



**Interim Contract
Between Beacon Health Strategies, LLC & Broward County**

In exchange for mutual and valuable consideration, the sufficiency of which is hereby acknowledged, **Broward County (FACILITY)** and **Beacon Health Strategies, LLC (BEACON HEALTH STRATEGIES)** hereby mutually agree to this **Interim Contract** for services herein described:

FACILITY agrees to provide and accept as payment in full from **BEACON HEALTH STRATEGIES** the rate as set out in **Table 1** for authorized services provided to Medicaid Members.

All parties shall comply with any and all applicable Agency for Health Care Administration (AHCA) and Centers for Medicare and Medicaid (CMS) laws and regulations, as well as applicable state laws, rules and regulations

Except for emergency services, **FACILITY** shall only provide Behavioral Health Services to a member upon receipt of a prior authorization from **BEACON HEALTH STRATEGIES** to provide such services. The ability for **FACILITY** to obtain an authorization from **BEACON HEALTH STRATEGIES** shall be made available by **BEACON HEALTH STRATEGIES** twenty-four (24) hours per day, seven (7) days per week, each day of the calendar year. **FACILITY** agrees to comply with **BEACON HEALTH STRATEGIES** Utilization Management process.

FACILITY shall cooperate with **Beacon Health Strategies**, NCQA and Joint Commission risk management processes, quality improvement program and activities and utilization management processes.

For all Behavioral Health Services for Covered Services provided by **FACILITY** under this Interim Contract, all factors related to electronic or hard copy claims, including the timeliness of claim submission, the establishment of the date a claim is considered received, the data required on a UB-04 or CMS-1500 form, the timeliness of payment of claims, the procedures and timeframes for notification of denial of claims, the procedures and timeframes for contesting claims, the procedures and timeframes for overpayment of claims, and the permissible error ratios for violation of terms related to payment of claims, shall be in accordance with applicable state and federal laws. **FACILITY** shall not, under any circumstances, surcharge or otherwise balance-bill a Member for any Behavioral Health Services; provided, however, that **FACILITY** may collect any applicable copayments, coinsurances and/or deductibles, as applicable

DATA REQUIRED:

Please fill in the data:

- Facility Medicare #: _____
- Facility Medicaid #: 060455100 (Main#) 060455101, 060455103
- Facility NPI #: 1326171034

Please provide a copy of the following documentation:

- W-9
- Facility Malpractice Insurance copy
- Licensure For Services Provided by Facility
- JCAHO, CARF or COA Accreditation Letter and Certificate
- Facility D.E.A. Certificate copy
- Claims

Payment Address: 900 NW 31st Avenue, Suite 2000

City/State/Zip: Fort Lauderdale, FL 33311



**Interim Contract
Between Beacon Health Strategies, LLC & Broward County**

IN WITNESS WHEREOF, the parties hereto have caused this **Interim Contract** to be executed by their duly authorized officers as of **August 1st, 2017** the Effective Date. Agreement shall commence as of the "Effective Date" and shall end **November 1st, 2017** or until such time as the full service agreement is executed by both parties whichever comes first.

Either party may terminate this **Interim Contract** by giving thirty (30) days notice to the other party.

Beacon Health Strategies, LLC

Broward County

By: _____

By: _____

Print Name: Joanne Wilson, RHIA

Print Name: _____

Title: AVP, Network Operations

Title: _____

Date: _____

Date: _____

Tax ID#: 59-6000531

Reviewed and approved as to form:
Joni Armstrong Coffey, County Attorney

By 
Karen S. Gordon, Assistant County Attorney

By 
Sharon V. Thorsen, Senior Assistant County Attorney

Table 1

DESCRIPTION OF EVENT	PROC CODE	MODIFIER	RATE	RATE DESC.
Alcohol and/or drug assessment, Bachelors degree level	H0001	HN	\$48.00	per assessment
Alcohol and/or drug assessment, Master's degree level	H0001	HO	\$125.00	per assessment
Alcohol and/or drug assessment, follow up service	H0001	TS	\$100.00	per assessment
Behavioral Health Related Medical services: verbal interaction, substance abuse	H0048		\$10.00	per event
Behavioral Health day treatment, per hour, substance abuse program	H2012	HF	12.50	Per hour
Therapeutic behavioral services, per 15 minutes, group setting	H2019	HQ	\$6.67	per quarter hour
Therapeutic behavioral services, per 15 minutes, family/couple with client present	H2019	HR	\$18.33	per quarter hour
Alcohol and/or substance abuse services, treatment plan development and/or modification	T1007		\$97.00	per event
Alcohol and/or substance abuse services, treatment plan development and/or modification, follow up service	T1007	TS	\$48.50	per event
Screening to determine appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter substance abuse program	T1023	HF	\$43.62	per event

REIMBURSEMENT SCHEDULE: MEDICAID

Revenue Code	Service Description	Reimbursement Rate
116/126/136/146/156	Inpatient Detox	\$650.00, Per Diem; All inclusive including physician fees