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Provider Guide for GHI/EMBLEMHEALTH EPO/PPO Accounts

Updated March 2022

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INTRODUCTION

The Beacon Health Options NY Provider Relations Team is proud to present this Provider Guide, specifically for the GHI/EmblemHealth EPO/PPO accounts.

As part of our continuing commitment to our provider network, this guide was de s i gne d to make participation with our networks easier for both practitioners and facilities alike. Inside you will find valuable information about the GHI/EmblemHealth EPOPPO accounts including authorization processes and claims payment guidelines.

If you have any questions or comments about the material in this guide, feel free to contact Provider Relations at: (800) 235-3149, Monday-Friday, 9:00 a.m.-5:00 p.m., or via e-mail at: newyorkservicecenter@beaconhealthoptions.com

Thank you again for your continuing participation with Beacon Health Options

- New York Provider Relations

About this Guide

The information in this guide is applicable to the GHI- BMP/EmblemHealth EPO/PPO, GHI-Medicare and accounts only. For general information about other Beacon Health Options plans, please reference our Web site at:

www.beaconhealthoptions.com/providers/Beacon/

PLAN OVERVIEW

What are the GHI/EMBLEMHEALTH EPO/PPO Plans?

GHI-Behavioral Management Program/EmblemHealth EPO/PPO (GHI-BMP/EmblemHealth EPO/PPO) is the term used for the mental health and substance abuse benefit plan for GHI/EmblemHealth EPO/PPO members.

GHI-Medicare Choice PPO (GHI Medicare) is a Medicare-based managed care plan.

GHI/EMBLEMHEALTH EPO/PPO and Beacon Health Options

Group Health Incorporated/EmblemHealth EPO/PPO (GHI/EmblemHealth EPO/PPO) is the insurance carrier and claims payer for mental health and substance abuse benefits for the GHI-BMP/EmblemHealth EPO/PPO plan.

Beacon Health Options is the program coordinator and utilization management (UM) company responsible for administrative tasks associated with these benefits. Beacon Health Options is also the claims payer for the GHI Medicare and plans.

PLAN PARTICIPATION

Referrals & Standards

All GHI/EmblemHealth EPO/PPO members have access to a Clinical Referral Line (CRL), staffed with licensed clinicians, 24 hours a day, and 7 days a week.

In order to ensure the highest possible quality of care for our members, the following referral standards have been established:

Risk Rating 1 - Moderate/Mild Risk, Routine (10 business days)

- When the member demonstrates some distress, but the precipitants of the distress and associated stressors can be easily identified and/or
- When the member manifests an adequate to good pre-morbid level of functioning with continuing adequate social/family supports and resources and/or
- When the member demonstrates mild impairment in judgment, functioning and/or impulse control and/or

- When a member's request can be addressed safely within 10 business days, it is considered to be a Risk Rating 1 – Moderate/Mild Risk (Routine).

Risk Rating 2 - Serious Risk, Urgent (24 hours)

A. The member is upset and distressed but not in immediate danger of harm to self or others, there is evidence of adequate pre-morbid functioning but social/ family supports have significantly changed or diminished and/or
B. The member is displaying moderate impairment in judgment, impulse control and/or functioning which is expected to further diminish and/or
C. The member indicates intoxication or the risk of withdrawal and/or
D. The member indicates an urgent need to be seen

Risk Rating 3 – Emergency (Immediate)

A. Failure to obtain immediate care would place the member's life, another's life, or property in jeopardy, or cause serious impairment of bodily functions, or B. Member/caller indicates that failure to obtain immediate care would place the member's life, another's life or property in jeopardy, or cause serious impairment of bodily functions, or

C. There exist severe medical complications concurrent with or as a consequence of psychiatric or substance abuse illness and its treatment.

- Appointments for life-threatening emergencies are available immediately.
- Appointments for non-life-threatening emergencies are available within 6 hours.
- Urgent appointments are available within 48 hours.
- Routine appointments are available within 10 business days.

Your Practice Profile

Your Beacon Health Options provider file is not only used to make referrals of patients to you, but also important correspondence, and claims payment.

It is therefore very important that we have the most up-to-date information on file for you at all times.

Any changes or updates to your provider record must be submitted via ProviderConnect. https://www.beaconhealthoptions.com/providers/beacon/providerconnect/

If you are experiencing any trouble making updates, Please reach out to (800) 235-3149

Quality Reviews

As part of a routine audit process, our Quality Management team may periodically request access to treatment records for select GHI/EmblemHealth EPO/PPO members for whom you are providing treatment.

If requested, please supply copies of the requested records and forward them to the Quality Management department within five (5) business days.

Records will be treated confidentially and destroyed after the review process is complete.

> ! NOTE: Release from the patient is not required in order to provide copies of these records to Beacon Health Options. HIPAA regulations allow release of records without consent in order to support operations of health care and quality reviews.

Balance Billing

The process known as "balance billing" is when an in-network provider knowingly bills an eligible Beacon Health Options member for any coverable service beyond the applicable copayment or co-insurance.

Please note that the process of balance billing is prohibited by your Beacon Health Options Individual Practitioner Agreement.

Initial Evaluations (90791)

An initial diagnostic evaluation (CPT code 90791) is allowed only once per patient, per calendar year.

Contracted mental health clinics can bill for two (2) initial diagnostic evaluations (90791) — one for the psychiatric evaluation and one for the psychosocial assessment.

AUTHORIZATION

Outpatient Mental Health

Initial Certification and Continuing Treatment

Provisions in the Federal Mental Health Parity (FMHP) legislation make preauthorization and passthrough visits unnecessary. There is no longer a preauthorization requirement for members enrolled in the GHI/EmblemHealth City of New York employee and the DC 37 Union plans along with their dependents effective 7/1/2010.

You may continue to see the member and provide services based on the medical treatment needs of the member as determined by you and your patient. Claims will be submitted and paid as per your contract and negotiated rates with Beacon Health Options. There are no benefit limits for mental health or substance abuse treatment.

In place of the previous pass through/preauthorization outpatient processes, Beacon Health Options has initiated an outlier care management model. This outlier model will focus on individual cases by diagnostic category where the course of treatment varies significantly from expected norms.

Beacon Health Options will also continue its focus on those members diagnosed with complex mental health and substance abuse illnesses. Although no precertification of the outpatient services these complex patients receive will be required, Beacon Health Options will be contacting the treating provider early in these patients' treatment regimen in order to develop, in conjunction with the provider, an individualized plan of care which may involve some reporting of the patients status similar to the ORF (Outpatient Review Form) that was previously used. The goal of this process is to insure, in cooperation with the provider, the best possible outcome for the patient.

Beacon Health Options will use a variety of indicators, in addition to their diagnosis, to identify these members and then contact the treating provider in order to create the care management plan. However, we encourage providers to contact Beacon Health Options whenever they believe they are treating a member whose care is likely to be complex so that the joint care planning process can be implemented.

** With any new patient Beacon Health Options encourages providers to call the Clinical Customer Service line for GHI-BMP/EmblemHealth EPO/PPO members to verify authorization requirements, patient eligibility and responsibility and any other pertinent benefit information.

Psychological Testing

Psychological testing is a pre-certified-only benefit. For testing, a Psychological Evaluation Request Form listing the tests and number of hours requested is required for approval. GHI-BMP/EmblemHealth EPO/PPO will review for medical necessity and notify you in writing of their determination. Valid Psych testing codes are 96130, 96131, 96136, 96137, 96138, and 96139.

Neuropsychological Testing

CPT procedure codes 96132, 96136, 96138, 96146 are covered and processed under the GHI/EmblemHealth EPO/PPO medical contract, and does not require GHI-BMP/EmblemHealth EPO/PPO authorization. GHI/EmblemHealth EPO/PPO will pay for up to 12 hours of neuropsychological evaluations. Additional hours will be subject to a medical necessity evaluation.

Electro-Convulsive Therapy

CPT procedure codes 90870 is covered as a medical/surgical benefit and does not require precertification through Beacon Health Options

Outpatient Substance Abuse

Precertification is no longer required for outpatient services for those plans that are now compliant with Federal Parity. Outpatient Substance Abuse services are authorized the same way as higher level of care (HLOC) programs are. Please see the next section for details.

Higher Levels of Care (HLOC)

Requests for outpatient substance abuse and higher levels of care are reviewed by Beacon Health Options Clinical Care Managers (CCMs) utilizing Beacon Health Options clinical criteria (located at https://www.beaconhealthoptions.com/providers/beacon/handbook/clinical-criteria/) for mental health treatment, and the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC2R) for substance abuse related treatment.

If the member has a different primary insurer (other than GHI/EmblemHealth EPO/PPO), no pre-certification is required.

To receive authorization, please call the appropriate customer service number listed below:

GHI-BMP/EmblemHealth EPO/PPO	(800) 619-0630
GHI Medicare Choice PPO	(866) 318-7595
Emblem Health	(888) 441-2526

ABOUT Beacon Health Options CLINICAL CARE MANAGERS

Beacon Health Options places a high value on the selection, training and performance evaluation of clinical staff performing utilization management services. All staff involved in clinical care management activities hold degrees and licensure in their field. Beacon Health Options requires that Clinical Care Managers (CCMs) be fully licensed mental health professionals with a minimum of three years prior clinical experience in a mental health/substance abuse setting providing direct patient care.

Peer Advisors

Beacon Health Options CCMs conduct medical necessity reviews utilizing Beacon Health Options clinical criteria (located at www.ValueOptions.com) for mental health treatment, and the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC2R) for substance-abuse related treatment.

- If the CCM is unable to approve the proposed treatment under Beacon Health Options criteria, the case will be referred to a Peer Advisor (PA) to perform additional review:
- The PA will make a decision as to the medical necessity of the requested care.
- If there is a lack of information to make a medical necessity decision, Beacon Health Options will notify the provider of the required information. This could require submission of documents or a verbal peer-to-peer review.
- If a response is not received in a timely manner from the provider, a PA may render a decision.

APPEALS

Clinical Appeals

Any non-certification or modification of the treatment requested due to medical necessity reasons is considered an adverse determination and eligible for a clinical appeal. Beacon processes appeals for GHI-BMP/EmblemHealth EPO/PPO and GHI-FHP plans. These plans have one level of internal appeal.

Beacon is not delegated to handle appeals for GHI Medicare enrollees. Please refer to the adverse determination letter or for appeal instructions or contact GHI directly at (866) 557-7300.

A clinical appeal can be initiated by the member, an Authorized Member Representative (AMR), or

in urgent cases the member's provider on the member's behalf. Beacon accepts appeal requests via phone, fax or in writing. For Medicaid, FHP, CHP and Medicare members, the appeal request must be filed within 60 days after notification of the adverse determination. For members with commercial coverage, the appeal request must be filed within 180 days after the notification.

Members are offered the right of representation throughout the appeals process. Members, AMRs and providers have the opportunity to submit written comments, documents and other information concerning the appeal. Every appeal receives fair consideration and timely determination and includes a thorough investigation by a qualified professional. All documents, records and/or other information submitted are taken into account without regard to whether such information was submitted or considered in the initial consideration of the case.

All medical necessity appeals are conducted by a Physician or Psychologist Advisor (PA) who was not the physician/psychologist that made the original adverse determination, nor is the subordinate of that physician/psychologist. The PA conducting the appeal must hold an active, unrestricted license to practice medicine/psychology (the same license status as the ordering practitioner), in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. The PA reviews all available information and, in the case of expedited appeals, attempts to speak with the member's attending physician.

Appeals are processed as standard (non-expedited) appeals unless they meet the definition of urgent care, in which case expedited review timeframes apply. Urgent Care is any request for medical care or treatment with respect to which the applications of the standard time-periods for making non-urgent care decisions:

- Could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on a prudent layperson's judgment, OR
- In the opinion of a practitioner with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care of treatment that is the subject of the request

For expedited appeals, a decision is made within 72 hours, subject to plan- and state-specific requirements, and as expeditiously as the member's condition requires. For standard appeals, a decision is made and written notification sent to the provider and the member within 30 calendar days of the request, subject to plan- and state-specific requirements.

Post-service appeal review typically requires review of medical records. The provider must submit the medical chart for review. If the medical record is not received, a decision will be rendered based on the information available.

The outcome of a level 1 appeal, if upheld, is considered a Final Adverse Determination (FAD).

Extension of Benefits (Aid in Continuing)

Throughout the course of an appeal, the member shall continue to receive services without liability for services previously authorized by Beacon, as long as all of the following criteria are met:

- The appeal was filed in a timely fashion
- The appeal involved the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider
- The original period covered by the authorization did not expire before the appeal
- The member requested an extension of the benefits

Administrative Appeal Procedures

An administrative denial is an adverse determination issued on a basis other than medical necessity or experimental/investigational services. Appeals of administrative denials are reviewed according to the same process as clinical appeals, except that non-clinical staff may make administrative appeal determinations; a physician/psychologist advisor is not required.

Please note that Beacon is not delegated to handle administrative appeals for GHI Medicare members.

External Appeal Process

Members or their representatives may have the right to request an External Appeal if their health plan denies coverage because a requested health service is not medically necessary. An external appeal is also available if a managed care plan denies coverage for an experimental treatment of a life-threatening or disabling condition. The member, representative or provider must complete Beacon's internal appeal process before requesting an IRO unless the appeal involves a life- threatening condition.

If Beacon denies coverage for the service because it is not medically necessary or because the proposed service is an experimental/investigational treatment, and the denial is upheld upon appeal, Beacon sends the member and provider a letter confirming the denial. This letter is called a notice of Final Adverse Determination, and includes instructions for requesting an external appeal along with an External Appeal Application.

A Provider's External Appeal Application to the New York State Department of Insurance must be submitted within 60 days of receiving the final adverse determination. (If both the provider and Beacon agree, the first level of appeal may be waived and the provider can apply for external review within 60 days of the initial denial of coverage.)

If a delay in rendering a decision would cause harm to the member, the member's primary care physician/provider (PCP) or other physician/provider will need to submit an attestation along with application for an expedited review.

The external appeal agent must render a decision on coverage within 30 days for a standard appeal or 3 days for an expedited appeal. The decision of the external appeal agent is binding on the member, the provider and the plan.

Beacon members are not required to pay any fees related to an External Review.

Participating providers may need to assist a member in completing the External Appeal Application. For appeals that require an urgent decision, providers will need to complete a Physician Attestation Form to be included with the External Appeal Application. The Department of Insurance will review the Physician's Attestation and determine if the matter should undergo an "expedited" external review. Providers may also complete an application to request an External Review of denied coverage for services that have already been provided.

Beacon benefits do not include payment for health care services that are not medically necessary. If a service/drug/device has been determined to be medically necessary through the New York State external review process, Beacon will cover the costs of the service/drug/device to the extent that it would otherwise be covered under the member's health benefit plan.

Similarly, if an external review determines the Beacon should cover an experimental or investigational treatment that is part of a clinical trial, Beacon will cover only the costs of the treatment provided to the member under the terms of the trial. Beacon will not be responsible for the costs of investigational drugs or devices or the costs of non- healthcare services such as the costs of managing research or the costs of collecting data that is useful for the research project but not necessary for the member's care.

To request a New York State External Appeal, send a written request to:

New York State Department of Financial Services
P.O. Box 7209
Albany, New York 12224-0209

You may also contact the New York State Department of Financial Services by calling 800.400.8882 or via email: externalappealquestions@dfs.ny.gov.

State Fair Hearing for Medicaid Members

In accordance with SSL 22, 364-j (9), 18 NYCRR 358, all Medicaid recipients shall be afforded the right to a fair hearing under appropriate circumstances. The federal government and the New York State Department of Health require the Fair Hearing provisions. Medicaid recipients are informed of

their right to apply to the New York State Department of Health Office of Administrative Hearings when they feel a managed care plan, local Department of Social Services, or provider has wrongly limited their Medicaid benefits.

Beacon, and the health plans with which it holds contracts, are required to provide information to Medicaid members about their right to a fair hearing whenever the following occurs:

- Requested services are denied because they are not medically necessary or are not part of the covered benefit package
- Requested continued services are denied, reduced, suspended or terminated
- Members or their representatives may request an expedited State Fair Hearing with the state.

Participating providers should be aware of Beacon policies, regarding fair hearings, which comply with applicable regulations. A Medicaid member may be entitled to appeal a Beacon decision sequentially or concurrently through the Beacon appeal process, the New York State external review process and the New York State Office of Administrative Hearings process. For Medicaid Members, the fair hearing decision is ultimately binding. Inquiries regarding this fair hearing procedure should be directed to the Beacon Clinical Program Manager for the member's plan.

A Medicaid member or their representative may request a New York State Fair Hearing by contacting:

NYS Office of Temporary and Disability Assistance

Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

www.otda.state.ny.us/oah

For assistance filing a request for a Fair Hearing, a Medicaid member or their representative may call Beacon's Customer Service Department, or write to Beacon's Appeals and Grievances Department.

Questions regarding the fair hearing process may also be directed to the New York State Office of Administrative Hearings at 518.474.8781.

! Tip: To view Beacon Health Options clinical criteria or to see more details about the appeal process, please reference the provider handbook located online at:

https://www.beaconhealthoptions.com/providers/beacon/handbook/

Claims Appeals

A specific claim denial may be disputed by phone, online, or in writing, as follows.

For EPO/PPO claims processed by Beacon Health Options:

- Login to Beacon's ProviderConnect portal at: providerconnect.beaconhealthoptions.com
- Call Beacon's Customer Service Department at 800-692-2489
- Submit a written request (including supporting documentation) to:
  Beacon Health Options
  Appeals and Grievances
  P.O. Box 1850
  Hicksville, NY 11802

For historical EPO/PPO claims processed by GHI:

- Login to myGHI for providers at: www.ghi.com
- Call GHI/EmblemHealth EPO/PPO at (800) 358-5500
- Submit a written request (including supporting documentation) to:
  GHI-BMP/EmblemHealth EPO/PPO Claims
  P.O. Box 2828
  New York, NY 10116-2828

For Medicare claims:

- Call the Claims Customer Service Department at (866) 424-3195
- Submit a written request (including supporting documentation) to:
  Beacon Health Options
  Appeals and Grievances
  P.O. Box 1851

CLAIMS & BILLING

Timely Filing

To be considered for payment, all claims received must be "clean claims." A clean claim is a UB-04 or CMS-1500 claim form submitted by the provider for health care services rendered to a covered member, complete and free of defect.

> ! Tip: For Outpatient Mental Health Claims, submitting a red ink CMS – 1500 form allows for quicker more accurate processing.

Claims for GHI/EmblemHealth EPO/PPO members must be submitted within the following timeframes:

GHI-BMP/EmblemHealth EPO/PPO is the Primary Insurer

- Claims must be submitted to GHI/EmblemHealth EPO/PPO within 365 days of the date of service

GHI Medicare is the Primary Insurer

- Claims must be submitted to Beacon Health Options within 180 days of the date of service.

www.valueoptions.com/providers/handbook.htm

Electronic Claims

Filing claims electronically has many advantages over paper claims submission:

- Rapid submission leads to faster reimbursement
- Elimination of paperwork and easier record-keeping
- Cost-saving over submitting on paper

Beginning on March 1, 2022, Availity Essentials is the preferred multi-payer portal of choice for submitting the following transactions to Beacon Health Options:

- Claim Submissions (Direct Data Entry Professional and Facility Claims) applications or EDI using the Availity EDI Gateway
- Eligibility & Benefits
- Claim Status

If you have questions, please contact Availity Client Services at 1-800-282-4548 between the

hours of 8:00 a.m. and 8:00 p.m. EST, Monday through Friday.

For the GHI-BMP/EmblemHealth EPO/PPO plan, participating providers, can submit claims electronically to GHI/EmblemHealth EPO/PPO via the Electronic Media Claims (EMC) process.

For the GHI Medicare and plans, participating providers can submit claims electronically to

Beacon Health Options via free Electronic Data Interchange (EDI) software.

To enroll in the EMC Program for GHI-BMP/EmblemHealth EPO/PPO Claims, please contact a GHI – EMC Representative @ (212) 615-4EMC or visit www.ghi.com
To begin submitting electronic claims for the GHI Medicare Please contact the EDI HelpDesk @ (888) 247-9311 or email: e-supportservices@beaconhealthoptions.com

Single Claims Submission

An even more convenient way to submit claims for either the GHI/EmblemHealth EPO/PPO Medicare plan is to submit single claims online via the Web using the Beacon Health Options ProviderConnect service. To sign up for this convenient service, please visit the provider section at:

https://www.beaconhealthoptions.com/providers/beacon/providerconnect/

Medicare Primary Claims

When a GHI-BMP/EmblemHealth EPO/PPO member has Medicare as their primary insurance, claims must be submitted to Medicare first before payment from GHI/EmblemHealth EPO/PPO or Beacon Health Options will be considered. The Medicare Explanation of Benefits must be attached to the claim for the claim to be paid.

If you do not participate with Medicare, either a denial of services or opt-out letter from Medicare is required or the claim will be denied. Because of this requirement, Medicare primary claims cannot be submitted electronically by the provider.

Reimbursement

All in-network practitioners will be reimbursed according to the agreed-upon Fee Schedule, less any applicable co-pay (if any). Payments will be made in accordance with NY State Prompt Pay guidelines.

Only one (1) professional visit per day per provider will be paid. Clinics can bill two (2) professional visits per day as long as a psychiatrist conducted one of the visits.

EFT (Electronic Funds Transfer)

Instead of receiving a paper check, you can sign-up to have GHI-BMP/EmblemHealth EPO/PPO claims payments sent electronically directly into your bank account. For more information or to enroll, please call (212) 615-4773.

Individual Provider Claims

Outpatient Mental Health claims for individual providers should be submitted on a red-ink CMS- 1500 claim form. The following minimum information is required to be considered a complete clean claim:

- Subscriber's ID/certificate number
- Last name and first name of subscriber
- Patient's first name
- Patient's date of birth
- Patient's address
- Relationship to subscriber
- DSM-IV diagnosis
- CPT procedure code(s) for each date(s) of service
- Date(s) of service
- Number of visits
- Type of service
- Place of service
- Your charge for each service line
- Total charges billed
- Tax identification number
- National Provider Identifier (NPI) number
- Name and address of facility where services were rendered (Box 32)
- Physician supplier's billing name, address, zip code and phone (Box 33)
- Rendering physician's signature
- Primary carrier's EOB (if applicable)

If the claim is a resubmission of previously denied services, please indicate on the claim that it is a resubmission. Please do not add new services that were not included on the original claim, these should be submitted separately.

Facility Claims

Facility paper claims for all levels of care should be submitted on a UB-04 claim form (a CMS-1500

form is acceptable for outpatient mental health services only). Special attention should be paid to the following:

- The facility name and address must appear on the UB-04 in Box 1
- The dates of service must match the dates authorized, and there must be a period start and end date in Box 6
- The facility TIN must appear on the UB-04 in Box 5
- The facility's National Provider Identifier (NPI) number must be listed
- The revenue and/or CPT codes must match the services authorized, and appropriate CPT/Revenue code descriptions must match the codes used
- For facilities that bill outpatient services on a UB-04, you must use both revenue and CPT codes
- You must be contracted for the services for which you are billing

If the claim is a resubmission of previously denied services, please indicate on the claim that it is a resubmission. Please do not add new services that were not included on the original claim, these should be submitted separately.

Claims Addresses

Paper claims can be submitted to the appropriate address listed below:

Outpatient MH Claims: I-BMP/EmblemHealth EPO/PPO Claims P.O. Box 2827 New York, NY 10116-2827	Inpatient MH Claims: GHI/EmblemHealth EPO/PPO Attn: Hospital Claims P.O. Box 2833 New York, NY 10116-2833
GHI Employees: GHI-BMP/EmblemHealth EPO/PPO Attn: Employee Claims P.O. Box 2861 New York, NY 10116-2861	GHI Medicare Choice PPO Claims: EmblemHealth PO Box 1850 Hicksville, NY 11802 - 1850

TIPS FOR AVOIDING ADMINISTRATIVE CLAIMS DENIALS

Beacon Health Options and GHI/EmblemHealth EPO/PPO are committed to the efficient processing of your claims. Therefore, the following claim submission tips were created based on the most common administrative denials:

Service Was Not Authorized: GHI-BMP/EmblemHealth EPO/PPO and GHI Medicare allow several visits with a new patient to pay automatically. If treatment is to continue beyond the initial sessions, an Outpatient Review Form (ORF2) must be submitted (see page 5 for more information).

Duplicate Claims: Beacon Health Options strives to have 100% of all claims processed within 25 days. If you have not received notification within 25 days, please take the following steps prior to submitting a duplicate claim:

- Check the claim status via the ProviderConnect online application at https://www.beaconhealthoptions.com/providers/beacon/providerconnect/
- Call Customer Service at one of the numbers listed on page 19
- Check the claim status via the Availity Essentials online portal at https://apps.availity.com/availity/web/public.elegant.login

Itemized Bill is Needed: Please ensure the following elements are included when submitting a claim:

- Dates of service should be listed individually on the CSM-1500 claim form (no date spans)
- Date ranges can be used on UB-04 forms if care is consecutive and the same procedure
- Valid DSM IV diagnosis code
- Rendering provider, provider billing information and NPI number entered in appropriate areas of UB-04 and CMS-1500 forms
- Appropriate and valid place of service codes with correlating appropriate and valid CPT codes
- Accurate member and/or patient information including member identification number, patient name and date of birth

Authorization and Claim Do Not Match: The services billed must correspond with the care that was registered andauthorized.

Timely Filing: Claims must be submitted to GHI/EmblemHealth EPO/ PPO or Beacon Health

Options within the timely filing guidelines listed on page 12. If the patient's GHI/EmblemHealth

EPO/PPO coverage is not the primary insurance, the primary carrier's EOB must be attached to the claim.

PROVIDER CONNECT

The ProviderConnect application is an entire suite of Web-based online tools designed to streamline as many of the administrative requirements of participation as possible.

ProviderConnect allows you to:

- Check the status of your claims, showing how much was paid and when
- Look up your patient's eligibility both currently and in the past
- See benefit information for your GHI/EmblemHealth EPO/PPO patients. Co-pay amounts and deductibles are listed for both in network and out-of-network care
- Check authorizations and print authorization letters
- Send an inquiry to customer service and receive a response within 5 days
- Enter an authorization request online
- Submit single claims for the GHI Medicare and GHI Family Health Plus plans

All online and in real-time,
24 hours a day, 7 days a week!

Sign Up

To get started with the ProviderConnect service, simply go to https://www.beaconhealthoptions.com/providers/beacon/providerconnect/ and click the "Provider Portal. Next, click the "Sign up here" button and fill out the simple online form.

Tech Support

If you need help registering or logging on, please contact our EDI Helpdesk at (888) 247-9311 or email e-supportservices@beaconhealthoptions.com.

! Tip: To register for ProviderConnect, you will need your 6 – digit Beacon Health Options provider ID# or your 7 – digit GHI/EmblemHealth EPO/PPO PIN#. If you do not know either of these #'s, please call Provider Relations at: (800) 235-3149

AVAILITY ESSENTIALS

Beginning on March 1, 2022, Availity Essentials is the preferred multi-payer portal of choice for submitting the following transactions to Beacon Health Options: claims submissions (i.e. direct data entry professional and facility claims) applications or EDI using the Availity EDI Gateway, eligibility and benefits, and claims status.

For more information or questions, please visit the Availity website at https://www.availity.com/ or contact Availity Client Services at 1-800-282-4548 between the hours of 8:00 a.m. and 8:00 p.m. EST, Monday through Friday.

ACHIEVE SOLUTIONS

Achieve Solutions® is designed to help you engage your patients to actively participate in their own treatment and recovery. Beacon Health Options offers you access to credible clinical content, featuring nearly 4,000 articles on over 200 topics including: depression, stress, anxiety, substance abuse, relationships, grief, parenting/elder care and workplace issues. This site includes news items, interactive calculators and quizzes, trainings and other resources.

Information can be printed and shared with your patients during office visits or you can refer your patients directly to the site. A Spanish version of the site is also available.

To access this site, go to www.achievesolutions.net/providers. You can also access Beacon Health Options Provider Referral Search (ReferralConnect), a fully searchable online directory that displays a list of network providers and facilities throughout the country.

FORMS

For your convenience the most frequently used Beacon Health Options forms are available for viewing and printing online at https://www.beaconhealthoptions.com/providers/beacon/forms/ including:

- Change of address forms
- Substitute W-9 forms
- Outpatient Registration Forms (ORF2)
- Medication management registration forms and many more

CONTACT

To contact Beacon Health Options, please refer to the list of phone numbers and/or e-mail addresses below:

Customer Service Member information (benefits, eligibility, etc.) Appeals and grievances GHI-BMP/EmblemHealth EPO/PPO: .....(866) 271-6403 GHIMedicare: ..... (866)318-7595
Claims Claim status/questions GHI-BMP/EmblemHealth EPO/PPO:..... (800)358-5500 GHI Medicare:..... (866)424-3195
Provider Relations Provider contract status/questions Provider complaints (800) 235-3149 Newyorkservicecenter@beaconhealthoptions.com
National Provider Services Line Provider File maintenance Network Status Contracting Credentialing/re-credentialing status (800) 397-1630

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