



Provider Connect Overview and Inpatient Treatment

November 2022

Introductions



Emily Swanzy

Manager of Clinical Services -
Kansas



Beth Bernasek

Network Relations Manager

Learning Objectives

01

Overview of Beacon's Provider Connect system

02

Overview of SB 123 Inpatient Level of care

03

Apply ASAM Criteria to treatment placement decisions

04

Documentation requirements and best practices

Review

- How to Find a Member
 - What to do if I don't
- How to make sure it's the correct Benefit/ID
- Do I need an authorization?
 - How to Submit the authorization?
 - Where can I check for approval?

How to Find a Member

- Click Specific Member Search on PC home screen

Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization/Notification Request
Enter a Treatment Plan
View Clinical Drafts
Enter a Special Program Application
Complete Provider Forms
Enter a Comprehensive Service Plan
Claim Listing and Submission
Enter EAP CAF
Manage Users
Enter an Individual Plan
Enter Case Management Referral
Enter a Referral
Review Referrals
Enter Bed Tracking Information
Search Beds/Opening
Weekly Behavior Analysis Measures
Enter Member Assessment
Enter Member Demographics

Welcome PETER TUMNUS . Thank you for using Beacon Health Options ProviderConnect.

YOUR MESSAGE CENTER (8 **NEW**) Message

Click on inbox to view your messages

WHAT DO YOU WANT TO DO TODAY?

- ▶ [Link/Unlink Accounts](#) **NEW**
- ▼ [Eligibility and Benefits](#)
 - [Find a Specific Member](#)
 - [Register a Member](#)
- ▼ [Enter or Review Authorization Requests](#)
 - [Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge](#)
 - [Enter an Authorization/Notification Request](#)
 - [Enter an Individual Plan](#)
 - [Enter a Special Program Application](#)
 - [Enter a Comprehensive Service Plan](#)
 - [Enter a Treatment Plan](#)
 - [Review an Authorization](#)
 - [Update Monthly Wage Information](#)
 - [View Clinical Drafts](#)
- ▼ [Enter or Review Claims](#)
 - [Enter a Claim](#)
 - [Enter EAP CAF](#)
 - [View EAP CAF](#)
 - [Review a Claim](#)
 - [View My Recent Provider Summary Vouchers](#)
 - [PaySpan](#)
- ▼ [Enter or Review Referrals](#)
 - [Enter a Referral](#)
 - [Review Referrals](#)
- ▶ [Enter Bed Tracking Information](#)
- ▶ [Search Beds/Opening](#)
- ▶ [Update Demographic Information](#)

INBOX SENT

How to Find a Member...Continued

Eligibility & Benefits Search

Required fields are denoted by an asterisk (*) adjacent to the label.

Verify a patient's eligibility and benefits information by entering search criteria below.

*Member ID	<input type="text"/>	(No spaces or dashes)
Last Name	<input type="text"/>	
First Name	<input type="text"/>	
*Date of Birth	<input type="text"/>	(MMDDYYYY)
As of Date	<input type="text"/>	(MMDDYYYY)
<input type="button" value="Search"/>		

- Enter KDOC or KBI in the Member ID box and DOB (KSSC)
- “As of Date” will pre-populate to today’s date. This helps ensure you’re getting current benefit information.

Not able to pull up a member?

- **Member Not Found**

- For KSSC: Email ISO to confirm client is entered correctly into Athena.
 - If yes: email KSSC and copy Beacon
 - sb123payments@ks.gov
 - kansasclinical@beaconhealthoptions.com
 - **PLEASE NOTE: Beacon can only adjust funding at direction of KSSC directly.**

- **Multiple Members Found (for ANY funding)**

- Email kansasclinical@beaconhealthoptions.com to request active ID.
 - Please make sure you indicate the funding you are requesting for.

Your client DOES pull up:

- This brings you to the Demographic screen (which is where you start for almost every need)

Demographics	Enrollment History	COB	Benefits	Additional Information	Primary Care Provider
--------------	--------------------	-----	----------	------------------------	-----------------------

Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Member?		Eligibility	
Member ID	KSS000079	Effective Date	07/01/2018
Alternate ID		Expiration Date	07/01/2018
Member Name	MEMBER POST, TEST	COB Effective Date?	
Date of Birth	01/01/1965		
Address	100 SE 9TH ST TOPEKA, KS 66612		
Alternate Address			
Marital Status	-		
Home Phone	785 -342 -4150		
Work Phone			
Relationship	1		
Gender	M - Male		

Subscriber	
Subscriber ID	KSS000079
Subscriber Name	MEMBER POST, TEST

Member Participates in Message Center Communication with Providers? **No**

How to double check funding

Demographics

Enrollment History

COB

Benefits

Additional Information

Primary Care Provider

Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Member?

Member ID

KSS000079

Alternate ID

Member Name

MEMBER POST, TEST

Date of Birth

01/01/1965

Address

100 SE 9TH ST
TOPEKA, KS 66612

Alternate Address

Marital Status

-

Home Phone

785 -342 -4150

Work Phone

Relationship

1

Gender

M - Male

Member Participates in Message Center Communication with Providers?

No

Eligibility

Effective Date

07/01/2018

Expiration Date

07/01/2018

COB Effective Date?

Subscriber

Subscriber ID

KSS000079

Subscriber Name

MEMBER POST, TEST

Benefit Tab

Demographics

Enrollment History

COB

Benefits

Additional Information

Primary Care Provider

Member eligibility does not guarantee payment. Benefits are as of today's date.
This is a summary of the member's benefits. For additional information, please submit an inquiry to Customer Service by selecting the inquiry button at the bottom of this page.

Member Detail

Client ID:

GHI

Client Name:

GHI/BMP

Benefit Package(s):

G045

Please click the Benefits link below to launch the Self-Service Portal (SSP) where Member benefits can be viewed.

[Benefits](#)

View Member Auths

View Member Claims

View Empire Claims

View GHI-BMP Claims

Enter Auth/Notification Request

Send Inquiry

- Benefits:
 - KSS3 = SB123 – typical treatment coverage
 - KSS2 = SB123 PRE SENTENCE

Do I need to enter an authorization request?


- Member is KSSC (SB123):
 - YES- for ALL levels of care and ALL services you will be providing.
 - MUST include signed CPA for correct dates.
 - If box for services is NOT checked on CPA then they CANNOT be approved

Client Placement Agreement - CPA

- I have highlighted the part that Beacon MUST have to process. The form should be filled out completely with every grey area having something in it

Kansas Sentencing Commission - Senate Bill 123 Program

Client Placement Agreement



Sentencing Date:
mm/dd/yyyy

Scheduled Treatment Start Date:
mm/dd/yyyy

KSSC Eligibility Expiration Date: _____
mm/dd/yyyy
(18 months from **FIRST** treatment start date)

KBI number:

Court Case number:

TOADS Legacy
KDOC#(if available):

ATHENA #

This agreement entered into on _____ day of _____, _____ by and between the
(Day) (Month) (Year)

("COMMUNITY CORRECTIONS") and _____

("PROVIDER") located at _____
(Provider Street Address) (City) (State) (Zip)
for and in consideration of the treatment/modalities and responsibilities listed below and placement of:

(Current Legal First Name/MI/Last Name) born on _____
(mm/dd/yyyy)
convicted in the county of _____
supervised by _____ with the provider for the following treatment:
Community Corrections Agency

CPA Continued:

Identify ALL modalities as reflected by ASAM criteria that apply for the continuum of care:

<input checked="" type="checkbox"/>	Assessment	
<input checked="" type="checkbox"/>	Social Detox	Estimated length of stay: <input type="text"/> (Maximum: 5 days)
<input checked="" type="checkbox"/>	Therapeutic Community (Jo Co only) (Maximum: 180 days)	Estimated length of stay: <input type="text"/>
<input checked="" type="checkbox"/>	Intermediate Residential	Estimated length of stay: <input type="text"/> (Maximum: 21 days)
<input checked="" type="checkbox"/>	Intensive Outpatient	Estimated program length: <input type="text"/> (Maximum: 100 hour units)
<input checked="" type="checkbox"/>	Outpatient Group	Estimated program length: <input type="text"/> (4 (minimum)- 8 (maximum) hours per week)
<input checked="" type="checkbox"/>	Outpatient Family	Estimated program length: <input type="text"/> (Maximum: 1 hour per week)
<input checked="" type="checkbox"/>	Outpatient Individual	Estimated program length: <input type="text"/> (Maximum: 3 hours per week)
<input checked="" type="checkbox"/>	Reintegration	Estimated length of stay: <input type="text"/> (Maximum: 60 days)
<input checked="" type="checkbox"/>	Peer Mentorship (Individual)	Estimated length of stay: <input type="text"/> (Maximum: 3 hours per week)
<input checked="" type="checkbox"/>	Relapse Prevention/Continuing Care	Estimated program length: <input type="text"/>

Page 1 of 4

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CPA Continued

- Signature can be electronic / typed

This agreement may be modified, amended or supplemented by written agreement signed by Community Corrections and the Provider. Modifications must be submitted to the KSSC.


Authorized Treatment Provider Signature: [Redacted]	Date: [Redacted] <small>mm/dd/yyyy</small>	Phone # [Redacted]
Printed Name: [Redacted]		
Email: [Redacted]		
Community Corrections Agency: [Redacted]	Date: [Redacted] <small>mm/dd/yyyy</small>	Phone # [Redacted]
ISO Signature: [Redacted]		Email: [Redacted]

Safeguarding of Client Information: The information contained on this form is confidential and not to be used or disclosed by any party, for any purpose that is not connected directly to the court's assignment of sentence or the case management responsibilities assigned by law to community corrections or by court order. Treatment providers are required to maintain confidentiality consistent with the requirements of their state license.

* A copy of this document must be retained by both ISO and Treatment Provider for auditing purposes.

How to Submit an Authorization Request

- Click Enter Auth/Notification Request

 Switch Account 132162KS-General Claims Account ValueOptions Home

Home
Specific Member Search
Register Member
Authorization Listing
Enter an Authorization/Notification Request
View Clinical Drafts
Claim Listing and Submission
Enter EAP CAF
Manage Users
Review Referrals
Enter Bed Tracking Information
Search Beds/Openings
Weekly Behavior Analysis Measures
EDI Homepage
Enter Member Reminders
Reports
Print Spectrum Release of Information Form
ABA Availability Survey
My Online Profile
My Practice Information
Provider Credentialing Application
Compliance
Handbooks

Demographics Enrollment History COB Benefits Additional Information

Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

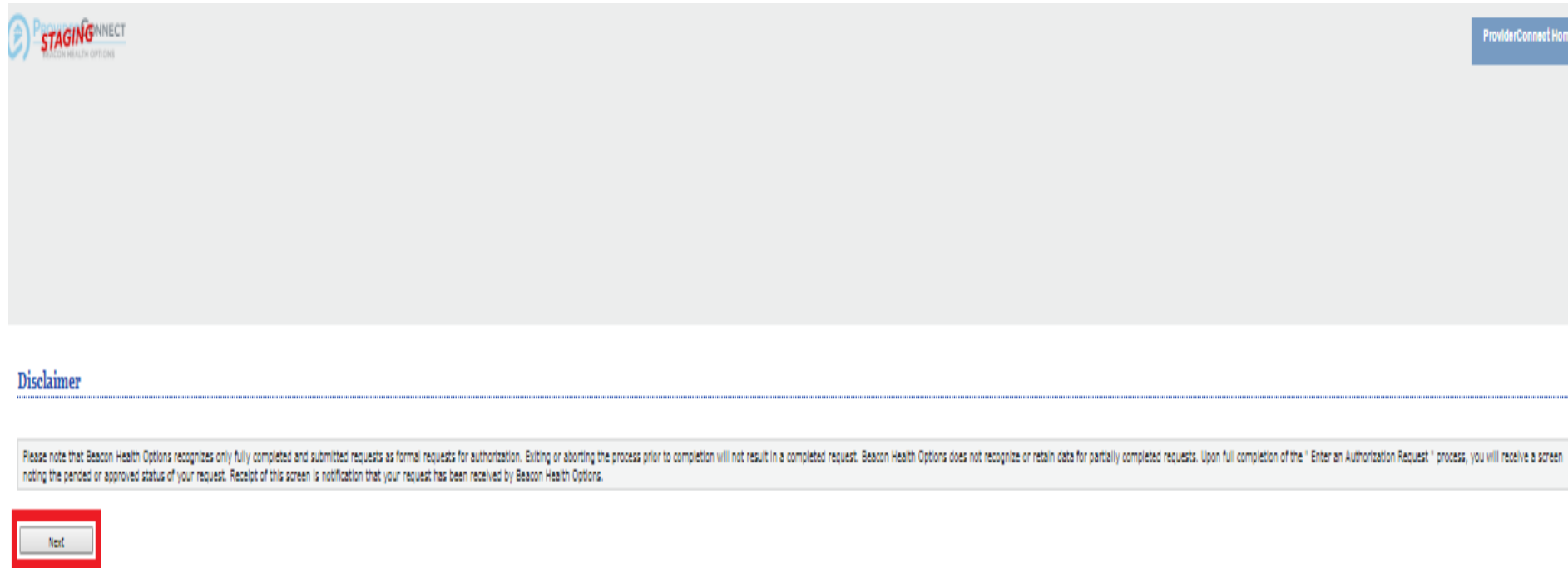
Member		Eligibility	
Member ID	KSS000042	Effective Date	08/07/2017
Alternate ID		Expiration Date	
Member Name	ROGERS, MAGGIE	COB Effective Date	
Date of Birth	01/01/1965		
Address	100 SE 9TH ST TOPEKA, KS 66612		
Alternate Address			
Marital Status	-	Subscriber	
Home Phone	785 -342 -4150	Subscriber ID	KSS000042
Work Phone		Subscriber Name	ROGERS, MAGGIE
Relationship	1		
Gender	M - Male		

Member Participates in Message Center Communication with Providers? No

View Member Profile	View Member Claims	View Empire Claims	View GHI-BNP Claims
Enter Auth/Notification Request	Enter Claim	Send Inquiry	View Clinical Drafts
Enter Member Reminders			
View Spectrum Record	Disable Member Communication		

Submitting an Auth

- Acknowledge the Disclaimer
- Click Next to acknowledge the disclaimer.
 - Please note that Beacon Health Options recognizes only fully completed and submitted requests as formal requests for authorization. Exiting or aborting the process prior to completion will not result in a completed request. Beacon Health Options does not recognize or retain data for partially completed requests. Upon full completion of the "Enter an Authorization Request" process, you will receive a screen noting the pended or approved status of your request. Receipt of this screen is notification that your request has been received by Beacon Health Options.



The screenshot displays a web interface for Beacon Health Options. At the top left is the logo for Beacon Health Options, and at the top right is a link labeled "ProviderConnect Home". The main content area is a light gray box. Below this box, the word "Disclaimer" is written in blue text. Underneath the disclaimer text is a small gray box containing the same disclaimer text as in the list above. At the bottom left of the interface is a "Next" button, which is highlighted with a red rectangular border.

Process initial
when it's a NEW
level of care or
NEW admission

Process Concurrent when
you're ADDING units/codes/etc

Prior Authorization Listing for Concurrent Review, Step/Transfer Review, or Discharge

Effective Date: 12/27/2018 (MMDDYYYY)

Expiration Date: 03/27/2019 (MMDDYYYY)

Search

Process Initial Review Process Concurrent Review Process Step/Transfer Review Enter Discharge Information

Inpatient


Would you like to proceed with the prior authorization vendor?

Yes No Cancel

Auth #	Effective Date	Member ID #	<div>Yes No Cancel</div>			Level of Service	Type Of Service	Level of Care	Type of Care
Client Auth #	Expiration Date	Member Name							
<input checked="" type="radio"/> 01- 031419- 1- 12	03/14/2019		12/02/1979	123456	A00001	INPATIENT/HLOC	SUBSTANCE USE	INTENSIVE OUTPATIENT	INTENSIVE OUTPATIENT
	05/13/2019			712345					
<input type="radio"/> 01- 030119- 1- 4	03/01/2019		12/02/1979	123456	A00001	INPATIENT/HLOC	SUBSTANCE USE	INTENSIVE OUTPATIENT	INTENSIVE OUTPATIENT
	04/30/2019			712345					
<input type="radio"/> 01- 031419- 1- 13	03/15/2019		12/02/1979	123456	A00001	INPATIENT/HLOC	SUBSTANCE USE	ICF-A (INPATIENT REHAB)	LEVEL 3.5 INPATIENT
	04/13/2019			712345					
<input type="radio"/> 01- 112918- 34- 39	11/29/2018		12/02/1979	123456	A00001	INPATIENT/HLOC	SUBSTANCE USE	INTENSIVE OUTPATIENT	INTENSIVE OUTPATIENT

Submitting an Auth continued

- Complete the Service Header

STAGING
BEACON HEALTH OPTIONS

ProviderConnect Home

Requested Services Header

All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.

*Requested Start Date (MM/DD/YYYY)
08/30/2018

*Level of Service
SELECT...

Provider				
Tax ID 237433368	Provider ID 132162	Provider Last Name THE MIRROR INC	Vendor ID 0802354	Provider Alternate ID 100106710
Member				
Member ID TEMP000863153	Last Name MEMBER	First Name TEMP	Date of Birth (MM/DD/YYYY) 01/01/1965	

Attach a Document

Complete the form below to attach a document with this Request

The following fields are only required if you are uploading a document

*Document Type:
SELECT...

Does this Document contain clinical information about the Member? Yes ☐ No ☐

*Document Description
SELECT...

Upload File Click to attach a document

Delete Click to delete an attached document

Attached Document:


Back Next

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Submitting an Auth continued

- Select the start date of the service (first date you need to bill).
 - Note that for a SASSI or DAAP request this will be the date this service was completed.
- Select the Level of Service from the drop down
 - Select Level of Service **Inpatient** for Detox, IP, Reintegration, **IOP** and TC (Johnson County Corrections ONLY)
 - Select Level of Service **Out Patient** for Assessment (DAAP), OP and all auxiliary services
- Attach all applicable documents -Note that all requests should have an attachment.
 - Post-Sentencing Assessment (DAAP) must include: Fully completed SB123 Assessment Summary Form, SASSI, and Clinical Narrative
 - If the request is for a SASSI, attach the SASSI
 - If the request is for outpatient or an initial admit to RTC attach Client Placement Agreement.
 - If the request is for 7 day continued stay in RTC, attach current clinical.
 - If request is for Re-admission to RTC (following initial 21 days) attach Current Clinical and CPA
- Click Next

Submitting an Auth continued



BEACON HEALTH OPTIONS

ProviderConnect Home

NOTIFICATIONREQUESTED SERVICESRESULTS

PAGE 1 of 3

Requested Services Header

Requested Start Date 10/01/2018	Member Name MEMBER POST, TEST	Provider Name TEST, ABCXYZ	Vendor ID E322101	Save Request as Draft
Type of Request INITIAL	Member ID KSS000079	Provider ID 994747	NPI # for Authorization SELECT...	
Level of Service OUTPATIENT	Type of Service SUBSTANCE USE	Level of Care OUTPATIENT	Type of Care BEHAVIORAL	Authorized User

* At least one contact name and phone number is required.

Admitting Physician 	Phone # [][][][]	Ext 	Attending Physician 	Phone # [][][][]	Ext
Preparer 	Phone # [][][][]	Ext 	Utilization Review Contact 	Phone # [][][][]	Ext
				Fax [][][][]	

Primary Care Coordination

PCP Contacted Status
SELECT...

PCP Contacted Name

Date Contacted

Diagnosis

Documentation of **primary behavioral condition** is required. Provisional working condition and diagnosis should be documented if necessary. Documentation of **secondary co-occurring behavioral conditions** that impact or are a focus of treatment (mental health, substance use, personality, intellectual disability) is strongly recommended to support comprehensive care. Authorization (if applicable) does NOT guarantee payment of benefits for these services. Coverage is subject to all limits and exclusions outlined in the members plan and/or summary plan description including covered diagnoses.

Behavioral Diagnoses

Primary Behavioral Diagnosis

* Diagnostic Category 1
SELECT...

* Diagnostic Code 1

* Description

Additional Behavioral Diagnosis

Diagnostic Category 2 SELECT...	Diagnostic Code 2 	Description
Diagnostic Category 3 SELECT...	Diagnostic Code 3 	Description
Diagnostic Category 4 SELECT...	Diagnostic Code 4 	Description
Diagnostic Category 5 SELECT...	Diagnostic Code 5 	Description

Submitting an Auth continued

Primary Medical Diagnosis

Primary medical diagnosis is required. Select primary medical diagnostic category from dropdown or select medical diagnosis code and description.

* Diagnostic Category 1 NONE ▼	Diagnosis Code 1 <input type="text"/>	Description <input type="text"/>
Diagnostic Category 2 SELECT... ▼	Diagnosis Code 2 <input type="text"/>	Description <input type="text"/>
Diagnostic Category 3 SELECT... ▼	Diagnosis Code 3 <input type="text"/>	Description <input type="text"/>

Social Elements Impacting Diagnosis

* Check all that apply

- | | | | |
|--|---|--|--|
| <input checked="" type="checkbox"/> None | <input type="checkbox"/> Problems with access to health care services | <input type="checkbox"/> Housing problems (Not Homelessness) | <input type="checkbox"/> Problems related to the social environment |
| <input type="checkbox"/> Educational problems | <input type="checkbox"/> Problems related to interaction w/legal system/crime | <input type="checkbox"/> Occupational problems | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Problems with primary support group | <input type="checkbox"/> Unknown | <input type="checkbox"/> Medical disabilities that impact diagnosis or must be accommodated for in treatment |
| <input type="checkbox"/> Other psychosocial and environmental problems | | | |

Functional Assessment

Please indicate the functional assessment tool utilized or select Other to write in other specific tool. Assessment score for specific tool should be noted in the Assessment Score field.

Assessment Measure SELECT... ▼	Assessment Score <input type="text"/>	Secondary Assessment Measure SELECT... ▼	Assessment Score <input type="text"/>
-----------------------------------	--	---	--

Please provide any additional information that would be beneficial in processing your request.


▼ Narrative Entry (12 of 2000)

ABC123 notes

Back Save Request as Draft Next

Adding Service Codes

- Click button that indicates “click here to add or modify service code”.

 **PROVIDERCONNECT**
BEACON HEALTH OPTIONS

ProviderConnect Home

NOTIFICATION

REQUESTED SERVICES

RESULTS

PAGE 2 of 3

Requested Services Header

Requested Start Date 10/01/2018	Member Name MEMBER POST, TEST	Provider Name TEST, ABCXYZ	Vendor ID E322101	Save Request as Draft
Type of Request CONCURRENT	Member ID KSS000079	Provider ID 994747	NPI # for Authorization SELECT...	
Level of Service OUTPATIENT	Type of Service SUBSTANCE USE	Level of Care OUTPATIENT	Type of Care BEHAVIORAL	Authorized User <input type="text"/>

All fields marked with an asterisk (*) are required.
Note: Disable pop-up blocker functionality to view all appropriate links.
For certain types of care, further clinical review is required before units can be determined. In these cases, the total number of units available as displayed on the bottom of this page will be zero.
Please indicate the CPT codes and any modifiers for services that are being requested. Units should remain as zero on request until this further clinical review is completed.

[Click Here to Add or Modify Service Codes](#)

Requested Services

* Place of Service	* CPT or HCPC Code	Modifier 1 (If Applicable)	Modifier 2 (If Applicable)	Modifier 3 (If Applicable)	Modifier 4 (If Applicable)	* Visits/ Units
SELECT...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
SELECT...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
SELECT...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
SELECT...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
SELECT...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
SELECT...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
SELECT...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Select Applicable Services

- Mark the applicable service codes
 - Please Reference the *Authorization and Claims Submission Reference Document*
- Click Save

close

[Close Window](#)

Save Close

NOTE Select codes for this authorization request by checking the box next to the service classes being requested prior to saving the selection. Units being requested may be adjusted after saving codes. To de-select a code, uncheck the box. A limit of 20 services can be requested via this form - if additional services are required please indicate the services within the free text of Focus of Care or as an attachment to the request.

	Code	Mod 1	Mod 2	Mod 3	Mod 4	Description
<input checked="" type="checkbox"/>	H0004					BEHAVIOR HEALTH COUNSELING AND THERAPY, PER 15 MINUTES
<input checked="" type="checkbox"/>	H0004	HR				BEHAVIOR HEALTH COUNSELING AND THERAPY, PER 15 MINUTES - FAMILY THERAPY WITH CLIENT
<input checked="" type="checkbox"/>	H0005	US				ALCOHOL AND/OR DRUG SERVICES; GROUP COUNSELING BY A CLINICIAN MEDICAID LEVEL OF CARE 5, AS DEFINED BY EACH STATE
<input checked="" type="checkbox"/>	H0024					ALCOHOL AND/OR DRUG PREVENTI
<input checked="" type="checkbox"/>	H0001					ALCOHOL AND/OR DRUG ASSESSMENT

Save Close

Submitting Service Request

- Enter Place of service and units
- Please remember: If you are requesting Relapse Prevention: you pick H0024 in the previous box and type **manually** H0026 in the list below
- Click Submit

Requested Services

* Place of Service	* CPT or HCPC Code	Modifier 1 (If Applicable)	Modifier 2 (If Applicable)	Modifier 3 (If Applicable)	Modifier 4 (If Applicable)	* Visits/ Units
OFFICE ▼	H0004					936
OFFICE ▼	H0004	HR				312
OFFICE ▼	H0005	US				999
OFFICE ▼	H0024					999
OFFICE ▼	H0001					1
SELECT... ▼						
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SELECT... ▼						
TOTAL VISITS/ UNITS						3247

Instructions

This request must include detailed information about CPT/HCPC procedure code(s) and the modifier, place of service, and number of visits/units requested for each procedure. Please enter the details on this screen.

Note: TOTAL # OF UNITS CANNOT EXCEED 5977

Back Save Request as Draft Submit

Checking an Authorization

STAGING

PROVIDER CONNECT

BEACON HEALTH OPTIONS

Switch Account 994747-General Account ▼

Beacon Health Options Home

Provider Home

Contact Us

Log Out

Home

Specific Member Search

Register Member

Authorization Listing

Enter an Authorization/Notification Request

View Clinical Drafts

Claim Listing and Submission

Enter Case Management Referral

Enter Bed Tracking Information

Search Beds/Opening

Weekly Behavior Analysis Measures

EDI Homepage

Enter Member Reminders

Reports

Print Spectrum Release of Information Form

APA Availability Survey

Demographics

Enrollment History

COB

Benefits

Additional Information

Primary Care Provider

Member eligibility does not guarantee payment. Eligibility is as of today's date and is provided by our clients.

Member?

Member ID KSS000079

Alternate ID

Member Name MEMBER POST, TEST

Date of Birth 01/01/1965

Address 100 SE 9TH ST
TOPEKA, KS 66612

Alternate Address

Marital Status -

Home Phone 785 -342 -4150

Work Phone

Relationship 1

Gender M - Male

Member Participates in Message Center Communication with Providers? No

View Member Auths

View Member Claims

View Empire Claims

View GHI-BMP Claims

Eligibility

Effective Date 07/01/2018

Expiration Date 07/01/2018

COB Effective Date?

Subscriber

Subscriber ID KSS000079

Subscriber Name MEMBER POST, TEST



beacon

Time here to search

12:37 PM

Checking an Authorization continued

- Then Scroll down to:

Provider ID	<input type="text" value="994747"/>	▼
Auth #	<input type="text"/> - <input type="text"/> - <input type="text"/>	(X-digits, no spaces or dashes)
Service From	<input type="text" value="09042018"/>	 (MMDDYYYY)
Service Through	<input type="text" value="09042019"/>	 (MMDDYYYY)
<input type="button" value="Search"/>		

- Choose your date range and click “search”

Checking an Authorization continued

- Auth results screen pops up.... Click the blue hyperlink on the left of the screen that matches the LOC you want

Authorization Search Results

This may not be the full list of EAP cases and may only show open EAP cases based on your search criteria.

The information displayed indicates the most current information we have on file. It may not reflect claims or other information that has not been received by Beacon Health Options. If requesting payment for EAP/non-medical counseling services, select the authorization related to the services and enter the request via either the Auth Details tab or the Auth Summary tab by selecting the Enter CAF button.

Next >>

Auth #	Member ID	Member DOB	Provider ID	Vendor ID	Service
View Letter	Member Name		Provider Alt. ID	Alternate Provider	
01-02232011-1-3	007654884	12/02/1979	12345	A00001	EAP
	[REDACTED]		712345		EAP
01-042210-1-10	007654884	12/02/1979	12345	A00001	Behavioral
	[REDACTED]		712345		Inpatient

This Auth will take to Process Consent and

Checking an Authorization continued

- Clicking the hyperlink takes you here:
- Note: You want **AUTH DETAILS**

Auth Summary

Auth Details

Associated Claims

The information displayed indicates the most current information we have on file. It may not reflect claims or other information that has not been received by Beacon Health Options.

Authorization Header

Member ID	<div></div>	<div>Return to search results</div>
Member Name	<div></div>	<div>Send Inquiry</div>
Authorization #	01-02232011-1-3	<div>Complete Discharge Review</div>
Client Auth # <div></div>	N/A	<div>Enter EAP CAF</div>
Authorization Status	O - Open	
From Provider	<div>PETER TURNER</div>	
Admit Date	01/14/2010	

Checking an Authorization continued

Authorization Header

Member ID

Member Name

Authorization #

Client Auth #[?]

NPI # for Authorization[?]


Authorization Status

Authorization Letter(s)

0003541789

N/A

O - Open

 (click to view)

Return to search results

Complete Discharge Review

Enter EAP CAF

Service Lines

Line #	Submission Date	Service Code	Modifier Code	Service Class Descrp.	Dates of Service	Visits Requested/ Approved	Visits Actually Used (As of Today)	Status	Reason
1	01/14/2010	12345678		EAP SERVICES	01/07/2010- 07/07/2010	5/ 5	3	O - Open	N/A

Authorization and Claims Submission Reference Document

Authorization and Claims Submission Reference Document												
Treatment Modality	Level of Service	Service Class	Type of Service	Level of care	Type of Care	Service Code	Modifier	Place of Service	Charge Amount	Max Per Request	Utilization Guidance	Unit Definition
Social Detox	INPATIENT/ HLOC/ SPECIALTY	SDX	SUBSTANCE USE	RESIDENTIAL TREATMENT CENTER	DETOX	H0014		55	\$175.00	5 days	5 day max length of stay	Day
Therapeutic Community	INPATIENT/ HLOC/ SPECIALTY	RES	SUBSTANCE USE	ASSERTIVE COMMUNITY TREATMENT	BEHAVIORAL	H0025		55	\$150.00	180 days	180 day Cap	Day
Intermediate Residential	INPATIENT/ HLOC/ SPECIALTY	RTC	SUBSTANCE USE	RESIDENTIAL TREATMENT CENTER	BEHAVIORAL	H0018		55	\$198.00	21 days initial 7 day concurrent	90 day Cap	Day
Re-integration	INPATIENT/ HLOC/ SPECIALTY	RRE	SUBSTANCE USE	HALFWAY HOUSE	BEHAVIORAL	H0019		55	\$126.00	60 days	60 day Cap	Day
Intensive Outpatient	INPATIENT/ HLOC/ SPECIALTY	IOP	SUBSTANCE USE	IOP/SOP	BEHAVIORAL	H2035		11	\$40.00	100 hours	100 hour Cap, 10 hr per week min	Hour
Outpatient Individual	OUTPATIENT	TIN	SUBSTANCE USE	OUTPATIENT	BEHAVIORAL	H0004		11	\$22.00	936 units	Max of 12 units per week, Case Max 936 units	15 min Unit
Outpatient Group	OUTPATIENT	TIN	SUBSTANCE USE	OUTPATIENT	BEHAVIORAL	H0005	U5	11	\$8.50	2496 units	32 unit max per week, Case Max 2496 units, 4 unit/week min	15 min Unit
Outpatient Family	OUTPATIENT	FAM	SUBSTANCE USE	OUTPATIENT	BEHAVIORAL	H0004	HR	11	\$20.00	312 unit	4 units per week, Case Max 312 units	15 min Unit
Relapse Prevention/ Continuing Care	OUTPATIENT	TIN	SUBSTANCE USE	OUTPATIENT	BEHAVIORAL	H0024 H0026		11	\$22.00 \$8.50	624 unit each	Max: 8 units per week 12 units per week	15 min Unit
Peer Support	OUTPATIENT	PEE	SUBSTANCE USE	OUTPATIENT	BEHAVIORAL	H0038	HF	11	\$12.00	936 units	12unit max per week, Case max 936 units	15 min Unit
SASSI only	OUTPATIENT	EV2	SUBSTANCE USE	OUTPATIENT	BEHAVIORAL	H0002		11	\$5	1 unit	1 per case only, available under presentencing benefit package only	1 unit
DAAP	OUTPATIENT	EVL	SUBSTANCE USE	OUTPATIENT	BEHAVIORAL	H0001		11	\$175	1 unit	1 per case, includes the SASSI	1 unit

Quick Claim Notes

- If the Authorization is NOT present in Provider Connect when you submit a claim- it will not pay out.
 - If you receive a denial for authorization and have obtained an authorization- as long as it's within 45 days – you can send a corrected claim through Provider Connect.
 - PR must be notified if you need timely waiver so as to outreach to KSSC for approval or denial.
- Timely can be waived if the delay is related to eligibility issues (please make sure to email Elizabeth.Bernasek@beaconhealthoptions.com if there is a delay so I can verify prior to waiver request.

Trainings

- Please be aware we are happy set up zoom trainings with new staff or refreshers with existing staff if there are consistent issues or questions within your facility.
 - Clinical and Provider Relations team up to run these trainings to cover the range of question when appropriate.
 - Power Point “walk through” also available at <https://kansas.beaconhealthoptions.com>
 - NOTE: Policy concerns/questions are directed to KSSC.

American Society of Addiction Medicine – ASAM Criteria

- Third edition, 2013
- Most widely used and comprehensive set of guidelines for placement, continued stay, transfer or discharge of individuals with addiction
- Applicable to both adolescents and adult treatment planning.
- 6 Dimensions for holistic, biopsychosocial assessment
- Focus on least restrictive Level of Care
- Each dimension will be rated as either mild, moderate, high. These rating will assist in determining medically necessary Level of Care.

ASAM Six Dimensions

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions & Complications
3. Emotional, Behavioral, or Cognitive Conditions & Complications
4. Readiness to Change
5. Relapse, Continued Use, or Continued Problem Potential
6. Recovery/Living Environment

<https://www.asam.org/asam-criteria/about>

Differentiating Level Of Care

- Social Detox – Current intoxication, current or immanent withdrawal symptoms that do not require medical oversight
- **Level 3.3 – Requires removal from community, intense relapse prevention and intense recovery education in order to establish recovery and interrupt substance use**
- Level 3.1 – Requires safe, supportive, accountable environment in which to practice newly learned recovery skills & education, needing to obtain safe/supportive housing and establish financial means of self-support
- Level 2 IOP – Requires high intensity recovery education and accountability

SB 123 Level 3.3 tx details

- Cost CAP 90 days per 18 month case
- CPA required for each admission
- Medical necessity per ASAM standards must be met for all Level 3.3 tx services following the initial 21 days for approval to be issued as well as CPA.
 - Provider's should be applying to all admissions regardless of funding as best practice
 - Beacon recommends submitting clinical with all level 3.3 tx requests to avoid delays in approvals and therefore billing

Clinical Documentation

- General & Admissions:
 - Recommended submit clinical on all Level 3.3 requests; REQUIRED for all L3.3 requests following this initial 21 days Level 3.3
 - Submitted timely – Beacon has no requirement around when an authorization is submitted however KSSC claims standards are billing within 45 days of service being delivered
 - Clinical on ALL 6 ASAM Dimensions required
 - Current information
 - Recent enough that a decision can be made about necessary level of care TODAY
 - Specific, include dates whenever possible
 - Medical/MH currently addressed or planned referral / explanation of barriers
 - Must be stable or under care to enter Level 3.3 or Level 3.1
 - If last use occurred more than 1 month ago, explanation of sobriety time
 - incarcerated, in hospital, etc.

Clinical Documentation

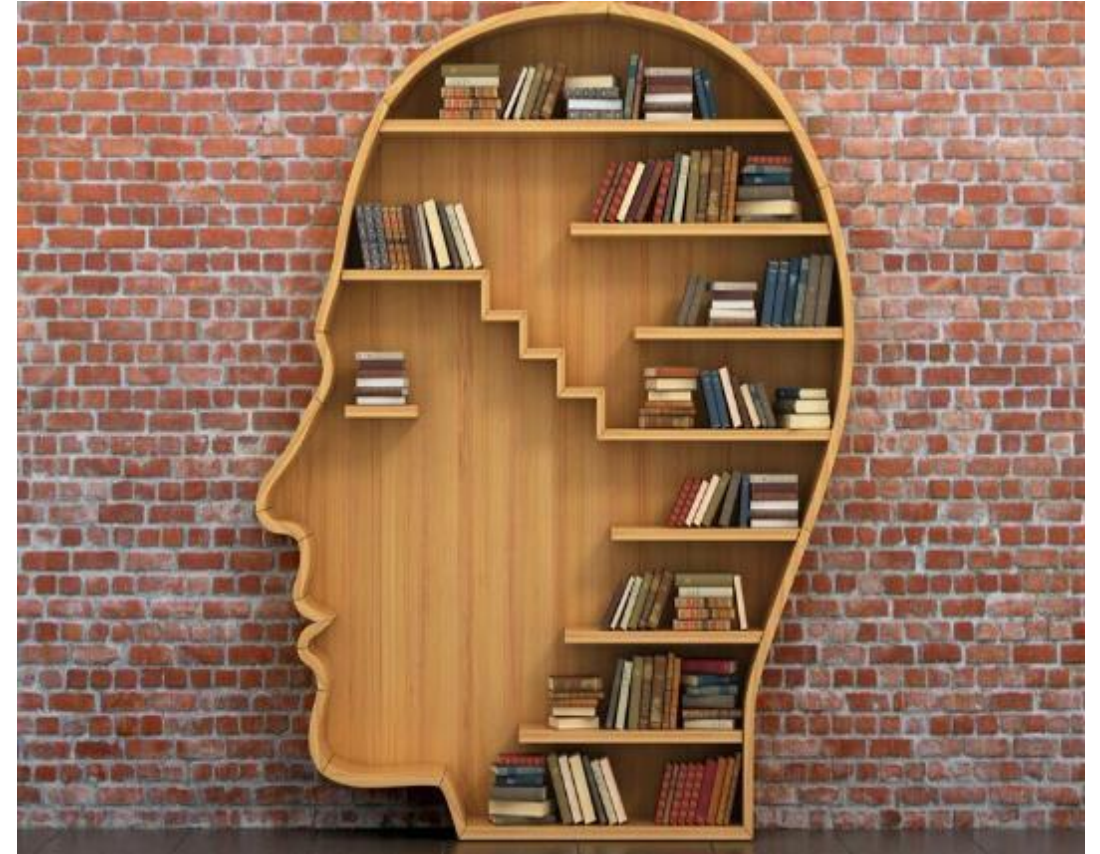
- Continued Stay Requests (CSR)
 - What has been accomplished and what treatment tasks are still needing to be accomplished that CANNOT be accomplished at the next lowest level of care.
 - Brief use history as if this is the first CSR no clinical has been reviewed
 - Ex: offender was using meth daily approx. 1/4 gram per day, smoking, until day prior to admission to treatment on _____ date
 - Discharge Planning
 - Where residing
 - Financial means
 - Medical/MH referral (Intake date best practice)
 - Next level of SUD treatment (Intake date best practice)

Last but not Least

- Individualized treatment planning – NOT 1 size fits all
- Treatment is an opportunity NOT a punishment
- Relapse does NOT always mean a higher level of care is clinically indicated
- Long term recovery occurs at community level of services
- Meet the client where they are
- If medical/mental health conditions are identified, how they will be addressed/referred should be included as well
- MAT should be recommended to individuals w/AUD and OUD
- Discharge planning begins Day 1 of treatment
 - Barriers and the plan to address them should identified at admission and communicated clearly to next level of care provider.

References

- The ASAM Criteria Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, American Society of Addiction Medicine Third Edition, 2013
- <https://www.asam.org/>



Contact

- PLEASE do not hesitate to call or email if you have questions or would like a walkthrough of the system while in your office.

Beth Bernasek, Network Relations Manager

- 785-213-3562
- Elizabeth.bernasek@beaconhealthoptions.com

Emily Swanzy, Manager Clinical Services

- Emily.Swanzy@beaconhealthoptions.com

Kansas Clinical:

- 1-866-645-8216
 - Option 3 for SB 123
- kansasclinical@beaconhealthoptions.com

THANK YOU!!!