Provider Manual
Section 16.0
Behavioral Health

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16.0 Behavioral Health

Passport's behavioral health program provides members with access to a full continuum of recovery and resiliency-focused behavioral health and substance disorders services through a network of contracted providers. The primary goal of the program is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings. By ensuring that all Passport members receive timely access to clinically appropriate behavioral health and substance disorder services, Passport believes that quality clinical services can lead to improved health outcomes for our members.

16.1 Administrative Procedures

Passport has partnered with Beacon Health Strategies, LLC to assist in the coordination of the behavioral health and substance disorder benefit for our members.

eServices, is a secure web portal, that supports all provider transactions, such as verifying member's eligibility, claims status, and authorization submission and inquiry while saving providers' time, postage expense, billing fees, and reducing paper waste. **eServices** provides important Provider communications and is completely free to Passport contracted providers. Providers may register and access these services through www.beaconhealthstrategies.com twenty four hours a day, seven days a week.

Interactive voice recognition (IVR) is available to providers as an alternative to **eServices**. It provides accurate, up-to-date information by telephone, and is available for selected transactions at (888) 210-2018. In order to maintain compliance with HIPAA and all other federal and state confidentiality/privacy requirements, providers must have their practice or organizational tax identification number (TIN), national provider identifier (NPI), as well as the member's full name, Plan ID and date of birth when verifying eligibility.

Electronic data interchange (EDI) is available for claim submission and eligibility verification directly by the provider to Passport Health Plan or via an intermediary. For information about testing and setup for EDI, download the 837 & 835 companion guides at the following web site locations:
http://www.beaconhealthstrategies.com/private/pdfs/Beacon_835CompanionGuide_v1.pdf
http://www.beaconhealthstrategies.com/private/pdfs/Beacon_837CompanionGuide.pdf

For technical and business related questions, email edi.operations@beaconhs.com. To submit EDI claims through an intermediary, contact the intermediary for assistance. If using Emdeon, use Emdeon Payer ID (43324) and the Passport Health Plan ID (028).

Electronic Transactions Availability:

Transaction / Capability	Available 24/7 On		
	eServices **at** www.beaconhealthstrategies.com	IVR **888.210.2018**	EDI **at** www.beaconhealthstrategies.com
• Verify member eligibility, benefits and copayment	Yes	Yes	Yes (HIPAA 270/271)
• Check number of visits available	Yes	Yes	Yes (HIPAA 270/271)
• Submit authorization requests	Yes		
• View authorization status	Yes	Yes	
• Update practice information	Yes		
• Submit claims	Yes		Yes (HIPAA 837)
• Upload EDI claims for Passport members and view	Yes		Yes (HIPAA 837)
• View claims status and print EOBs	Yes	Yes	Yes (HIPAA 835)
• Print claims reports and graphs	Yes		
• Download electronic remittance advice	Yes		Yes (HIPAA 835)
• EDI acknowledgment & submission reports	Yes		Yes (HIPAA 835)
• Pend authorization requests for internal approval	Yes		
• Access the level-of-care criteria	Yes		

16.2 Access to Care

Passport members may access behavioral health services 24 hours a day, seven days a week by contacting Passport's Behavioral Health Hotline, at (855) 834-5651. Members do not need a referral to access behavioral health services and authorization is never required for emergency services. Passport adheres to State and National Committee for Quality Assurance (NCQA) guidelines for access standards for member appointments. Contracted providers may only provide such behavioral health and physical health services within the scope of their license and must adhere to the following:

Appointment Standards and After Hours Accessibility:

Type of Care	Appointment Availability
Emergency Care with Crisis Stabilization	Within twenty four (24) hours
Urgent Care	Within forty eight (48) hours
Post Discharge from Acute Hospitalization	Within 7 days of discharge
Other routine referrals/appointments	Within ten (10) days

In addition, Passport providers must adhere to the following guidelines to ensure members have adequate access to services:

Service Availability	Hours of Operation:
On-Call	• 24-hour on-call services for all members in treatment; and, Ensure that all members in treatment are aware of how to contact the treating or covering provider after hours and during provider vacations.
Crisis Intervention	• Services must be available 24 hours per day, 7 days per week; Outpatient facilities, physicians and practitioners are expected to provide these services during operating hours; and After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.
Outpatient Services	• Outpatient providers should have services available Monday through Friday from 9:00 a.m. to 5:00 p.m. EST at a minimum; and, Evening and/or weekend hours should also be available at least two (2) days per week.

All members receiving inpatient psychiatric services should be scheduled for outpatient follow-up and/or continuing treatment prior to discharge. Outpatient treatment must occur within seven (7) days from the date of discharge (note: subject to latest statewide changes). Providers are required to contact members who have missed appointments within twenty-four (24) hours to reschedule appointments.

16.2.1 Out of Network Providers

Out of network behavioral health benefits are limited to those services that are not available in the existing Passport network, emergency services and transition services for members who are currently in treatment with an out of network provider who is either not a part of the network or who is in the process of joining the network.

Out of network providers must complete a Behavioral Health single case agreement with Passport. Out of network providers may provide one evaluation visit for Passport members without an authorization upon completion and return of the signed single case agreement. After the first visit, services provided must be authorized. Authorization requests for outpatient services can be obtained through the electronic outpatient request form (eORF) which can be requested by calling (855)834-5651 or on the website www.beaconhealthstrategies.com. If this process is not followed, Passport may administratively deny the services and the out of network provider must hold the member harmless.

Notifications of authorization will be provided within seven (7) days of the request. The member must be eligible at the time of authorization. However, the member's eligibility is subject to change.

Out of network providers are encouraged to verify eligibility.

16.3 Behavioral Health Benefits

Passport covers behavioral health and substance disorder services to members located within the Commonwealth. Under Passport, the following levels of care are covered, provided that services are medically necessary, delivered by contracted network providers, and that the authorization procedures outlined in this manual are followed. DSM-IV (or DSM-V upon DMS implementation) multi-axial classification should be used when assessing members for services and documented in the member's medical record. Covered Services include:

- Inpatient mental health
- Crisis stabilization – adult and child
- Emergency room visits
- Medical detoxification
- Psychiatric Residential Treatment Facilities (PRTF)
- Extended Care Units (ECU)
- Residential substance abuse rehabilitation
- Outpatient mental health services, such as therapy, groups, peer support, therapeutic rehabilitation, case management services, etc.
- Electroconvulsive Therapy (ECT)
- Psychological testing
- Community Mental Health Center Services, such as outpatient services, therapeutic rehabilitation, tiered case management services, etc.
- Mobile Crisis
- Substance Disorder Inpatient (detox, rehabilitation, SUDS) and Outpatient (individual/group/PHP, Day Treatment, Wellness Recovery) services
- Partial Hospitalization (BH and SA)
- Assertive Community Outreach Team (ACT)

Access to behavioral health and substance disorder treatment is an essential component of a comprehensive health care delivery system. Plan members may access behavioral health and substance disorder services by self-referring to a network provider, by calling the behavioral health hotline, or by referral through acute or emergency room encounters. Members may also access behavioral health and substance disorder services by referral from their primary care provider (PCP); however, a PCP referral is not required for behavioral health or substance disorder services. Network providers are expected to coordinate care with a member's primary care and other treating providers whenever possible.

16.4 Care Management and Utilization Management

16.4.1 Care Management

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

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

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

- Member has a prior history of acute psychiatric or substance use admissions authorized by Passport with a readmission within a 60 day period;
- First inpatient hospitalization following lethal suicide attempt, or treatment for first psychotic episode;
- Member has combination of severe, persistent psychiatric clinical symptoms, and lack of family or social support, along with an inadequate outpatient treatment relationship which places the member at risk of requiring acute behavioral health services;
- Presence of a co-morbid medical condition that when combined with psychiatric and/or substance use issues could result in exacerbation of fragile medical status;
- Member that is actively using substances, or requires acute behavioral health treatment services;
- ICM for member that is pregnant or 6 months post partum;
- A child living with significant family dysfunction and continued instability following discharge from inpatient or intensive outpatient family services that requires support to link family, providers and state agencies, which places the member at risk of requiring acute behavioral health services;
- Multiple family members that are receiving acute behavioral health and/or substance disorder treatment services at the same time; and,
- Other, complex, extenuating circumstances where the ICM team determines the benefit of inclusion beyond standard criteria.

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

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

ICM and Behavioral Health Case Management Services are voluntary programs and member consent is required for participation. For further information on how to refer a member to care management services, please contact the Behavioral Health Hotline at (855) 834-5651.

16.4.2 Utilization Management

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

The Behavioral Health's UM program is administered by licensed, experienced clinicians who are specifically trained in utilization management techniques and in behavioral health's standards and protocols. Employees with responsibility for making UM decisions have been made aware that:

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

16.4.2.1 Medical Necessity

All requests for authorization are reviewed by clinicians based on the information provided according to the definition of medical necessity that is outlined in the Kentucky Administrative Regulations. 907 KAR 3:130 defines medical necessity in the following way:

"Medical necessity means a covered benefit is: Reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; Clinically appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice; Provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons; Provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided; Needed, if used in reference to an emergency medical service, to exist using the prudent layperson

standard; Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 U.S.C. 1396d(r) and 42 CFR Part 441 Subpart B for individuals under twenty-one (21) years of age; and Provided in accordance with 42 CFR 440.230."

16.4.2.2 Level-of-Care Criteria (LOCC)

Passport's LOCC is the basis for all medical necessity determinations, are accessible through **eServices**, and includes specific LOCC for Kentucky for each level-of-care. Providers can also contact the Behavioral Health Hotline at (855) 834-5651 to request a printed copy of the LOCC.

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

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

Behavioral Health Providers must refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment with the members or the members' legal guardian's consent. Behavioral Health providers may only provide physical health care services if they are licensed to do so.

16.4.2.3 Utilization Management Terms and Definitions

The definitions below describe utilization review including the types of the authorization requests and UM determinations used to guide the UM reviews and decision making. All determinations are based upon review of the information provided and available to the reviewer at the time.

Adverse Determination:	A decision to deny, terminate, or modify (an approval of fewer days, units or another level-of-care other than was requested, which the practitioner does not agree with) an admission, continued inpatient stay, or the availability of any other behavioral health care service, for: a) failure to meet the requirements for coverage based on medical necessity, b) appropriateness of health care setting and level-of-care effectiveness, or c) Health plan benefits.

Adverse Action:	The following actions or inactions by Passport or the provider organization: 1. The denial, in whole or in part, of payment for a service; failure to provide covered services in a timely manner in accordance with the waiting time standards; 2. The denial or limited authorization of a requested service, including the determination that a requested service is not a covered service; 3. The reduction, suspension, or termination of a previous authorization for a service; 4. The denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including but not limited to denials based on the following: a. Failure to follow prior authorization procedures b. Failure to follow referral rules c. Failure to file a timely claim 5. The failure to act within the timeframes for making authorization decisions; 6. The failure to act within the timeframes for making appeal decisions.
Non-Urgent Concurrent Review & Decision	Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments. A non-urgent concurrent decision may authorize or modify requested treatment over a period of time or a number of days or treatments, or deny requested treatment, in a non-acute treatment setting.
Non-Urgent Pre-Service Review & Decision	Any case or service that must be approved before the member obtains care or services. A non-urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment, in non-acute treatment setting.
Post-Service Review & Decision (Retrospective Decision)	Any review for care or services that have already been received. A post-service decision would authorize, modify, or deny payment for a completed course of treatment where a pre-service decision was not rendered, based on the information that would have been available at the time of a pre-service review.
Urgent Care Request & Decision	Any request for care or treatment for which application of the normal time period for a non-urgent care decision: • Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment; *or,* • In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the
Urgent Concurrent Review Decision	Any review for a requested extension of a previously approved, ongoing course of treatment over a period of time or number of days or treatments in an acute treatment setting, when a member's condition meets the definition of urgent care above.
Urgent Pre-Service Decision	Formerly known as a pre-certification decision. Any case or service that must be approved before a member obtains care or services in an inpatient setting for a member whose condition meets the definition of urgent care above. An urgent pre-service decision may authorize or modify requested treatment over a period of time or number of days or treatments, or deny requested treatment in an acute treatment setting.

16.5 Authorization Procedures and Requirements

Authorization Procedures and Requirements

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

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

16.5.1 Member Eligibility Verification

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

Member eligibility can change and possession of a health plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check eServices, or by calling their IVR line at (888) 210-2018.

16.5.2 Emergency Services

Definition

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

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

16.5.2.1 Passport Health Plan Behavioral Health Crisis Line

Our toll-free crisis line, (855) 834-5651, is available to members in the event of an emergency and is staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year. Behavioral Health Services professionals are available to assess, triage

and address behavioral health emergencies through this crisis line. Passport can arrange for emergency and crisis Behavioral Health Services through mobile crisis teams in the member's community. Face to face emergency services are available twenty-four (24) hours a day, seven (7) days a week through Passport's behavioral health network.

16.5.2.2 Emergency Screening and Evaluation

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

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

16.5.2.3 Behavioral Health Clinician Availability

All behavioral health clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention, triage and referral procedures. Clinicians are available 24 hours a day, 7 days a week, to take emergency calls from members, their guardians, and providers.

Disagreement between Behavioral Health Physicians and Attending Physician

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

16.5.2.4 Authorization Requirements

16.5.2.4.1 Outpatient Treatment (Initial Encounters):

Passport members are allowed thirty (30) initial therapy sessions without prior authorization. These sessions, called initial encounters or IEs, must be provided by contracted in-network providers and are subject to meeting medical necessity criteria.

To ensure payment for services, providers are strongly encouraged to ask new patients if they have

been treated by other therapists. Via **eServices**, providers can look up the number of IEs that have been billed; however, the member may have used additional visits that have not been billed by your agency. If the member has used some IEs, the new provider may contact the Behavioral Health Hotline before beginning treatment.

The following services count against the member's 30 IEs:

1. Outpatient behavioral health, including individual and family therapy
2. Outpatient substance use services, including individual and family therapy
3. Combined psychopharmacology and therapy visits. For example, 90833, 90836 and 90838.

The following services require no authorization and do not count against the member's IEs.

1. Medication management sessions; and E&M codes
2. Group therapy sessions (CPT code 90853); and,
3. Collateral therapy (90887)

The following table outlines the authorization requirements for each service. Services that indicate "eRegister" will be authorized via the eServices portal. Providers will be asked a series of clinical questions to support medical necessity for the service requested. If sufficient information is provided to support the request, the service will be authorized. If additional information is needed, the provider will be prompted to contact UM staff via phone to continue the request for authorization. While it is preferred that providers make requests via eServices, Health staff will work with providers who do have technical or staffing barriers to requesting authorizations in this way.

Outpatient Services:

Benefit/Service	Authorization Requirements
Medication Management Injection Administration Diagnostic Interview Assessment Individual Therapy Family Therapy Group Therapy Collateral Services Peer Support	No authorization required for medication management injection, group counseling, collateral therapy or evaluations. For all other services, provider may see member for 30 visits without prior authorization. Submission of Electronic Outpatient Request Form (eORF) required before the 31st visit. This form can submitted via eServices or faxed to (781) 994-7633.
Psychological Testing	Faxed Prior Authorization Required to (781) 994-7633.
ECT	Telephonic Prior Authorization

Community Based Services:

Benefit/Service	Notification Requirement	Initial Authorization Parameters (All determinations based on medical necessity)
Therapeutic Rehabilitation Services (Adult and Child)	eRegister within 2 weeks of initial date of service	Authorization as requested, up to 6 hours daily for initial 30 days. Submit eServices request prior to 30th day for continued stay review.
Intensive Outpatient	Telephonic Prior Authorization	Initial authorization up to 6 hours days/per week; weekly telephonic continued stay review.
Partial Hospitalization	Telephonic Prior Authorization	Initial authorization up to 5 hours daily/per week; weekly telephonic continued stay review
Assertive Community Treatment (ACT)	Telephonic Prior Authorization	Initial authorization up to max monthly; monthly telephonic continued stay review
Day Treatment	Telephonic Prior Authorization	Initial authorization up to max weekly; weekly telephonic continued stay review
Targeted Case Managemen Adult with SMI and Childr with SED	eServices within 2 weeks of initial date of service	Initial authorization for 3 months; submit continued stay request through eServices prior to 90th day of service.
Targeted Case Management for individuals with Substance Use Disorder	eServices within 2 weeks of initial date of service	Initial authorization for 3 months; submit continued stay request through eServices prior to 90th day of service
Targeted Case Management for individuals with co-occurring mental health disorders for chronic or complex physical health conditions	eServices within 2 weeks of initial date of service	Initial authorization for 3 months; submit continued stay request through eServices prior to 90th day of service
Emergency Services/Mobile Crisis	No authorization Required	No authorization required

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

All forms can be found on this web site under Provider Tools - **http://www.beaconhealthstrategies.com/private/provider/provider_tools.aspx.**

16.5.2.4.2 Inpatient Services

All inpatient services (including inpatient ECT and inpatient EPSDT special services such as chemical dependency, residential substance abuse services, and extended care units) require

telephonic prior authorization within 24 hours of admission. Providers should call the Behavioral Health Hotline at (855) 834-5651 for all inpatient admissions, including detoxification that is provided on a psychiatric floor or in freestanding psychiatric facilities. Behavioral Health typically authorizes inpatient stays in 2-3 day increments, depending on medical necessity. Continued stay reviews require updated clinical information that demonstrates active treatment. Additional information about what is required during pre-service and concurrent stay reviews is listed below.

UM Review Requirements – Inpatient and Diversionary

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

Authorization determinations are based on the clinical information available at the time the care was provided to the member.

Notice of inpatient authorization is mailed to the admitting facility. Members must be notified of all pre-service and concurrent denial decisions. Members are notified by mail of all acute pre-service and concurrent denial decisions. For members in inpatient settings, the denial letter is delivered by mail to the member on the day the adverse determination is made, prior to discharge. The service is continued without liability to the member until the member has been notified of the

adverse determination. The denial notification letter sent to the member or member's guardian, practitioner, and/or provider includes the specific reason for the denial decision, the member's presenting condition, diagnosis and treatment interventions, the reason(s) why such information does not meet the medical necessity criteria, reference to the applicable benefit provision, guideline, protocol or criterion on which the denial decision was based, and specific alternative treatment option(s) offered by Passport, if any. Based on state and/or federal statutes, an explanation of the member's appeal rights and the appeals process is enclosed with all denial letters. Providers can request additional copies of adverse determination letters by contacting the Behavioral Health Hotline.

16.5.2.4.3 Return of Inadequate or Incomplete Treatment Requests

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

16.5.2.4.4 Notice of Inpatient/Diversionary Approval or Denial

Verbal notification of approval is provided at the time of pre-service or continuing stay review. Notice of admission or continued stay approval is mailed to the member or member's guardian and the requesting facility within the timeframes specified later in this chapter.

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

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

16.5.2.4.5 Termination of Outpatient Care

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

16.5.2.4.6 Decision and Notification Timeframes

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

The timeframes below present Passport's internal timeframes for rendering a UM determination, and notifying members of such determination. All timeframes begin at the time of Passport's receipt of the request. Please note, the maximum timeframes may vary from those on the table below on a case-by-case basis in accordance with state, federal government, NCQA or URAC requirements that have been established for each line of business.

Decision and Notification Timeframes:

	Type of Decision	**Decision Timeframe**	**Verbal Notification**	**Written Notification**
Pre-Service Review				
Initial Auth for Inpatient Behavioral Health	Urgent	Within 24 hours	Within 24 hours	Within 24 hours
Initial Auth for Other Urgent Behavioral Health Services	Urgent	Within 72 hours	Within 24 hours	Within 24 hours
Initial Auth for Non-Urgent Behavioral Health Services	Standard	Within 2 Business Days	Within 2 Business Days	Within 2 Business Days
Concurrent Review				
Continued Auth for Inpatient and Other Urgent Behavioral Health Services	Urgent/ Expedited	Within 24 hours	Within 24 hours	Within 24 hours
Continued Auth for Non Urgent Behavioral Health Services	Non--Urgent/ Standard	Within 2 Business Days	Within 2 Business Days	Within 2 Business Days
Post Service				
Authorization for Behavioral Health Services Already Rendered	Non-Urgent/ Standard	Within 30 Business Days	Within 30 Business Days	Within 30 Business Days

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

16.6 Quality Improvement

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

Providers are also required to communicate (with member consent) with Primary Care Providers (PCPs) on a regular basis. Providers are required to send initial and quarterly (or more frequently if clinically indicated) summary reports of a members' behavioral health status to the PCP (with the member's or the member's legal guardian's consent). The purpose of this reporting is to ensure coordination between the PCP and behavioral health provider and improve the quality of member care.

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

Communication between Behavioral Health Providers and Other Service Providers:

Communication between Outpatient Behavioral Health Providers and PCPs, Other Service Providers	**Communication between Inpatient/ Diversionary Providers and PCPs, Other Outpatient Service Providers**
Outpatient behavioral health providers are expected to communicate with the member's PCP and other OP behavioral health providers if applicable, as follows: • Notice of commencement of outpatient treatment within 4 visits or 2 weeks, whichever occurs first; • Updates at least quarterly during the course of treatment; • Notice of initiation and any subsequent modification of psychotropic medications; and, • Notice of treatment termination within 2 weeks. • Refer for known or suspected and untreated physical health problems or disorders for examination and treatment. Behavioral health providers may use the Authorization for Behavioral Health Provider and PCP to Share Information and the Behavioral Health-PCP Communication Form available for initial communication and subsequent updates, in Appendix B, or their own form that includes the following information: • Presenting problem/reason for admission; • Date of admission; • Admitting diagnosis; • Preliminary treatment plan; • Currently prescribed medications; • Proposed discharge plan; and • Behavioral health provider contact name and telephone number.	With the member's informed consent, acute care facilities should contact the PCP by phone and/or by fax, within 24 hours of a member's admission to treatment. Inpatient and diversionary providers must also alert the PCP 24 hours prior to a pending discharge, and must fax or mail the following member information to the PCP within 3 days post-discharge: • Date of Discharge; • Diagnosis; • Medications; • Discharge plan; and • Aftercare services for each type, including: - Name of provider; - Date of first appointment; - Recommended frequency of appointments; - Treatment plan. Inpatient and diversionary providers should make every effort to provide the same notifications and information to the member's outpatient therapist, if there is one. Acute care providers' communication requirements are addressed during continued stay and discharge reviews and documented in Passport's member

Request for PCP response by fax or mail within 3 business days of the request to include the following health information: • Status of immunizations; • Date of last visit; • Dates and reasons for any and all hospitalizations; • Ongoing medical illness; • Current medications; • Adverse medication reactions, including sensitivity and allergies; • History of psychopharmacological trials; and, • Any other medically relevant information Outpatient providers' compliance with communication standards is monitored through requests for authorization submitted by the provider, and through chart reviews.	record.

16.6.1 Transitioning Members from one Behavioral Health Provider to Another

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

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

16.6.2 Follow Up After Mental Health Hospitalization

Members discharged from inpatient levels of care are assigned an aftercare coordinator/case manager by Passport prior to or on the date of discharge. The Behavioral Health case managers and other behavioral health service providers participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Members being discharged from inpatient levels of care are scheduled for follow up appointments within 7 days of discharge from an acute care setting. Providers are responsible for seeing members within that timeframe and for outreaching members who miss their appointments to reschedule. Behavioral Health case managers and aftercare coordinators work with providers to assist in this process by sending reminders to members; working to remove barriers that may prevent a member from keeping his or her discharge appointment and coordinating with treating providers. Network providers are expected to aid in this process as much as possible to ensure that members have the supports they need to maintain placement in the community and to prevent unnecessary readmissions.

16.6.3 Accessing Medications

Behavioral health service providers will assist member in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.

16.6.4 Reportable Incidents and Events

Passport requires that all providers report adverse incidents, sentinel events and other reportable incidents involving Passport members as follows:

	Adverse Incidents	Sentinel Events	Other Reportable Incidents
Incident / Event Description:	An adverse incident is an occurrence that represents actual or potential serious harm to the wellbeing of a health plan member who is currently receiving or has been recently discharged from behavioral health services.	A sentinel event is any situation occurring within or outside of a facility that either results in death of the member or immediately jeopardizes the safety of a health plan member receiving services in any level-of-care.	An "other reportable incident" is any incident that occurs within a provider site at any level-of-care, which does not immediately place a health plan member at risk but warrants serious concern.
	• All medico-legal or non-medico-legal deaths; • Any Absence without Authorization (AWA) involving a member who does not meet the criteria above; • Any injury while in a 24-hour program that could or did result in transportation to an acute care hospital for medical treatment or hospitalization; • Any sexual assault or alleged sexual assault; • Any physical assault or alleged physical assault by a staff person or another patient against a member; • Any medication error or suicide attempt that requires medical attention beyond general first aid procedures; • Any unscheduled event that results in the temporary evacuation of a program or facility (e.g. fire resulting in response by fire department;	•All medico-legal deaths; •Any medico-legal death is any death required to be reported to the Medical Examiner or in which the Medical Examiner takes jurisdiction; •Any absence without authorization (AWA) involving a patient involuntarily admitted or committed and/or who is at high risk of harm to self or others; •Any serious injury resulting in hospitalization for medical treatment; •A serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is subsequently medically admitted;	•Any non-medico-legal death; •Any absence without authorization from a facility involving a member who does not meet the criteria for a sentinel event as described above; •Any physical assault or alleged physical assault by or against a member that does not meet the criteria of a sentinel event; •Any serious injury while in a 24hour program requiring medical treatment, but not hospitalization; •A serious injury, defined as any injury that requires the individual to be transported to an acute care hospital for medical treatment and is not

		•Any medication error or suicide attempt that requires medical attention beyond general first aid procedures; •Any sexual assault or alleged sexual assault; • Any physical assault or alleged physical assault by a staff person against a member; and •Any unscheduled event that results in the evacuation of a program or facility whereby regular operations will not be in effect by the end of the business day and may result in the need for finding alternative placement options for member.	subsequently medically admitted; and • Any unscheduled event that results in the temporary evacuation of a program or facility such as a small fire that requires fire department response. Data regarding critical incidents is gathered in the aggregate and trended on a quarterly basis for the purpose of identifying opportunities for quality improvement.
Reporting Method:	• Behavioral Health Clinical Department is available 24 hours a day; • Providers must call, regardless of the hour, to report such incidents; • Providers should direct all such reports to their Passport clinical manager or UR clinician by phone; • In addition, providers are required to fax a copy of the Adverse Incident Report Form (for adverse and other reportable incidents and sentinel events) to the Ombudsperson at (781)994-7500. All adverse incidents are forwarded to health plan for notification as well. • Incident and event reports should not be emailed unless the provider is using a secure messaging system.		
Prepare to Provide the Following:	Providers should be prepared to present: • All relevant information related to the nature of the incident; • The parties involved (names and telephone numbers); and, • The member's current condition.		

16.7 Behavioral Health Provider Billing Manual

16.7.1 Billing Transactions

This chapter presents all information needed to submit behavioral health claims. Passport strongly encourages providers to rely on electronic submission, either through EDI or **eServices** in order to achieve the highest success rate of first-submission claims payment.

16.7.2 General Claim Policies

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

16.7.3 Definition of "Clean Claim"

A clean claim, as discussed in this provider manual, the provider services agreement, and in other Passport informational materials, is defined as one that has no defect and is complete including

required, substantiating documentation of particular circumstance(s) warranting special treatment without which timely payments on the claim would not be possible.

16.7.4 Electronic Billing Requirements

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

16.7.5 Provider Responsibility

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

16.7.6 Limited Use of Information

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

16.7.7 Prohibition of Billing Members

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

16.7.8 Passport's Right to Reject Claims

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

16.7.9 Recoupments and Adjustments

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

16.7.10 Claim Turnaround Time

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

16.7.11 Claims for Inpatient Services

- The date range on an inpatient claim for an entire admission (i.e., not an interim bill) must include the admission date through the discharge date. The discharge date is not a covered day of service but must be included as the "to" date. Refer to authorization notification for correct date ranges.
- Passport accepts claims for interim billing that include the last day to be paid as well as the correct bill type and discharge status code. On bill type X13, where X represents the "type of facility" variable, the last date of service included on the claim will be paid and is not considered the discharge day.
- Providers must obtain authorization from Passport for all ancillary medical services provided while a plan member is hospitalized for a behavioral health condition. Such authorized medical services are billed directly to the health plan.
- Passport's contracted reimbursement for inpatient procedures reflect all-inclusive per diem rates.

16.7.12 Coding

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

- Providers are required to submit HIPAA-compliant coding on all claim submissions; this includes HIPAA-compliance revenue, CPT, HCPCS, and ICD-9 codes.
- Providers should refer to their exhibit A for a complete listing of contracted, reimbursable procedure codes.
- Passport accepts only ICD-9 diagnosis codes listed as approved by CMS and HIPAA. In order to be considered for payment by Passport, all claims must have a Primary ICD-9 diagnosis in the range of 290-298.9, 300.00-316.
- All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.
- Claims for inpatient and institutional services must include the appropriate discharge status code. Table 6-1 lists HIPAA-compliant discharge status codes.
- DSM-V (or most recent) classification should be used for behavioral health billing.

Table 6-1 Discharge Status Codes

Code	Description
01	Discharged to Home / Self Care
02	Discharged/Transferred to Another Acute Hospital
03	Discharged/Transferred to Skilled Nursing Facility
04	Discharged/Transferred to Intermediate Care Facility
05	Discharged/Transferred to Another Facility
06	Discharged/Transferred to Home / Home Health Agency
07	Left Against Medical Advice or Discontinued Care

08	Discharged/Transferred Home / IV Therapy
09	Admitted as Inpatient to this Hospital
20	Expired
30	Still a Patient
51	Hospice
65	Discharge/Transferred to Psychiatric Hospital or Psychiatric unit
70	Discharge/Transferred to another Health Care Institute not defined

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

Table 6-2 Bill Type Codes

Type of Facility 1st Digit	Bill Classification 2nd Digit	Frequency – 3rd Digit
1. Hospital	1. Inpatient	1. Admission through Discharge Claim
1. Skilled Nursing Facility	2. Inpatient Professional Component	2. Interim – First Claim
2. Home Health Care	3. Outpatient	3. Interim Continuing Claims
3. Christian Science Hospital	4. Diagnostic Services	4. Interim – Last Claim
5. Christian Science Extended Care Facility	5. Intermediate Care – Level I	5. Late Charge Only
6. Intermediate Care Facility	6. Intermediate Care – Level II	6 – 8. Not Valid

* BHSO –All claims, including residential services, should be submitted on a CMS1500.

16.7.13 Modifiers

Modifiers can reflect the discipline and licensure status of the treating practitioner or are used to make up specific code sets that are applied to identify services for correct payment. Table lists HIPAA-compliant modifiers accepted by Passport.

Table 6-3 Modifiers

Professional Provider Type	Modifier
Psychiatrist	AF
Licensed Psychologist	AH
Licensed Clinical Social Worker	AJ
Physician	AM
Community Support Associate or Non-Bachelor's Level Providers	HN
Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, Licensed Behavioral Analyst (pending DMS approval), Licensed Professional Art Therapist (pending DMS approval)	HO

Advance Registered Nurse Practitioner	SA
Physician Assistant	U1
Certified Social Worker, Licensed Professional Counselor Associate, Licensed Psychological Associate, Marriage, Family Therapy Associate, Licensed Professional Art Therapist Associate (pending DMS approval) and Licensed Behavioral Analyst Associate (pending DMS approval)	U4
Mental Health Associate	U5
Peer Counselor	U7
Licensed Psychological Practitioner	U8

16.7.14 Time Limits for Filing Claims

Passport Health Plan must receive claims for covered services within the designated filing limit:

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

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

16.7.15 Coordination of Benefits (COB)

Passport follows a Coordination of Benefits policy when members have other medical insurance including Medicare. Because Passport administers a Medicaid program, it is considered the "payer of last resort" on all claims. All insurance including any automobile (personal protection) coverage or other medical coverage, including Medicare, pays the member's claims before Passport. These types of coverage are considered "primary" coverage.

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

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

16.7.16 Claim Inquiries and Resources

Additional information is available through the following resources:

Email Contact

- Provider.relations@beaconhs.com
- EDI.Operations@beaconhs.com

Telephone

- **Interactive Voice Recognition (IVR): (888)210-2018**
  You will need your practice or organization's tax ID, the member's identification number and date of birth, and the date of service.
- **Behavioral Health Hotline: (888) 249-0478**
  Hours of operation are 8:30 a.m. to 5:30 p.m. EST Monday through Thursday and 9:00 a.m. to 5:00 p.m. EST on Friday.
- **Behavioral Health's Main Telephone Numbers**

Provider Relations	(855)834-5651
EDI	(855)834-5651
TTY	(866)727-9441

16.7.17 Electronic Media Options

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

- **Electronic Data Interchange (EDI)** supports electronic submission of claim batches in HIPAA- compliant 837P format for professional services and 837I format for institutional services. Providers may submit claims using EDI/837 format directly to Beacon or through a billing intermediary. If using Emdeon as the billing intermediary, two identification numbers must be included in the 837 file for adjudication:
  - Beacon's payor ID is 43324; and
  - Beacon's health plan-specific ID is 028.
- **eServices** enables providers to submit inpatient and outpatient claims without completing a CMS 1500 or UB04 claim form. Because much of the required information is available in The behavioral health database, most claim submissions take less than one minute and contain few, if any errors.
- **IVR** provides telephone access to member eligibility, claim status and authorization status.

16.7.18 Claim Transaction Overview

Table 6-4 below, identifies all claim transactions, indicates which transactions are available on each of the electronic media, and provides other information necessary for electronic completion. Watch for updates as additional transactions become available on EDI, eServices and IVR.

Table 6-4: Claim Transaction Overview

Transaction	Access on:			Applicable When:	Timeframe for Receipt by Beacon	Other Information
	EDI	eServices	IVR			

Member Eligibility Verification	Y	Y	Y	• Completing any claim transaction; and • Submitting clinical authorization requests	n/a	n/a
Submit Standard Claim	Y	Y	N	Submitting a claim for authorized, covered services, within the timely filing limit	Within 180 days after the date of service.	n/a
Resubmission of Denied Claim	Y	Y	N	Previous claim was denied for any reason *except* timely filing	Within 2 years after the date on the EOB.	• Claims denied for late filing may be resubmitted as reconsiderations. • Rec ID is required to indicate that claim is a resubmission.
180-Day Waiver* (Request for waiver of timely filing limit)	N	N	N	A claim being submitted for the *first time* will be received by Passport after the original 180-day filing limit, *and* must include evidence that one of the following conditions is met: • Provider is eligible for reimbursement retroactively; or • Member was enrolled in Plan retroactively; or • Services were authorized retroactively. • Third party coverage is available and was billed first. (A copy of the other insurance's explanation of benefits or payment is required);	Within 180 days from the qualifying event.	• Waiver requests will be considered only for these 3 circumstances. A waiver request that presents a reason not listed here will result in a claim denial on a future EOB. • A claim submitted beyond the filing limit that does not meet the above criteria may be submitted as reconsideration request. • The waiver determination is reflected on a future EOB with a message of Waiver Approved or Waiver Denied: if waiver of the filing limit is approved, the claim appears adjudicated; if the request is denied, the denial reason appears.

Request for Reconsideration of Timely Filing Limit*	N	Y	N	Claim falls out of all timeframes and requirements for resubmission, waiver and adjustment.	Within 180 days from the date of payment or nonpayment.	Future EOB shows "Reconsideration" "Approved" or "Reconsideration Denied" with denial
Request to Void Payment	N	N	N	• Claim was paid to provider in error; and, • Provider needs to return the entire paid amount to Passport.	n/a	Do NOT send a refund check.
Request for Adjustment	Y	Y	N	• The amount paid to provider on a claim, was incorrect; • Adjustment may be requested to correct: o Underpayment (positive request); or, o Overpayment (negative request)	• Positive request must be *received* within **180 days** from the date of original payment; • No filing limit applies to negative requests.	• Do NOT send a refund check • A RecID is required to indicate that the claim is an adjustment. • Adjustments are reflected on a future EOB as recoupment of the previous (incorrect) amount and, if money is owed to provider, re-payment of the claim at the correct amount. • If an adjustment appears on an EOB and is not correct, another adjustment request may be submitted based on the previous incorrect adjustment. • Claims that have been denied cannot be adjusted, but may be resubmitted.
Obtain Claim Status	N	Y	Y	Available 24/7 for all claim transactions submitted by provider.	n/a	Claim status is posted within 48 hours after receipt.

View/Print Remittance Advice (RA)	N	Y	N	Available 24/7 for all claim transactions received.	n/a	Printable RA is posted within 48 hours after receipt.

***Please note that waivers and reconsiderations apply only to the claims filing limit; claims are still processed using standard adjudication logic and all other billing and authorization requirements must be met. Accordingly, an approved waiver or reconsideration of the filing limit does not guarantee payment, since the claim could deny for another reason.**

16.7.19 Paper Claim Transactions

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

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

Mail paper claims to:

Passport Health Plan Claims
Attn: Beacon Health Strategies
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393

Beacon does not accept claims transmitted by fax.

Passport discourages paper transactions.
BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS EARLIER IN THIS CHAPTER.
Paper submissions have more fields to enter, a higher error rate / lower approval rate, and slower payment.

16.7.20 Professional Services: Instructions for Completing the CMS 1500 Form

Table 6-5 below lists each numbered block on the CMS 1500 form with a description of the requested information, and indicates which fields are required in order for a claim to process and pay.

Table 6-5: CMS 1500 Form

Table Block #	Required?	Description
1	No	Check Applicable Program
1a	Yes	Member's Health Plan ID Number
2	Yes	Member's Name
3	Yes	Member's Birth date and Sex
4	Yes	Insured's Name
5	Yes	Member's Address
6	No	Member's Relationship to Insured
7	No	Insured's Address
8	Yes	Member's Status
9	Yes	Other Insured's Name (If Applicable)
9a	Yes	Other Insured's Policy or Group Number
9b	Yes	Other Insured's Date of Birth and Sex
9c	Yes	Employer's Name or School Name
9d	Yes	Insurance Plan Name or Program Name
10a-c	Yes	Member's Condition Related to Employment
11	No	Member's Policy, Group or FICA Number (If Applicable)
11a	No	Member's Date of Birth (MM, DD, YY) and Sex (check box)
11b	No	Employer's Name or School Name (If Applicable)
11c	No	Insurance Plan Name or Program Name (If Applicable)
11d	No	Is there another health benefit plan?
12	Yes	Member's or Authorized Person's Signature and Date On File
13	No	Member's or Authorized Person's Signature
14	No	Date of Current Illness
15	No	Date of Same or Similar Illness
16	No	Date Client Unable to Work in Current Occupation
17	No	Name of Referring Physician or Other Source (If Applicable)
17 B	No	NPI of referring Physician
18	No	Hospitalization Dates Related to Current Services (If Applicable)
19	Yes	Former Control Number (Record ID If Applicable)
20	No	Outside Lab?
21	Yes	Diagnosis or Nature of Illness or Injury
22	No	Medicaid Resubmission Code
23	Yes	Prior Authorization Number (If Applicable)
24a	Yes	Date of Service
24b	Yes	Place of Service code (HIPAA Compliant)
24d	Yes	Procedure Code (HIPAA-compliant between 290 and 319) and Modifier when applicable (See Table 6-3 for acceptable modifiers)
24e	Yes	Diagnosis Code- 1,2,3 or 4
24f	Yes	Charges
24g	Yes	Days or Units

24h	No	EPSDT
24i	No	ID Qualifier
24 j	Yes	Rendering Provider Taxonomy Code-shaded & Rendering Provider NPI-unshaded
25	Yes	Federal Tax ID Number
26	No	Provider's Member Account Number
27	No	Accept Assignment (check box)
28	Yes	Total Charges
29	Yes	Amount Paid by Other Insurance (If Applicable)
30	Yes	Balance Due
31	Yes	Signature of Physician/Practitioner NPI
32	Yes	Name and Address of Facility where services were rendered (Site ID). If missing, a claim specialist will choose the site shown as 'primary' in behavioral health's database
32a	No	NPI of Servicing Facility
33	Yes	Provider Name
33 a	Yes	Billing Provider NPI
33 b	No	Pay to Provider Passport ID Number

Institutional Services: Instructions for Completing the UB04 Form

Passport discourages paper transactions.
BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS EARLIER IN THIS CHAPTER
Paper submissions have more fields to enter, a higher error rate/lower approval rate, and slower payment.

Table 6-6 below lists each numbered block on the UB-04 claim form, with a description of the requested information and whether that information is required in order for a claim to process and pay.

Table 6-6 UB-04 Claim Form

Block #	Required?	Description
1	Yes	Provider Name, Address, Telephone #
2	No	Untitled
3	No	Provider's Member Account Number
4	Yes	Type of Bill (See *Table 6-2 for 3-digit codes)*
5	Yes	Federal Tax ID Number
6	Yes	Statement Covers Period (Include date of Discharge)
7	Yes	Covered Days (Do not include date of Discharge)
8	Yes	Member Name
9	Yes	Member Address
10	Yes	Member Birth Date
11	Yes	Member Sex
12	Yes	Admission Date
13	Yes	Admission Hour
14	Yes	Admission Type

15	Yes	Admission Source
16	Yes	Discharge Hour
17	Yes	Discharge Status (See *Table 6-1: Discharge Status Codes*)
18 -28	No	Condition Codes
29	No	ACDT States
30	No	Unassigned
31-34	No	Occurrence Code And Date
35-36	No	Occurrence Span
37	No	REC.ID For Resubmission
38	No	Untitled
39-41	No	Value CD/AMT
42	Yes	Revenue Code (If Applicable)
43	Yes	Revenue Description
44	Yes	Procedure Code (CPT) (Modifier may be placed here beside the HCPCS code. See *Table 6-3 for acceptable modifiers*)
45	Yes	Service Date
46	Yes	Units Of Service
47	Yes	Total Charges
48	No	Non-Covered Charges
49	Yes	Modifier (If Applicable - See *Table 6-3 for acceptable modifiers*)
50	Yes	Payer Name
5	Yes	Beacon Provider Id Number
5	Yes	Release Of Information Authorization Indicator
5	Yes	Assignment Of Benefits Authorization Indicator
5	Yes	Prior Payments (If Applicable)
5	No	Estimated. Amount Due
5	Yes	Facility NPI
5	No	Other ID
5	No	Insured's Name
5	No	Member's Relationship To Insured
6	Yes	Member's Identification Number
6	No	Group Name
6	No	Insurance Group Number
6	Yes	Prior Authorization Number (If Applicable)
6	No	Document Control Number
6	No	Employer Name
6	No	Employer Location
6	Yes	Principal Diagnosis Code
6	No	A-Q Other Diagnosis
6	Yes	Admit Diagnosis
7	No	Patient Reason Diagnosis
7	No	PPS Code
7	No	ECI
7	No	Unassigned
7	No	Principle Procedure
7	No	Unassigned

7	Yes	Attending Physician NPI First And Last Name (Required)
7	No	Operating Physician NPI
78 -79	No	Other NPI
8	No	Remarks
8	No	Code-Code

16.7.21 Paper Resubmission

Passport discourages paper transactions.
BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS EARLIER IN THIS CHAPTER
Paper submissions have more fields to enter, a higher error rate/ lower approval rate, and slower payment.

- See Table 6-4 for an explanation of claim resubmission, when resubmission is appropriate, and procedural guidelines.
- If the resubmitted claim is received by Passport more than 180 days from the date of service. The REC.ID from the denied claim line is required and may be provided in either of the following ways:
  - Enter the REC.ID in box 64 on the UB04 claim form or in box 19 on the CMS 1500 form.
  - Submit the corrected claim with a copy of the EOB for the corresponding date of service; or
- The REC.ID corresponds with a single claim line on the Passport EOB. Therefore, if a claim has multiple lines there will be multiple REC.ID numbers on the Passport EOB.
- The entire claim that includes the denied claim line(s) may be resubmitted regardless of the number of claim lines; Passport does not require one line per claim form for resubmission. When resubmitting a multiple-line claim, it is best to attach a copy of the corresponding EOB.
- Resubmitted claims cannot contain original (new) claim lines along with resubmitted claim lines.
- Resubmissions must be received by Passport within 2 (two) years after the date on the EOB. A claim package postmarked 2 (two) years after the date on the EOB is not valid.
- If the resubmitted claim is received by Passport within 2 (two) years from the date of service, the corrected claim may be resubmitted as an original. A corrected and legible photocopy is also acceptable

16.7.21.1 Paper Submission of 180-Day Waiver

- See Table 6-4 for an explanation of waivers, when a waiver request is applicable, and procedural guidelines;
- Watch for notice of waiver requests becoming available on eServices.
- Download the 180-Day Waiver Form;
- Complete a 180-Day Waiver Form for each claim that includes the denied claim(s),per the instructions below;
- Attach any supporting documentation;

- Prepare the claim as an original submission with all required elements;
- Send the form, all supporting documentation, claim and brief cover letter to:

Passport Health Plan
Attn: Beacon Health Strategies
Claim Department / Waivers
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393

16.7.21.2 Completion of the Waiver Request Form

To ensure proper resolution of your request, complete the 180-Day Waiver Request Form as accurately and legibly as possible.

1. **Provider Name:**
   Enter the name of the provider who provided the service(s).
2. **Provider ID Number:**
   Enter the provider ID Number of the provider who provided the service(s).
3. **Member Name:**
   Enter the member's name.
4. **Passport Health Plan Member ID Number:**
   Enter the Plan member ID Number.
5. **Contact Person**
   Enter the name of the person to be contacted if there are any questions regarding this request.
6. **Telephone Number**
   Enter the telephone number of the contact person.
7. **Reason for Waiver**
   Place an "X" on all the line(s) that describe why the waiver is requested.
8. **Provider Signature**
   A 180-day waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. Passport will not accept "Signature on file."
9. **Date**
   Indicate the date that the form was signed.

16.7.22 Paper Request for Adjustment or Void

Passport discourages paper transactions.
BEFORE SUBMITTING PAPER CLAIMS, PLEASE REVIEW ELECTRONIC OPTIONS EARLIER IN THIS CHAPTER
Paper submissions have more fields to enter, a higher error rate/lower approval rate, and slower payment.

- See Table 6-4 for an explanation of adjustments and voids, when these requests are applicable, and procedural guidelines;
- Do not send a refund check to Passport. A provider who has been incorrectly paid by Passport must request an adjustment or void;
- Prepare a new claim as you would like your final payment to be, with all required elements; place the REC.ID in box 19 of the CMS 1500 claim form, or box 64 of the UB04 form or;

- Download and complete the Adjustment/Void Request Form per the instructions below;
- Attach a copy of the original claim;
- Attach a copy of the EOB on which the claim was paid in error or paid an incorrect amount; Send the form, documentation and claim to:

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

16.7.22.1 To Complete the Adjustment/Void Request Form

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

1. **Provider Name**
   Enter the name of the provider to whom the payment was made.
2. **Provider ID Number**
   Enter the Passport provider ID Number of the provider that was paid for the service. If the claim was paid under an incorrect provider number, the claim must be **voided** and a new claim must be submitted with the correct provider ID Number.
3. **Member Name**
   Enter the member's name as it appears on the EOB. If the payment was made for the wrong member, the claim must be **voided** and a new claim must be submitted.
4. **Member Identification Number**
   Enter the Plan member ID Number as it appears on the EOB. If a payment was made for the wrong member, the claim must be **voided** and a new claim must be submitted.
5. **Claim Record ID number**
   Enter the record ID number as listed on the EOB.
6. **Claim Paid Date**
   Enter the date the check was cut as listed on the EOB.
7. **Check Appropriate Line**
   Place an "X" on the line that best describes the type of adjustment/void being requested.
8. **Check All that Apply**
   Place an "X" on the line(s) which best describe the reason(s) for requesting the adjustment/void. If
   "Other" is marked, describe the reason for the request.
9. **Provider Signature**
   An adjustment/void request cannot be processed without a typed, signed, stamped, or computer- generated signature. Passport will not accept "Signature on file".
10. **Date**
    List the date that the form is signed.

16.7.23 Provider Education and Outreach

Summary

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

Passport also provides regular communication about claims and authorization process changes through the use of Passport eNews. Providers are encouraged to sign up at www.passporthealthplan.com/sign-up-for-free-email-service-enews-form/ to receive regular updates about services impacting providers and members.

Clarification on appropriate time-based billing codes and modifiers to use for behavioral health services has been released by the Kentucky Department for Medicaid Services (DMS) and are effective April 1, 2015 for dates of service since August 1, 2014. These changes enable adherence to required NCCI edits.

Passport's goal through regular outreach programs is to assist providers in as many ways as possible to receive payment in full, based upon contracted rates, for all services delivered to members.

16.7.23.1 How the Program Works

- A quarterly approval report is generated that lists the percentage of claims paid in relation to the volume of claims submitted.
- All providers below 75% approval rate have an additional report generated listing their most common denials and the percentage of claims they reflect.
- An outreach letter is sent to the provider's Billing Director as well as a report indicating the top denial reasons. A contact name is given for any questions or to request further assistance or training.

16.7.24 Grievances

Providers with grievances or concerns should contact the Behavioral Health Hotline at the number provided below and ask to speak with the clinical manager for Passport. All provider complaints are resolved within thirty (30) days of receipt. The Provider or Passport may request a fourteen (14) day extension for resolution of the grievance or appeal.

If a Passport member complains or expresses concern regarding procedures or services, Plan procedures, covered benefits or services, or any aspect of the member's care received from providers, he or she should be directed to call the Ombudsperson at (855)834-5651 or TTY at (866)727-9441.

16.7.24.1 Appeals and Grievances

Please see Section (2.9) for information concerning provider appeals and grievances.

16.7.24.2 Peer Review

A peer review conversation may be requested at any time by the treating provider, and may occur prior to or after an adverse determination, upon request for a reconsideration. UR clinicians and PAs are available daily to discuss denial cases by phone at (855)834-5651.