions about authorizations or benefits, call the toll-free number on the back of the member's identification card.
Member Customer Service	To reach Member Customer Service, call the toll-free number on the back of the member's identification card.
Provider Coverage During Absences	To update Beacon of California if there will be lack of provider coverage due to absences (e.g. coverage while on vacation), contact the National Provider Services Line or the Clinical Care Manager with whom the participating provider conducts reviews during absences or call the number on the member's card to provide coverage information.
All Other Questions	Please contact the Beacon of California Provider Relations office listed below for general questions via email. Please do not include member information in the email: provider.inquiry@beaconhealthoptions.com

E-Commerce Initiative

Providers in the Beacon of California network are strongly encouraged to conduct all routine transactions electronically, including:

- Submission of claims
- Submission of authorization requests
- Verification of eligibility inquiries
- Submission of recredentialing applications
- Updating of provider information
- Electronic fund transfer/direct deposit through PaySpan Health
- Provider claims and authorization status checks

- Reviewing claims remittance information

To conduct these transactions referenced above, Beacon of California encourages providers to utilize the resources detailed further in this section, as well as those sections titled *Claim Procedures*, *Credentialing and Recredentialing*, and *Updating Provider Information*. These resources will expedite claims processing and facilitate administrative tasks.

For questions or further assistance regarding this recommendation, please email your Beacon of California's Provider Relations team at provider.inquiry@beaconhealthoptions.com or contact the National Provider Service Line at (800) 397-1630 Monday through Friday, 8 a.m. to 8 p.m. ET.

Electronic Resources

The following electronic resources are available to assist providers in complying with Beacon of California's E-Commerce initiative:

ProviderConnect

Links to information and documents important to providers are located on the ProviderConnect website at www.beaconhealthoptions.com. ProviderConnect is a secure, password protected site where participating providers conduct certain on-line activities with Beacon of California directly 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen systems issues). Currently, participating providers are provided access to the following on-line activities:

- Authorization or certification requests for all levels of care
- Concurrent review requests and discharge reporting
- Single and multiple electronic claims submission
- Claim status review for both paper and electronic claims submitted to Beacon of California
- Verification of eligibility status
- Submission of inquiries to Beacon of California's Provider Customer Service
- Updates to practice profiles/records
- Electronic access to authorization/certification letters from Beacon of California
- Provider summary vouchers (PSVs)

Note: Use of these E-Commerce solutions offered by Beacon of California is strongly recommended.

Clearinghouses

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 of California receives those claims. The provider must register for online services and submit the Intermediary Authorization Form to be linked with the clearinghouse.

PaySpan® Health

Beacon of California participating providers must use PaySpan Health for electronic fund transfer.

PaySpan Health enables providers to receive payments automatically in their bank account of choice, receive email notifications immediately upon payment, view remittance advices online, and download an 835 file to use for auto-posting purposes.

Beacon Electronic Data Interchange (EDI) Claims Link for Windows®

The EDI Claims Link for Windows application is another tool available to providers, or their designated representatives, to generate HIPAA compliant electronic claims. This tool requires installation and creation of a database of providers and members. Refer to the EDI Claims Link for Windows User Manual located on www.beaconhealthoptions.com.

Beacon of California Website

Beacon of California's website, www.beaconhealthoptionsca.com contains information about Beacon of California and its business. Links to information and documents important to providers are located in the Beacon of California Providers' section. Important documents specific to Beacon of California include, but are not limited to:

- Provider Dispute Resolution (PDR) Request form
- Language Capability Attestation form
- Member Grievance form

Achieve Solutions

Achieve Solutions is an educational behavioral health and wellness information website. This website is educational in nature and is not intended as a resource for emergency crisis situations or as a replacement for medical care or counseling. The website includes self-management tools and other resources that can support members. We encourage you to promote the use of this award-winning website with the individuals you serve.

Participating Providers

Beacon of California does not refuse to contract or terminate existing contractual relationships with providers because a provider: (a) advocates on behalf of a member, (b) files a complaint with or against Beacon of California, or (c) appeals a decision or determination made by Beacon of California.

Participating providers are independent contractors of Beacon of California. This means that participating providers practice and operate independently, are not employees of Beacon of California, and are not partners with or involved in a joint venture or similar arrangement with Beacon of California. Beacon of California does not direct, control or endorse health care or treatment rendered or to be rendered by providers or participating providers.

Beacon of California encourages participating providers to communicate with members to discuss available treatment options, including medications and available options, regardless of coverage determinations made or to be made by Beacon of California or a designee of Beacon of California. Treating providers, in conjunction with the member (or the member's legal representative), make decisions regarding what services and treatment are rendered. Any preauthorization, certification or medical necessity determinations by Beacon of California relate solely to payment. Participating

providers should direct members to Beacon of California or their respective benefit plan representatives for questions regarding coverage or limitations of coverage under their benefit plan prior to rendering non-emergency services.

Beacon of California's Provider Identification Numbers

The Beacon of California provider number is a participating provider's unique six-digit number assigned by Beacon. The provider number identifies a provider in the Beacon of California system and is used for giving access to ProviderConnect. The provider number is on file with Beacon of California. Participating providers should contact the National Provider Services Line at (800) 397-1630 Monday through Friday, 8 a.m. to 8 p.m. ET for questions regarding Provider Identification Numbers and/or for assistance in obtaining a Provider Identification Number.

The provider's service location vendor number is a number that identifies where services are or were rendered. A participating provider may have multiple vendor locations and each vendor location is given a five-digit number preceded by a letter (e.g. A23456, D45678).

The pay-to vendor number is a vendor number issued by Beacon and indicates the mailing address for all payments and when using our electronic payments service through PaySpan Health. A provider can have more than one pay-to vendor number and each number needs to be registered with PaySpan.

The National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI is different from a Beacon of California assigned provider number. The NPI is a single provider identifier that replaces the different identifiers used in standard electronic transactions. HHS adopted the NPI as a provision of HIPAA. This number is also contained in the Beacon of California system and can be used to locate a provider record for claims, referrals and authorization purposes.

Provider Satisfaction Survey

Beacon of California conducts an annual provider satisfaction survey to measure participating providers' opinions regarding Beacon of California clinical and administrative processes. Data is aggregated, trended and used to identify improvement opportunities. Results are shared with participating providers through the Quality Management Committee, Clinical Advisory Committees, and provider newsletters. Corrective action plans, where appropriate, are managed through the Quality Management Committee.

Changes to Provider Directory Information

Participating provider information is used in credentialing and recredentialing activities as well as in provider directories and listings made available to clients and members. California Health & Safety Code §1367.27(I) requires the verification of the accuracy of information concerning each provider listed in the Beacon of California's provider directory. It is of the utmost importance that provider directory information is accurate and current so that members are able to easily select and make appointments with providers that match their needs. As a Knox-Keene licensed health plan, Beacon of California, must take certain measures to assure the accuracy of its provider directory.

To be compliant participating providers must notify Beacon of California or its designee in advance of any changes or updates to the following information:

- Name

- Service physical addresses and locations
- Email address
- Phone number
- Hours of operation
- Discipline
- NPI
- Board certification(s)
- Accreditation
- License
- Clinical specialties
- Services actually provided
- Whether accepting new patients
- Hospital and Medical Group affiliations
- Language(s) spoken
- Population served
- Ethnicity
- Gender
- Handicapped access
- Public transportation
- Whether offers outpatient appointments or only through hospital/inpatient facility

Each element of information must be customized and accurate as to the ***individual*** practitioner; it should not be based on the profile of the group practice or facility. Changes and updates to participating practitioner information should be submitted to Beacon only via CAQH (unless expressly requested otherwise by Beacon). Participating practitioners are contacted by CAQH at least quarterly to notify them to update or verify their directory information and then attest to the accuracy of that information. Failure to attest to the accuracy of the information for a period of 12 months within CAQH will result in removal from the directory and termination from the network. ***Note***: the obligation to respond to CAQH is in addition to, and not in lieu of, the obligation to provide notice of changes in information in advance of the change occurring,

Participating facility or provider groups are to submit changes and updates via ProviderConnect or by contacting Beacon of California directly. Participating facilities are to provide the following additional information:

- Facility Name
- Type
- Location(s) – physical addresses of primary and affiliated locations

- Accreditation Status
- telephone contact information

If availability changes, all participating providers are required to notify Beacon of California and update CAQH within five business days of the date they are no longer accepting new patients as well as when availability has resumed. If a participating provider is unable to accept new referrals for more than six months, the network participation of the provider may be reevaluated.

Policies & Procedures

Pursuant to the terms of the provider agreement, participating providers must comply with Beacon of California policies and procedures, and as outlined in this handbook. As more specifically detailed in other parts of this handbook, Beacon of California maintains continuous quality improvement and utilization management programs that include policies and procedures and measures designed to provide for ongoing monitoring and evaluation of services rendered to members (e.g., clinical review criteria, member and participating provider surveys, evaluations and audits). Participating provider involvement is an integral part of these programs. Participating providers must cooperate with and participate in Beacon of California quality improvement and utilization management programs and activities. Refusal to cooperate with Beacon of California quality improvement and/or utilization management activities may adversely affect continued network participation status or result in sanctions up to and including termination of network participation status.

Credentialing and Recredentialing

Beacon of California's credentialing processes for new providers seeking to contract with Beacon of California and recredentialing processes for participating providers currently contracted with Beacon of California are designed to comply with national accreditation standards, as well as applicable state and/or federal laws, rules and regulations. Credentialing and recredentialing is required for all providers and participating providers, respectively, including without limitation individual practitioners and organizations (clinics, facilities or programs). All provider/participating provider office or facility locations where services are rendered and that share the same federal tax identification number that are identified in credentialing/recredentialing applications are considered for participation status under that application.

Providers and participating providers are credentialed and recredentialed, respectively, for participation status for designated services and/or level(s) of services. Should participating providers have other or additional services or levels of services available, additional credentialing and/or recredentialing may be necessary prior to designation as a 'participating provider' for such additional services and/or levels of services. Services and/or levels of services for which a participating provider is not credentialed are subject to all applicable out-of-network authorization, certification and any benefit or coverage limitations under the member's benefit plan.

As provided for in Beacon of California policies and procedures, decisions to approve or decline initial credentialing applications, to approve recredentialing applications and/or to submit a given credentialing or recredentialing application for further review are made by the Beacon of California Credentialing Committee.

Participating providers have the right to:

- Request review of information submitted in support of credentialing or recredentialing applications
- Correct erroneous information collected during the credentialing or recredentialing processes
- Request information about the status of credentialing or recredentialing applications

All requests to review information must be submitted in writing. Verbal requests for the status of a credentialing or recredentialing application can be made by calling the National Provider Services Line at (800) 397-1630, Monday through Friday, 8 a.m. to 8 p.m. Eastern Time. Regardless of the above, Beacon of California will not release information obtained through the primary source verification process where prohibited by applicable state and/or federal laws, rules and/or regulations.

Credentialing

Initial credentialing processes begin with submission of completed and signed applications, along with all required supporting documentation using one of the following methods:

- After completing the online universal credentialing process offered by the Council for Affordable Quality Healthcare (CAQH), give Beacon access to your credentialing information and ensure a current attestation. Call the CAQH Help Desk at (888) 599-1771 for answers to your questions related to the CAQH application or website; or
- Complete a Beacon application by going to the Beacon website at www.beaconhealthoptions.com.
- on-line application by calling the National Provider Service Line at (800) 397-1630 Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

This includes without limitation an attestation as to:

- Any limits on the provider's ability to perform essential functions of their position or operational status
- With respect to individual practitioner providers, the absence of any current illegal substance or drug use
- Any loss of required state licensure and/or certification
- Absence of felony convictions
- With respect to individual practitioner providers, any loss or limitation of privileges or disciplinary action
- The correctness and completeness of the application

Failure of a provider to submit a complete and signed credentialing application, and all required supporting documentation timely and as provided for in the credentialing application and/or requests from Beacon and/or Beacon of California, may result in rejection of request for participation status with Beacon of California.

Recredentialing

Recredentialing for participating providers is required every three years. The process for recredentialing begins approximately four months prior to the end of the initial credentialing cycle or the preceding recredentialing cycle, as applicable, and can be accomplished using one of the following methods:

- After completing the online universal credentialing process offered by the Council for Affordable Quality Healthcare (CAQH), give Beacon access to your credentialing information and ensure a current attestation. Call the CAQH Help Desk at 1-888-599-1771 for answers to your questions related to the CAQH application or website; or
- Beacon will mail a recredentialing application via USPS to the participating provider or notify the participating provider via email, voicemail or fax that their online recredentialing application is available via ProviderConnect.

Required documentation includes without limitation an attestation as to:

- Any limits on the participating provider's ability to perform essential functions of their position or operational status
- With respect to individual practitioner participating providers, the absence of any current illegal substance or drug use
- The correctness and completeness of the application (including without limitation identification of any changes in or updates to information submitted during initial credentialing)

Failure of a participating provider to submit a complete and signed recredentialing application, including all required supporting documentation timely and as provided for in the recredentialing application and/or requests from Beacon and/or Beacon of California, may result in termination of participation status with Beacon of California and such providers may be required to go through the initial credentialing process.

Standards

Standards applicable to providers in the initial credentialing process and to participating providers in the recredentialing process include, but are not limited to the following:

- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements) and valid license to practice as an independent provider at the highest level certified or approved by California where services are performed for the provider's/participating provider's specialty (individual practitioners)
- Current, unencumbered (not subject to probation, suspension, supervision and/or other monitoring requirements) and valid license to practice and/or operate independently at the highest level certified or approved by California where services are performed for the provider's/participating provider's facility/program status (organizations)
- Accreditation currently accepted by Beacon of California for organizations (currently TJC, CARF, COA, HFAP, AAAHC, NIAHO, CHAP and AOA) (organizations). Structured site visits are required for all unaccredited organizations.
- Clinical privileges in good standing at the institution designated as the primary admitting facility, with no limitations placed on the ability to independently practice in his/her specialty (individual practitioners)
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline or licensure (individual practitioners)
- Current specialty board certification, if indicated on the application (individual practitioners)

- A copy of a current Drug Enforcement Agency (DEA) certificate, and/or Controlled Dangerous Substance (CDS) Certificate where applicable (individual practitioners)
- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the provider/participating provider which disclose an instance of, or pattern of, behavior which may endanger members
- Good standing with state and federal authorities and programs (organizations)
- No exclusion or sanctions from government sponsored health benefit programs (e.g., Medicare/Medicaid) (individual practitioners and organizations)
- Current specialized training as required for certain levels or areas of specialty care (individual practitioners)
- Malpractice and/or professional liability coverage in amounts consistent with Beacon of California policies and procedures (individual practitioners and organizations)
- An appropriate work history for the provider's/participating provider's specialty (individual practitioners)
- A signed Beacon of California Language Capability Attestation (available on the *Beacon of California Forms* section of this Handbook at www.beaconhealthoptionsca.com) if provider/participating provider is able to provide behavioral health services in any language other than English (individual practitioners)

Changes or updates to any of the above noted information is subject to re-verification from primary sources during the recredentialing process, or at the time of notice of such a change or update from the participating provider. Additionally, providers/participating providers must have:

- No adverse record of failure to follow Beacon of California policies and procedures or Quality Management activities
- No adverse record of provider actions that violate the terms of the provider agreement
- No adverse record of indictment, arrest or conviction of any felony or any crime indicating potential or actual member endangerment
- No criminal charges filed relating to the participating provider's ability to render services to members
- No action or inaction taken by a participating provider that, in the sole discretion of Beacon of California, results or may result in a threat to the health or well-being of a member or is not in the member's best interest

Site Visits

In addition, and as part of credentialing or recredentialing, Beacon of California may conduct a structured site visit of a provider's/participating provider's offices/locations. Site visits include, but may not be limited to an evaluation using the Beacon of California site and operations standards and an evaluation of clinical record keeping practices against Beacon of California's standards.

The current Beacon of California site visit tool is available for review on the Beacon of California website. As the site visit tool is subject to modification without notice, participating providers are encouraged to check the website for the most current site visit tool prior to scheduled site visits. While Beacon of

California, at its discretion, may require a site visit in the course of credentialing and/or recredentialing processes based on information submitted and/or obtained in the process, site visits are conducted for providers/participating providers in the following categories: (a) unaccredited organizations; (b) providers/participating providers with two or more documented member complaints in a six month time frame relating to physical accessibility, physical appearance, adequacy of waiting/examining room space; and/or (c) alleged quality of care issues.

Site visits are arranged in advance. Following the site visit, Beacon of California provides a written report detailing the findings, which may include required monitoring where applicable and/or requirements for the participating provider to submit an action plan.

Updates

Providers/participating providers are required to report material changes to information included in credentialing and/or recredentialing applications submitted to Beacon of California. Except as noted below, all such changes must be reported in writing within the time period provided for in the provider agreement, but not to exceed 10 calendar days of the provider/participating provider becoming aware of the information. Failure to comply may result in immediate termination of network participation status. The following is a list of examples of the types of material changes for which the above report is required:

- Any action against licenses, certifications, registrations, and/or accreditation status (The suspension, revocation, expiration and/or voluntary surrender of professional license/certification, DEA certificate, CDS certificate, and/or board certification must be reported within five calendar days of the effective date of the action)
- Any legal or government action initiated that could materially affect the rendering of services to members
- Any legal action commenced by or on behalf of a member
- Any initiation of bankruptcy or insolvency proceedings, whether voluntary or involuntary
- Any other occurrence that could materially affect the rendering of services to members
- Discovery that a claim, suit or criminal or administrative proceeding is being brought against the provider/participating provider relating to the provider's delivery of care (i.e. malpractice suite), compliance with community standards and/or to applicable laws, including, but not limited to any action by licensing or accreditation entities and/or exclusions from a government sponsored health benefit program (e.g., Medicare/Medicaid)

Expiration, non-renewal and/or decrease in required malpractice or professional liability coverage must be reported 30 calendar days prior to such change in coverage.

Any changes in demographic information or changes in practice patterns such as change of services and/or billing address, name change, coverage arrangements, tax identification number, hours of operation, and/or changes in ownership must be provided to Beacon of California in advance of such changes. Beacon of California must receive 60 calendar days advance notice of any new programs or services offered by a facility provider in order to allow for completion of the credentialing process prior to provision of services to members.

Changes in ownership and/or management of participating providers may require negotiation and execution of consent to assignment and assumption agreements as related to provider agreements and the parties to provider agreements.

Practice Full

Individual participating providers are required to notify Beacon of California within five business days of the date in which the participating provider is no longer accepting new patients. If a participating provider remains on "practice full" status and is unable to accept new referrals for more than six months, the network participation of the provider may be reevaluated.

Sanctions

While efforts are made to resolve provider/participating provider credentialing/recredentialing issues and/or quality issues through consultation and education, occasionally further action is necessary to provide for quality service delivery and protection of members. Sanctions may be imposed for issues related to member complaints/grievances, credentialing/recredentialing issues, professional competency and/or conduct issues, quality of care concerns/issues, and/or violations of state and/or federal laws, rules and/or regulations. Beacon of California processes comply with all applicable local, state and/or federal reporting requirements regarding professional competence and/or conduct. Subject to modification based on the facts and circumstances in a given case, the following is a list of possible sanctions that may be imposed on participating providers by the Beacon of California Credentialing Committee, and/or the Beacon of California Provider Appeals Committee. The descriptions below are not in any specific order and should not be interpreted to mean that there is a series of sanctions; any one or more possible sanctions described below may be imposed in any order or sequence.

TYPE	DEFINITION
Consultation	A call is placed to notify the participating provider of the alleged action or incident. The participating provider is provided with an explanation of possible sanctions if corrective actions are not taken. The call is documented to include the date and subject for consultation. A copy of the consultation is placed in the participating provider's file. Appropriate educational materials are sent via certified mail.
Written Warning	A written notice is sent to the participating provider notifying him/her of the alleged action or incident. Possible sanctions, if corrective actions are not taken, are explained. A copy of the letter is retained in the participating provider's file; educational material is sent via certified mail. Corrective action is monitored as necessary.

TYPE	DEFINITION
Second Written Warning	A second written notice may be sent to the participating provider notifying him/her of the alleged improper action or incident after the participating provider previously had received a written warning regarding an action or incident (whether the same or different). A copy of the letter is retained in the participating provider's file.
Monitoring	An increased level of oversight (e.g. scheduled site visits, treatment record reviews, monitoring of member complaints) of a provider as determined by Beacon of California when data indicates nonconformance with standards. An action plan is provided consisting of steps that, when taken, will remedy the deficiencies or concerns that created the need for monitoring. The participating provider is expected to use best efforts to comply with the monitoring action plan. The written notice includes the date and circumstances leading to the monitoring determination. Monitoring lasts no more than 90 calendar days from the date of notification, during which time the participating provider continues network participation. At the completion of the monitoring period, the participating provider is re-evaluated to determine further action and network status.

TYPE	DEFINITION
Reduction of Privileges	The participating provider's participation status is changed in order to prevent new member referrals. During this suspension period, an investigation in to the alleged improper action is conducted. Utilization of the investigative period is for serious infractions that are probable cause for disenrollment, but must be proven first. The written notice includes the date and circumstances leading to the reduction of privileges. A copy of the reduction of privileges notice is filed in the participating provider's file. The reduction of privileges lasts for a period of no more than 30 calendar days, during which time the investigation is concluded. The suspension period may be extended if necessary, in which case the participating provider receives written notification of the extension. If it is determined that the alleged improper action has taken place, the participating provider may be subject to further actions, up to and including disenrollment from the network.

TYPE	DEFINITION
Summary Suspension	The participating provider's participation status is changed without prior notice or hearing where the failure to take that action may result in an imminent danger to the health of any individual, preventing new member referrals, new patient authorizations, and/or redirecting all current patients to other participating providers. During the suspension period, an investigation in to the alleged improper action is conducted. Utilization of the investigative period is for serious infractions that are probable cause for disenrollment but must be proven first. The written notice of suspension includes the date and circumstances leading to the suspension. A copy of the summary suspension notification is filed in the participating provider's file. The suspension lasts for a period of no more than 14 calendar days during which time the investigation is concluded. The suspension period may be extended if necessary, in which case the participating provider receives written notification of the extension. If it is determined that the alleged improper action has taken place, the participating provider may be subject to further actions, up to and including disenrollment from the network.
Termination	The participating provider may be terminated from the network. The participating provider is given written notice via certified mail that the participating provider is being terminated from the network and the reason for the termination. A copy of the letter is put in the participating provider's file. Members in care are notified and given assistance for a referral to a new participating provider for continuing care, as necessary.

Provider Appeals

Providers/participating providers have the right to formally appeal the decisions of the Beacon of California Credentialing Committee and decisions made through the Provider Dispute resolution process. Appeals of adverse credentialing/recredentialing decisions regarding acceptance into the network, corrective and/or disciplinary actions (not related to quality of care, competence, or professional conduct reasons), change in network participation, and any disagreements related to unresolved contractual or administrative disputes (e.g. claim or billing disputes, contract language or administrative requirements, or

disputing a provider network participation decision related to administrative reasons such as disenrollment from the network for not being responsive to recredentialing efforts or denied for Beacon of California network participation for not meeting credentialing criteria) that have not been resolved through routine Beacon of California processes may be appealed to the Beacon of California Provider Appeals Committee. Unless otherwise identified in such written notice, providers/participating providers have 30 calendar days from the date of the Committee's notice of an adverse decision to file a written request for an appeal. The Provider Appeals Committee is comprised of representatives from major clinical disciplines and at least one participating provider, none of whom participated in the original Beacon of California adverse decision under review.

Requests for an appeal should include an explanation of the reasons the provider/participating provider believes the Beacon of California Credentialing Committee or the Provider Dispute resolution process reached a decision to be in error and include supporting documentation. The Beacon of California Provider Appeals Committee will review the explanation provided, the information previously reviewed by the Beacon of California Credentialing Committee or through the Provider Dispute resolution process, and any additional information determined to be relevant. The Beacon of California Provider Appeals Committee may request additional information from the provider/participating provider in order to make a determination or decision. The Beacon of California Provider Appeals Committee will support, modify, or overturn the decision of the Beacon of California Credentialing Committee or the Provider Dispute resolution. Written notification of the Beacon of California Provider Appeals Committee's decision and an explanation of the decision will be sent to the provider/participating provider within 14 business days after the Beacon of California Provider Appeals Committee's record is complete. All decisions of the Beacon of California Provider Appeals Committee relative to provider/participating provider appeals are final.

Fair Hearing Process

A provider/participating provider (individual practitioners only) may request a fair hearing for issues related to quality of care, competence and/or professional conduct as a result of a proposed action or recommendation as determined by the Beacon of California Credentialing Committee. The affected practitioner/participating practitioner may request a formal fair hearing when the proposed action or written recommendation is for one of the following causes:

- Medical disciplinary cause or reason, meaning an aspect of a practitioner's/participating practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
- Conduct or professional competence of a practitioner/participating practitioner, which adversely affects or could affect adversely the health or welfare of a patient(s).

Only the following types of actions or recommendations shall give rise to hearing rights:

- A practitioner's/participating practitioner's application for Beacon of California network participation is denied or rejected for a medical disciplinary cause or reason as described above;
- Termination or non-renewal of an agreement for a medical disciplinary cause or reason as described above;
- Suspension or reduction of privileges to perform patient care services for a cumulative total of 30 calendar days or more in any 12-month period for a medical disciplinary cause or reason as described above; and/or

- Summary suspension of privileges to perform patient care service for more than 14 consecutive days for a medical disciplinary cause or reason as described above.

A request for a Fair Hearing must be made within 30 calendar days of the date of receipt of notification of an adverse action. The request must be submitted in writing and directed to the Chairperson of the Beacon of California Credentialing Committee. The practitioner/participating practitioner receives written notice of the place, time and date of the Fair Hearing, which shall not be less than 30 calendar days or more than 60 calendar days after the date the request for a Fair Hearing is received from the practitioner/participating practitioner. If the practitioner/participating practitioner does not request a formal hearing within the time and in the manner prescribed, the practitioner/participating practitioner shall be deemed to have accepted the recommendation, decision, or action involved and it may be adopted by Beacon of California as final action.

A supplemental notice, if applicable, will be provided at the same time as the notice of the Fair Hearing and charges. The supplemental notice includes a list of the patient records, if any, which are to be discussed at the hearing and the names and addresses of individuals who are expected to give testimony or evidence in support of the original Beacon of California Credentialing Committee action at the hearing. At least 10 calendar days prior to the hearing, the practitioner/participating practitioner shall furnish to the Beacon of California Credentialing Committee Chairperson a written list of the names and addresses of the individuals who will give testimony or evidence in support of the practitioner/participating practitioner at the hearing.

The Chairperson of the Beacon of California Credentialing Committee will identify peer reviewers who will participate on the Fair Hearing panel. The following criteria will be utilized in selecting panel members:

- A minimum of three California licensed practitioners/participating practitioners who have the requisite expertise to ensure a fair hearing.
- Members shall be impartial and shall not have actively participated in the formal consideration of the matter at any previous level (i.e., they shall not have acted as an accuser, investigator, fact finder or initial decision maker in the same matter).
- Members shall not be in direct economic competition with the affected practitioner/participating practitioner, and shall stand to gain no direct financial benefit from the outcome of the hearing.
- Whenever possible, at least one member should practice the same specialty as the affected practitioner/participating practitioner.

One member of the Fair Hearing panel will be selected to act as the hearing officer and will preside over the Fair Hearing. In lieu of appointing a hearing panel, the Beacon of California Credentialing Committee shall have the discretion, to hold the hearing before an arbitrator or arbitrators mutually acceptable to the practitioner/participating practitioner and the Committee.

Fair Hearings are provided for the purpose of addressing issues of professional conduct or competence in healthcare. Accordingly, neither the practitioner nor the Beacon of California Credentialing Committee may be represented by an attorney at the hearing unless the Hearing Officer, in his/her discretion, permits both sides to be represented. In no case may the Beacon of California Credentialing Committee be represented by an attorney if the practitioner/participating practitioner is not represented. Within 30 calendar days of the final adjournment of the hearing, the Hearing Panel shall issue a decision, which shall include finding of fact and conclusions articulating the connection between the evidence produced at the hearing and the result. A copy shall be sent to the Chairperson of the Beacon of California

Credentialing Committee, and via certified mail to the practitioner/participating practitioner involved. The Hearing Panel's decision is final and there are no further rights of practitioner/participating practitioner to appeal to Beacon of California following a formal hearing.

Office Procedures

Member Rights and Responsibilities

Beacon of California's Member Rights and Responsibilities Statement is available in English and Spanish for download from the Beacon of California website. Participating providers are encouraged to post the statement in their offices or waiting rooms or distribute the Statement to members at their initial visit.

Access to Treatment Records and Treatment Record Reviews/Audits

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

- On an unplanned basis as part of continuous quality improvement and/or monitoring activities
- As part of routine quality and/or billing audits
- In response to an identified or alleged specific quality of care, professional competency or professional conduct issue or concern
- In the course of claims reviews and/or audits
- As may be necessary to verify compliance with the provider agreement.

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

Access to and any copies of member treatment records requested by Beacon of California shall be at no cost.

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

Confidentiality, Privacy and Security of Identifiable Health Information

Providers/participating 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 (HIPAA) of 1996 and the rules and regulations promulgated thereunder, Substance Abuse Confidentiality Regulations 42 C.F.R. Part 2, and the California Confidentiality of Medical Information Act
- 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 of California receives a complaint or becomes aware of a potential violation or breach of an obligation to secure or protect member information, Beacon of California will notify the provider/participating provider utilizing the general complaint process, 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 of California.

Providers/participating providers and their business associates interacting with Beacon of California staff should make every effort to keep protected health information (PHI) and personally identifiable information (PII) secure. If provider/participating provider does not use email encryption, Beacon of California recommends sending protected health information to Beacon of California through an inquiry in ProviderConnect or by secure fax.

Appointment and Availability Standards

Participating providers are expected to maintain established office/service hours and access to appointments with standards established by Beacon of California. Beacon of California's provider contract requires that the hours of operation of all of our network providers are convenient to the population served and do not discriminate against members and that services are available twenty-four hours a day, seven days a week, when medically necessary. The following are standards of availability for appointments, which participating providers are required to maintain:

Emergencies

In an emergency situation, the member must be offered the opportunity to be seen in person immediately. Participating providers who do not maintain coverage 24 hours per day, seven days per week are required to maintain a system for referring members to a source of emergency assistance during non-business hours. The preferred methods are through a live answering service or an on-call pager system. However, participating providers may elect to maintain a reliable recorded answering machine system, through which members experiencing an emergency are given clear instructions about how to access immediate assistance after hours.

Non-Life Threatening Emergencies

When there is significant risk of serious life deterioration such as impending inpatient hospitalization, the member must be seen within six hours of the request for an appointment.

Urgent

In an urgent situation, a member must be offered the opportunity to be seen within 48 hours of the request for an appointment.

Routine

In a routine situation, a member must be offered the opportunity to be seen within 10 business days of the request for an appointment for Mental Health or Substance Use Disorder or Mental Disorder (MHSUD) services.

Rescheduling an Appointment

When it is necessary for a provider/participating provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs, and ensures continuity of care consistent with good provider practice.

Out-of-Office Coverage

Participating providers should:

- Contact Beacon of California's Provider Relations team via email at provider.inquiry@beaconhealthoptions.com or the National Provider Services Line at (800) 397-1630 during normal business hours Monday through Friday, 8 a.m. to 8 p.m. ET to inform Beacon of California of any unavailability or absence
- Submit the Leave of Absence/Out-of-Office Notification form, located under the Administrative Forms on the Providers' section at www.beaconhealthoptions.com, to the address below and advise of coverage arrangements in advance of vacation, sabbatical, illness, maternity leave (where applicable), and/or any other situation when participating provider is unable to continue to treat Beacon of California members in active treatment. Such advance written notice should include participating provider's name, licensure, practice locations affected, the reason for unavailability or absence and date range of unavailability or absence. Upon receipt of such advance notice, the participating provider's status in Beacon of California systems is changed to 'inactive'.

Mail to: Beacon Health Options, Inc.
P.O. Box 989
Latham, NY 12110

OR

Fax: (866) 612-7795

Upon return, participating providers should contact the National Provider Service Line at (800) 397-1630 Monday through Friday, 8 a.m. to 8 p.m. ET and should notify Beacon of California at the address above in writing. Failure to contact Beacon of California within 30 calendar days of return may result in referral, utilization management and claims processing delays due to the 'inactive' status placed in Beacon of California systems. Failure to respond to communications from Beacon of California related to 'inactive' or out-of-office versus 'active' status in Beacon of California systems within the time period provided for such communications may result in termination of participation in Beacon of California provider networks.

Termination and Leave of Absence

If a participating provider remains on inactive status for longer than six (6) months, a reminder is sent informing the provider of the expiration date and the disenrollment process for failure to respond to said notice.

Requests for Additional Information

To maintain in-network status, participating providers must furnish Beacon of California with any requested documentation or information promptly. Failure to do so may result in the participating provider's status being changed from active to inactive. Inactive providers are ineligible to receive

referrals or reimbursement as participating providers for services rendered to members of Beacon of California.

Services to Members

Pursuant to the terms of the provider agreement, participating providers are contracted and credentialed to provide identified covered services to members. Covered services should be rendered in:

- The same manner as services rendered to other patients
- Accordance with accepted medical standards and all applicable state and/or federal laws, rules and/or regulations
- A quality and cost-effective manner

Participating providers should note that coverage for behavioral health services and any limitations and/or exclusions as well any pre-authorization and/or certification requirements for non-emergency services vary by benefit plan.

Participating providers must:

- Verify member eligibility and benefits using ProviderConnect prior to rendering non-emergency services;
- Document other or third party health benefit coverage for members (claims should be submitted to the primary payor initially);
- Preauthorize or certify care where required in Beacon of California policies and procedures or the applicable member benefit plan, prior to rendering non-emergency services, using ProviderConnect;
- Collect member expenses from the member prior to, at the time of, or subsequent to services being rendered;
- Provide continuous care for members or arrange for on-call coverage by other Beacon of California participating providers;
- Adhere to the accessibility and availability standards established by Beacon of California;
- Provide equal treatment to patients in a non-discriminatory manner, regardless of source of payment or coverage type or product;
- Update demographic, office and/or participating provider profile information promptly and in advance of changes, using ProviderConnect;
- Notify Beacon of California of potential inpatient discharge problems;
- Advise members in writing of financial responsibility regarding services that are not covered, prior to rendering such service;
- Cooperate with Beacon of California in coordinating continued care through alternative agencies, other vendors or community resources when benefits end;
- Notify Beacon of California of members who may be candidates for potential Care Management;

- Coordinate care with a member's other health/medical care provider(s), either behavioral and/or medical providers who are treating the same or related (co-morbid) conditions;
- Refer members to other participating providers when alternative or different mental health or substance use disorder services are required;
- Submit claims on behalf of members;
- Upon written request by Beacon of California, submit copies of member treatment records without charge; and
- Make resources available to members who require culturally, linguistically, and/or disability competent care, such as, but not limited to disability and language lines.

Emergency Services

In the event of an emergency admission, participating providers should notify Beacon of California of the date of admission as soon as reasonably practicable and in any event within 48 hours, or within such alternative period of time specified in the provider agreement. Retrospective review of such admissions and associated services is subject to the terms of the member's benefit plan.

Emergency services that are necessary to screen and stabilize a member are authorized without prior approval when:

- A prudent layperson, acting reasonably, believes that an emergency behavioral health condition exists
- An authorized representative, acting on behalf of Beacon of California, has authorized the provision of emergency services
- As otherwise required under applicable law

Beacon of California shall at all times authorize an emergency psychiatric evaluation as per the member's benefit plan.

Referrals

Participating providers may receive referrals from several sources, including but not limited to:

- Providers and/or other participating providers
- Self-referral of members
- From Beacon of California
- Through an Employee Assistance Program (EAP)

Participating providers needing to refer a member for other or additional services should contact Beacon of California to identify what are covered services under the member's benefit plan and any limitations, exclusions and/or notice, pre-authorization or certification or notification requirements under their benefit plan.

EAP Transition to Health Plan Benefits

For those members participating in an EAP administered by Beacon of California and who may schedule and/or be referred for appointments for behavioral health services by participating providers under their

benefit plan, participating providers must be sure to obtain pre-authorization or certification as may be required under the member's benefit plan. Questions regarding what are covered services under the member's benefit plan and associated member expenses for covered services should be directed to Beacon of California by calling the number on the back of the member's identification card.

Coordination with Primary Care/Treating Providers

As part of care coordination activities, participating providers should identify all providers/participating providers involved in the medical and/or behavioral health care and treatment of a member. Subject to any required consent or authorization from the member, participating providers should coordinate the delivery of care to the member with these providers/participating providers. All coordination, including PCP coordination, should be documented accordingly in the member treatment record.

Continuation following Provider Agreement Expiration or Termination

Non-renewal and termination of the provider agreement is the process by which the provider agreement is not renewed at the end of the identified period of time and accordingly ends by its own terms, or the provider agreement is terminated as provided for in the terms of the provider agreement.

All notices of non-renewal and/or termination of the provider agreement should be in writing and in accordance with the applicable terms of the provider agreement.

If a participating provider chooses to resign from the network and voluntarily surrender participation status, the participating provider must send Beacon of California written notice of such request and/or notice of termination of the provider agreement pursuant to the without cause termination provisions of the provider agreement. Beacon of California will send the participating provider written acknowledgement of receipt of the participating provider's written request/notice and confirmation of the effective date of disenrollment/termination consistent with the provisions of the provider agreement. Providers who resign from the network or voluntarily/involuntarily terminate the provider agreement are not eligible for re-application for six months following the effective date of disenrollment/termination. Exceptions to the six-month timeframe may be considered in certain situations

The effective date of non-renewal or termination of the provider agreement is that date:

- Identified in the notice of non-renewal or termination of the provider agreement and consistent with the end of the specific notice period
- Mutually agreed upon in writing by the participating provider and Beacon of California

On or before the effective date of non-renewal or any termination of the provider agreement, participating providers must provide Beacon of California with a list of members for whom the participating provider has rendered services in the six-month period prior to the effective date of non-renewal or any termination of the provider agreement.

Participating providers must continue to provide covered services to members following the non-renewal or termination of the provider agreement pursuant to the terms of the provider agreement and for such time period(s) as are set out in the provider agreement. Payment for such covered services rendered to members following non-renewal or termination will be at the rates in the provider agreement.

Special Circumstances Continuing Care Obligations

For reasons other than medical disciplinary cause or reason, fraud or other criminal activity, participating

providers shall, at the request of the applicable member and in accordance with Beacon of California policies and procedures, continue to provide covered services in Special Circumstances to members as described in this section. Participating providers shall continue to provide covered services in Special Circumstances to members, at the rates and pursuant to the requirements specified in the provider agreement, at the time of termination of the provider agreement until the course of treatment is completed in accordance with the time periods listed below. This section shall not require participating providers to cover services or provide benefits that are not otherwise covered under the terms and conditions of the provider agreement.

Time Periods for the Provision of Covered Services in Special Circumstances

- **Acute Conditions** – Completion of covered services shall be provided for the duration of the acute condition or until the member's benefits are exhausted, whichever comes first.
- **Serious Chronic Conditions** – Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another participating agreement, as determined by Beacon of California in consultation with the member and the terminated participating provider and consistent with good professional practice. Completion of covered services shall not exceed 12 months from the provider's contract termination date or until the member's benefits are exhausted, whichever comes first.
- **Newborn Child** – Completion of covered services shall not exceed 12 months from the participating provider's contract termination date or until the member's benefits are exhausted, whichever comes first.
- **Surgery/Other Procedure** – Performance of a surgery or other procedure that is authorized by Beacon of California as part of a documented course of treatment and has been recommended and documented by the participating provider to occur within 180 days of the participating provider's contract termination

Members and providers/participating providers are encouraged to contact Beacon of California to learn what options are available for continuing treatment after the transition period.

Certain Regulatory Requirements

Provider agreements include provisions requiring participating providers to comply with all applicable state and/or federal laws, rules and/or regulations, including without limitation those related to the provision of mental health and substance use disorder services (e.g., required licensure/certification, workplace standards, non-discrimination, etc.); child or elder abuse, and duty to warn or obligation to report certain types of disclosures by patients; and those related to fraud, waste and abuse. It is the responsibility of providers and participating providers to understand and comply with the professional and legal requirements within California.

By way of example, the Americans with Disabilities Act of 1990, as amended (ADA) contains provisions regarding services to certain individuals identified as covered under the ADA. Participating providers are encouraged to adapt services and their offices/locations to meet the special needs of members.

Fraud, Waste and Abuse

Beacon of California interacts with employees, clients, vendors, providers/participating 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 of California's compliance and anti-fraud plan was established to prevent and detect fraud, waste or abuse in the behavioral health system through effective communication, training, review and investigation. The plan, which includes a code of conduct, is intended to be a systematic process aimed at monitoring of operations, subcontractors and provider's/participating provider's compliance with applicable laws, regulations, and contractual obligations, as appropriate. Participating providers are required to comply with provisions of the 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. The code of conduct is accessible at www.beaconhealthoptions.com.

Provider Disputes and Member Grievances

There are several avenues within Beacon of California for providers/participating providers and members to attain resolution to their concerns. Opportunities exist to present concerns and to obtain a decision through the Beacon of California provider dispute resolution process or the member grievance process.

Provider Dispute Resolution Process

Beacon of California has a provider dispute resolution process that is intended to provide for the fast, fair and cost-effective resolution of disagreements related to unresolved contractual or administrative disputes, such as claim or billing disputes, contract language, administrative requirements or provider network participation decisions related to administrative reasons (i.e. disenrollment from the network for not being responsive to recredentialing efforts, denied network participation for not meeting credentialing criteria). In the event a provider/participating provider has any dispute with respect to the performance or interpretation of the provider/participating provider agreement, the provider/participating provider agrees to attempt in good faith to resolve any matters of controversy according to Beacon of California policies and procedures prior to the initiation by the provider of any legal action. Any disputes between the parties that cannot be resolved following such procedures shall be resolved through binding arbitration pursuant to the Rules of the American Arbitration Association for Arbitration of Commercial Disputes.

A copy of the provider dispute form(s) can be found at www.beaconhealthoptionsca.com under *Forms* or by contacting a Beacon of California representative at (866) 501-0777 Monday through Friday, 8 a.m. to 5:00 p.m. PT.

Provider disputes may be submitted to the Beacon of California Provider Dispute Department through the client specific telephone number printed on the member's identification card or at one of the following:

Phone: (866) 501-0777

Fax: (877) 563-3480

OR

Mail:

Beacon of California
C/o Provider Dispute Department
P.O. Box 6065
Cypress, CA 90630

A provider dispute may be received by Beacon of California within 365 days of the date of the remittance statement. Beacon of California will acknowledge the dispute within 15 business days of the date of receipt of the provider dispute. The written determination is sent within 45 business days of receipt of the provider dispute.

At no time does Beacon of California discriminate or retaliate against a provider/participating provider (including but not limited to the cancellation of the participating provider's contract) because the provider filed a dispute. There is no charge to providers/participating providers for the dispute process and Beacon of California has no obligation to reimburse a provider/participating provider for any costs incurred in connection with utilizing the provider dispute resolution mechanism.

Information for Assisting Members

As a participating provider for Beacon of California, a provider may occasionally have a patient who requests assistance in submitting a grievance or appeal related to a determination or issue involving the member's Beacon of California coverage.

Contact Beacon of California

If a member has an administrative question or inquiry regarding eligibility, benefit coverage or any other matter relating to the benefit plans, the member may telephone Beacon of California's Member Services Department at the toll-free number on the back of the member's identification card or by calling the telephone number listed in the Combined Evidence of Coverage and Disclosure Form. Beacon of California's Member Services staff will work with the member to resolve the matter.

Member or Member Representative Grievance Process

Beacon of California has a grievance procedure for receiving and resolving member grievances involving Beacon of California and/or providers/participating providers. A grievance may be submitted up to 180 calendar days following receipt of an adverse determination notice, or following any incident or action, that is the subject of the member's dissatisfaction. A member, member's representative, or provider/participating provider may submit a grievance to Beacon of California in writing, by telephone, or by fax. Upon request, a Beacon of California representative will mail a grievance form and a copy of the grievance procedure. A copy of the grievance form can also be found at www.beaconhealthoptionsca.com for use by the member or provider/participating provider. Member grievance forms are currently available in English and Spanish; if a grievance form is needed in another language contact Beacon of California directly. A Beacon of California Member Services representative will assist in completing the grievance form, if needed.

A grievance may be submitted to Beacon of California through the client specific telephone number printed on the member's identification card or at one of the following:

Phone: (800) 228-1286

Fax: (855) 861-0314

OR

Mail:

Beacon of California
C/o Grievance Unit

P.O. Box 6065
Cypress, CA 90630

Beacon of California will send written acknowledgment of receipt of a grievance or appeal within five calendar days. Beacon of California will respond in writing with a resolution to a grievance or appeal within 30 calendar days of receipt.

Urgent Grievances

Beacon of California also maintains a process for the expedited review of urgent grievances. The member has the right to an expedited review for cases involving an imminent and serious threat to the health of the member, including but not limited to severe pain, potential loss of life, limb, or major bodily functions. The request may be initiated by the member, member's representative or provider/participating provider by calling (800) 228-1286 (TTY 800-735-2929) Monday through Friday, 8 a.m. to 5 p.m. Pacific Time and notifying the Beacon of California representative that you are requesting an expedited review for an urgent grievance. Beacon of California will notify the member's provider of the decision in no more than 72 hours and send the member a written statement on the disposition or pending status of the grievance, dispute or appeal within the same 72 hours from receipt of the grievance.

Independent Medical Review of Grievances Involving a Disputed Behavioral Health Care Service

A member may request an independent medical review (IMR) of Disputed Behavioral Health Care Services from the Department of Managed Health Care (DMHC) if a member believes that behavioral health care services have been improperly denied, modified, or delayed by Beacon of California in whole or in part because the service is not medically necessary. The IMR process is in addition to any other procedures or remedies that may be available to the member. The member pays no application or processing fees of any kind for IMR. A decision not to participate in the IMR process may cause the member to forfeit any statutory right to pursue legal action against Beacon of California regarding the Disputed Behavioral Health Care Service. A Beacon of California coverage decision is not eligible for an IMR request. Once a member has applied for an IMR, a provider/participating provider agrees to cooperate with Beacon of California in complying with all requirements of the IMR process.

Review by the Department of Managed Health Care (for Beacon of California Members only)

The California Department of Managed Health Care is responsible for regulating health care service plans. If a member has a grievance against Beacon of California, the member should first telephone Beacon of California at (**800) 228-1286** (TTY 800-735-2929) Monday through Friday, 8 a.m. to 5 p.m. PT and use Beacon of California's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to the member. If the member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Beacon of California, or a grievance that has remained unresolved for more than thirty (30) calendar days, the member may call the Department for assistance. The member may also be eligible for an Independent Medical Review (IMR). If the member is eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a **TDD** line (**1-877-688-9891**) for

the hearing and speech impaired. The department's internet web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Copies of the Beacon of California Provider Dispute and Grievance policies are available upon request by calling (800) 228-1286 Monday through Friday, 8 a.m. – 5 p.m. Pacific Time.

Claims Procedures

Beacon of California maintains claims processing procedures designed to comply with the requirements of client plans and applicable California laws, rules and/or regulations.

Providers in the Beacon of California networks are strongly encouraged to electronically submit all claims. To electronically submit claims, Beacon of California participating providers may 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 with conducting certain claim submissions 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 of California 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 website at www.beaconhealthoptions.com.

Member Expenses

Member expenses due from the member for covered services are determined by the member's benefit plan. Detailed information about most of the amounts of member expenses due for inpatient, outpatient or emergency covered services can be obtained by viewing a member's benefits on the "Benefit" tab in ProviderConnect. Participating providers are encouraged to contact Beacon of California for questions regarding member expenses.

It is the responsibility of the participating provider to collect member expenses due to the participating provider for covered services rendered.

Preauthorization, Certification or Notification

Preauthorization, certification or notification requirements vary from plan to plan. Participating providers must determine if such requirements exist prior to the provision of non-emergency services to members. Information regarding Beacon of California's policies and procedures on authorization, certification or notification is located in the utilization management/review section of this handbook. Participating providers may not bill, charge or seek reimbursement or a deposit from members for services determined not to be medically necessary.

Providers/participating providers may verify member eligibility, submit and review authorization/certification requests, and view authorizations/certifications through ProviderConnect.

No Balance Billing

Participating providers may not balance bill members for covered services rendered. This means that the participating provider may not bill, charge or seek reimbursement or a deposit from the member for covered services except for applicable member expenses, and non-covered services.

Claim Submission Guidelines

Participating providers must file or submit claims within 90 calendar days from the date of service or the date of discharge for inpatient admission, or where applicable from date of determination by the primary payor. Claims after the above noted 90 calendar daytime period 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 in processing. To electronically submit claims, Beacon of California participating providers are strongly encouraged 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.

Participating 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 participating 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).

Participating providers should submit claims consistent with national and industry standards. To ensure adherence to these standards, Beacon of California relies on claims edits and investigative analysis processes to identify claims that are not in accordance with national and industry standards and therefore were paid in error. The claims edits and investigative analysis process includes 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

- 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

Claims for covered services rendered to members should be submitted electronically through ProviderConnect or by using one of the electronic claims resources detailed further in the section titled *Electronic Resources*.

Note: If a participating provider uses a clearinghouse to electronically submit claims, please provide the clearinghouse with Beacon's payer id, FHC & Affiliates. The provider must also submit the Intermediary Authorization form to be linked with the clearinghouse.

All billings by the participating provider are considered final unless adjustments or a request for review is received by Beacon of California within the time period identified in the provider agreement, or if no time period is identified in the provider agreement within 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.

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 of California included. Tip sheets containing required claim fields to make a clean claim for the UB04 and CMS-1500 are located at www.beaconhealthoptions.com.

**All data elements noted as required must be provided, but they must also be current and match what the subscriber's employer has on file. If the member's ID on the claim is illegible, or does not match what the subscriber's employer has provided, 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 needed to consider the claim clean and will cause the claim to reject or take a longer processing time. Claims submitted on old claim forms may be returned.

**Electronically submitted claims must also be in a HIPAA 5010 compliant format and conform to the Beacon 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.

Claims submission guidance, including required claim fields to make a clean claim, is available on the Provider section at www.beaconhealhealthoptions.com.

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 participating provider does not follow these guidelines, claims may be returned from the scanning vendor:

- 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., 10212013)
- Use a fixed width font (Courier, for example)

Requests for Additional Information

To maintain in-network status and upon request by Beacon of California, or its authorized designee, participating 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 participating provider for covered services rendered to members.

Claim Processing

Beacon of California, or its designee, processes complete and accurate claims submitted by providers/participating 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/participating provider for covered services or in a request for submission of treatment records.

Participating 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 would be at the contracted reimbursement rate in effect on the day of the 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, participating 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 of California.

Provider Summary Vouchers

Provider Summary Vouchers (PSVs) or remittance advices are the documents that identify the amount(s) paid and member expenses due from the member. Providers/participating providers should access PSVs through ProviderConnect or request copies of PSVs via facsimile through Beacon of California's automated PSV faxback service at (866) 409-5958. Accessing PSV's electronically is a transaction subject to the e-commerce initiative. Additional information regarding access to PSV's is available at the Provider section at www.beaconhealthoptions.com.

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 payors.

Participating 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 of California.

Coordination of benefits amongst different sources of coverage (payors) is governed by the terms of the member's benefit plan and applicable state and/or federal laws, rules and/or regulations. To the extent not otherwise required by applicable laws or regulations, participating providers agree that in no event will payment from primary and secondary payors for covered services rendered to members exceed the rate specified in the provider agreement.

Participating providers must submit a copy of the EOB through ProviderConnect that includes the primary payor's determination when submitting claims to Beacon of California. The services included in the claim submitted to Beacon of California should match the services included in the primary payor 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

Participating providers should routinely review claims and payments in an effort to assure that they code correctly and have not received any overpayments. Beacon of California will notify providers and participating providers of overpayments identified by Beacon of California, 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 of California or its designee will pursue recovery of overpayments through:

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

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 of California 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 of California 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 90 calendar days, Beacon of California reserves the right to issue a demand for re-payment. Should a provider/participating provider fail to respond and/or provide amounts demanded within the 30 calendar days of the date of the demand letter, Beacon of California will pursue all available legal and equitable remedies, including without limitation placing the outstanding overpayment amount (negative balance) into collections.

If the provider/participating provider disagrees with an overpayment recovery and/or request for re-payment of an overpayment, the provider/participating provider may request a review in writing, such that the written request for review is received by Beacon of California 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/participating 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.

Requests for Review

Participating providers may request review of a Beacon of California 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 60 calendar days or the time period specified in the provider agreement (if any) from the date of Beacon of California's original claim determination.

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

Claims Disputes

Participating 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 Billing Audits

Beacon of California reviews and monitors claims and billing practices of providers/participating 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

Beacon of California also conducts unplanned audits. Beacon of California conducts the majority of its audits by reviewing records providers/participating providers either scan or mail to Beacon of California, 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/participating provider to compare against claims submission records. Following the review of the initial sample, Beacon of California 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 of California 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/participating providers must supply copies of requested documents to Beacon of California within the required timeframe. The required timeframe will vary based on the number of records requested, but will not normally be less than 10 business days when providers/participating providers are asked to either scan or mail records to Beacon of California. For the purpose of on-site audits, providers/participating providers must make records available to Beacon of California staff during the

[1] Unless otherwise required by a specific client or government agency, Beacon of California 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.

provider's audit. Providers/participating providers are required to sign a form certifying all requested records and documentation were submitted or made available for the audit. Beacon of California 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 of California will not reimburse providers/participating providers for copying fees related to providing of documents and/or treatment records requested in the course of a claims billing audit.

In the course of an audit, documents and records provided are compared against the claims submitted by the provider/participating provider. Claims must be supported by adequate documentation of the treatment and services rendered. Participating 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 *Treatment Record Standard and Guidelines* section of the Provider Handbook. Beacon of California coordinates claims billing audits with appropriate Beacon of California 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 of California will provide a written report of the findings to the provider/participating provider. In some instances, such report of the findings may include a request for additional records.

Beacon of California has established an audit error rate threshold of 10 percent to determine whether the provider/participating 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 of California's report of findings may include specific requirements for corrective action to be implemented by the provider/participating provider if the audit identifies improper or unsubstantiated billings. Requirements may include, but are not limited to:

- **Education/Training** – Beacon of California may require the provider/participating provider to work with Provider Relations to develop an educational/training program addressing the deficiencies identified. Beacon of California may provide tools to assist the provider/participating provider in correcting such deficiencies.
- **Corrective Action Plan** – Beacon of California may require the provider/participating provider to submit a corrective action plan identifying steps the provider/participating provider will take to correct all identified deficiencies. Corrective action plans should include, at a minimum, confirmation of the provider's/participating 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 Beacon of California. 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 of California does not use extrapolation to determine recovery amounts. The provider/participating provider will be responsible for paying the actual amount owed, based on Beacon of California findings within 10 business days, unless the provider/participating provider has an approved installment payment plan.
- **Monitoring** – Beacon of California may require monitoring of claims submissions and treatment

records in 90-day increments until compliance is demonstrated. The provider's/participating provider's monitored claims are not submitted for payment until each is reviewed for accuracy and correctness

- **Referral to the Beacon of California Credentialing Committee** – Beacon of California's audit team may decide that the results of an audit warrant referral to the Beacon of California Credentialing Committee. If a provider/participating provider reported to the Beacon of California Credentialing Committee 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/participating provider may be re-addressed by the Beacon of California Credentialing Committee and involuntarily disenrolled for breach of contract.

Appeal

If the provider/participating provider disagrees with an audit report's findings, the provider/participating provider may request an appeal of the audit report of findings. All appeals must be submitted in writing and received by Beacon of California on or before the due date identified in the report of findings letter. Beacon of California has no obligation to consider late filed appeals. Appeals must include:

- A copy of the audit report of findings letter;
- The provider's/participating provider's name and identification number;
- Contact information;
- Identification of the claims at issue, include the name or names of the members, dates of service, and an explanation of the reason/basis for the dispute.

Absent extraordinary circumstances, Beacon of California will not accept or consider documentation and/or records that were not submitted with the original audit submission.

The provider's/participating provider's appeal will be presented to Beacon Health Options (Beacon) National Compliance – Corporate SIU Subcommittee within 45 days of receiving the provider's/participating provider's request for an appeal. The subcommittee is comprised of Beacon employees who have not been involved in reaching the prior findings. The subcommittee will review the provider's/participating provider's appeal documentation, discuss the facts of the case, as well as any applicable contractual, state or federal statutes. The Beacon staff member/auditor who completed the provider's/participating 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/participating provider within 10 business days of the subcommittee meeting. If additional time is needed to complete the appeal, Beacon will submit a letter of extension to the provider/participating provider requesting any additional information required of the provider/participating provider and estimating a time of completion. If repayments or corrective action plan (CAP) are required, the provider/participating provider must submit the required repayments or CAP within 10 business days of receiving the subcommittee's findings letter, unless an installment payment plan is approved.

Beacon of California will take appropriate legal and administrative action in the event a provider/participating provider fails to supply requested documentation and member records or fails to cooperate with a Beacon of California investigation corrective action plan. Beacon of California 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 of California will report any suspicion or knowledge of fraud, waste and abuse to the appropriate authorities or regulatory agency as required or when appropriate.

Reporting Fraud, Waste and Abuse

Providers/participating providers should report fraud, waste and abuse, or suspicious activity thereof, such as inappropriate billing practices (e.g., billing for services not rendered, or use of CPT codes not documented in the treatment record). Reports and questions may be made in writing to the address below or by calling the Ethics Hotline at 1-888-293-3027.

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

program.integrityreferrals@beaconhealthoptions.com

Utilization Management

The Beacon of California utilization management program encompasses management of care from the point of entry through discharge using objective, standardized, and widely distributed clinical protocols and enhanced outpatient care management interventions. Specific utilization management activities may apply for high-cost, highly restrictive levels of care and cases that represent clinical complexity and risk. Participating providers are required to comply with utilization management policies and procedures and associated review processes.

Examples of review activities included in Beacon of California's utilization management program are determinations of medical necessity, preauthorization, certification, notification, concurrent review, retrospective review, care/case management, discharge planning and coordination of care.

The Beacon of California utilization management program includes processes to address:

- Easy and early access to appropriate treatment
- Working collaboratively with participating providers in promoting delivery of quality care according to accepted best-practice standards
- Addressing the needs of special populations, such as children and the elderly
- Identification of common illnesses or trends of illness
- Identification of high-risk cases for intensive care management
- Screening, education and outreach

Objective, scientifically based medical necessity criteria and clinical practice guidelines, in the context of provider or member supplied clinical information, guide the utilization management processes.

Prior to beginning a course of outpatient treatment and/or a non-emergency admission, providers/participating providers must verify member eligibility and obtain authorization or certification (where applicable). Providers/participating providers are strongly encouraged to verify eligibility and

benefits and submit authorization requests (where applicable) via ProviderConnect.

In order to verify member eligibility, the provider/participating provider will need to have the following information available:

- Patient's name, date of birth and member identification number
- Insured or covered employee's name, date of birth and member identification number
- Information about other or additional insurance or health benefit coverage

Based on the most recent data provided by the employer/benefit plan, Beacon of California will:

- Verify member eligibility
- Identify benefits and associated member expenses under the member's benefit plan
- Identify the authorization or certification procedures and requirements under the member's benefit plan

Note: Verification of eligibility and/or identification of benefits and member expenses are not authorization or certification or a guarantee of payment.

Healthcare Effective Data and Information Set (HEDIS®)

There are a number of ways to monitor the treatment of individuals with mental health and/or substance use conditions. Many of you who provide treatment to these individuals measure your performance based on quality indicators such as those to meet CMS reporting program requirements, specific state or insurance commission requirements, managed care contracts, and/or internal metrics. In most cases, there are specific benchmarks that demonstrate the quality that you strive to meet or exceed.

Beacon of California utilizes a number of tools to monitor population-based performance in quality across the state, lines of business and diagnostic categories. One such tool is the Healthcare Effectiveness Data and Information Set (HEDIS) behavioral health best practice measures as published by the National Committee for Quality Assurance (NCQA) as one of our tools. Like the quality measures utilized by CMS, Joint Commission, and other external stakeholders, these measures have specific, standardized rules for calculation and reporting. The HEDIS measures allow consumers, purchasers of health care and other stakeholders to compare performance across different health plans.

While the HEDIS measures are population-based measures of our partner health plan performance and major contributors to health plan accreditation status, our partner health plans rely on us to ensure behavioral health measure performance reflects best practice. Our providers are the key to guiding their patient to keep an appointment after leaving an inpatient psychiatric facility; taking their antidepressant medication or antipsychotic medication as ordered; ensuring a child has follow up visits after being prescribed an ADHD medication; and ensuring an individual with schizophrenia or bipolar disorder has annual screening for diabetes and coronary heart disease.

There are six domains of care and service within the HEDIS library of measures:

1. Effectiveness of Care
2. Access and Availability
3. Utilization and Relative Resource Use
4. Measures Collected Using Electronic Clinical Data Systems (ECDS)

5. Experience of Care
6. Health Plan Descriptive Information

A brief description of these measures:

1. **Effectiveness of Care**: Measures that are known to improve how effective care is delivered. One very important measure in this domain is Follow-up after Mental Health Hospitalization (Aftercare). In effect, this means how long someone waits to get mental health care after they are discharged from an inpatient mental health hospital. To prevent readmission and help people get back into the community successfully, best practice is from seven to thirty days after discharge.
2. **Access/Availability**: Measures how quickly and frequently members receive care and service within a specific time. For example, the Initiation and Engagement of Drug and Alcohol Abuse Treatment measure relies on frequency and timeliness of treatment to measure treatment initiation and treatment engagement. Studies show that an individual who engages in the treatment process have better outcome and success in recovery and sobriety.
3. **Utilization and Relative Resource Use**: This domain includes evidence related to the management of health plan resources and identifies the percentage of members using a service. For example, Beacon of California measures Mental Health Utilization and Plan All Cause Readmissions.
4. **Measures Collected Using Electronic Clinical Data Systems (ECDS)**: This is the newest domain, and it requires calculation of outcomes by accessing data through the electronic submission of a member's electronic health record (EHR). An example of an ECDS measure is the Utilization of the PHQ-9. This demonstrates whether a PHQ-9 was administered to a patient with depression four months after initiation of treatment to measure response to treatment.
5. **Experience of Care**: This domain is specific to health plans.
6. **Health Plan Descriptive Information**: We supply Board Certification of physicians and psychologists to the plan; all other information is specific to the health plan.

Below is a brief description of the HEDIS measures that apply to the behavioral health field requirements associated with each:

1. Follow-up after Hospitalization for Mental Illness

Best practice for a member aged six or older to transition from acute mental health treatment to the community is an appointment with a licensed mental health practitioner (outpatient or intermediate treatment) within seven and/or 30 calendar days of discharge.

For this measure, NCQA requires organizations to substantiate by documentation from the member's health record all nonstandard supplemental data that is collected to capture missing service data not received through claims, encounter data, laboratory result files, and pharmacy data feeds. Beacon of California requires proof-of-service documentation from the member's health record that indicates the service was received. All proof-of-service documents must include all the data elements required by the measure. Data elements included as part of the patient's legal medical record are:

- Member identifying information (name and DOB or member ID)
- Date of service

- DSM diagnosis code
- Procedure code/Type of service rendered
- Provider site/facility
- Name and licensure of mental health practitioner rendering the service
- Signature of rendering practitioner, attesting to the accuracy of the information

The critical pieces of this measure for providers/participating providers are:

Inpatient facilities need to:

- Use accurate diagnoses when submitting claims for inpatient treatment. If the diagnosis on admission is a mental health diagnosis but subsequent evaluation during the stay confirms that the primary diagnosis is substance use, please use the substance use diagnosis on the claim submitted at discharge.
- Ensure that discharge planners educate patients about the importance of aftercare for successful transition back to their communities.
- Ensure that follow-up visits are within seven calendar days of discharge. **NOTE:** It is important to notify the provider/participating providers that the appointment is post hospital discharge and that an appointment is needed in seven calendar days.
- Ensure that the appointment was made with input from the patient. If the member has a pre-existing provider and is agreeable to going back to the provider, schedule the appointment with that provider. If not, the location of the outpatient provider or PHP, IOP, or other alternative level of care, must be approved by the member and be realistic and feasible for the member to keep that appointment.

Outpatient providers/participating providers need to make every attempt to schedule appointments within seven calendar days for members being discharged from inpatient care. Providers/participating providers are encouraged to contact those members who are “no show” and reschedule another appointment.

2. Initiation and Engagement of Alcohol and other Drug Use Treatment

This measure aims to define best practice for initial and early treatment for substance use disorders by calculating two rates using the same population of members who receive a new diagnosis of Alcohol and Other Drug (AOD) use from any provider (dentist, primary care physician, etc.):

Initiation of AOD Use Treatment: The percentage of adults diagnosed with AOD Use who initiate treatment through either an inpatient AOD admission, or an outpatient service for AOD from a substance abuse provider AND an additional AOD service within 14 calendar days.

- **Engagement of AOD Treatment**: An intermediate step between initially accessing care and completing a full course of treatment. This measure is designed to assess the degree to which the members engage in treatment with two additional AOD services within 34 calendar days after the initiation phase ends. The services that count as additional AOD services include IOP, Partial Hospital, or outpatient treatment billed with CPT-4 or revenue codes associated with substance use treatment.

3. Antidepressant Medication Management (AMM)

The components of this measure describes best practice in the pharmacological treatment of newly diagnosed depression treated with antidepressant by any provider by measuring the length of time the member remains on medication. There are two treatment phases:

- **Acute Phase**: The initial period of time the member must stay on medication for the majority of symptoms to elicit a response in 12 weeks.
- **Continuation Phase**: The period of time the member must remain on medication in order to maintain the response for at least six months.

4. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

The components of this measure describes best practice in the pharmacological management of children 6-12 years newly diagnosed with ADHD and prescribed an ADHD medication by measuring the length of time between initial prescription and a follow up psychopharmacology visit in the continuation and maintenance phases of treatment.

- **Initiation Phase**: For children, 6–12 years of age, newly prescribed ADHD medication best practice requires a follow up visit with a prescriber within 30 days of receiving the medication.

For ongoing treatment with an ADHD medication, best practice requires:

- **Continuation and Maintenance (C&M) Phase**: At least two additional follow up visits with a prescriber in the preceding nine months; and, the child remains on the medication for at least seven months.

5. Diabetes Screening for People with Bipolar Disorder or Schizophrenia Who Are Using Antipsychotic Medications (SSD)

For *members* with Schizophrenia or Bipolar diagnosis who were being treated with an antipsychotic medication, this measure monitors for potential Type 2 Diabetes with an HbA1C test.

6. Diabetes Monitoring for People with Diabetes and Schizophrenia Who Are Using Antipsychotic Medications (SMD)

For members who have Type 2 Diabetes, a Schizophrenic or Bipolar diagnosis and are being treated with an antipsychotic this measure's best practice is an annual or more frequent LDL-C test and an HbA1c test (SMD).

7. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)

For members with Schizophrenia or Bipolar diagnosis who are being treated with an antipsychotic medication this measure monitors for potential cardiac disease with a LDL-C test.

8. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

This measure is described as the percentage of members 19 – 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

9. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

For child and adolescent members (1-17) prescribed antipsychotic medication on an ongoing basis, best practice requires testing at least annually during the measurement year to measure glucose levels (Blood Glucose or HbA1C) and cholesterol levels to monitor for development of metabolic syndrome.

10. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

This measure identifies children and adolescents who are on two or more concurrent antipsychotic medications.

The best practice here is that multiple concurrent use of antipsychotic medications is not best practice nor approved by the FDA. While there are specific situations where a child or adolescent requires concurrent medications, the risk/benefit of the treatment regime must be carefully considered and monitoring in place to prevent adverse outcome.

11. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

For children and adolescents with a new prescription for an antipsychotic, best practice requires that the child receive psychosocial care as part of first line treatment.

First line treatment is associated with improved outcomes and adherence.

12. Utilization of the PHQ-9 to Monitor Depression for Adolescents and Adults (DMS)

For members diagnosed with depression treated in outpatient settings the PHQ-9 or PHQ-A (adolescent tool) must be administered by the outpatient treater at least once during a four-month treatment period.

13. Depression Remission or Response for Adolescents and Adults (DRR)

The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within five to seven months of the elevated score. Four rates are reported:

- **ECDS Coverage**. The percentage of members 12 and older with a diagnosis of major depression or dysthymia, for whom a health plan can receive any electronic clinical quality data.
- **Follow-Up PHQ-9**. The percentage of members who have a follow-up PHQ-9 score documented within the five to seven months after the initial elevated PHQ-9 score.
- **Depression Remission**. The percentage of members who achieved remission within five to seven months after the initial elevated PHQ-9 score.
- **Depression Response**. The percentage of members who showed response within five to seven months after the initial elevated PHQ-9 score.

Note: These measures are collected utilizing Electronic Clinical Data Sets (ECDS) as found in the provider's Electronic Medical Record. While NCQA/HEDIS is looking to expand the options for collecting this data, Beacon of California has yet to begin discussing this requirement with providers.

14. Follow-up After Emergency Department Visit for Mental Illness (FUM)

The percentage of emergency department (ED) visits for members six years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported:

- Follow-up visit to occur within seven days of ED discharge.
- If the seven-day visit goal is missed, the next goal is a visit within 30 days of ED discharge.

15. Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA)

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow up visit for AOD. Two

rates are reported:

- Follow-up visit to occur within seven days of ED discharge.
- If the seven-day visit goal is missed, the next goal is a visit within 30 days of ED discharge.

Here is the complete list of HEDIS Behavioral Health measures:

Effectiveness of Care:

- **AMM:** Antidepressant Medication Management
- **ADD:** Follow-Up Care for Children Prescribed ADHD Medication
- **FUH:** Follow-Up After Hospitalization for Mental Illness
- **SSD:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- **SMD:** Diabetes Monitoring for People with Diabetes and Schizophrenia
- **SMC:** Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
- **SAA:** Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- **APC:** Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- **APM:** Metabolic Monitoring for Children and Adolescents on Antipsychotics
- **FUM:** Follow-up After Emergency Department Visit for Mental Illness
- **FUA:** Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence

Other Domains:

Access and Availability

- **IET:** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- **APP:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Utilization/Relative Resource Use - **Utilization**

- **PCR:** Plan All-Cause Readmissions
- **IAD:** Identification of Alcohol and Other Drug Services
- **MPT:** Mental Health Utilization

Health Plan Descriptive Information

- **BCR:** Board Certification

Electronic Clinical Data Systems

- **DMS:** Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
- **DRR:** Depression Remission or Response for Adolescents and Adults

New and Emerging Technologies

Beacon of California recognizes the need for knowledge of emerging technologies to provide access to optimum care for members. Beacon of California evaluates these technologies in terms of their overall

potential benefits to members and in some instances recommends these technologies to clients for inclusion in their respective benefit packages. Examples of new technologies are psychotropic medications or new, approved uses of current medications, innovative community service programs and new approaches to provision of psychotherapy and treatment. Beacon of California has established committees that conduct formal reviews of potential new technologies. The effectiveness of new service technologies will be considered in medical necessity decisions.

Treatment Planning

Providers/participating providers must develop individualized treatment plans that utilize assessment data, address the member's current problems related to the behavioral health diagnosis, and actively include the member and significant others, as appropriate, in the treatment planning process. Clinical Care Managers (CCMs) review the treatment plans with the providers/participating providers to ensure that they include all elements required by the provider agreement, and at a minimum:

- Specific measurable goals and objectives
- Reflect the use of relevant therapies
- Show appropriate involvement of pertinent community agencies
- Demonstrate discharge planning from the time of admission
- Reflect active involvement of the member and significant others as appropriate

Providers/participating providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate.

Clinical Review Process

Provider/participating provider cooperation in efforts to review care prospectively is an integral part of care coordination activities. Subject to the terms of the member's benefit plan and applicable state and/or federal laws and/or regulations, providers/participating providers must notify Beacon of California prior to admitting a member to any non-emergency level of care. The Mental Health Parity & Addiction Equity Act of 2008 requires that mental health and substance use disorder benefits, provided by group health plans with more than 50 employees, must be available on an equivalent or better basis to any medical or surgical benefits. Some benefit plans, but not all, may fall under this guideline and do not require notification or authorization for standard outpatient services. Others may allow for a designated number of outpatient sessions without prior-authorization, certification, or notification. Beacon of California may request clinical information at various points in treatment to ensure the ongoing need for care and treatment that is appropriate and effective in improving health outcomes for members.

In all cases, providers/participating providers are encouraged to contact Beacon of California prior to initiating any non-emergency treatment to verify member eligibility and to clarify what the authorization or certification requirements are, if any, for the proposed treatment.

Coverage and payment for services proposed for and/or provided to members for the identification or treatment of a member's condition or illness is conditioned upon member eligibility, the benefits covered under the member's benefit plan at the time of service, and on the determination of medical necessity of such services and/or treatment. Overpayments made as a result of a change in eligibility of a member are subject to recovery.

Subject to verification of eligibility under the member's benefit plan, upon request for authorization or certification of services, the Clinical Care Manager (CCM) gathers the required clinical information from the provider/participating provider, references the appropriate medical necessity criteria for the services and/or level of care, and determines whether the services and treatment meets criteria for medical necessity. The CCM may authorize or certify levels of care and treatment services that are specified as under the member's benefit plan (e.g., acute inpatient, residential, partial hospitalization, intensive outpatient, or outpatient). Authorizations or certifications are for a specific number of services/units of services/days and for a specific time period based on the member's clinical needs and provider characteristics.

Prior to initial determinations of medical necessity, the member's eligibility status and coverage under a benefit plan administered by Beacon of California should be confirmed. If eligibility information is not available in non-emergency situations, a CCM may complete a screening assessment and pend the authorization/certification awaiting eligibility verification. CCMs will work with members and providers/participating providers in situations of emergency, regardless of eligibility status.

If a member's benefits have been exhausted or the member's benefit plan does not include coverage for behavioral health services, the CCM, in coordination with the provider/participating provider as appropriate, will provide the member with information about available community support services and programs, such as local or state-funded agencies or facilities, that might provide sliding scale discounts for continuation in outpatient therapy.

Retrospective Review

When a provider/participating provider requests a retrospective review for services previously rendered, Beacon of California will first determine whether such a retrospective review is available under the member's benefit plan and request the reason for the retrospective review (e.g., emergency admission, no presentation of a Beacon of California member identification card, etc.). In cases where a retrospective review is available, services will be reviewed as provided for in this handbook. In cases where a retrospective review is not available under the member's benefit plan and/or where the provider/participating provider fails to follow administrative process and requirements for authorization, certification and/or notification, the request for retrospective review may be administratively denied. Subject to any client health benefit program and/or benefit plan specific requirements, the chart below references the standard timeframes applicable to the type of review request.

TYPE OF REVIEW	URGENCY OF CASE	TIMEFRAME TO MAKE DECISION	TIMEFRAME TO PROVIDE NOTIFICATION	
			CERTIFICATIONS	NON-CERTIFICATIONS
Prospective	Urgent (e.g. Emergency Services, Inpatient, Observation Holding Beds) Cases meeting expedited definition (Knox-Keene)	72 hours after receipt of request for services	Telephonic or facsimile notification to provider on the same day the determination is made; provider must agree to notify the member of the determination on the same day Written or electronic notice issued to member, provider, and facility within 72 hours of receipt of the request for services	Telephonic or facsimile notification to provider on the same day the determination is made; provider must agree to notify the member of the determination on the same day. Written or electronic notice issued to member, provider, and facility within 72 hours of receipt of the request for services
	Non-urgent (i.e. RTC, Partial Hospitalization and Outpatient)	Five business days after receipt of request for services.	Telephonic or facsimile notification to provider on the same day the determination is made. Written notice issued to member, provider, and facility within two business days of the determination	Telephonic or facsimile notification to provider on the same day the determination is made. Written notice issued to member, provider, and facility within two business days of the determination
Concurrent (Continued Stay)	Urgent (e.g. Inpatient)	24 hours after receipt of request for services if the concurrent review request defaults to an urgent prospective review request.	Telephonic notification or facsimile to provider on the same day as the determination; provider must agree to notify the member of the decision on the same day Written notice to member, provider, and facility within 24 hours of request	Telephonic notification or facsimile to provider on the same day as the determination; provider must agree to notify the member of the decision on the same day Written notice to member, provider, and facility within 24 hours of request

TYPE OF REVIEW	URGENCY OF CASE	TIMEFRAME TO MAKE DECISION	TIMEFRAME TO PROVIDE NOTIFICATION	
			CERTIFICATIONS	NON-CERTIFICATIONS
	Non-urgent (e.g., RTC, Partial Hospitalization and Outpatient)	Five business days after receipt of request for services	Telephonic or facsimile notification to provider within 24 of the determination Written notification to member, provider, and facility within two business days of the determination	Telephonic or facsimile notification to provider within 24 of the determination Written notification to member, provider, and facility within two business days of the determination
Retrospective	Non-urgent (all levels of care)	30 calendar days after receipt of request for retrospective review.	Written notice to member, provider, and facility within the overall time frame of 30 calendar days of request for retrospective review	Written notice to member, provider, and facility within the overall time frame of 30 calendar days of request for retrospective review

Beacon of California's procedures for authorization, certification and/or notification apply to services and treatment proposed and/or previously rendered in instances where the member benefit plan administered by Beacon of California is primary and instances where the member benefit plan administered by Beacon of California is secondary.

Beacon of California, at times, may administer both primary and secondary benefit plans of a given member. To avoid possible duplication of the review process in these cases, providers/participating providers should notify Beacon of California of all pertinent employer and other insurance information for the member being treated.

Note: Failure to follow authorization, certification and/or notification requirements, as applicable, may result in administrative denial/non-certification and require that the member be held harmless from any financial responsibility for the provider's/participating provider's charges.

Definition of Medical Necessity

Unless otherwise defined in the provider agreement and/or the applicable member benefit plan, Beacon of California's reviewers, Clinical Case Managers, Peer Advisors, and other individuals involved in Beacon of California's utilization management processes use the following definition of medical necessity or medically necessary treatment in making authorization and/or certification determinations as may be amended from time to time:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (current ICD or DSM) that threatens life, causes pain or suffering, or results in illness or infirmity

- Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications
- Reflective of a level of service that is safe, where no equally effective, more conservative and less costly treatment is available
- Not primarily intended for the convenience of the recipient, caretaker, or provider/participating provider
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency
- Not a substitute for non-treatment services provided for the enrichment of a patient's environment, such as the provision of custodial or housing services that may otherwise enhance patient wellness.

Medical Necessity Criteria

Beacon of California's clinical criteria, also known as medical necessity criteria, are based on nationally recognized resources, including but not limited to, those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), the American Society of Addiction Medicine (ASAM), MCG (formerly known as Milliman Care Guidelines), and the Center for Medicaid and Medicare (CMS). For management of substance use services, Beacon of California uses ASAM criteria.

Beacon of California's medical necessity criteria are reviewed at least annually, and during the review process, Beacon of California will leverage its Scientific Review Committee to provide input on new scientific evidence when needed. Medical necessity criteria are reviewed and approved by the Beacon of California Board of Directors and Quality Management Committee.

Participating providers are given an opportunity to comment or give advice on development or adoption of UM criteria and on instructions for applying the criteria. These comments and opinions are solicited through practitioner participation on committees and through provider requests for review.

Beacon of California facilitates discussions with outside senior consultants in the field as well as other practicing professionals. Beacon of California also leverages various criteria sets from other utilization management organizations and third party payers. In addition, Beacon of California disseminates criteria sets via the website, provider handbook, provider forums, newsletters, and individual training sessions. Upon request, members are provided copies of Beacon of California's medical necessity criteria free of charge.

Access to Beacon of California's medical necessity criteria is available at www.beaconhealthoptions.com. To order a copy of the ASAM criteria, please go to the following website: www.asam.org/PatientPlacementCriteria.html.

Clinical Practice Guidelines

In addition to medical necessity criteria, Beacon of California has a set of Diagnosis-Based clinical practice guidelines. These guidelines are used in collaboration with providers to help guide appropriate

and clinically effective care for a variety of complex psychiatric conditions. These guidelines represent standards of best practice for treating these complex conditions and can be referred to by CCMs and Peer Advisors during reviews. Beacon of California seeks input from participating providers, consultants, and other expert clinicians to develop some of the guidelines; however, in most instances Beacon of California adopts established and/or published guidelines such as those developed by the American Psychiatric Association and the American College of Child and Adolescent Psychiatrists. Information about and access to clinical practice guidelines used by Beacon of California is available at www.beaconhealthoptions.com.

Beacon of California's Care Management System

Members and participating providers may access the Beacon of California care management system through any of the following avenues:

24-hour toll-free emergency care/clinical referral line

Direct registration/certification of care through ProviderConnect for participating providers

Direct authorization/certification of all levels of care through referral by a Beacon of California Clinical Care Manager (CCM)

Emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms or crisis response teams

If a call is received from a member requesting a referral and/or information about participating providers in the member's location, CCMs may conduct a brief screening to assess whether there is a need for urgent or emergent care. Referrals are made to participating providers, taking into account member preferences such as geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the participating provider holds and gender. Additionally, the member may require a clinician with a specialty such as treatment of eating disorders. In all cases, where available, the CCM will assist in arranging care for the member. The name, location and phone number of at least three participating providers will be given to the member.

Clinical Care Manager Reviews

Beacon of California Clinical Care Managers (CCMs) base reviews on established criteria adopted by Beacon of California and/or criteria developed by Beacon of California. CCMs are trained to match the needs of members to appropriate services, levels of care, treatment and length of stay, and community supports. This requires careful consideration of the intensity and severity of clinical data presented, with the goal of quality treatment in the least restrictive environment. The clinical integrity of the utilization management program seeks to provide that members who present for care are appropriately monitored and that comprehensive reviews of all levels of care are provided. Those cases that appear to be outside of best practice guidelines or appear to have extraordinary treatment needs are referred for specialized reviews. These may include evaluation for intensive care management, clinical rounds, peer advisor review or more frequent CCM review.

CCMs obtain clinical data from the provider/participating provider or designee relating to the need for care and treatment planning. The CCM evaluates this information and references applicable clinical criteria to determine medical necessity of the requested level of care or service. Where appropriate, care is pre-certified for a specific number of services/days for a specific time period at a specific level of care, based on the needs of the member.

Except where disclosure of certain information is expressly prohibited by or contrary to applicable state or federal laws or regulations, participating providers must be prepared to provide Beacon of California with the following information at the time of the review, as necessary and appropriate:

Demographics

Diagnosis (current DSM or ICD)

Reason for admission/precipitant

Suicidal/homicidal risk, including:

- Ideation
- Plan
- Intent
- psychotic/non-psychotic (e.g., command hallucinations, paranoid delusions)

Substance use disorder history

- Type
- Amount
- Withdrawal symptoms
- Vital signs
- Date(s) of initial use and last use
- Date(s) of periods of sobriety

Other presenting problem/symptomatology description, if applicable

Progress since admission (if concurrent review)

Medical problems

- Medical history
- Organic cause of psychiatric symptoms/behaviors
- Medical problems which exacerbate psychiatric or substance use symptoms/behaviors

Current medications

- Types(s)
- Dosage(s)
- Date(s)
- Duration
- Response
- Provider(s)

Primary care physician (PCP) interface, if applicable

Other behavioral health care provider interface, if applicable

General level of functioning

- Sleep
- Appetite
- Mental status
- ADLs (Activities of Daily Living)

Psychological stressors and supports

- Socioeconomic
- Family
- Legal
- Social
- Abuse, neglect, domestic violence (as appropriate)

Response to previous treatment

- Previous treatment history, most recent treatment, past treatment failures
- Relapse/recidivism, motivation for treatment
- Indications of compliance with treatment recommendations

Treatment plan

- Estimated length of stay
- Treatment goals
- Specific planned interventions
- Family involvement
- Precautions for specific risk behaviors
- Educational component for regulatory compliance and substance use disorder situations

Discharge plan

- Aftercare required upon discharge
- Barriers to discharge

Inpatient or Higher Levels of Care

All inpatient and alternative level of care programs (this does not include outpatient therapy rendered in a provider's/participating provider's office or outpatient therapy in a clinic or hospital setting) will be subject to the review requirements described in this section. Prior to non-emergency admission and/or beginning treatment, the provider/participating provider must contact Beacon of California:

For notification

To confirm benefits and verify member eligibility

To provide clinical information regarding the member's condition and proposed treatment

For authorizations or certifications, where required under the member's benefit plan

It is preferred that providers use the ProviderConnect web portal, available 24 hours a day, seven days a week (excluding scheduled maintenance and unforeseen systems issues) to confirm benefits and provide notification and clinical information as appropriate. Providers/participating providers can secure copies of the authorization/certification requests at time of submission for their records. The web portal can be utilized for concurrent reviews and discharge reviews as well as initial or precertification reviews.

Clinical Care Managers (CCMs) and/or Referral Line Clinicians are available 24 hours a day, seven days a week, 365 days a year and can provide assessment, referrals, and conduct authorization or certification reviews if such processes are unavailable through ProviderConnect.

Where authorization, certification or notification is required by the member's benefit plan and unless otherwise indicated in the provider agreement, providers/participating providers should contact Beacon of California within 48 hours of any emergency admission for notification and/or to obtain any required authorization or certification for continued stay.

If prior to the end of the initial or any subsequent authorization or certification, the provider/participating provider proposes to continue treatment, the provider/participating provider must contact Beacon of California by phone or ProviderConnect for a review and recertification of medical necessity. It is important that this review process be completed more than 24 hours prior to the end of the current authorization or certification period.

Continued stay reviews:

- Focus on continued severity of symptoms, appropriateness and intensity of treatment plan, member progress and discharge planning
- Involve review of treatment records and discussions with the provider/participating provider or appropriate facility staff, Employee Assistance Program (EAP) staff or other behavioral health providers and reference to the applicable clinical criteria

In instances where the continued stay review by a CCM does not meet medical necessity criteria and/or where questions arise as to elements of a treatment plan or discharge plan, the CCM will forward the case file to a Peer Advisor for review.

Discharge Planning

Discharge planning is an integral part of treatment and begins with the initial review. As a member is transitioned from inpatient and/or higher levels of care, the Clinical Care Manager (CCM) will review/discuss with the provider/participating provider the discharge plan for the member. The following information may be requested and must be documented:

Discharge date

Aftercare date

- Date of first post-discharge appointment (must occur within seven days of discharge)
- With whom (name, credentials)
- Where (level of care, program/facility name)

Other treatment resources to be utilized

- Types
- Frequency

Medications

- Patient/family education regarding purpose and possible side effects
- Medication plan including responsible parties

Support systems

- Familial, occupational and social support systems available to the patient. If key supports are absent or problematic, how has this been addressed
- Community resources/self-help groups recommended (note purpose)

EAP linkage

- If indicated (e.g., for substance use aftercare, workplace issues, such as Return-to- Work Conference, enhanced wrap-around services) indicate how this will occur

Medical aftercare (if indicated, note plan, including responsible parties)

Family/work community preparation

- Family illness education, work or school coordination, (e.g., EAP and Return-to-Work Conference) or other preparation done to support successful community reintegration. Note specific plan, including responsible parties and their understanding of the plan.

Case Management Services (for select patients who meet high-risk criteria)

As part of the case management program at Beacon of California, we offer assistance with:

- Discharge planning
- Assessment and integration of service for on-going needs
- Coordination with behavioral health services
- Collaboration with healthcare providers and care givers
- Providing information about what benefits might be available
- Medication education and monitoring

Hospitals may be asked for assistance in enrolling patients in case management during inpatient admissions.

When requested, please:

1. Have the patient complete the authorization form, with help if needed.
2. Send the authorization to Beacon of California by faxing it to the number on the form.
3. Schedule a discharge appointment within seven days after discharge. If you need help with getting an appointment within seven days, please contact Beacon of California.

Adverse Clinical Determination/ Peer Review

If a case does not appear to meet medical necessity criteria at the requested level of care, the CCM attempts to discuss the member's needs with the provider/participating provider and to work collaboratively with the provider/participating provider to find an appropriate alternative level of care. If no alternative is agreed upon, the CCM cannot deny a request for services. Requests that do not appear to meet medical necessity criteria or present quality of care issues are referred to a peer reviewer for second level review. It is important to note that only a doctoral level peer reviewer can clinically deny a request for services.

The peer reviewer considers the available information and may elect to conduct a Peer-to-Peer Review, which involves a direct telephone conversation with the attending or primary participating provider to discuss the case. Through this communication, the peer reviewer may obtain clinical data that was not available to the CCM at the time of the review. This collegial clinical discussion allows the peer reviewer the opportunity to explore alternative treatment plans with the provider/participating provider and to gain insight into the attending provider's anticipated goals, interventions and timeframes. The peer reviewer may request more information from the provider/participating provider to support specific treatment protocols and ask about treatment alternatives.

When an adverse determination is made, the treating provider (and hospital, if applicable) is notified telephonically of the decision. In urgent care cases, notification is given telephonically at the time of the determination. Written notification of an adverse determination is issued to the member, member representative, practitioner, and facility within decision timeframes. If an adverse decision is rendered, the provider/participating provider has the right to speak with the peer reviewer who made the adverse determination by calling Beacon of California at the toll free phone number of the member's plan. For substance use treatment and treatment of minors, Beacon of California follows federal and state guidelines regarding release of information in determining the distribution of adverse determination letters.

All written or electronic adverse determination notices include:

- The specific reason(s) for the determination not to certify
- A statement that the clinical rationale criteria (or copy of the relevant clinical criteria), guidelines, or protocols used to make the decision will be provided, in writing, upon request
- Information regarding how the member may file a grievance or appeal with Beacon of California
- Information regarding the member's right to file a complaint with the Department of Managed Health Care
- Disclosures required by Sections 1368.01, 1368.02, (Grievance rights) and 1374.30 (Independent Medical Review process) of the Knox-Keene Act
- The name and direct telephone number of the health care professional responsible for the denial
- The right of the provider to request a reconsideration within three business days of receipt of the notice when a medical necessity denial is issued without a Peer-to-Peer conversation having taken place, or when an administrative denial is issued because of the failure of a provider/participating provider to respond to a request for Peer-to-Peer conversation within a specified timeframe

Lack of Information (LOI) Process

When there is insufficient information to make a medical necessity determination, the peer reviewer may elect to make the decision based on the information that has been received, or may invoke the Lack of Information (LOI) process. If the decision is made based on available information, written notification is issued within the determination timeframe for the type of care request (e.g. urgent, non-urgent). If the peer reviewer invokes the LOI process, the provider/participating provider is notified of the information needed within prescribed timeframes based on the type of care requested. A minimum period of time is given for the provider/participating provider to furnish the necessary information. A Peer-to-Peer conversation may be initiated by either the peer advisor or the provider/participating provider in order to discuss the needed information. Once information is received, or the time period for furnishing the information has expired, the decision and notice must be issued within the specified timeframe for the type of care requested. See the LOI chart below for a listing of all relevant timeframes by type of request.

Type of Review	Urgency of Case	Timeframe to make over all decision *	Timelines for reviews when there is a lack of information to make a decision[1]			Timeframe to provide notification	
			Timeframe to notify provider/ member that information is not sufficient to conduct review	Timeframe to allow provider/ member to provide information	When information obtained, timeframe to make decision	Certification	Non-Certification[2]
Prospective	Urgent (e.g. Emergency Services, Inpatient, Observation Holding Beds) Cases meeting expedited definition (Knox-Keene)	72 hours after receipt of request for services	Within 24 hours from request for services	At least two calendar days after notification; time frame given must be documented	Two calendar days from the earlier of receipt of specified information, or the end of the period allowed to supply the necessary information. The total process is to be completed within 72 hours of the initial request for services.	Telephonic or facsimile notification to provider on the same day the determination is made; provider must agree to notify the member of the decision on the same day. Written or electronic notice issued to member, provider, and facility within 72 hours of receipt of the request for services	Telephonic or facsimile notification to provider on the same day the determination is made; provider must agree to notify the member of the decision on the same day Written or electronic notice issued to member, provider, and facility within 72 hours of receipt of the request for services

Type of Review	Urgency of Case	Timeframe to make over all decision *	Timelines for reviews when there is a lack of information to make a decision[1]			Timeframe to provide notification	
			Timeframe to notify provider/ member that information is not sufficient to conduct review	Timeframe to allow provider/ member to provide information	When information obtained, timeframe to make decision	Certification	Non-Certification[2]
	Non-urgent (i.e. RTC, Partial Hospitalization and Outpatient)	Five business days after receipt of request for services	Within five business days after request for services	At least 45 calendar days after notification; time frame given must be documented	Five business days from receipt or the required information.	Telephonic or facsimile notification to provider on the same day the determination is made Written notice issued to member, provider, and facility within two business days of the determination	Telephonic or facsimile notification to provider on the same day the determination is made Written notice issued to member, provider, and facility within two business days of the determination
Continued Stay Concurrent	Urgent	24 hours after receipt of request for services	Within 24 hours from request for services	At least two calendar days from request for services; time frame given must be documented	24 hours from the earlier of receipt of specified information, or the end of the period allowed to supply the necessary information	Telephonic or facsimile notification to provider on the same day as the determination; provider must agree to notify the member of the decision on the same day Written or electronic notice issued to member, provider, and facility within 24 hours of receipt of the request for services	Telephonic or facsimile notification to provider on the same day as the determination; provider must agree to notify the member of the decision on the same day Written or electronic notice issued to member, provider, and facility within 24 hours of receipt of the request for services

Type of Review	Urgency of Case	Timeframe to make over all decision *	Timelines for reviews when there is a lack of information to make a decision[1]			Timeframe to provide notification	
			Timeframe to notify provider/ member that information is not sufficient to conduct review	Timeframe to allow provider/ member to provide information	When information obtained, timeframe to make decision	Certification	Non-Certification[2]
	Non-urgent (i.e. RTC, Partial Hospitalization and Outpatient)	Five business days after receipt of request	Notice to member and provider within five business days from request for services	At least 45 calendar days after notification; time frame given must be documented	Five business days from receipt or the request for services	Telephonic or facsimile notification to provider within 24 hours of the determination Written notice issued to member, provider, and facility within two business days of the determination	Telephonic or facsimile notification to provider within 24 hours of the determination Written notice issued to member, provider, and facility within two business days of the determination
Retrospective	Non-urgent (all levels of care)	30 calendar days after receipt of request for retrospective review.	Notice to member and provider within 15 calendar days after request for services.	At least 45 calendar days from notification; time frame given must be documented	15 calendar days from the earlier of receipt of the required information, or the end of the period allowed to submit the necessary information	Written notice to member, provider, and facility within the overall determination timeframe of 30 calendar days from receipt or the request for review	Written notice to member, provider, and facility within the overall determination timeframe of 30 calendar days from receipt or the request for review

(1) Extensions are one-time only per request for services (i.e. a concurrent review would constitute a new request for services). Lack of information extension is one type of extension. In addition, if a lack of information extension is not used; non-urgent claims may be extended by Beacon of California for "reasons beyond the control of the Plan" other than for lack of information (as shown above). Extensions are also subject to Knox-Keene requirements. Beacon of California must notify the member and provider before the end of the determination time frame of the reasons for the delay and the date by which the decision will be made.
*Example of notification time calculation: a non-urgent initial request must be decided within five business days of receipt of request. Beacon of California may notify the member and provider on or before the 5th business day that it is extending the time frame and why. The decision must then be made and a determination notice issued by the end of the five business day of the extension, or 20 days from receipt of the request for services (initial 5 business day determination date + the 15-day extension). **For urgent care claims, there is no provision for extension other than for lack of information.**

(2) Per Knox-Keene regulations-In the case of concurrent review, care shall not be discontinued due to a denial or a modification of service until the member's treating provider has been notified of Beacon of California's decisions and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient.

Electroconvulsive Therapy

Prior to conducting Electroconvulsive Therapy (ECT), providers/participating providers must contact Beacon of California for pre-certification of such therapy. All pre-certification requests for ECT are reviewed for medical necessity.

Telehealth

Beacon of California offers outpatient behavioral health and substance use disorder treatment using telehealth. Telehealth is a mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth counseling sessions are provided by California licensed health care providers and are offered according to client arrangements and may not be available to all members. Telehealth services can be accessed by calling Beacon of California member services.

Outpatient Services

Providers/participating providers should request authorization or certification for outpatient services electronically through ProviderConnect. If the electronic method is not available, providers/participating providers should submit an Outpatient Review, or use the toll-free number for a telephonic review. In instances where a review does not meet medical necessity criteria and/or where questions arise as to elements of a treatment plan, the case file may be forwarded to a Peer Advisory for review.

Appeals (Grievance) Process

Beacon of California has an established system to allow for appeals of determinations of no medical necessity. Appeals for Beacon of California members are considered a form of grievance and subject to the requirements of Section 1368 et seq. of the California Knox-Keene Health Care Service Plan Act of 1975 as amended and Rules 1300.68 and 1300.68.01 of Title 28 of the California Code of Regulations. The Beacon of California process allows for a review subsequent to a no medical necessity determination, with the review being conducted by health professionals who are clinical peers to the provider of the services being appealed, hold active, unrestricted license to practice medicine or a health profession, are board-certified if applicable, are in the same profession and in a similar specialty as typically manages the clinical condition, procedure or treatment, and is neither the individual who made the original non-certification, nor the subordinate of such an individual. Appeals are conducted, as appropriate to the nature of the case, by a peer reviewer, committee, or external reviewer having the qualifications stated above. This allows for objectivity and impartiality.

Beacon of California allows the member, member's representative, provider/participating provider rendering services at least 180 calendar days after the receipt of a non-certification to initiate the appeal process by telephone, by facsimile, in person, by e-mail, by an on-line member grievance submission process at Beacon of California's web site, or in writing. The member, member's representative, or provider/participating provider may submit any information they feel is pertinent to their appeal request and all such information is considered in the appeals review, whether such information was available to Beacon of California reviewers during the initial consideration.

Non-Urgent Appeals

All non-urgent appeals (grievances) will be resolved and responded to within 30 calendar days (or

sooner) of Beacon of California's receipt of the appeal/grievance. This 30 calendar day time period includes completion of any/all multiple internal/external levels of review that Beacon of California may need to utilize due to the nature of an appeal/grievance. For example, the Beacon of California Medical Director may review a clinical appeal/grievance but may determine a committee or external review is needed due to the nature of the issues involved.

Urgent Appeals

All urgent appeals (grievances) will be resolved and responded to within three calendar days or less of receipt of the appeal/grievance by Beacon of California. This three calendar day time period includes completion of any/all multiple internal/external levels of review that Beacon of California may need to utilize due to the nature of an appeal/grievance. An urgent appeal/grievance is a case requiring expedited review because it involves an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function.

Additional Appeal (Grievance) Rights

Review by Department of Managed Health Care (DMHC)

After completing the appeal (grievance) process as described in Beacon of California policies and procedures or after participating in the process for at least 30 calendar days (the 30 day period is not required if the case meets the urgent definition above) or after completing voluntary mediation, the member or member's representative may submit their grievance/appeal to the DMHC. The DMHC has a toll-free telephone number (**1-888-466-2219**) and a **TDD** line (**1-877-688-9891**) for the hearing and speech impaired. The DMHC's Internet Web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review

Under California law, the member may be entitled to an external, independent medical review (IMR) when a determination for a member's health care service has been denied, delayed, or modified by Beacon of California in whole or in part due to a determination that the service is not medically necessary. If the member is eligible for IMR, the IMR process will provide an impartial review of medical decisions made by Beacon of California related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. If the case meets these criteria, the written notification responding to the grievance/appeal request must advise the member of the availability of an independent review and how to request such a review.

Voluntary Mediation

In the event the member is dissatisfied with the Beacon of California appeal/grievance process determination, the member may request voluntary mediation (process required to be available by California law) with Beacon of California prior to exercising the right to submit a grievance to the DMHC as described above. The request must be made within 60 calendar days of the Beacon of California determination.

Arbitration

If the member is not satisfied with Beacon of California's response to an appeal/ grievance, the member may submit a request to Beacon of California for binding arbitration within 60 calendar days of receipt of

Beacon of California's response. However, in the case of binding arbitration, if the member has legitimate health or other reasons that would prevent the member from electing binding arbitration within 60 calendar days, the member may have as long as reasonably necessary to accommodate special needs in order to elect binding arbitration.

ERISA appeals

The member may also have the right to challenge an adverse benefit determination on review by bringing a civil action under the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). This act governs some health benefits that are obtained through a non-government employer.

Beacon of California does not make appeal decisions based on findings that a device, procedure, or other therapy is investigational or experimental.

Provider Disputes

Beacon of California has established a system to provide a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. The Beacon of California provider dispute resolution process is available for claims and other types of billing and contract disputes, as well as disputes related to provider network participation decisions related to administrative reasons (i.e. disenrollment from the network for not being responsive to recredentialing efforts, denied network participation for not meeting credentialing criteria). The provider dispute resolution process is used to resolve Mental Health or Substance Use Disorder or Mental Disorder (MHSUD) and Employee Assistance Program (EAP) disputes from all provider types (practitioners, facilities, and provider organizations).

Any provider dispute submitted on behalf of a member or a group of members treated by the provider/participating provider (e.g. a clinical appeal of a UM certification decision, a clinical dispute during the concurrent care review process, provider is attempting to get an expedited review on behalf of a member meeting the urgent grievance definition, etc.) will be handled in the Beacon of California grievance process as described above and not in the Beacon of California provider dispute resolution mechanism. Beacon of California may verify the member's authorization to proceed with the grievance prior to submitting the complaint to Beacon of California grievance process. When a provider/participating provider submits a dispute on behalf of a member or a group of members, the provider/participating provider shall be deemed to be joining with or assisting the member within the meaning of section 1368 (grievance regulations) of the Health and Safety Code.

Additional information regarding the provider dispute resolution process is available under the *Provider Disputes and Member Grievances* section of this same Handbook.

Appeal Notification Requirements

For Beacon of California members, written notification of the clinical appeal decision rendered is sent to the member, provider/participating provider as soon as the review is completed and a determination is made but no later than within 30 calendar days after receipt of a non-urgent appeal request or three calendar days from receipt of an urgent appeal request.

Quality Management/Quality Improvement

To assure services are appropriately monitored and continuously improved, Beacon of California has

developed and implemented a comprehensive Quality Management (QM) Program. As a Knox-Keene Plan, Beacon of California is regulated by the California Department of Managed Health Care (DMHC) and the QM Program reflects the Knox-Keene regulations for Beacon of California business.

Beacon of California utilizes a Continuous Quality Improvement (CQI) philosophy through which Beacon of California directly or through its authorized designees, monitors and evaluates appropriateness of care and service, identifies opportunities for improving quality and access, establishes quality improvement initiatives, and monitors resolution of identified problem areas. This includes monitoring and evaluation of services performed by Beacon of California or its designees, as well as behavioral health services rendered by providers and participating providers.

Beacon of California's comprehensive Quality Management Program (QMP) includes Quality Management (QM) policies and procedures applicable to all participating providers, strategies and major activities performed to provide for consistency and excellence in the delivery of services, includes a program description, an annual work plan that includes goals and objectives, and specific quality management related activities for the upcoming year and the evaluation of the effectiveness of those activities. Participating providers are responsible for adhering to the QMP and are encouraged to provide comments to Beacon of California regarding ongoing QMP activities.

Quality Management/Utilization Management/Care Management Committee

The Beacon of California Board of Directors has ultimate accountability for the oversight and effectiveness of the QM Program. The Board has delegated authority for QM Program implementation and planning to the multi-disciplinary Quality Management/Utilization Management/Case Management (QM/UM/CM) Committee. Beacon of California's President is administratively responsible for the direction and overall functioning of the QM Program and ensures allocation of adequate resources and staffing. The Medical Director is responsible for implementation of the QM Program.

The Board of Directors reviews and approves the QM Program Description, QM Program Evaluation, and QM Work plan at least annually, and at the time of any revision. The Board receives a quarterly summary of all quality management activities included in the work plan from the QM/UM/CM Committee.

In addition, certain functional areas within Beacon of California maintain quality management programs specific to the activities and services performed. Quality programs within functional areas are responsible for coordinating their quality management programs with the Quality Management Program.

Scope of the Quality Management Program

The Beacon of California Quality Management Program (QMP) monitors and evaluates quality across the entire range of services provided by Beacon of California. The QMP is intended to ensure that structure and processes are in place to lead to desired outcomes for members, clients, providers/participating providers, and Beacon of California functional areas.

The scope of the QMP includes:

- Clinical services and Utilization Management Programs
- Supporting improvement of continuity and coordination of care
- Case Management/Intensive Case Management/Targeted Case Management
- Quality Improvement Activities (QIAs)/Projects (QIPs)

- Outcome Measurement and data analysis
- Network Management/Provider Relations Activities
- Member Experience Survey
- Clinical Treatment Record Evaluation
- Service Availability and Access to Care
- Practitioner and Provider Quality Performance
- Annually evaluating member Complaints and Grievances using valid methodology
- Member Rights and Responsibilities
- Patient Safety Activities (including identification of safety issues during prospective reviews)
- Clinical and Administrative Denials and Appeals
- Performance Indicator development and monitoring activities
- Health Literacy and Cultural Competency assurance
-
- Complaints and grievances
- Establishment and ongoing monitoring of the Language Assistance Program in accordance with the standards and requirements of the Knox-Keene Act.
- Development, communication, and ongoing monitoring of access and availability guidelines to ensure accessibility to behavioral healthcare and Employee Assistance Program services in according with the standards and requirements of the Knox-Keene Act

Several of the above activities and processes are described in greater detail in other sections of this handbook.

Role of Participating Providers

Beacon of California participating providers are informed about the QMP through this handbook, provider newsletters, the Beacon of California website, direct mailings, email provider alerts, seminars and training programs. Many of these media venues provide participating providers with the opportunity to be involved and provide input in to the quality management and utilization management programs. Additional opportunities to be involved include representation on the Quality Management/Utilization Management/Case Management Committee, Credentialing Committee, Provider Appeals Committee, and the Public Policy Committee. Involvement includes, but is not limited to:

- Providing input into the Beacon of California medical necessity criteria
- Providing peer review and feedback on proposed practice guidelines, clinical quality monitors and indicators, new technology and any critical issues regarding policies and procedures of Beacon of California
- Reviewing Quality Improvement (QI) activities and making recommendations to improve quality of clinical care and services

- Reviewing, evaluating and making recommendations for the credentialing and recredentialing of participating providers
- Reviewing, evaluating and making recommendations regarding sanctions that result from participating provider performance issues

As part of the QMP, Beacon of California incorporates principles designed to encourage the provision of care and treatment in a culturally competent and sensitive manner. These principles include:

- Emphasis on the importance of culture and diversity
- Assessment of cross-cultural relations
- Expansion of cultural knowledge
- Consideration of sex and gender identity
- Adaptation of services to meet the specific cultural and linguistic needs of members

Participating providers are reminded to take the cultural background and needs of members into account when developing treatment plans and/or providing other services.

Role of Members/Consumers

Beacon of California values its members/consumers and believes that members/consumers are resources and active participants in their treatment and recovery. Consequently, Beacon of California invites and includes member/consumer input in the Quality Management Program, which is reflected in member participation on Beacon of California's Public Policy Committee. This participation allows them to speak to health plan member issues. Beacon of California also utilizes member suggestions that may be received through Beacon of California's grievance or inquiry processes.

Quality Performance Indicator Development and Monitoring Activities

A major component of the quality management process is the identification and monitoring of meaningful performance indicators. These key performance indicators are selected by functional areas along with associated goals or benchmarks and are approved by Beacon of California's Quality Management/Utilization Management/Case Management Committee. Measures are reported to the Beacon of California's Board of Directors at least quarterly.

All functional areas are responsible for prioritizing their resources to meet or exceed performance goals or benchmarks established for each indicator. When performance is identified below established goals and/or trends are identified, a corrective action plan is established to improve performance.

Behavioral health care access and service performance is monitored regularly, including but not limited to:

- Access and availability to behavioral health services
- Telephone service factors
- Utilization decision timeliness and adherence to medical necessity and regulatory requirements
- Member and provider complaints and grievances
- Member and provider satisfaction with program services

- Nationally recognized quality indicators such as HEDIS® measures whenever possible

Potential quality of care and/or service indicators monitored by Beacon of California include, but are not limited to:

- Provider Inappropriate/Unprofessional Behavior
  - Sexual relationship with member
  - Seductive behavior, inappropriate physical contact
  - Aggressive behavior
  - Threats of aggressive behavior
  - Displays signs of substance use
  - Displays signs of mental health problems
  - Displays signs of organicity
  - Inappropriate pharmacy/drug prescribing
  - Inappropriate boundaries/relationship with member/enrollee
  - Practitioner not qualified to perform services
- Clinical Practice-Related Issues
  - Treatment setting not safe
  - Adequacy of assessment
  - Timeliness of assessment
  - Accuracy of diagnosis
  - Delay in treatment
  - Appropriateness of treatment
  - Effectiveness of treatment
  - Adequacy of referral
  - Failure to appropriately refer
  - Timeliness of referral
  - Failure to coordinate care
  - Abandoned member
  - Premature discharge
  - Inadequate discharge planning
  - Prescribed wrong, too much, too many, too little medication
  - Medication error
  - Failure to follow practice guidelines
  - Failure to involve family in treatment

    - Over or under utilization of services
    - Site, materials or equipment dirty/unsanitary or in disrepair
- Access to Care-Related Issues
    - Failure to provide appropriate appointment access
    - Lack of timely response to telephone calls
    - Prolonged in-office wait time
    - Session too short
    - Falling asleep
    - Failure to keep an appointment
    - Non-compliance with ADA requirements
    - Refusal to schedule appointment
    - Services not available or accessible
- Attitude and Service-Related Issues
    - Failure to maintain confidentiality
    - Poor communication skills
    - Lack of caring/concern
    - Poor or lack of documentation
    - Fraud and Abuse
    - Failure to release medical records
    - Failure to allow a site visit
- Quality of Care-Related issues
    - Any action or failure to take action on the part of a provider that has the potential to decrease the likelihood of a positive health outcome and/or is inconsistent with current professional knowledge and/or puts the safety of the member at risk. Examples of quality of care issues may include, but are not limited to:
- Any performance outside established parameters, structures, policies and procedures that may be viewed as contributing to unexpected outcomes.
- Treatment and/or discharge planning issue
- Medication management issues
- Access to appropriate treatment
- Inappropriate or unprofessional behavior
- Over- and under-utilization
- Clinical guideline adherence

- Fraud and abuse
- Adverse Incidents (see “Adverse Incidents” on page 10 for more information)

Service Availability and Access to Care

Beacon of California uses a variety of mechanisms to measure member’s access to care with participating provider. Behavioral health service availability is assessed based on the following standards for participating providers:

- An individual with life-threatening emergency needs is seen immediately
- An individual with non-life-threatening emergency needs is seen within six hours
- An individual with urgent needs are seen within 48 hours
- Routine office visits are available within 10 business days

The following methods may be used to monitor participating provider behavioral health service availability and member access to care:

- Analysis of member complaints and grievances related to availability and access to care.
- Member satisfaction surveys specific to their experience in accessing care and routine appointment availability.
- Open shopper staff surveys for appointment availability – an approach to measuring timeliness of appointment access in which a surveyor contacts participating provider’s offices to inquire about appointment availability and identifies from the outset of the call that he or she is calling on behalf of Beacon of California.
- Referral line calls are monitored for timeliness of referral appointments given to members.
- Analysis and trending of information on appointment availability obtained during site visits.
- Analysis of call statistics (e.g. average speed of answer, abandonment rate over five seconds)
- Annual Geo-Access and network density analysis.

In addition to these monitoring activities, participating providers are required by contract to report to Beacon of California when they are at capacity. This assists clinical care managers in selecting appropriate, available participating providers for member referral.

Continuity and Coordination of Care

Beacon of California monitors continuity and coordination of care throughout its continuum of behavioral health services. Monitoring may include reviews and audits of treatment records, coordination of discharge planning between inpatient and outpatient providers/participating providers, and monitoring provider/participating provider performance on pre-determined coordination of care indicators. Processes are established seeking to avoid disruption of care for the member when there is a change in their treating provider/participating provider. Such changes may include, but are not limited to:

- A member requires a change in level of care, necessitating a new participating provider
- There are multiple providers/participating providers involved in treatment simultaneously (psychiatrist for medication management, therapist for on-going treatment)
- A change in health plans or benefit plans
- Termination of a participating provider
- A member is being treated for several (co-morbid) conditions simultaneously with multiple providers/participating providers (both behavioral health specialists, primary care, medical specialists, or providers specializing in development disabilities)

Subject to any member consent or authorization required by applicable state and/or federal laws and/or regulations, participating providers should coordinate care as appropriate, sharing information with other treating providers/participating providers, within the context of providing quality care and within the guidelines of protecting a member's privacy and confidentiality.

Treatment Record Standards and Guidelines

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

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

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

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

- Each page (electronic or paper) contains the member's name or identification number.
- Each record includes the member's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
- All entries in the treatment record are dated and include the responsible clinician's name, professional degree, and relevant identification number, if applicable. The length of the visit/session is recorded, including visit/session start and stop times.

- Reviews may include comparing specific entries to billing claims as part of the record review.
- The record, when paper based, is legible to someone other than the writer.
- Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the individual has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
- Presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status and the results of a mental status exam, are documented.
- Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented and revised in compliance with written protocols.
- Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
- A medical and psychiatric history is documented, including previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data and relevant family information.
- For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events (when available), along with a developmental history (physical, psychological, social, intellectual and academic).
- For members 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs.
- A DSM (most current version) diagnosis is documented, consistent with the presenting problems, history, mental status examination and/or other assessment data.
- Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable.
- Treatment plans are updated as needed to reflect changes/progress of the member.
- Continuity and coordination of care activities between the primary clinician, consultants, ancillary providers and health care institutions are documented, as appropriate.
- Informed consent for medication and the member's understanding of the treatment plan are documented.
- Additional consents are included when applicable (e.g., alcohol and drug information releases).
- Progress notes describe the member's strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives.
- Documented interventions include continuity and coordination of care activities, as appropriate.
- Dates of follow-up appointments or, as applicable, discharge plans are noted.

In addition to other requests for member treatment records included in this handbook and/or the provider

agreement, member treatment records are subject to targeted and/or random audits by Beacon of California's Quality Management Department, as well as audits required by state, local and federal regulatory agencies and accreditation entities to which Beacon of California is or may be subject.

Treatment Record Reviews

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

Beacon of California may conduct treatment record reviews and/or audits:

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

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

Beacon of California will use and maintain treatment records supplied by participating providers for review and/or audit in a confidential manner and in accordance with applicable laws and regulations regarding the privacy or confidentiality of protected health information and/or patient identifying information. Never send original records, as they will not be returned at the completion of the review or audit. Only send those sections of the record that are requested.

Records are reviewed by licensed clinicians. Treatment records reviews and/or audits conducted as part of Quality Management activities include application of an objective instrument. The instrument is reviewed no less than annually; Beacon of California reserves the right to alter/update, discontinue and/or replace such instrument in its discretion and without notice.

Following completion of treatment record reviews and/or audits, Beacon of California will give the

participating provider a written report that details the findings. If necessary, the findings report will include a corrective action plan with specific recommendations that will enable the participating provider to more fully comply with Beacon of California standards for treatment records.

Improving Member/Patient Safety

Beacon of California has a defined procedure for the identification, reporting, investigation, resolution and monitoring of quality of care and service issues and trends. Quality of care and service issues and trends are those that decrease the likelihood of desired health outcomes and that are inconsistent with current professional knowledge. A provider quality of service issue involves administrative or operational concerns or processes where a provider does not comply with Beacon of California standards or contractual requirements. These types of issues may be identified from a variety of sources, including without limitation member and provider/participating provider complaints, internal reviews, clients, government agencies and others. These concerns are resolved and monitored through Beacon of California's Quality of Care Committee, in which the Medical Director participates. The Committee oversees the investigation and resolution of these issues through to completion.

Adverse Incidents

Participating providers are required to report to Beacon of California within 24 hours all "adverse incidents" involving members. Adverse incidents are defined as "occurrences that represent actual or potential serious harm to the wellbeing of members, or to others by a member who is in treatment, or has been recently discharged (i.e. within the past six months) from behavioral health treatment/EAP services." Participating providers are required to report Sentinel Events/Adverse Incidents that either result in death of the member or immediately jeopardize the safety of a member receiving services in any level of care. Participating providers should report all adverse incidents to the Clinical Care Manager with whom the participating provider conducts reviews. Examples of reportable adverse incidents include, but are not limited to:

- Unanticipated death occurring in any behavioral setting (e.g., suicide, homicide, unexpected death by medical cause), that is related to a behavioral health condition or treatment (e.g. medication toxicity, cardiac arrest due to multiple psychotropic, lethal drug interactions, untreated/unrecognized medical conditions that would have required intervention). Note: Deaths due to natural causes and/or expected as a result of a disease process are excluded.
- Absence without authorization (AWA) involving a member who is unstable/at risk or under the age of 18 including AWA of a member of any age who was admitted or committed pursuant to State laws and who is at high risk of harm to self or others. Note: this excludes AWA of an adult from a substance use disorder facility (rehab) that is not deemed to be at risk to self or others and excludes youth running away behaviors as part of acting out when staff have followed all protocols and the individual is returned to the facility within the same day without indication of harm to self or others (e.g., member remains in the line of site of staff and is returned to the service area).
- Falls that have serious consequences or multiple falls without evidence of safety precautions being put in place in a treatment setting.
- Any serious injury when in a treatment setting resulting in urgent/emergent interventions. A serious injury is an injury that requires the individual to receive medical treatment including

transport to an ER or acute care hospital. This is regardless of whether medical admission occurs.

- Unplanned transfers to a medical unit (i.e. when a member has an exacerbation of symptoms related to a chronic or current medical condition) that went undetected and/or there was inadequate evaluation and monitoring of chronic or current conditions. Note: Unexpected illness such as the flu, would not by itself, indicate that there was an adverse incident or quality of care issue unless there was a deviation in the expected standards of care and/or assessment.
- Significant sexual behavior with other patients or staff, whether consensual or not, while in a behavioral health treatment setting. The circumstances and severity of the actual act needs to be taken into account in determining the severity rating. All incidents that results in police contact or legal involvement are considered significant.
- Serious adverse reaction to behavioral health treatment requiring urgent or emergent medical treatment (e.g. neuroleptic malignant syndrome, tardive dyskinesia, other serious drug reaction). Note: If transferred to a medical unit it may be categorized as unplanned transfer per the above bullet.
- Medication/treatment errors.
- Violent/Assaultive behavior with physical harm to self or others (e.g., attempted murder, physical assault) and requiring urgent or emergent medical intervention (indicate in documentation if perpetrator was staff or member/visitor, etc.)
- Unscheduled event that results in the evacuation of a program or facility and may result in the need for finding alternative placement options for members.
- Suicide attempt demonstrating significant risk to member at a behavioral health facility resulting in serious injury that may or may not require medical admission.
- Self-inflicted harm in a behavioral health treatment setting that may or may not require urgent or emergent treatment (i.e. self- injurious behaviors, suicide gestures, non-lethal, such as cutting).
- Property damage, including that which occurs secondary to the setting of a fire, due to the intentional actions of a Beacon of California member while in a behavioral health treatment setting.
- Human Rights Violations (e.g. neglect, exploitation).
- Illegal activity (i.e. possession/sale of illicit drugs, alcohol, weapons, prostitution, public nudity in a treatment setting this is independent of harm to self or others including if there were any arrest(s).
- Other occurrences representing actual serious harm to a member not listed above – requires explanation.

Participating provider reports of adverse incidents are treated confidentially and are processed in accordance with “peer protection” statutes. Based on the circumstances of each incident, or any identified trend of incidents, Beacon of California may undertake an investigation designed to provide for member safety. As a result, participating providers may be asked to furnish records, and/or engage in corrective action to address quality of care concerns and any identified or suspected deviations from a reasonable standard of care. Participating providers may also be subject to disciplinary action through the Beacon of California Credentialing Committee based on the findings of an investigation or any failure to cooperate

with a request for information pursuant to an adverse incident investigation.

Quality Improvement Activities/Projects

One of the primary goals of Beacon of California's Quality Management Program (QMP) is to continuously improve care and services. Through data collection, measurement and analysis, aspects of care and service that demonstrate opportunities for improvement are identified and prioritized for quality improvement activities. Data collected for quality improvement projects and activities are frequently related to key industry measures of quality that tend to focus on high-volume diagnoses or services and at high-risk special populations. Data collected are valid, reliable and comparable over time. Beacon of California takes the following steps to ensure a systematic approach to the development and implementation of quality improvement activities:

- Monitoring of clinical quality indicators
- Review and analysis of the data from indicators
- Identification of opportunities for improvement
- Prioritization of opportunities to improve processes or outcomes of behavioral healthcare delivery based on risk assessment, ability to impact performance, and resource availability
- Identification of the affected population within the total membership
- Identification of the measures to be used to assess performance
- Establishment of performance goals or desired level of improvement over current performance
- Collection of valid data for each measure and calculation of the baseline level of performance
- Thoughtful identification of interventions that are powerful enough to impact performance
- Analysis of results to determine where performance is acceptable and, if not, the identification of current barriers to improving performance

Experience/Satisfaction Surveys

Beacon of California, either directly or through authorized designees, conducts some form of experience and/or satisfaction survey to identify areas of improvement as a key component of the QMP. Satisfaction survey participation may include members, participating providers and/or clients.

Member experience and/or satisfaction surveys measure opinions about clinical care, participating providers, and Beacon of California's administrative services and processes. Members are asked to complete satisfaction surveys at various points in the continuum of care and/or as part of ongoing quality improvement activities. The results of these member surveys are summarized on an annual basis. Where appropriate, corrective actions are implemented in the Beacon of California's functional department.

Annual participating provider satisfaction surveys measure opinions regarding clinical and administrative practices. The results of participating provider surveys are aggregated and used to identify potential improvement opportunities within Beacon of California and possible education or training needs for participating providers. Where appropriate, corrective actions are implemented in the Beacon of California's functional department.

Practitioner Satisfaction Survey – Access to Care

The State of California's Timely Access to Non-Emergency Health Care Services Regulation (§1300.67.2.2, Title 28, California Code of Regulations) requires Beacon of California to maintain an adequate provider network to ensure members receive timely access to care appropriate for their condition. In order to ensure compliance in this area, Beacon of California conducts a provider satisfaction survey on an annual basis. Beacon of California is required to solicit feedback from participating practitioners about their perspective and satisfaction with their Beacon of California patient's access to care within the timelines set forth under California law. Beacon of California must also assess the provider's perspective and concerns with Beacon of California's language assistance program regarding the:

- Coordination of appointments with an interpreter;
- Availability of an appropriate range of interpreters; and
- Training and competency of available interpreters.

Site Visits for Quality Reviews

Beacon of California, or its designee, conducts site visits at participating provider facilities and/or offices. A site visit may be conducted as part of monitoring an investigation stemming from a member complaint or other quality issue. The current Beacon of California site visit tool and associated forms are available for review on the Beacon of California website. Beacon of California reserves the right to modify or replace the site visit tool and associated forms without notice.

Beacon of California will contact the participating provider to arrange a mutually convenient time for the site visit. The QM site visit process is intended to be consultative and educational. Following the site visit, the participating provider will receive a written report detailing the findings of the site visit. If necessary, the report will include an action plan that will provide guidance in areas that the participating provider needs to strengthen in order to comply with Beacon of California's standards.

Complaints and Grievances

One method of identifying opportunities for improvement in processes at Beacon of California is to collect and analyze the content of member, provider/participating provider, and client complaints. Beacon of California's grievance policies and procedures have been developed to address customer complaints, quality of care and service issues, and appeals. The grievance process provides a system for resolving customer issues promptly and appropriately. Beacon of California also offers an expedited grievance process when there is an imminent and serious threat to the health of the member. The Beacon of California Medical Director oversees and reviews findings from the grievance process; grievance policy changes are submitted to the QM/UM/CM Committee for review and approval as applicable. The grievance process, a printable grievance form, and instructions for submitting grievances on-line are described in more detail in the Beacon of California member section at www.beaconhealthoptionsca.com

Language Assistance Program

As a California health plan, Beacon of California is required to provide language assistance services to members with limited English proficiency, including members who require sign language services. Beacon of California has established a Language Assistance Program designed to provide its members translation and interpretation services at no charge. Services, materials, and information are provided to

members in a language that they speak and understand. Participating providers should be aware of Beacon of California's standards and mechanisms for providing language assistance services at no cost to all members.

Beacon of California participating providers are required to comply with Beacon of California's Language Assistance Program. Members may request certain Beacon of California documents, which are translated into a language that they speak and understand. Members may also request they be provided with translator services when they seek treatment with a provider.

Beacon of California has contracted with a company that can provide telephonic interpreter services. The phone interpreter services are available 24 hours per day, seven days a week. Participating providers need to have available a speakerphone or dual headset phone in the areas in which telephone interpreter services will be provided. For members requiring American Sign Language (ASL), Beacon of California has contracted with a company able to provide in-person interpreter services 24 hours per day, seven days a week. Participating providers should provide as much advance notice as possible when requesting an ASL interpreter, as well as at least 24 hours in advance for cancellations.

Participating providers must comply with all HIPAA requirements when providing interpreter services to members. While the law does not prohibit adult family members from serving as interpreters for members, Beacon of California discourages this practice. Minor children should not be used as interpreters, except in emergency situations where any delay could result in harm to a member and only until a qualified interpreter is available. Participating providers should remind members that Beacon of California provides free interpreter services with qualified interpreters.

When providing language assistance services to members with limited English proficiency, participating providers must document the following in medical records:

- How the language assistance was provided (i.e. name of interpreter, employee name and ID, over the phone or in-person, etc.)
- If language assistance was refused by the member, specifically why it was refused (i.e. patient preferred to use own English skills, etc.)

If a member needs assistance in receiving services, material and/or information in a language that they speak and understand, if you need assistance in communicating with a member in a language that they speak and understand, or if you have a question about the Beacon of California's Language Assistance Program, call the toll-free number on the back of the member's identification card.

During the initial credentialing and recredentialing process, if a provider has indicated on the credentialing application that he/she is fluent in language(s) other than English and can provide behavioral health services in another language, the provider is required to sign an attestation to that fact (available on the *Beacon of California Forms* section of this Handbook).