Lyra Behavioral Health, Inc.
Provider Manual

Updated: April 16, 2018

OVERVIEW

Lyra Behavioral Health, Inc. ("Lyra," "our," "us," "we") is licensed (or is seeking licensure) by the Department of Managed Health Care ("DMHC"), which will subject us to The Knox-Keene Health Care Service Plan Act of 1975, as amended. The policies here are intended for use by healthcare providers contracted to be included in Lyra's behavioral health network ("Provider(s)," "you," "your").

In these policies, you will find what you need to know to successfully work with Lyra.[1] As a Provider in our network, you will be required to comply with these policies and all contractual terms at all times, and to display the utmost professionalism. If you have any questions or concerns regarding the materials contained herein, please do not hesitate to contact Lyra Behavioral Health, Inc. directly through https://provider-support.lyrahealth.com or via secure email to **providers@lyrahealth.com** for **administrative** matters and **care@lyrahealth.com** for **clinical** or **patient-specific** matters.

Revisions

Lyra may revise these policies from time to time, and will provide you with any and all updates in writing. If you have questions or concerns about any update, you should immediately contact Lyra.

Contact information:
Lyra Behavioral Health, Inc.
205 Park Road
Burlingame, CA 94010
https://provider-support.lyrahealth.com

For administrative matters
Email: providers@lyrahealth.com
Telephone: 877.707.5972

For clinical or patient-specific matters:
Email: care@lyrahealth.com
Telephone: 877.505.7147

1 As permitted under HIPAA, Lyra Behavioral Health, Inc. works closely with Lyra Health, Inc as a contracted partner and business associate to deliver technology and services to streamline operations and communication with providers and clients, including the collection and analysis of protected health information (PHI) and personally identifiable information.

PROVIDER POLICIES FOR LYRA BEHAVIORAL HEALTH, INC.

PROVIDER ONBOARDING

Credentialing

In order to be considered for participation in Lyra's network, all Providers must meet, and continue to meet, Lyra's standards as completed during the (re-)credentialing process. As part of your application, you were required to complete a profile, phone interview, and an online credentialing process, including but not limited to uploading copies of:

- a government-issued photo ID
- evidence of a valid DEA/CDS license, if applicable
- proof of current malpractice insurance (typically the face sheet) as well as an explanation of any professional liability claims that resulted in settlement or judgment paid on your behalf
- a curriculum vitae (CV) the covers your education, training, board certification status, if applicable, and at least the last five years of your clinical work history (as well as an explanation of any gaps in your work history of more than 6 months)

If you are registered with the Council for Affordable Quality Healthcare (CAQH), you may have provided us with your ProView number in lieu of providing the referenced materials. We perform primary source verification of your credentials, including a current and unrestricted clinical license to practice, as well as a criminal background check.

Our credentialing process includes answering a series of questions, a peer review committee, and generally takes two weeks once we receive all of the necessary information. However, for some Providers, necessary follow-up research on a particular issue may elongate the process by up to sixty (60) calendar days. Every effort to quickly resolve any credentialing issues is made, but if your application is not completed and/or follow-up research questions are not answered by you within sixty (60) calendar days, we may deem your application withdrawn. Information obtained in the credentialing process is kept confidential, except as otherwise required by law. In addition, there will be ongoing monthly monitoring of practitioner-specific complaints, licensure maintenance, and criminal and civil backgrounds, and you will be notified of any discrepancies in credentialing information. All Providers are re-credentialed approximately every two (2) years.

Data Sharing and PHI - Compliance and Confidentiality

Lyra is committed to best practices for security and patient privacy. We comply with HIPAA and state requirements for the use and disclosure of protected health information (PHI). Before we make any care recommendations to a client, they must consent and acknowledge receipt of our HIPAA Notice of Privacy Practices and Consent to Limited Disclosures. (you can read full Privacy Practices here). In addition, since you are contracted with a covered entity, to provide behavioral health care to our clients, under HIPAA (The Health Insurance Portability and Accountability Act of 1996), it is permissible for us to share PHI for payment, treatment, and healthcare operations purposes.

Our team includes professionals who have put in place physical, technical and administrative safeguards for the privacy and security of client data, including obtaining HITRUST certification. Lyra has privacy and security policies that govern all use of PHI and patient data. All PHI and clinical data shared with Lyra is securely encrypted using 128-bit or stronger Advanced Encryption Standard (AES), and as required under HIPAA, all of our relevant technology partners have signed Business Associate Agreements that bind them to the same standard of care. (Please remember, as a Lyra Provider, you have also agreed to use HIPAA-compliant technology.)

PROVIDING CARE

Eligibility

An employee who is eligible for medical benefits, at a company that sponsors Lyra as a benefit, is eligible for care. In addition, benefit eligible dependent(s), as defined by each sponsoring company, are eligible for care.

Before booking an appointment, you should ask your prospective client 1) if they (or the relevant employee) are eligible for medical benefits through their company, 2) if the company offers Lyra as a benefit, and 3) if they have registered with Lyra. Clients should register with Lyra through our online system or over the phone before using their Lyra benefit. Clients should not self-refer to a Lyra therapist without first contacting Lyra, as we provide each client with a personalized list of nearby therapists whose expertise matches their specific needs. If the client does not appear to be eligible for Lyra's services or has not registered with Lyra, please refer the client back to Lyra by contacting Lyra's care team at 877.505.7147.

Covered Services

Lyra's mission is to provide short-term, evidence-based interventions for clients with behavioral health concerns, and employers contract with Lyra to provide their members short-term, outpatient care using evidence-based treatment methods. Lyra cannot provide long-term care or counseling, and as Lyra can only provide short-term care, we may not always be the most

appropriate avenue for clients looking to access more intensive behavioral health services.

We request then that if you are referred a client for whom longer care is indicated, defined here as more than 20 sessions of once-weekly therapy, contact Lyra so that we can work together to support the client in accessing the right resources for care. Similarly, if you are working with a Lyra client in short-term care and come to recognize the client would benefit from more intensive care, please contact Lyra as soon as possible so that we can work to support the client in accessing the appropriate level of care.

Consistent with our commitment to provide short-term care only, some of our sponsoring employer customers have given us annual limits on the number of therapy sessions that they will pay for, and you will receive a notification in Lyra's Provider Portal of the approaching limit when you submit payment requests for clients who fall under one of these contracts.

For more explanation and examples, please visit the Provider Help Center.

Videotherapy

Research on video therapy has found it to be effective with a diverse client population and a number of mental health concerns. Lyra believes that video therapy can reduce barriers to accessing mental health care, reduce costs associated with the provision of psychological services, and increase frequency of contact and engagement in therapy. However, given the complexity of providing psychological services over the internet, Lyra requires you to (i) conduct video therapy according to the laws of the client's state on a HIPAA-compliant video platform, (ii) secure informed patient consent that includes information about video therapy, (iii) maintain a plan for dealing with emergencies, (iv) watch Lyra's training webinar on video therapy or submit documentation of prior CEs related to video therapy, and (v) review Lyra's video therapy training documents available at www.lyrahealth.com/videotherapy.

Complex Cases

For clients looking to access more intensive behavioral health services, Lyra is not the most appropriate avenue for care. Lyra recognizes that some individuals, particularly those with severe, complex, or chronic concerns, may need more treatment than Lyra provides. We require that you contact Lyra if you are referred a client for whom longer care is indicated, defined here as more than 20 sessions of once-weekly therapy, so that we can all work together to support the client in accessing the right resources for care.

Similarly, if you are actively working with a client in short-term care and come to recognize the client would benefit from more intensive care, please contact Lyra at 877.505.7147 as soon as possible so that we can work to support the individual in accessing the appropriate level of care.

In many cases, Lyra can work with the client and their health insurance company to access , longer-term or higher level care, including additional providers, residential, IOP, or inpatient treatment options.

Please contact us (care@lyrahealth.com or 877.505.7147) if you have any questions or believe a client may benefit from additional care. In addition, if you believe that you are not a good fit for any client, for any additional reason, we recommend that you contact Lyra at 877.505.7147 for assistance with finding a more suitable provider.

Lyra for Families

In many cases, Lyra clients are eligible for family or couples therapy. However, consistent with ethical standards that discourage dual relationships with clients, it is Lyra's policy that a client being seen for individual therapy must see a different therapist for couples or family therapy and vice versa.

Language Assistance

Lyra strives to meet the needs of all clients, including those with Limited English Proficiency (LEP). As such, and by law, Lyra will periodically survey clients to understand its population's linguistic needs. Lyra will provide for the translation of certain documents as required by law and / or requested by clients, including grievance forms and procedures.

If your client indicates that they would benefit from free language assistance, either with regards to Lyra information, or while receiving services, we ask that you please direct the client to contact Lyra at 877.505.7147. If a client declines such assistance, we ask that you record this decision in their file.

BILLING FOR SERVICES

Claims Submission

During onboarding, you will be prompted to register for Lyra's online payment portal. We request that you submit all invoices through this tool, by logging into https://provider.lyrahealth.com. If you encounter a problem, have questions, or need to update your payment portal information (including bank account information), please submit your request in writing via email to providers@lyrahealth.com.

When submitting a claim, you will be required to provide your client's name, and name and date of birth of the eligible employee, if different, and the sponsoring employer company. You can also include a reference number which is a number of your choosing, for your personal invoicing system / tracking. Unless otherwise specified in your LOA, all claims must be submitted within 90 days following the date of service.

For some sponsoring companies, Lyra has been given permission to submit invoices directly to the employer's group health plan for certain clinically appropriate sessions. For client(s) who are covered under these employers' programs AND to the extent appropriate, you give Lyra permission to submit claims for these client(s) to the employer group health plan.

Timely Reimbursement

We aim to reimburse all complete claims as soon as possible, often within 1-2 business days, but in no case later than 30 working days after receipt for uncontested claims. If any portion of your claim is contested, or a claim is missing information needed for processing, you will be contacted within the same time period with additional information and instructions.

In the rare case that Lyra mistakenly overpays you, we will notify you in writing to request a refund within 365 days. If you neither dispute the overpaid amount, nor repay it within 30 days, Lyra will have the right to offset any current or future claims.

Prohibited Practices

If you have any concern with our claims process, we ask that you please reach out to Lyra as soon as possible so we can respond to and resolve your issue. Even in the case that you are dissatisfied with us or your contracted reimbursement rate, in no case are you contractually permitted to invoice or balance bill any clients for the difference between your customary charges and the agreed upon reimbursement rate, or attempt to collect from the client should we delay payment, or fail to pay for any Covered Services.

DISPUTES, GRIEVANCES, AND APPEALS

For Providers

We work hard to always be on the same page as our Providers. However, should you have any dispute with us, including with regards to a claim that has been denied, adjusted, or contested, a billing determination, another contract issue, or dispute our request for the reimbursement of an overpaid claim, we request that you please submit your concern in writing, online (www.lyrahealth.com/feedback), via email to providers@lyrahealth.com, or by writing to us at 205 Park Road, Burlingame, CA 94010. We also ask that you clearly identify the disputed item, and include the date of service (if applicable) and a clear explanation of the issue and your position. You may bundle substantially similar disputes in one form, so long as you clearly identify the separate issues by claim number, date of service, client, or contract section, as applicable.

If any information is missing from your dispute, we will provide you with notice and 30 working days to resubmit your dispute, including the information required. Lyra will provide you with a written determination within 45 working days of your original submission, or resubmission, as applicable.

We will never discriminate or retaliate against you (including but not limited to the cancellation of the Provider's contract) because you filed a dispute, nor will we ever charge you for doing so (but we will not reimburse you, either).

If you choose to submit a dispute on behalf of a client, that dispute will be handled in accordance with the client grievance and appeal section, described below.

For Clients

Complaints and Grievances

Lyra attempts to provide clients with the highest level of service at all times. However, we recognize that there may be times when a client is dissatisfied with services rendered either directly by Lyra, or by a Provider. If a client would like to file a complaint or grievance, please have them reach out to Lyra, and we'd be happy to help. We ask that you be prepared to support us in our efforts to handle any complaint, grievance, or appeal, if and as requested, in accordance with our policies and procedures.

Clients and their authorized representatives may review more information and file a Grievance Form online at www.lyrahealth.com/feedback or at Lyra's headquarters. Clients or their authorized representatives may also seek assistance by calling 877.505.7147.

Any grievance that cannot be resolved in real time by the Care Navigator or Client Support Specialist will be initially reviewed by a member of the Customer Success team ("Reviewer").

Lyra will acknowledge receipt of all grievances within 5 days of receipt, except for those received by telephone, facsimile, email, or online through Lyra's website, that are resolved by the next business day (unless the dispute involves a coverage dispute, disputed health care services involving medical necessity, or experimental or investigational treatment).

Appeals

If a grievance is nonetheless a request for services that have been denied (in whole or in a part), the client or client's authorized representative may appeal the denial through the grievance process.

Grievance Form should be filed, along with details of the appeal, including any documents, records or other information pertinent to the appeal. Lyra will provide written or electronic notice of of its appeal decision, and, if denied, information on obtaining an independent medical review through DMHC.

Independent Medical Review

If a client believes that they have experienced an improper denial, delay, or modification of services, they may be eligible for an Independent Medical Review (IMR). The IMR process provides an impartial review of medical decisions related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. Clients or their

authorized representatives may reach the DMHC by toll-free telephone number (1-888-HMO-2219) or TDD line (1-877-688-9891) for the hearing and speech impaired. DMHC's website http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions.

QUALITY ASSURANCE PROGRAM

Lyra will be responsible for maintaining a quality assurance program in compliance with Title 28 of the California Code of Regulations §1300.70, as amended. However, you are an integral part of this program, and, as such, you will may be requested from time to time to assist Lyra in maintaining its program, consistent with program policies and procedures.

For example, Lyra is required to monitor quality of care, accessibility, availability, and continuity of care. Should we identify any areas for improvement, we will work directly with you, and following our established policies and procedures, to address such concerns.

FRAUD, WASTE, ABUSE

Lyra relies on its providers, customers, staff, and individual clients to act in good faith at all times. Unfortunately, Lyra recognizes that this may not always be the case, and has created an Anti-Fraud plan to detect, prevent, and remedy instances of Fraud, Waste, or Abuse ("FWA"). Lyra requires all providers to report suspected instances of FWA in a timely manner.

Fraud, Waste, and Abuse can take many forms - it can been seen when a provider knowingly bills for sessions or services that weren't actually received by the member (fraud); extra and unneeded services are provided, often as a result of poor organization (waste); or patterns of providing costly services outside of industry standards emerge (abuse).

Lyra will never retaliate against any client, staff member, provider, customer, or third party that reports suspected FWA. A report of suspected FWA is not treated as a finding of FWA until Lyra completes a full and thorough investigation, and makes such determination.

FWA should be reported through the Grievance process or by emailing care@lyrahealth.com.

EXHIBITS

Exhibit A - Regulatory Requirements

This Exhibit A sets forth requirements applicable to services provided to members ("Member(s)") enrolled in a commercial EAP program operated by Lyra Behavioral Health, Inc. ("Plan"), which is licensed or is pursuing a license as a health care services plan in California. These requirements shall not be applicable where the requirements below are preempted by federal law.

Plan is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code, as amended, and Chapter 2 of Title 28 of the California Code of Regulations, as amended (collectively, the "Knox-Keene Act and Rules"), and as a Provider in Plan's network, you agreed to comply with requirements set forth in the Knox-Keene Act and Rules, as applicable, and unless preempted by federal law.

Exhibit A will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes. If there is a conflict between the terms of this Exhibit and terms elsewhere (in the manual or in your contract with us), the terms of this Exhibit will control.

1. Client Confidentiality. Provider will not disclose medical information regarding a client unless such disclosure complies with the requirements of California Civil Code §56.10 and §56.104, as amended.

2. Continuation of Care after Termination for Certain Conditions. If your letter of agreement with us ("LOA") is terminated by either party for any reason other than termination for a medical disciplinary cause or reason, or fraud or other criminal activity, you will, at the request of the client and Plan, continue to provide Covered Services to clients with certain medical conditions as described in and pursuant to the California Health & Safety Code §1373.96, as amended, until the services are completed or the time limitations described therein have been reached. The provision of the continued services for clients with these medical conditions is subject to the same contractual terms and conditions that were imposed upon you prior to termination, including the rate of compensation. Upon termination of the LOA, Plan is liable for the covered services rendered by you (other than any permissible co-payments, coinsurance or deductibles, as set forth in the client's Evidence of Coverage) to a client who retains eligibility under the applicable Evidence of Coverage or by operation of law and who is under your care at the time of termination of the LOA until the services you render to the client are completed or until Plan makes reasonable and medically appropriate provisions for the assumption of such services by another contracted Provider. [[H&S 1373.95 and 1373.96]]

3. No Action at Law Against a Client; use of Surcharges. Neither you nor your agent, trustee, or assignee shall collect a surcharge from a client for services provided to the client pursuant to the LOA, nor shall you nor your agent, trustee or assignee maintain any action at law against a client to collect sums owed by Plan to you for services provided to the client pursuant to the LOA. Upon notice of any such action or upon notice that you have imposed surcharges for Covered Services, Plan will take appropriate action. As used in this Exhibit, the term "surcharges" means an additional fee which is charged to a client for a service but which is not approved by the Director of the DMHC, provided for in Evidence of Coverage, and disclosed in the Evidence of Coverage or the disclosure form used as the Evidence of Coverage.

4. Maintenance and Access to Records. You will prepare and maintain such records and provide such information to Plan or to the Director of the DMHC as may be necessary for Plan's compliance with the provisions of the Knox-Keene Act and the rules thereunder. Such records must be maintained for at least two years, except that if other regulatory requirements require a longer retention period, that longer period will apply. This obligation is not terminated upon a termination of the LOA, whether by rescission or otherwise. In addition, you will permit Plan to access at reasonable times upon demand your books, records and documents relating to the services provided to clients, to the cost thereof and to payments you received from clients (or from others on their behalf) for such services.

5. Access to Services. Plan Services shall be provided in a manner which provides continuity of care including the availability of case managers who will be responsible for coordinating the provision of health care services for each client. Your hours of operation and provision for after-hour services will be reasonable. Plan will have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which will include, but is not limited to, waiting times and appointments. In addition, you will provide or arrange for the provision of emergency health care services 24 hours a day, 7 days a week. [[H&S § 1367.03; 28 CCR § 1300.67.2.2]]

6. Authorization of Plan's Right to Offset any Uncontested Notice of Overpayment. In the event of an overpayment and prior to any adjustment Plan makes in future claims payments to you, Plan will furnish you with a separate written notice of the overpayment of a claim or claims which clearly identifies the overpaid claim or claims, client's name and dates of service and explains the basis of Plan's request for reimbursement of the overpayment. Plan will furnish you such notice of overpayment within 365 calendar days after the date of the overpayment, unless the overpayment was caused in whole or in part by your fraud or misrepresentation. If you intend to contest Plan's notice, you must send written notice of your intent to contest within 30 business days of your receipt of Plan's notice. If Plan does not receive a notice of intent to contest notice of the overpayment of a claim or claims or the requested reimbursement from you within the above timeframes, you authorizes Plan to recoup the requested reimbursement amount from Plan's current claims payments to you.

7. Submission of a Provider Dispute. You may obtain specific information regarding Plan's Provider dispute resolution mechanism in the relevant section of this provider manual. Plan will inform you of any changes to Plan's provider dispute procedures including any changes to the procedures for processing and resolving disputes and the location and telephone number where information regarding disputes may be submitted. You will receive the rights listed in California Health & Safety Code §1375.7, as amended, if Plan makes any changes to the provider dispute resolution mechanism.

8. Appeals and Grievances of Clients. Plan will be responsible for resolving client appeals and grievances pursuant to California Health & Safety Code §1368, as amended, and Title 28 of the California Code of Regulations §1300.68 as amended. You will assist Plan in handling complaints, grievances and appeals of clients consistent with client appeals and grievances policies and procedures.

9. Quality Assurance Program. Plan will be responsible for maintaining a quality assurance program in compliance with Title 28 of the California Code of Regulations §1300.70, as amended. You will assist Plan in maintaining Plan's quality assurance program, as applicable consistent with Plan's quality assurance program policies and procedures.

10. No Balance Billing. Except for applicable co-payments, coinsurance and deductibles, Provider will not invoice or balance bill any clients for the difference between Provider's customary charges and the reimbursement paid for any Covered Service. In addition, in the event Plan fails to pay for Covered Services, the client will not be liable to Provider for any sums owed by Plan.

11. Reporting or Surcharges and Co-Payments. Provider will report to Plan all surcharge and Copayments paid by clients directly to Provider.

13. Language Assistance Program Standards. Provider will comply with Plan's language assistance program developed pursuant to California Health and Safety Code Section 1367.04 and Title 28 of the California Code of Regulations Section 1300.67.04.

14. No Inducement to Deny Covered Services. You acknowledge and agree that this Agreement does not contain any financial incentive or make any payment that acts directly or indirectly as an inducement to limit medically necessary health care services. [H&S Code Section 1348.6]

15. The provisions in this Exhibit will survive the termination of the LOA.

16. If there is a conflict between the terms of this Exhibit and terms elsewhere in the Manual, the terms of this Exhibit shall control.

FORMS

PLEASE NOTE, THIS LIST OF FORMS MAY BE UPDATED FROM TIME TO TIME

GRIEVANCES, FEEDBACK, CONCERNS, AND COMPLAINTS
All concerns and complaints should be submitted via the form at: https://lyrahealth.com/feedback.