BOSTON MEDICAL CENTER HealthNet Plan

Network Notification

Date: **November 1, 2014** **Number: 152**

TO: **All BMC HealthNet Plan Providers**

FROM: **BMC HealthNet Plan**

SUBJECT: **CHANGES TO PROVIDER MANUAL: Sections 1.2, 2.1, 4.3, 5.3, 6.13, 9.3, 9.7, 10.5, 14.5**

PRODUCT: **MassHealth** ☒ **Commonwealth Care** ☒ **Commonwealth Choice** ☒ **Qualified Health Plan** ☒ **Employer Choice Direct** ☒

Summary

The information in this notification summarizes updates to the *BMC HealthNet Plan Provider Manual* - **effective November 1, 2014**. The updated Manual **is available at bmchp.org.**

The following Provider Manual sections have been updated:

- **1.2**: *General Information, Health Coverage Program:* The Commonwealth Care program is expected to end in the first quarter of 2015.
- **2.1**: *Member Eligibility, Steps to Verify Newborn Eligibility for Commonwealth Choice, Qualified Health Plan and Employer Choice Direct:* Clarification of guidelines for enrolling newborns.
- **4.3**: *Provider Responsibilities, Responsibilities by Provider Type; General requirements for all providers:* We use best efforts to notify you in writing 60 calendar days in advance of changes to our policies or procedures *unless a policy and/or procedure is required to be implemented sooner due to regulatory compliance reasons.*
- **4.3**: *Provider Responsibilities, Care coordination requirements for all providers*: Clarification that providers must not discriminate against an individual/member on the basis of gender identity or an individual seeking gender re-assignment/transgender services.
- **5.3**: *Provider Resources, Additional Website Features:* Enhancement for Prior Authorization Requests: CPT & HCPCS Look-up Tool that provides a quick and efficient method of verifying if your procedure requires prior authorization.
- **6.13**: *Member Information, Member Outreach and Communications:* Clarification of provider obligations related to member marketing.
- **9.3**: *Billing and Reimbursement, Accountable Care Act (ACA) Grace Period for Delinquent Premium Payments – Qualified Health Plans:* Clarification of 90 day grace period allowed for QHP

members to make premium payments. The Plan will pay claims for covered services rendered in the second and third months of the grace period, but will give required notice that these claims are subject to later denial and payment retraction if the member does not pay his/her premiums by the end of the grace period.

- **9.7**: *Billing and Reimbursement, Remittance Advice:* Reminder that as of June 30, 2014, all BMC HealthNet Plan providers will receive electronic remittance advices.
- **10.5**: *Appeals, Inquiries and Grievances, Provider Administrative Appeal:* Reminder that for QHP plans, provider administrative appeals must be filed within 90 calendar days from the original denial date and no later than 180 calendar days from the date of service.
- **14.5**: *Quality Management, Provider Reporting of Serious Reportable Events (SREs) , Provider Preventable Conditions (PPCs) and Adverse Incidents:* Clarification of definitions.

Questions?

If you have any questions about this Network Notification, please contact your Provider Relations Consultant or call the provider line at 1-888-566-0008. All BMC HealthNet Plan Network Notifications are available online at bmchp.org.