

Beacon Comprehensive Behavioral Health Management Policy and Procedure Manual	
Policy Name: Transition of Care	Utilization Management
Date: 11-97 Reviewed by QI Committee: 9-06, 7-07, 9-07, 9-08, 9-09, 9-10, 9-11 Revised by QI Committee: 9-06, 7-07, 9-07, 9-08, 9-09, 9-10, 9-11	Page: 1 of 2 Policy Number: UM-7

Purpose: To ensure quality consumer care, whenever a patient can no longer continue in treatment due to benefit exhaustion, eligibility ending, and/or provider terminating from panel, Beacon Comprehensive Behavioral Health Management (Beacon CBHM) will provide options for patient to transition to appropriate resources.

Policy:

1.0 Outpatient

1.2 Provider Termination

- 1.2.1 At the time a provider resigns and/or his/her contractual agreement with Beacon CBHM is terminated, Beacon CBHM will identify all patients currently in treatment with provider.
- 1.2.2 Beacon CBHM notifies the member via telephone or mailed letter that the provider is no longer contracted with Beacon CBHM and offers alternative in-network referrals and/or referrals to community resources. Beacon CBHM does not disclose to the member the reason the provider is no longer contracted. Beacon CBHM documents patient’s choice for ongoing care in the electronic medical record.

1.3 Member Ineligibility or Exhaustion of Benefits

- 1.3.1 At the time Beacon CBHM becomes aware that a member has become ineligible with the health plan or has exhausted their benefit, all registrations and/or authorizations are closed as of the date of ineligibility or date last benefit utilized.
- 1.3.2 Beacon CBHM Case Manager informs provider that he/she is responsible to inform patient of the following options:
 - 1.3.2.1 Patient may choose to develop a financial arrangement with provider to pay for services privately. In such cases, provider and patient must sign a written agreement.
 - 1.3.2.2 Provider may seek reimbursement through another health plan if the patient is eligible.
 - 1.3.2.3 Provider may refer the patient to community resources. If a provider needs assistance in identifying community resources, s/he may contact the Beacon CBHM Director of Care Management who will complete a resource search and report back the results.
- 1.3.3 The patient and provider are mailed a written notification, which includes instructions for seeking assistance with community resource referrals as needed.

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1.3.4 In the event that Beacon CBHM receives a request for authorization of sessions after the member has become ineligible or exhausted benefits, per Beacon CBHM delegation agreements, an administrative denial letter, or request for the payer to issue an administrative denial, will be sent within 72 hours. Reference Beacon CBHM Policy UM-6, Denials and Appeals.

2.0 Inpatient/Alternative Levels of Care

- 2.1 Beacon CBHM UM Coordinator will advise facility via telephone that patient either has exhausted benefits or is no longer eligible with the health plan.
- 2.2 Per Beacon CBHM delegation agreements, an administrative denial letter, or request for the payer to issue the denial, will be sent to the facility within 72 hours. Reference Beacon CBHM Policy UM-6, Denials and Appeals.
- 2.3 Beacon CBHM UM Coordinator will confer with facility staff regarding appropriate community referrals, conversion to private pay, or possible coverage through a secondary health plan.
- 2.4 A transition plan will be documented in the clinical notes by the UM Coordinator.