Provider Manual

Includes MassHealth, Qualified Health Plan and Senior Care Options
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Section 1: General Information

1.1 About BMC HealthNet Plan
BMC HealthNet Plan (BMCHP) was founded in 1997 by Boston Medical Center to expand the hospital’s mission to provide excellent and accessible care to all in need regardless of status or ability to pay. BMCHP was licensed by the Massachusetts Division of Insurance as a Health Maintenance Organization (HMO) in October 2008. As a provider-sponsored health plan, we view our participating providers as partners with whom we collaborate.

1.2 Health Coverage Programs
We offer the following Massachusetts health coverage programs:

**MassHealth:** This Medicaid program is offered through the following contracts with the Massachusetts Executive Office of Health and Human Services (EOHHS):
- Accountable Care Organization Partnership Plan (ACO)
- Managed Care Organization (MCO)

**Qualified Health Plans (QHP):** QHPs were established as part of the Affordable Care Act. The Massachusetts QHP program consists of the following qualified health plans which we offer through the Health Connector to individuals/families and small groups:
- ConnectorCare (Silver Network)
- QHP Platinum (Select Network)
- QHP Gold (Select Network)
- QHP Silver (Silver Network)
- QHP Bronze (Select Network)

We also offer QHP plans directly to certain small groups. These plans are referred to as Employer Choice Direct plans.

**Senior Care Options Program (SCO):** BMCHP has contracts with the Massachusetts Executive Office of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS) to offer a Medicare Advantage Special Needs Plan which serves members ages 65 or older who have MassHealth Standard and Medicare Part A and Part B (individuals who only have MassHealth Standard are eligible for our Medicaid only SCO plan). Under the SCO program, BMCHP provides a fully integrated geriatric model of care. We authorize, coordinate, and arrange for the delivery of all services currently covered by Medicare and MassHealth Standard, including primary care, acute care, and specialty care; community and institutional long-term care; behavioral health; medical transportation and drugs.

1.3 BMCHP Provider Networks
BMCHP has the following provider networks:

**MassHealth ACO:** The Plan is contracted with four (4) Partnership Plan ACOs.
• BMCHP Community Alliance
• BMCHP Mercy Alliance
• BMCHP Signature Alliance
• BMCHP Southcoast Alliance

MassHealth MCO: We contract statewide with physicians, health centers, hospital systems, and other providers.

Qualified Health Plans (QHPs): We the following provider networks:

• **Silver Network**: This network serves members in our ConnectorCare and QHP Silver plans, as well as our Employer Choice Direct Silver plan.
• **QHP Select Network**: This network serves members in our QHP Platinum, QHP Gold and QHP Bronze plans, and the corresponding Employer Choice Direct plans.

Senior Care Options (SCO): We contract with physicians, health centers, hospital systems, long term support service providers, skilled nursing facilities, Aging Service Access Points (ASAPS) and other providers to support our SCO members.

For all our health coverage programs, each member must select (or will be assigned to) a primary care provider (PCP) who delivers primary care – and works with other participating providers in that member’s provider network – for appropriate specialty and other needed care.

When sending members to providers for care, it is critical that you:

• Verify and ensure the provider participates in the appropriate BMCHP provider network.

Please visit our online Provider Directory at [bmchp.org](http://bmchp.org) > Find a Provider to search for participating providers in the applicable provider network, or call the Provider Service Center at 888-566-0008 for more information; and,

• Verify if the service requires prior authorization by the BMCHP. Please visit our website at [bmchp.org](http://bmchp.org) for a list of services requiring prior authorization by product line.

Contracted providers are responsible for obtaining prior authorizations from BMCHP when required.

### 1.4 Using this Provider Manual

We developed this manual to serve as a helpful reference tool for providers. Your provider contract with the BMCHP incorporates the terms of this Provider Manual, as amended from time to time. Therefore, this manual is part of your contract with us. You are obligated to comply with the contract, this manual, and any policies and procedures referenced in this manual (such as the BMCHP’s Reimbursement and Clinical Coverage policies), as part of your participation in our network.

### 1.5 Revisions to the Manual

We notify providers of changes to this manual, including changes to policies and procedures, via Network Notifications and provider notices. These communications are mailed, faxed or emailed and also posted at
bmchp.org in advance of their effective dates. Please note that information contained in the Network Notifications adds to, modifies or replaces information in this Provider Manual. The most current version of this manual is always available at bmchp.org.

1.6 Contacts Directory

For a complete directory of BMC HealthNet Plan contact information, visit bmchp.org.
Section 2: Member Eligibility

2.1 Verifying Member Eligibility

We offer providers the convenience of checking member eligibility 24 hours a day, 7 days a week as outlined in the sections below. Providers should always check member eligibility – before delivering services – on the date of service and daily during inpatient admissions. See below for instructions on how to check member eligibility.

Steps to verify eligible for: MassHealth, Qualified Health Plan (including ConnectorCare), Employer Choice Direct Plan, and Senior Care Options eligibility.

<table>
<thead>
<tr>
<th>Steps to verify member eligibility for MassHealth (except newborns)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step One</strong></td>
</tr>
<tr>
<td>Providers first must verify that an individual is enrolled in MassHealth before determining membership in BMCHP. An individual is only eligible to participate in our BMCHP if the state has determined he/she is eligible for MassHealth. Verify eligibility for MassHealth in one of two ways:</td>
</tr>
<tr>
<td>Call MassHealth’s automated voice response (AVR) at 800-554-0042, or</td>
</tr>
<tr>
<td>Access MassHealth’s WebEVS website at gateway.hhs.state.ma.us/authn/login.do.</td>
</tr>
<tr>
<td>You must use the member’s identification number or certain personal attributes (gender, name, date of birth). See Important Contact Information at bmchp.org for a list of MassHealth phone numbers and contact information if you have questions about MassHealth enrollment.</td>
</tr>
<tr>
<td><strong>Step Two</strong></td>
</tr>
<tr>
<td>Once you confirm that an individual is enrolled in MassHealth, you may check member eligibility for BMCHP in any of the following ways:</td>
</tr>
<tr>
<td>Access our online eligibility tool at bmchp.org.</td>
</tr>
<tr>
<td>Use our Interactive Voice Response (IVR) line by calling 888-566-0008 and selecting option 1.</td>
</tr>
<tr>
<td>During business hours (8 a.m. to 6 p.m., Mon. –Fri.) speak directly with a Provider Services Representative by calling 888-566-0008 and selecting option 3.</td>
</tr>
<tr>
<td>Member panel reports are not an accurate method for verifying eligibility. These reports are only intended to inform you of the member’s assignment to your panel. If you find a discrepancy in eligibility between MassHealth and BMCHP, use the MassHealth eligibility tools noted above and notify us of the discrepancy by calling our provider line at 888-566-0008. We will update the membership information once we have confirmed the information with MassHealth.</td>
</tr>
</tbody>
</table>
**Steps to verify eligibility for Qualified Health Plan (including ConnectorCare), and Employer Choice Direct members**

Access our online eligibility tool at [bmchp.org](http://bmchp.org) > ‘Provider Login’.
During business hours (8 a.m. to 6 p.m., Mon. – Fri.), call our provider line at 888-566-0008.

<table>
<thead>
<tr>
<th>Eligibility timeframes:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MassHealth members</td>
<td>Eligibility may change daily.</td>
</tr>
<tr>
<td>Qualified Health Plan (including ConnectorCare) and Employer Choice Direct members</td>
<td>Eligibility is usually effective on the first day of a given month and terminates on the last day of the appropriate month. Exceptions apply.</td>
</tr>
</tbody>
</table>

**Verify eligibility for Senior Care Options**

To confirm that an individual is enrolled in SCO, you may check member eligibility for BMCHP in any of the following ways:

Access our online eligibility tool at [bmchp.org](http://bmchp.org).
Use our Interactive Voice Response (IVR) line by calling 888-566-0008 and selecting option 1.
During business hours (8 to 6 p.m., Mon. – Fri.), speak directly with a Provider Services Representative by calling 888-566-0008 and selecting option 3.
Member panel reports are not an accurate method for verifying eligibility. These reports are only intended to inform you of the member’s assignment to your panel.

**Steps to verify newborn eligibility for MassHealth members**

**Step One**
Check the newborn’s BMCHP eligibility on the date of birth of the newborn (following the step-by-step instructions listed in the previous section).
Use WebEVS and/or Automated Voice

**Step Two**
For MassHealth members, hospitals must submit a completed NOB-1 Form to the MassHealth Enrollment Center Notification of Birth Unit in a timely manner, no later than 30 calendar days after the delivery. MassHealth will generate a permanent ID for the newborn. There will be no record of the newborn on MassHealth ebEVS until MassHealth creates a permanent ID for the member.
### Step Three
If the mother is enrolled in BMCHP on the newborn’s date of birth, the hospital or treating provider must complete a BMCHP notification within one business day of the newborn’s date of birth. We will generate a temporary identification number that starts with the letter “T” for the newborn within one business day of successful receipt of notification, and give you a reference number after receiving clinical information from you. Include the temporary “T” number or MassHealth ID on the claim form when billing the BMCHP for newborn services.

### Step Four
For MassHealth members, MassHealth will generate an ID number after it receives the completed NOB-1 form from the hospital. When the ID number is assigned to the newborn, the baby may be listed in WebEVS as a MassHealth member without a managed care plan or PCP assignment.

MassHealth then assigns the newborn to a managed care plan. If the mother is a member of BMCHP, the newborn will be retroactively enrolled in our MassHealth product as of the newborn’s date of birth. Therefore, it is essential that the hospital completes a BMCHP notification process even though the newborn is not initially documented in WebEVS as a BMCHP member. The newborn may have multiple RIDs in MassHealth WebEVS. Please contact our provider line at 888-566-0008 and select the member eligibility option if you have questions or need clarification on newborn member eligibility.

### Steps to verify newborn eligibility for Qualified Health Plan (including ConnectorCare) and Employer Choice Direct members

<table>
<thead>
<tr>
<th>Step One</th>
<th>Check the mother’s eligibility for BMCHP on the date of birth of the newborn.</th>
</tr>
</thead>
</table>
| Step Two | If the mother is enrolled in BMCHP on the newborn’s date of birth, the hospital or treating provider must bill well-newborn charges under the mother’s member ID number.  
Sick-newborn charges should be billed to the appropriate health plan MCO once the newborn has been enrolled in a health plan and its permanent member ID number is available. |
| Step Three | Qualified Health Plan (including ConnectorCare) members must enroll newborns within 60 days of the newborn’s date of birth via the Connector. The Connector then enrolls the newborn in a managed care plan. If the mother remains a member of BMCHP, the newborn may be retroactively enrolled in our Qualified Health Plan or Commonwealth Choice product as of the newborn’s date of birth.  
Employer Choice Direct members must contact their Group Administrator to enroll the newborn into BMCHP, subject to Group Administrator and BMCHP eligibility guidelines. If the mother remains a member of BMCHP, the newborn may be retroactively enrolled in our Employer Choice Direct Plan. |
It is the provider’s responsibility to verify member eligibility at the time of service to ensure that services rendered are eligible for BMCHP reimbursement. However, if delivering emergency services, providers may verify member eligibility after delivering the service. Providers will be denied payment for services if the member is not eligible on the date of service.

Please note that verification of eligibility for the date of service does not authorize services requiring BMCHP prior authorization. See bmchp.org for instructions on how to obtain BMCHP prior authorization.

**Summary of plan eligibility verification process**

Contact our provider line at 888-566-0008 to verify BMCHP member benefits and eligibility, determine which benefit plan applies to a member, confirm the member’s PCP assignment, and determine provider participation status before services are rendered. We also provide this information when you complete BMCHP’s prior authorization process.

See the member’s page of our website for a list of covered benefits (bmchp.org for our MassHealth and QHP members) and seniorsgetmore.org for our SCO members). For MassHealth members, there are also certain additional benefits covered directly by MassHealth known as “wraparound” benefits. Providers should bill MassHealth directly for these additional “wraparound” benefits.

**Newborn Eligibility Guidelines**

Any newborn, whose mother is a MassHealth member, is given temporary MassHealth coverage.

Qualified Health Plan (including ConnectorCare) members’ newborns are not given temporary eligibility. Well-baby charges are covered under the mother’s maternity benefits.

To ensure continuity of care, the admitting hospital or the hospital where the newborn delivery occurred must notify our Enrollment Department by fax at 617-897-0838 within 24 hours of each new birth for any MassHealth member.

**This fax should include the following information:**

- Newborn mother’s first and last name
- Newborn mother’s member ID number
- Newborn mother’s address and phone number
- Newborn’s first and last name
- Birth weight (in grams)
- Gender
- Gestational age
- Date of delivery

To ensure a smooth and efficient process for reporting all newborn deliveries and billing for services provided to MassHealth members, we assign a temporary ID number (T number) to each newborn upon notification of birth to our Enrollment department. For MassHealth members only, providers may use the T number to submit claims to us if the MassHealth recipient ID number (RID) is not available.
When the facility notifies us of the newborn birth, we give the facility the T number. The T number is a BMCHP-specific, temporary member ID number and may be used only for claims submitted to BMCHP. We use the newborn’s given name to generate the T number unless a name is not provided, in which case we use the mother’s last name and BabyBoy or BabyGirl as the first name until notified of the newborn’s given name. Follow the instructions above to verify member eligibility of the mother and the newborn in BMCHP.

Hospitals treating our MassHealth members must complete a MassHealth Notification of Birth (NOB-1) form and submit it directly to the MassHealth Enrollment Center Notification of Birth Unit in a timely manner, no later than 30 calendar days after the delivery. Please indicate birth weight and gestational age on this form. We automatically assign the newborn to the mother’s primary care site if the PCP specialty is appropriate for the newborn (such as a family medicine site), a sibling’s PCP, or randomly assign a primary care pediatric or family medicine site unless the mother requests another PCP assignment. The mother may request a PCP assignment by calling our Member Services department or faxing a completed Primary Care Provider Selection Form (which includes the appropriate fax number for the Enrollment department).

We encourage providers to deliver prenatal, third-trimester, and post-partum visits as appropriate.

- See Section 8: Maternity Program related notification requirements of this manual: Maternity Programs for more maternity program guidelines and requirements.
- See bmchp.org for a description of how our Care Management program is involved with pregnant members and their babies.

### 2.2 Member ID Cards

<table>
<thead>
<tr>
<th>Product Type</th>
<th>Member ID Card Information</th>
</tr>
</thead>
</table>
| MassHealth (including ACO and MCO) | Two Member Identification Cards Issued  
Each MassHealth member receives two member identification (ID) cards:  
- A MassHealth member ID card, and  
- A BMCHP member ID card.  
Our member ID card includes a BMCHP member ID number, the member’s MassHealth-issued ID number, the name of the member’s ACO (when applicable) and important phone numbers.  
Presentation of the member’s ID cards does not ensure member eligibility. Please note that you will need to verify that the member is currently enrolled with both MassHealth and BMCHP on each date of service. |
| Qualified Health Plans (including ConnectorCare), and Employer Choice Direct | Qualified Health Plan (including ConnectorCare), and Employer Choice Direct members are issued one BMCHP member ID card. This card includes a member ID number and important phone numbers. We inform members that they must present this card to providers on each date of service. Presentation of the member’s ID card does not ensure member eligibility. For Qualified Health Plan (including ConnectorCare), and Employer Choice Direct members, you will need to verify that the member is currently enrolled with BMCHP on each date of service. |
Section 3: Credentialing

3.1 Overview

All credentialing information below applies to providers participating in all BMCHP products, except when noted otherwise.

All physicians and other allied health practitioners must be credentialed by the BMCHP before becoming participating providers. They must be re-credentialed every two years to maintain active participation within the Plan’s network. The requirements for credentialing are mandated by our government contracts, and are consistent with National Committee for Quality Assurance (NCQA) standards and applicable Massachusetts professional licensing board regulations.

Practitioners cannot deliver care to our members until credentialed by BMCHP. All covering practitioners must also be credentialed by the Plan; this includes temporary and permanent coverage. Any change in coverage arrangements must be submitted to, and approved by BMCHP prior to coverage occurring. See Section 4: Provider Responsibilities for our policy on the use of locum tenens physicians.

3.2 BMCHP Credentialing/Re-credentialing Policies and Procedures

The following is a summary of the BMCHP Credentialing/ Re-credentialing Policies and Procedures. A complete copy of these policies is available upon request by calling our provider line at 888-566-0008.

Responsibility

Our Quality and Clinical Management Committee (Q&CMC) is a board-level committee that is responsible for overseeing the Plan’s credentialing and re-credentialing program, which includes but is not limited to the oversight of the Credentialing Committee. The Credentialing Committee is a peer review committee that approves or denies practitioner participation based upon review of the application, supporting documents, and results of the credentialing verification process.

Delegation

In some specific instances, BMCHP delegates the credentialing function to another entity, such as a contracted hospital or an NCQA-certified credentialing verification organization. Notwithstanding any delegation, BMCHP retains the right to approve, suspend or terminate practitioners from participating in our networks.

BMC HealthNet Plan and HealthCare Administrative Solutions, Inc. (HCAS)

BMCHP is an active member of HealthCare Administrative Solutions (HCAS), Inc. HCAS offers a single point-of-entry for practitioners to submit information that HCAS-participating health plans use to verify a practitioner’s qualifications during the Credentialing process. HCAS plans partner with the Council for Affordable Quality HealthCare (CAQH) to collect and store a practitioner’s credentialing information. For more information about HCAS, please visit their website at hcasma.org
Steps to become credentialed and enrolled in the BMCHP

<table>
<thead>
<tr>
<th>Step</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step One</td>
<td>Complete an <a href="#">HCAS Enrollment Form</a>.</td>
</tr>
<tr>
<td>Step Two</td>
<td>Complete a <a href="#">BMCHP Provider Data Form</a>.</td>
</tr>
<tr>
<td>Step Three</td>
<td>Ensure that the CAQH application is completed, and that the applicant has a current attestation. BMCHP must also be granted permission to access each CAQH account.</td>
</tr>
<tr>
<td>Step Four</td>
<td>Please submit completed forms to BMCHP through one of the following methods:</td>
</tr>
<tr>
<td></td>
<td>• Email: <a href="#">Provider.ProcessingCenter@BMCHP-wellsense.org</a></td>
</tr>
<tr>
<td></td>
<td>• Fax: 617-897-0818</td>
</tr>
<tr>
<td></td>
<td>• Mail: Attn: Provider Processing Center</td>
</tr>
<tr>
<td></td>
<td>Boston Medical Center HealthNet Plan</td>
</tr>
<tr>
<td></td>
<td>529 Main Street, Suite 500</td>
</tr>
<tr>
<td></td>
<td>Boston, MA 02129</td>
</tr>
</tbody>
</table>

3.3 Credentialing and Re-credentialing Process

Types of providers credentialed

BMCHP credentials practitioners who have an independent relationship with us, and who are permitted to practice independently under Massachusetts law. This includes but is not limited to the following types of practitioners:

- Audiologists
- Chiropractors
- Certified Nurse midwives
- Nurse practitioners
- Nutritionists
- Occupational Therapists
- Optometrists
- Oral and maxillofacial surgeons (DDS)
- Physical Therapists
- Physicians (MD and DO), including locum tenens physicians
- Physician assistants
- Podiatrists
- Speech-language pathologists

Last updated May 9, 2018
• Acupuncturists

**Hospital and facility-based physicians:** BMCHP does not fully credential practitioners who practice exclusively within a hospital inpatient setting or freestanding facility, and who provide care for our members only incident to members being directed by BMCHP participating providers to the facility (unless those practitioners are separately identified in enrollee literature as available to enrollees). Hospital and facility-based practitioners include, but may not be limited to, Pathologists, Anesthesiologists, Radiologists and Emergency Department physicians.

**Locum tenens physicians:** Locum Tenens physicians who intend on providing services for ninety (90) days or less require only an abbreviated credentialing process. The abbreviated credentialing request includes, but is not limited to:

* An [HCAS Enrollment Form](#) and BMCHP’s [Provider Data Form](#) with an indication the provider requests locum tenens status
* A [Locum Tenens Credentialing Form](#).
* A malpractice face sheet.
* Hospital admitting privileges. If the physician does not have current admitting privileges, he/she must provide his/her applicable coverage arrangements.

All contracted providers using locum tenens physician services must comply with the guidelines specified in this section of the Provider Manual. These services may be extended past the initial ninety (90) days when required by the practice. If a locum tenens physician needs to be in place beyond ninety (90) days, he/she must become fully credentialed. To facilitate an extension beyond ninety (90) days, notify BMCHP at least thirty (30) calendar days prior to the end of the locum tenens physician’s term so we can conduct the full credentialing process. Failure to notify us will result in claim denials. Locum tenens physicians are also required to bill for their services according to the guidelines established in Section 9.2: Billing and Reimbursement.

**Nurse practitioners:** We recognize independent nurse practitioners as participating providers. We treat services delivered to our members by participating nurse practitioners in a nondiscriminatory manner when the care provided is for the purposes of health maintenance, diagnosis and treatment. Such nondiscriminatory treatment includes coverage of benefits for primary care, intermediate care and inpatient care, including care provided in a network hospital, clinic, professional office, home care setting, long-term care setting, or any other setting, when rendered by a participating nurse practitioner practicing within the scope of his or her professional license, to the extent that BMCHP covers the identical services rendered by another Massachusetts-licensed provider of healthcare.

### 3.4 Credentialing/Re-credentialing Criteria

Practitioners are not entitled to be credentialed or re-credentialed on the basis that they are licensed by the state to practice a particular health profession, or that they are certified by any clinical board or have clinical privileges in a BMCHP-contracted entity. BMCHP, in its sole discretion, credentials and re-credentials practitioners based on its Credentialing Criteria set forth in its Credentialing Policies and...
summarized in this manual. BMCHP is responsible for all final determinations regarding whether a practitioner is accepted or rejected as a BMCHP participating provider.

The Plan uses a standardized process to ensure that it treats all applicants in a fair and non-discriminatory manner. No BMCHP credentialing or re-credentialing decisions are based on a practitioner’s race, ethnic/national identity, religion, gender, age, sexual orientation, patient type or the types of procedures in which the practitioner specializes. BMCHP does not discriminate in participation, reimbursement, or indemnification of any practitioner who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of that license or certification. Furthermore, BMCHP does not exclude any practitioner from consideration based solely on the types of procedures he/she conducts, or the type of patients the practitioner serves. BMCHP may include practitioners in the networks who meet certain demographic, specialty or cultural needs of members.

Applicants must meet the following criteria in order to participate in the Plan’s networks:

- **Contract**: Practitioners must be contracted to provide services to Plan members without evidence that he/she is in breach of his/her contractual obligations to the Plan.

- **Credentialing Application**: Practitioners must have a current and complete Council for Affordable Quality Healthcare (CAQH) credentialing application, which includes the Standard Authorization, Attestation and Release form.

- **Education & Training**: [Initial credentialing only] Practitioners must successfully complete all education and/or professional training relevant to his/her contracted specialty, and as applicable to his/her scope of practice and licensure. This includes graduate and post-graduate education, professional school, residency training, fellowship training and/or other accredited training programs, as applicable.

- **License**: Practitioners must have a current and unrestricted license in the state in which he/she provides care to Plan members. Additional certifications may be required, as applicable to the practitioner’s specialty.

- **Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) Certification**: A DEA or CDS certificate must be issued in the state where the practitioner prescribes. If a practitioner chooses not to possess an active certificate, he/she must sign a waiver and provide the name the individual that will prescribe on his/her behalf. (This requirement applies to Physicians (MDs & DOs), Podiatrists, Oral & Maxillo-Facial Surgeons, Nurse Practitioners and Physician Assistants only.)

- **Professional Liability Insurance**: Practitioner must possess and maintain a current malpractice liability insurance policy with a minimum coverage of $1,000,000 per claim/ $3,000,000 annual aggregate, unless otherwise required by State or Federal law. Dentists must have and maintain a minimum coverage of $1,000,000 per claim/$2,000,000 annual aggregate, unless otherwise required by State or Federal law.
Malpractice liability coverage may also be issued under the Federal Tort Claims Act (FTCA). Under this coverage, services may only be provided to members who are patients of the entity that is covered by the FTCA, or are otherwise deemed to be covered under the FTCA.

- **Board Certification:** In accordance with the BMCHP Board Certification Policy, Physicians, Podiatrists, Certified Nurse Midwives Oral & Maxillo-Facial Surgeons, Nurse Practitioners and Physician Assistants must:
  - Be board certified by a BMCHP-recognized specialty board; or
  - Be in the process of achieving initial board certification by a BMCHP-recognized specialty board and achieve board certification in a time frame relevant to the guidelines established by the applicable specialty board. Waivers will be considered by the BMCHP only when necessary for us to maintain adequate member access. All waivers must be approved by MassHealth for those providers participating in our MassHealth programs.

- **Hospital Privileges:** If applicable to the practitioner’s specialty and scope of practice, he/she must have current hospital affiliations and admitting privileges with at least one Plan-contracted hospital. If the practitioner has any restrictions against his/her hospital privileges, he/she must provide a detailed description regarding the nature of the restriction(s). All restrictions will be considered and evaluated by the Credentialing Committee in its discretion.

**Alternative Admitting Arrangements:** If the practitioner does not have an active affiliation and admitting privileges at a Plan-contracted hospital, he/she must provide an explanation of what arrangements that are in place for his/her patients to be admitted to a Plan-contracting hospital (e.g. covering physician who has current privileges at a plan-contracting hospital, or thorough the use of a hospitalist program at a Plan-contracted hospital).

In order to complete credentialing, the practitioner must provide the Plan with the names of two plan-contracting physicians (who are not financially linked to his/her practice) who can provide reference letters attesting to the practitioner’s clinical competence.

- **Supervising Physician:** Nurse Practitioners and Physician Assistants must provide the name of their Plan-participating supervising physician.

- **Federal/State Program Exclusions:** Practitioners must not be currently debarred, suspended, or otherwise excluded from participation in Medicare, Medicaid or any other federal or state health care programs.

- **Criminal Proceedings.** Practitioners must not have been involved in any felony convictions or criminal proceedings that may be grounds for suspension or termination of the practitioner’s license to practice.

- **Compliance with Legal Standards:** Practitioners must be in compliance with all applicable legal requirements relating to the practice of his/her profession; including meeting all required continuing education requirements.
• **Quality Care and Service**: Practitioners can be reasonably expected to provide quality and cost-effective clinical care and service to Plan members. In evaluating whether this criterion has been met, the following credentialing information is required:

- Work history and explanation of any gaps in employment for the ten (10) years preceding the signature date on the practitioner’s credentialing application (Applies to initial applicants only);

- Ten (10) years of pending or closed disciplinary actions or alterations in privileges; professional performance, integrity, judgment, clinical skills; ability to perform the essential obligations of the affiliation agreement;

- The extent and nature of practitioner’s professional liability claims history. This includes any malpractice cases that are currently open, closed and/or paid during the last ten (10) years preceding the signature date on practitioner’s credentialing application;

- Results of Plan site visits (if applicable);

- Sanction activity;

- Information internally generated by the Plan’s Quality Improvement Program, such as member complaints and appeals, quality of care, appropriate utilization of services and member satisfaction surveys (Applies to recredentialing applicants only).

Please note: The Credentialing Committee may, in its discretion, look back further than ten (10) years if necessary to appropriately inform its decision making.

Practitioners must not have engaged in behaviors which may adversely impact member care or service, including but not limited to, behaviors which:

- Negatively impact the ability of other participating practitioners/providers to work cooperatively with the practitioner;

- Reflect a lack of good faith and fair dealing in his or her dealings with the Plan, its provider network or its members;

- Reflect a lack of commitment to managed care principles or a repeated failure to comply with the Plan’s managed care policies and procedures;

- Indicate a lack of cooperation with the Plan’s Quality Improvement or Utilization Management Programs; or

- Constitutes unlawful discrimination against a member under any state or federal law or regulation.

- Practitioners have not engaged in any behaviors which could harm other health care professionals, patients or Plan employees. Such behavior includes, but is not limited to, acts of violence committed within or outside the practitioner’s practice, whether or not directed towards other health care professionals, patients or Plan employees, and must be judged by the Credentialing Committee to create a significant risk to other health care professionals, patients or Plan employees.
Primary Care Practitioners (PCPs): In addition to meeting the above criteria, applicants applying for credentials as PCPs must be one of the following:

- An Allopathic (MD) or Osteopathic (DO) Physician that is trained and/or board certified in Family Medicine, Internal Medicine, General Practice, Adolescent & Family Medicine, Pediatric Medicine or Obstetrical & Gynecological Medicine (for female members only);
- Nurse Practitioner (NP) that is board certified as an Adult Nurse Practitioner, Pediatric Nurse Practitioner or Family Nurse Practitioner, or
- Physician Assistants (PA)

Exceptions: The Credentialing Committee may authorize a specialist physician to serve as a member’s PCP if the member has a life-threatening, degenerative, or disabling condition or disease that requires prolonged specialized care, e.g., HIV, end stage renal disease, or an oncology diagnosis, and the Committee believes it will be in the best interests of the member to make this exception. The Plan’s Medical Director must review and approve the request before it is brought to the Committee for review. Specialists acting in the capacity of a PCP must be, or must become a Plan-participating physician, and are required to adhere to all Plan standards applicable to PCPs.

Addiction Specialists: In order for a physician to prescribe or dispense buprenorphine for opioid dependency treatment (i.e. Suboxone®), he/she must possess a current Medication-Assisted Treatment (MAT) physician waiver with the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The physician must continue to meet Plan’s board certification policy requirements.

- **Access and Availability**: As part of its credentialing determinations, the Credentialing Committee may consider, in its discretion, network access and availability needs.
- **Waiver**: The Credentialing Committee may waive any credentialing requirement which is not required by contract, statute, regulation or accreditation standard when, in its discretion, to do so will advance patient care or service and the Plan’s objectives.

### 3.5 Re-credentialing

BMCHP re-credentials all practitioners who have a current contractual arrangement with the Plan to provide services to its members. Re-credentialing will be completed within twenty-four (24) months of the decision date of when the practitioner was previously credentialed. The application process will be initiated directly by the Plan’s Credentialing Verification Organization (CVO) vendor, and will be scheduled based on the practitioner’s date-of-birth.

Practitioners must continue to satisfy BMCHP’s credentialing criteria to be recredential by the Plan. They must ensure that CAQH contains up-to-date information, and must re-attest periodically or as needed, so their CAQH application remains current. If a practitioner does not keep his/her CAQH current, or re-attest to information to ensure it is available for re-credentialing, termination may result; in this case the practitioner would need to re-apply to BMCHP as an initial applicant.
3.6 Notice of Rights

- **Correcting erroneous information:** If the information that BMCHP receives from outside sources (e.g., malpractice carriers, state licensing boards) varies substantially from information that you submit to us, the Plan will notify you in writing of the discrepancy. (Note: the Plan is not required to reveal the source of the external information if the information is not obtained to meet our credentialing verification requirements or if the law prohibits disclosure.)

The notification will include a description of the discrepancy, the timeframe for making the corrections, the format for submitting corrections, and the person to whom corrections must be submitted.

- **Reviewing information:** You have a right to review information that we have obtained to evaluate your credentialing application. This may include the application, attestation and CV, and may include information from outside sources, except for references, recommendations or other peer-review protected information.

- **Requesting the status of your application:** You have a right to be informed, upon request, of the status of your application at any time during the credentialing process. When you make such an inquiry, the Credentialing Department will respond to your questions, inform you of any outstanding information needed to complete your application, and if none, the date that the application is scheduled to be reviewed for a final credentialing determination.

3.7 Credentialing file review, determinations, notice and reporting

- **File Review and Determination:** After all necessary information has been collected and verified, BMCHP’s Medical Director and/or the Credentialing Committee will review the applications to determine if the practitioner meets our Credentialing Criteria outlined in this section. Based on this review, practitioners may be approved (i.e. credentialed), approved with conditions, denied initial credentials or terminated.

- **Notice to practitioners:** All applicants granted initial credentials are notified in writing of the approval no later than sixty (60) calendar days from the approval date. Note that the effective date for a practitioner is the credentialing date or contract effective date, whichever is later.

- **An initial applicant who is denied BMCHP credentials, or a participating practitioner whose credentials are approved with conditions or terminated, is notified in writing of the action and the reasons within sixty (60) calendar days from the committee’s decision. Practitioners who are re-credentialed in the ordinary course do not receive written notice.**

- **Notice to members:** If a practitioner is terminated for any reason, we are required to notify members who have been obtaining services from these practitioners that the practitioner is no longer affiliated with the BMCHP.

- **Reporting:** BMCHP complies with all regulatory and government reporting requirements. All denials, conditional approvals or terminations that constitute disciplinary actions under state law and/or adverse professional review actions under federal law will be reported as required.
3.8 Ongoing Monitoring and Off-Cycle Credentialing Reviews and Actions

Between re-credentialing cycles, BMCHP conducts ongoing information monitoring from external sources, such as sanctions from state licensing boards (e.g., Board of Registration in Medicine), Medicare/Medicaid or the OIG, and internal sources, such as member grievances and adverse clinical events. As necessary, this information may be reviewed by a Medical Director or the Credentialing Committee at any time between re-credentialing cycles. After review, the Committee may take no action, may continue the practitioner’s credentials with conditions, may require the practitioner to complete a full off-cycle credentialing application and review, or may terminate the practitioner.

If information we receive through the monitoring process causes the Medical Director and/or the Chief Medical Officer to believe that a practitioner has placed or is at substantial risk for placing a member in imminent danger, and that failure to summarily suspend credentials is contrary to the immediate best interests of member care, he/she may summarily suspend a practitioner’s credentials. In such event, we notify the practitioner in writing immediately, including the reasons for the action, and the subsequent procedure to be followed by BMCP. Any summary suspension will be reviewed by the full Credentialing Committee at its next regularly scheduled meeting. The Committee may reinstate the practitioner, or take any action described in the preceding paragraph.

Under its state and federal contracts, if BMCHP receives a direct notification from MassHealth or other regulatory authorities to suspend or terminate a practitioner, we are required to suspend or terminate the practitioner from our MassHealth, SCO and/or any other BMCHP networks. (BMCHP is not permitted to authorize any providers terminated or suspended from MassHealth, Medicare, or from another state’s Medicaid program to treat members and must deny payment to such providers.) BMCHP will also monitor Medicare Opt-out lists to ensure that practitioners participating in our SCO network are eligible to receive Federal reimbursement from Medicare. In such a case, we will notify the practitioner in writing with the reasons no later than three (3) business days from the date we receive such notice. There is no right of appeal from a BMCHP suspension or termination based on a termination directive from MassHealth, Medicare, or due to sanction screening.

3.9 Credentialing appeals process for practitioners

Right of appeal

If the Credentialing Committee denies your initial credentials, or credentials you with conditions, or terminates your credentials, and such action constitutes a “disciplinary action” as defined in BMCHP’s Credentialing Policies, you are entitled to appeal the disciplinary action. A disciplinary action is an adverse action taken by BMCHP’s Credentialing Committee, up to and including termination from BMCHP, on the basis of a Committee determination that the practitioner does not meet BMCHP Credentialing Criteria related to the competence or professional conduct of the practitioner (i.e., quality of care or service). Examples include a denial or termination due to the volume or nature of malpractice suits against the practitioner, or the quality or quantity of adverse clinical events generated during a practitioner’s affiliation with BMCHP.
• Practitioners have no right of appeal from an action that is:
  • An “Adverse Administrative Action”: An adverse action taken by the Credentialing Committee against a practitioner, up to and including termination from BMCHP, that is not related to the Committee’s assessment of your competence or professional conduct. Examples include a denial or termination due to failure to meet BMCHP board certification requirements, failure to maintain adequate professional liability coverage, or failure to meet other contractually-specified obligations; or
  • A BMCHP termination based on a directive from MassHealth, CMS or other regulatory authority to terminate or suspend a practitioner who participates in BMCHP’s MassHealth, SCO or Qualified Health Plan (QHP) programs.

Disciplinary notice

If the Credentialing Committee recommends a disciplinary action, the practitioner will be notified in writing within thirty (30) calendar days following the decision date. The notice will contain a summary of the reasons for the disciplinary action and a description of the appeal process.

Practitioner request for appeal

The practitioner may request an appeal in writing by sending a letter to BMCHP’s Chief Medical Officer postmarked no more than thirty (30) calendar days following your receipt of BMCHP’s notice of disciplinary action. We will not accept provider appeals after the thirty (30) calendar day period. You have a right to be represented in an appeal by another person of your choice (including an attorney). Your appeal should include any supporting documentation you wish to submit.

When we receive a timely appeal, we will send you an acknowledgement letter. The Medical Director will arrange for your case to be sent back to the Credentialing Committee for reconsideration.

If we do not receive an appeal request by the filing deadline, the Credentialing Committee’s action will be considered final.

Credentialing Committee reconsideration

Upon timely receipt of an appeal request, the Credentialing Committee will review the appeal and reconsider its original decision. Upon reconsideration, if the Committee over-turns its original decision, we will notify you in writing. If the Committee upholds its original decision or modifies it such that another type or level of disciplinary action is taken, we will notify you in writing that an Appeals Panel will be assembled to review the appeal, the date and time of the Appeal Panel hearing, and other administrative details.

Appeals Panel hearing and notice

The Appeals Panel is a medical peer review committee appointed by the BMCHP Chief Medical Officer (CMO) to hear the appeal. The hearing will occur no earlier than thirty (30) calendar days, and no later than ninety (90) calendar days after the practitioner is notified of the decision of the Credentialing
Committee’s reconsideration, unless otherwise agreed to by the practitioner and BMCHP. The hearing will consist, at a minimum, of BMCHP’s review of the written submissions by BMCHP and the practitioner. The Panel is empowered to uphold, modify or overturn the Credentialing Committee’s decision. The Appeals Panel’s decision is final.

You will be notified of the Appeals Panel’s decision and the reasons no later than forty-five (45) calendar days from the date of the Hearing.

**Re-application following denial or termination**

In the event that initial credentialing is denied, or if a practitioner is terminated, we will not reconsider his/her reapplication for credentialing for two (2) years following the effective date of denial or termination, unless the Credentialing Committee, in its sole discretion, deems a shorter period to be appropriate.

**3.10 Role of the credentialed practitioner**

Please review the list of responsibilities for credentialed providers found below in the Roles sections. You are responsible for determining member eligibility, adhering to BMCHP administrative guidelines, following access to care guidelines and waiting time standards, complying with provider contract terms and associated reimbursement and clinical coverage requirements, and adhering to cultural and linguistic requirements. See [Section 4: Provider Responsibilities](#) for our policy on the use of locum tenens physicians.

**Role of the credentialed primary care practitioner (PCP)**

A primary care practitioner (PCP) is responsible for supervising, coordinating and providing initial and basic care of members who have selected that provider for general healthcare services. The PCP also arranges for specialty care needed by a member and maintains overall continuity of a member’s care. The PCP provides 24-hour, seven-days-a-week coverage for members. A PCP is a provider selected by the member, or assigned by BMCHP, to provide and coordinate the member’s care.

PCPs are physicians practicing in one of the following specialties: family medicine; internal medicine, general practice, adolescent and family medicine, geriatric medicine, pediatric medicine and obstetrics/gynecology (for female members only). Nurse practitioners (NPs) and Physician Assistants also may function as PCPs, if they are trained in internal medicine, pediatrics, family medicine or women’s health.

Specialists as Primary Care Practitioner (PCP): When designated as a PCP, a specialist assumes all administrative and clinical responsibilities of a PCP, including responsibility for arranging care with other specialists and addressing the preventive and routine care needs of the assigned member. A PCP who believes that one of his/her BMCHP patients should receive primary care from a specialist should call our Care Management Department at 866-853-5241. Specialists acting in the capacity of a primary care practitioner must follow the billing guidelines outline in [Section 9: Billing and Reimbursement](#).
Role of the credentialed specialist

Credentialed specialists are physicians who are board-certified in a specific specialty recognized by the American Board of Medical Specialties. In addition to specialty physicians, contracted providers may be credentialed in the disciplines of Podiatry, Chiropractic, Audiology or other specialties where an accrediting body has established criteria for education and continuing medical education. We must credential all covering providers.

3.11 Organizational providers

BMCHP assesses the quality of all organizational providers prior to contracting. We will confirm that the provider is in good standing with all state and federal regulatory bodies, has been reviewed and approved by an accrediting body, or if not accredited, we will compare the facility’s most recent Department of Public Health survey against BMCHP standards. We will conduct an onsite assessment if the facility is not accredited and has not had a recent Department of Public Health survey.

BMCHP credentials the following types of medical/ancillary organizational providers:

- Acute care hospitals
- Acute rehabilitation hospitals
- Skilled nursing facilities
- Medical / physical rehabilitation facilities
- Home health care providers
- Home infusion providers
- Hospice providers
- Free-standing surgical centers
- Sleep centers
- Family planning clinics
- Infertility clinics
- Free standing urgent care facilities
- Minute Clinics (e.g., limited services clinics)
- Durable medical equipment, prosthetic, orthotic suppliers (please refer to BMCHP’s DMEPOS vendor Northwood for specific requirements)
- Laboratories
- Kidney dialysis centers
- Free-standing or mobile magnetic resonance imaging (MRI) centers
- Radiation therapy centers
- Radiology centers
- Ultrasound/vascular imaging providers
- Mammography providers

Standards for Participation
All providers must submit documentation and meet the following Criteria in order to participate in the BMCHP network, unless otherwise stated.

- Current and complete credentialing application
- Completion of a Federally Required Disclosures (FRD) form. As further detailed in our Federally Required Disclosures form policy, you must inform BMCHP on an annual basis of any changes to the information submitted on the Federally Required Disclosures form submitted with your provider application, if you contract with BMCHP auto-renews. The Federally Required Disclosures form policy is available upon request.
- Copy of current state license issued by the Department of Health or appropriate state agency. If license is not current, the provider must provide a letter from the Department of Health indicating the licensure status.
- Completion of the Massachusetts Hospital Attestation form to demonstrate that the provider has met the patient safety standards, as required in 45 CFR 156.1110. The form will include the provider’s Medicaid-only CMS Certification Number (“CCN”). (This requirement applies only to hospitals participating in the Plan’s Qualified Health Plans network, with fifty (50) beds or greater).
- Providers must not be currently debarred, suspended or otherwise excluded from participation in Medicare, Medicaid or any other Federal or State health care programs.
- Copy of current malpractice liability policy with a minimum coverage amount of $1,000,000 / $3,000,000.
- Copy of current Clinical Laboratory Improvement Amendments (CLIA) certification, or waiver of a certificate of registration with a CLIA identification number (applies to providers with laboratories only)

- Accreditation, Site-Survey or Plan On-Site Quality Assessment:
  - Copy of current accreditation certificate with one of the following Plan-recognized accreditation agencies:
    - Accreditation Association for Ambulatory Health Care (AAAHC)
    - Accreditation by the American College of Radiology (ACR)
    - Accreditation Commission for Health Care (ACHC)
    - American Association of Blood Banks (AABB)
    - American Association of Rehabilitation Facilities (CARF)
    - College of American Pathologists (CAP)
    - Commission on Office Laboratory Accreditation (COLA)
    - Community Health Accreditation Program (CHAP)
    - Continuing Care Accreditation Commission (CCAC)
    - Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL)
- Joint Commission for Accreditation of Healthcare Organizations (JCAHO)\(^1\)
- National Association of Childbearing Centers (NACC)

- The provider must submit evidence that it has participated in a survey ("Survey") with the Centers for Medicare & Medicaid Services (CMS) or Department of Health (DPH) within the past thirty-six (36) months. The Plan requires a letter or report from the agency that includes the results of the survey as well as any deficiencies that may have been discovered. If the provider has requested a plan of correction, the Plan must receive a letter showing that the plan of correction has been accepted by CMS or DPH.

- If the provider does not hold an accreditation, has not participated in a survey within the past thirty-six (36) months or does not have a survey that meets Plan standards, the Plan will complete an on-site quality assessment ("Site Visit"). During the Site Visit, the plan will use the appropriate form addressing the specific criteria for each provider type (Attachment A). The Site Visit may include interviews with the provider’s senior management, chiefs of major services and key personnel in nursing, quality management and utilization management. The Plan will also review the provider’s process for credentialing the practitioners employed at the organization. The Plan adopts Massachusetts’ site-visit standards for Skilled Nursing Facilities and Urgent Care Facilities.

- A provider may be considered exempt from having to meet this requirement if it is located within a Rural Area, as defined by the US Census Bureau.

**Re-credentialing**

All contracted organizational providers are re-credentialled every three (3) years, or more often, as determined necessary or as requested by the Credentialing Committee.

**Quality of Care Issues**

Organizational providers may be required to have a site visit if a serious quality of care issue has been identified, the provider has been sanctioned, the provider’s accreditation has been withdrawn, or if we have identified a pattern of quality of care problems. Organizational providers are required to notify BMCHP within ten (10) business days of any actions by a state agency that might impact their credentialing status with us, including, but not limited to a change in license status, change in ability to perform specific procedures, or a freeze in admissions, type, or number of patients the provider is allowed to admit.
Section 4: Provider Responsibilities

We are your partners in delivering the best possible care to your BMC HealthNet Plan (BMCHP) patients. We know that delivering excellent care comes with many responsibilities. If you have questions or need help verifying a member’s enrollment, check the Provider section of our website bmchp.org.

4.1 Overview

Providers participating in our network are expected to verify member eligibility, adhere to our administrative and clinical guidelines, follow access to care and office waiting time standards, comply with provider contract terms (including all clinical coverage guidelines and reimbursement policies), follow cultural and linguistic requirements, and adhere to our quality and utilization management programs. Provider responsibilities defined within this Provider Manual apply to all contracted providers. For information on maintaining positive provider/member relationships, PCP selection and assignments, transfers and confidentiality issues, please refer to Section 6: Member Information.

4.2 New Provider Request to Participate in Our Network or Request to Join a New Product Line

A provider not affiliated with a BMCHP-contracted entity may request participation in our provider network by submitting a Letter of Interest to the Provider Engagement department. Your Letter of Interest must include the following information:

- The reason you are interested in participating in our network
- Your specialty
- Your practice location(s)
- Your hospital affiliation(s)
- Number and percentage of MassHealth recipients (if applicable) treated in your practice per year
- Language(s) you speak and other cultural competencies
- W-9

Letters should be mailed to:

BMC HealthNet Plan
Provider Engagement Department 529 Main Street, Suite 500
Boston, MA 02129

Or email to provider.info@bmchp.org

If a new provider joins a BMCHP-contracted entity:
All providers treating BMCHP members must be credentialed by BMCHP. We or our credentialing
designee must credential any provider joining a practice, facility or ancillary site contracted with us before
treating members.

A provider joining a BMCHP-contracted entity must:

- Complete BMCHP’s Provider Data Form available on our website at bmchp.org, as well as an
  HCAS Enrollment Form (for a new individual professional medical/surgical provider or for a new
  facility affiliated with a BMCHP-contracted facility), also available on our website.
- Submit forms in one of the following ways:
  - Fax the documents to 617-897-0818.
  - E-mail the documents to BMCHP at providerprocessingcenter@bmchp.org.
  - Postal-mail the documents to: BMC HealthNet Plan Provider Processing Center 529 Main Street,
    Suite 500
  - Boston, MA 02129
- After receiving the appropriate forms, we will notify the new provider of his/her credentialing
  status and assist with the credentialing process, as needed.
- **To request BMCHP participation of an additional provider site:**
  - Complete BMCHP’s Provider Data Form available on our website at bmchp.org, as well as an
    HCAS Enrollment Form (for a new individual professional medical/surgical provider or for a new
    facility affiliated with a BMCHP-contracted facility), also available on our website.
  - Submit forms to the Provider Processing Center in one of the ways listed above. After receiving
    the forms, we will notify you when we have credentialed the additional location and when
    members may be treated at this location.

**To request BMCHP participation in an additional product line (MassHealth, QHP or Senior Care Options)**

If you are an existing provider and would like to participate in an additional BMCHP product, please send
a letter of intent requesting product participation to:

**Letters should be mailed to:**

BMC HealthNet Plan
Provider Engagement Department 529 Main Street, Suite 500
Boston, MA 02129

or email to provider.info@bmchp.org

Based on product network need, we will notify you if the new product line can be added.
4.3  Responsibilities by Provider Type

General requirements for all providers
Many of our members have specialized medical needs. You must work with them to promote, to the greatest extent possible, self-care, independent living, and the minimization of secondary disabilities. We contract with PCPs and specialists who have experience working in multidisciplinary teams to provide care management for high-risk members.

You must comply with the obligations specified in your BMCHP provider agreements and with the most current version of this manual including Network Notifications. Network Notifications may be issued throughout the year and are sent to all contracted providers. The Provider Manual and Network Notifications are also posted at bmchp.org. In instances when providers are not in compliance with BMCHP requirements, we will work with them to implement corrective actions, as appropriate. 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.

If you have questions or would like to request provider training, please contact your dedicated Provider Relations Consultant by calling the provider line at 888-566-0008.

Contract requirements for all providers
Below is a list of some of the most important contractual obligations for participating PCPs, specialty physicians, health centers, ancillary providers, hospitals, and vendors affiliated with us. We encourage you to become familiar with all of the terms of your contract with us.

Care coordination requirements for all providers

- Supervise, coordinate, and provide medically necessary BMCHP-covered services in accordance with accepted standards of clinical practice by provider type.
- Request a benefit modification if you believe that a member’s health is jeopardized because a particular service or item is medically necessary but not covered. See Section 8: Utilization Management and Prior Authorization for guidelines on submitting a benefit modification request.
- Complete a behavioral health assessment upon initial contact with the member in order to identify the member’s need for behavioral health treatment. If a member requires behavioral health services, promptly direct him/her to a behavioral health provider according to Beacon guidelines at beaconhealthstrategies.com or by calling 866-444-5155.
- Maintain the confidentiality of member information and records at all times.
- Make best efforts to provide foster parents with current medical information about young members placed in their care in a timely manner.
- Treat members promptly and courteously in a clean, comfortable environment, with staff that is mindful of the members’ needs for dignity and respect.
• Accept and treat members without regard to race, age, gender, sexual preference, national origin, religion, health status, economic status, or physical disabilities. No provider may engage in any practice, with respect to any BMCHP member, that constitutes unlawful discrimination under any state or federal law or regulation.

• Providers must not discriminate against an individual/member on the basis of gender identity or an individual seeking gender re-assignment/transgender services.

• Communicate freely with members about their treatment options, regardless of the benefit coverage limitations.

• Maintain complete medical records consistent with all statutory and regulatory requirements and BMCHP policies. Medical records must be available to us to fulfill our quality management responsibilities. See Section 14: Quality Management for the medical record charting standards for participating physicians.

• Comply with any advance directive instructions that a member or his/her proxy has given you, and note it in the member’s medical record as mandated by state law.

• Comply with our authorization and notification guidelines by service type for:
  • Medical/surgical services, as specified in Section 8: Utilization Management and Prior Authorization.
  • Pharmacy services, as outlined in the Pharmacy section of our website at bmchp.org/pharmacy.
  • Behavioral health services at beaconhealthstrategies.com or 866-444-5155.

• Notify us as soon as possible, but no later than within three business days of each confirmed pregnancy of BMCHP member by contacting our Prior Authorization department; call the provider line at 888-566-0008 and select the medical prior authorization option. Please note: this guideline does not apply to ancillary providers.

• Report immediately to BMCHP any adverse medical incident, and to Beacon any behavioral health reportable adverse incident related to a BMCHP member. See Section 14: Quality Management for a description of the adverse incidents and beaconhealthstrategies.com for a description of the behavioral health reportable adverse incidents, including policy information and instructions on the appropriate notification process by incident category.

• Direct members to other BMCHP-participating providers for needed medical and behavioral health services, unless the required medical services are unavailable through a BMCHP-participating provider. Providers must seek prior authorization from BMCHP prior to referring members to non-participating providers. If notification is required, providers must agree to notify BMCHP no later than the next business day following an emergency referral.

• Assist BMCHP staff with care coordination and care management activities for members.

• Review BMCHP’s utilization reports related to care management, care coordination or quality improvement activities, as appropriate. Work collaboratively with BMCHP staff to evaluate level
of care, appropriateness of service or treatment for a member’s condition, and under- and over-utilization of services for a BMCHP member.

- For MassHealth and SCO members, providers cannot refuse to deliver services to members who have missed appointments or who have an outstanding debt to you from a time prior to the time that individual became a BMCHP member. Please work with MassHealth members (if applicable) and BMCHP to help members keep their appointments.
- Furnish member clinical information, with lawful member consent, to other providers, as necessary, to ensure proper coordination and behavioral health treatment of members who express suicidal or homicidal ideation or intent.
- For providers participating in our Senior Care Options network, additional responsibilities include:
  - Participate in member Primary Care Team (PCT), as necessary.
  - Attend PCT meetings for SCO members as necessary and be available to communicate through PCT meetings, as needed.
  - Request an organizational determination if you believe that a member’s health is jeopardized because a particular service or item is medically necessary but not covered. See Section 8: Utilization Management and Prior Authorization for guidelines on submitting an organizational determination request.
  - Direct the member to contact BMCHP to request an organizational determination when there is member disagreement with a provider decision related to a service or course of treatment.
  - Provide BMCHP with updates to the information in the provider directory timely, and respond to BMCHP outreach requests for accuracy of the provider directory information on at least a quarterly basis.

Primarycareproviderrequirements

A primary care provider (PCP) is a physician or mid-level nurse practitioner or physician assistant selected by the member or assigned to the member by us. PCPs provide and coordinate all of the member’s healthcare needs and arrange for specialty services when required. (See Section 3: Credentialing for BMCHP’s definition of a PCP.) Primary care services should be delivered by the member’s PCP or a covering contracted PCP.

In addition to the responsibilities of all BMCHP providers described above, PCPs have the following additional responsibilities:

- Deliver primary care services to the member. Primary care services do not require BMCHP authorization if a member obtains those services from his/her assigned PCP or a covering physician who is contracted and listed with us as one of the PCP’s covering physicians. PCPs may deliver services in their offices, a healthcare facility or the member’s home.
- To accurately identify whether a member has selected you or a physician in your group as his/her PCP:
• If a member presents for services and is not on your panel or on that of your covering group, and if that member wishes to have you serve as his/her PCP, the member should, on the same day of the visit:

• Call our Member Services department to change his/her PCP assignment at 888- 566-0010 (MassHealth), 877-492-6967 (Commercial and Qualified Health Plans (including ConnectorCare), or 855-833-8125 for Senior Care Options; Or

• Request that his/her PCP assist in completing and faxing to our Enrollment department a [PCP Selection Form](#) available on our website at bmchp.org.

• Schedule a baseline physical examination for each new member according to the access to care standards outlined in this section (unless you determine that the exam has been previously performed and documented within our approved timeframes for the member’s age/gender category).

• Be available to respond to urgent healthcare needs of BMCHP members 24 hours a day, seven days a week, with a telephone answered by a live voice, or have arrangements for such coverage by another BMCHP-participating PCP. A BMCHP medical director must approve coverage arrangements that are not in compliance with this requirement.

• Meet our applicable appointment availability and office waiting time standards outlined in this section.

• For medical/surgical admissions, admit or arrange to admit BMCHP members to a participating hospital (if clinically appropriate) in the member’s BMCHP network and coordinate the medical care of the member while hospitalized.

• PCPs should direct members to other BMCHP-participating providers for needed medical and behavioral health services, unless the required services are unavailable through a BMCHP-participating provider. Providers must seek prior authorization from us prior to referring members to non-participating providers. If notification is required, providers must agree to notify us no later than the next business day following an emergency referral

• In addition, if a PCP refers a member to an out-of-network provider, he/she must inform the member that the provider is out of network and must ask the member to contact the health plan before seeing the out-of-network provider.

• Follow the latest Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) schedule for MassHealth members under age 21. To ensure that the schedule is current, we recommend that you visit the MHQP website at [mhqp.org](http://mhqp.org).

• Review our enrollment report that lists all eligible members in your panel as of the time the report was printed. We generate reports to identify new members, disenrolled members, and those who have historically been seeking care at the health site. These reports include member name, address, BMCHP member ID number and gender. Your panel report does not guarantee current member eligibility or PCP assignment. Please follow the instructions in Section 2: Member Eligibility to determine member eligibility.

• For PCPs participating in our Senior Care Options network, additional responsibilities include:
- Participate in the development of member’s Individual Care Plans
- Participate in the member’s Primary Care Team meetings and be available to communicate with member’s Care Manager or Care Coordinator, as necessary

PCPs must coordinate all BMCHP members’ behavioral health and medical care needs by communicating with members’ behavioral health providers. PCPs must request written consent from the member to release information for these purposes. The consent form must conform to the requirements set forth in 42 CFR 2.00 et. seq. when applicable. Visit bmchk.org for a copy of the Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form. PCPs also must document all instances in which consent was not given and, if possible, the reason why.

Covering physicians

Participating specialists and ancillary providers must comply with all applicable requirements in their BMCHP contract and this manual. You must coordinate all care with the member’s PCP, and:

- Provide the member’s PCP with copies of all medical information, reports and discharge summaries resulting from the specialist’s provision of care.
- Meet the applicable appointment availability and office/service waiting time standards as outlined in this section.

See Section 8: Utilization Management and Prior Authorization for additional information about this requirement. Also, please refer to our Prior Authorization Matrix available on the Forms and Documents page of our website at bmchk.org. The matrix is toward the bottom of the page in the Documents section.

Responsibilities of Contracted Hospitals

Contracted hospitals must comply with all applicable requirements in their BMCHP contract, and information within and referenced in this manual, as well as all associated clinical coverage and reimbursement policies. Providers must obtain BMCHP authorization for medical/surgical hospital services and providing BMCHP notification of emergency care and observation services rendered to members. Providers also must update BMCHP on maternity/newborn services used by our members according to our notification guidelines. In addition providers’ staff must:

- Work collaboratively with our hospital care coordinators on concurrent review and discharge planning activities for medical/surgical services.
- Coordinate a member’s behavioral healthcare services with our behavioral health care managers
- Immediately contact an Emergency Services Program (ESP), listed in See Section 12: Behavioral Health Management when a member presents in a behavioral health crisis.

Hospital responsibilities related to medical/surgical services

Please follow the guidelines either outlined or referenced in Section 8: Utilization Management and Prior Authorization.

BMCHP investigation of non-behavioral health adverse incidents and serious reportable events
Please see Section 14: Quality Management for detailed information and guidelines on Serious Reportable Events (SRE), Adverse Incidents and Provider Preventable Conditions.

**Provider training for Senior Care Options participating providers**

**Model of Care:** BMCHP’s Provider Engagement staff will provide training on the Model of Care (MOC) to providers when they initially join BMCHP SCO and on a yearly basis thereafter. These trainings may include face-to-face training, printed instruction materials, as well as, web-based and audio/visual conferencing. Topics may include:

- Medicare Advantage D-SNP Benefits
- Target Populations
- Cultural Competency
- Role of Participating Provider Network
- Performance and Health Outcome Measures
- Credentialing and Re-credentialing Process
- Health Risk Assessments
- Primary Care Team
- Appeals and Grievance Process
- Member Eligibility
- Risk Adjustment

Training can be conducted in different mechanisms, such as in person, through a LMS system or on line. Once training is finished, providers will be asked to attest they have completed the training. If the MOC training is completed using a LMS system, completion within that system is considered to be sufficient documentation. If training is completed on-line, once the provider completes the self-study/on-line training, they will be asked to attest they have completed the training by completing an on-line survey. If a provider receives the training through a meeting or takes it independently, they will be asked to sign the attestation at the back of the training presentation and to return it to their designated representative.

Provider Engagement will track the attestations as evidence of the completed training. For providers who do not attest to taking the training, BMCHP Provider Engagement Staff will outreach via phone or visit the provider office to obtain the attestation. If the training is done in person, an attendance listing will be compiled and recorded as evidence of the completed training.

**CMS Compliance Training:** Providers are required to complete this training within 90 days of hire and annually thereafter. This training is available through the [CMS Medicare Learning Network](https://www.medicarelearningnetwork.com).

**CMS Fraud, Waste and Abuse Training:** Non Medicare approved providers are required to complete this training within 90 days of hire and annually thereafter. Providers who have met the FWA certification requirement through accreditation as suppliers of DMEPOS, or enrolled in the Medicare Part A or B program, are not required to take this FWA training.
4.4 Fraud, Waste and Abuse

A provider’s submission of a claim for payment constitutes a representation by the provider that the services or supplies on the claim, including all quantities on the claim, were:

- medically necessary in the provider’s reasonable judgment;
- performed by the provider or under a licensed clinician’s supervision;
- filed accurately, using appropriate coding; and
- properly documented in the member’s medical records.

A provider’s submission of a claim for payment also constitutes the provider’s representation that the claim submitted is not false or misleading.

Any amount billed by a provider in violation of this policy, if paid by BMCHP, constitutes an overpayment and is subject to recovery by BMCHP. Any amounts billed to and paid by members in violation of this policy must be immediately refunded to the member.

Fraud, waste and abuse may include, but are not limited to, the following:

- Charging in excess of usual, customary and reasonable fees
- Performing unnecessary or inappropriate services
- Billing a service that was not performed or misrepresenting a service that was provided
- Billing duplicate claims
- Unbundling services
- Collecting money from a member - except for appropriate member cost-sharing (deductibles, coinsurance and copayments)
- Failure to refund known BMCHP overpayments within 60 calendar days of receipt
- Providing non-covered services to members

Providers must maintain an environment in which employees may report any suspicion of fraudulent behavior. Providers themselves should also report any such concerns. Complaints or allegations of suspected provider or member fraud, waste and/or abuse, whether from an internal or an external source, are investigated by the Special Investigations Unit. Complaints or allegations of suspected fraud, waste or abuse by a Plan employee are investigated by the Compliance Officer.

Concerns involving a provider or a BMCHP member should be reported by:

- Calling our anonymous, independent Fraud Hotline, available 24 hours a day, seven days a week, at 1-888-411-4959
- Emailing the Special Investigations Unit at FraudandAbuse@bmchp.org
- Faxing the Special Investigations Unit at 1-866-750-0947
- Mailing BMCHP at:
BMC HealthNet Plan
Attn: Special Investigations Unit
529 Main Street, Suite 500
Boston, MA 02129

Concerns involving a BMCHP employee should be reported by:
- Calling the anonymous, independent Fraud Hotline at 1-888-411-4959
- Mailing BMCHP at:
  - BMC HealthNet Plan
  - Attn: Compliance Officer
  - 529 Main Street, Suite 500
  - Boston, MA 02129

4.5 Provider Demographic Changes

For provider demographic changes, please submit a Provider Change and Termination Form, available on our website at bmchp.org, and include the following:

- Billing and/or mailing address
- Tax Identification Number or Entity Affiliation (W-9 required)
- Group name or affiliation
- National Provider Identifier
- Telephone and/or fax number

Submit to:

BMC HealthNet Plan
Provider Engagement Department 529 Main Street, Suite 500
Boston, MA 02129

Or email to: providerprocessingcenter@bmchp.

For providers who participate in our Senior Care Options product, BMCHP is required to verify the accuracy of the provider directory information on a quarterly basis.

4.6 Access to Care Standards

To ensure that members have timely access to care, providers must comply with the standards outlined below. We perform quality assessments of provider practices to ensure our appointment availability standards are met. We monitor access using provider self-reported data and validate with site audits.
Access to care standards for behavioral health providers as well as consumer satisfaction measurement guidelines for behavioral health providers are available by visiting Beacon’s website at beaconhealthstrategies.com or by calling 866-444-5155.

<table>
<thead>
<tr>
<th>Service</th>
<th>Access Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hours of Operation</strong></td>
<td>Hours offered to our members must be no less than the hours offered to commercial enrollees (or MassHealth fee-for-service enrollees if the provider serves only BMCHP members and other individuals enrolled in any MassHealth program).</td>
</tr>
<tr>
<td><strong>Office/Service Waiting Time</strong></td>
<td>20 minutes or less</td>
</tr>
<tr>
<td><strong>After Hours Services</strong></td>
<td>Provide one of the following:</td>
</tr>
<tr>
<td></td>
<td>24-hour answering service with option to page the physician, or</td>
</tr>
<tr>
<td><strong>Emergency and Psychiatric Services</strong></td>
<td>Immediately upon entrance to delivery site, including network and out-of-network facilities.</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, seven days a week.</td>
</tr>
<tr>
<td><strong>Primary Care Services</strong></td>
<td>Routine, non-symptomatic: 45 days, unless otherwise required by the EPSDT Periodicity Schedule.</td>
</tr>
<tr>
<td></td>
<td>Non-urgent, symptomatic: 10 days</td>
</tr>
<tr>
<td></td>
<td>Urgent: 48 hours</td>
</tr>
<tr>
<td><strong>Outpatient Specialty Services and Newborn Care</strong></td>
<td>Non-symptomatic care: 60 days</td>
</tr>
<tr>
<td></td>
<td>Non-urgent, symptomatic care: 30 days</td>
</tr>
<tr>
<td></td>
<td>Urgent care: 48 hours</td>
</tr>
<tr>
<td></td>
<td>Initial prenatal visit: 21 days</td>
</tr>
<tr>
<td></td>
<td>Initial family planning visit: 10 days</td>
</tr>
</tbody>
</table>
Members affiliated with the Massachusetts Department of Mental Health (DMH), children in care or custody of the Department of Children and Families (DCF) (formerly DSS), and youth affiliated with the Massachusetts Department of Youth Services (DYS) must undergo an A DCF or DYS screening within 7 calendar days. Initial comprehensive medical evaluation (including EPSDT screens) within 30 calendar days, unless otherwise required by the EPSDT Periodicity schedule.

Communicate and inform DMH, DYS and DCF caseworkers assigned to members of services provided through BMCHP that support our members.

Other Healthcare Services

For MassHealth members, provide services in accordance with MassHealth standards and guidelines available at mass.gov. All BMCHP rules apply.

### 4.7 Physician Panel Closing

When requesting closure of a panel to new and/or transferring BMCHP members, PCPs or specialists must:

- Keep the panel open to all BMCHP members who were provided services prior to the panel closing;
- Submit the request in writing at least 60 days prior to the effective date of closing the panel (or such other period of time provided in your provider contract) to:
  
  **BMC HealthNet Plan**
  
  Provider Engagement Department 529 Main Street, Suite 500
  
  Boston, MA, 02129

- Or submit via email to providerprocessingcenter@bmchp.

You also must submit written notice to BMCHP of the re-opening of the panel, including a specific effective date.

### 4.8 Requesting a Change in a Member’s PCP Assignment

MassHealth MCO members may request a PCP change at any time.

MassHealth ACO members may change their PCP to another PCP within their ACO at any time. Members who want to change to a PCP not within their assigned ACO, must contact MassHealth.

Qualified Health Plan (including ConnectorCare) members may request a PCP change only three times per year.

Senior Care Options members may request a PCP change at any time.
See Section 7: BMC HealthNet Plan Product Information for information about member selection and assignment of PCPs.

4.9 Member Transfer or Termination
Providers must make best efforts to communicate with the member and address any healthcare or interpersonal issues. If you cannot achieve a reasonable working relationship with the member, you may request that the member be removed from your panel and transferred to another PCP. After addressing your concerns with the member, document interventions taken to:

- Establish a satisfactory patient/physician relationship
- Develop and maintain an effective individual care plan
- Ensure the member does not experience an interruption in care or services

You must provide BMCHP with 60 calendar days' notice before the effective date of the member termination from your member panel. Complete a Member PCP Transfer Request Form available on our website at bmchp.org. Please include all appropriate documentation and fax the form to the Enrollment department (using the fax number on the form). If you don't have a copy of the form, contact your dedicated Provider Relations Consultant and request assistance re-assigning the member with 60 calendar days' notice. We will initiate the outreach and re-assignment of the member, and we will arrange a transition plan, when necessary, to ensure that the member does not experience an interruption in care or services.

We will also:

- Track PCP requests for member termination from their panel
- Monitor the occurrence of such situations on a quarterly basis as part of our Quality Management program.

4.10 Second Opinion
Members may request a second medical opinion, at no cost to them, whenever there is a concern about diagnosis, surgery options or treatment for other health conditions.

The second opinion must be provided by a qualified health care professional within the appropriate BMCHP network. If there is no BMCHP provider with expertise in the medical condition, a non-network provider can furnish the second opinion, but first must obtain prior authorization from BMCHP.

4.11 Early Periodic Screening, Diagnostic and Treatment (EPSDT) Program
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) services are available to BMCHP’s MassHealth members under age 21. This important screening requirement applies to:

- EPSDT: MassHealth Standard and CommonHealth
- PPHSD: MassHealth Family Assistance
We pay for these members to see their PCPs on a periodic schedule. At all well-child visits, PCPs perform a series of health screens, including approved, standardized behavioral health screens, as outlined on MassHealth’s website at mass.gov. If the member’s behavioral health screen indicates the need for behavioral health follow-up, we pay for further assessment, diagnosis and treatment services. We also pay for visits to primary care doctors or nurses between periodic visits when there might be something wrong.

To ensure the health of young members and to comply with contractual and legal requirements, all BMCHP PCPs must:

- Screen all MassHealth Standard and CommonHealth members under age 21, in accordance with the Executive Office of Health and Human Services (EOHHS) EPSDT medical protocol and periodicity schedule.
- Provide or refer these members for all medically necessary care in accordance with EPSDT requirements.
- Screen all MassHealth Family Assistance members under age 21 in accordance with EOHHS’s Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) medical protocol and periodicity schedule found at 130 CMR 450.140-450.150.
- Provide or refer these members for medically necessary treatment services included in their benefit package.

In addition:

- For BMCHP members entitled to EPSDT services, we pay for all medically necessary assessments, diagnoses and treatment services that are covered by federal Medicaid law, even if the services are not described in BMCHP’s MassHealth contract, MassHealth regulations or procedure codes covered for the member’s coverage type.
- PCPs must offer to perform behavioral health (mental health and substance abuse) and developmental screens as part of every EPSDT or PPHSD visit.

We reimburse for behavioral health and developmental screening services (CPT 96110) performed as part of all EPSDT visits when using a standardized behavioral health screening tool to administer the behavioral health screen. For detailed reimbursement information, see Section 9: Billing and Reimbursement. Providers must choose a clinically appropriate behavioral health screening tool from a menu of MassHealth-approved standardized tools, available on our website at bmchp.org. These tools accommodate a range of ages while permitting some flexibility for provider preference and clinical judgment. The EPSDT Periodicity Schedule controls the approved behavioral health screening tools.

**EPSDT Medical Protocol and Periodicity Schedule**

The EPSDT Medical Protocol and Periodicity Schedule (Appendix W) applies to providers treating MassHealth members only and consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be provided. See 130 CMR 450.140 through 450.150 for more information about EPSDT services and Preventive Pediatric Health-Care Screening and Diagnosis (PPHSD) services.
Providers eligible for reimbursement of behavioral health screening tools

We pay for administering and scoring approved, standardized behavioral health tools when administered in an office or clinic, community health center or hospital outpatient department, and when services are rendered by the following types of network providers:

- Physicians
- OB/GYNs
- Independent nurse practitioners
- Nurse practitioners, nurse midwives and physician assistants under a physician’s supervision

Reimbursement terms

Submit your claim using Current Procedural Terminology (CPT) service code 96110. We will reimburse you for administering one standardized behavioral health screening tool per MassHealth member, per day, regardless of the number of behavioral health screening tools administered on the same day for a given member. See Section 9: Billing and Reimbursement for details. You must submit an encounter form every time you conduct the standardized behavioral health and developmental screening services (CPT 96110 plus appropriate modifier U1 – U8 required). Section 9: Billing and Reimbursement for specific details.

4.12 Adult Health Screening

Physicians should perform an adult health screening for members age 21 or older in accordance with federal preventative care regulations. The adult member should receive an appropriate assessment and intervention as indicated or upon request.

4.13 Advance Directives

Advance Directives are legal documents that offer individuals the ability to outline the decisions they want made for end-of-life care before they become terminally ill or incapacitated. There are two types of advance directives:

Living Will – This is a legal document that outlines specific information on which life-prolonging measures one does and does not want to be taken if that individual becomes terminally ill or incapacitated. Many measures can be considered, including but not limited to the use of dialysis and breathing machines, tube feeding, organ and tissue donation and whether or not individuals want healthcare professionals to save their lives if their heartbeat or breathing stops.

Health Care Proxy – This is a legal document in which one names another trusted individual as their Durable Power of Attorney for Health Care. A Power of Attorney is responsible for making decisions on the patient’s behalf if the patient is unable to do so.

PCPs should ask whether members have made an advance directive and ask for a copy of the advance directives for the member’s record. PCPs should instruct members to report to BMCHP the existence and terms of their advance directive. The PCP should keep a copy in the patient’s medical records and the member should keep a copy at home.
Hospitals, including critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of personal care services and hospices must maintain written policies and procedures concerning advance directives, including providing written information to members about their rights, educating the member about any limitations on the provider’s ability to honor an advance directive, and notifying members that their care will not be conditioned based on whether they have executed an advance directive. This information must be given to the member at the time of admission as an inpatient, or, for home health, hospice or personal care, coming under the agency’s care.

Call the Member Services department (see contact information outlined in Section 6: Member Information for questions about Advance Directives.

4.14 Provider-Preventable Conditions

Consistent with applicable state and federal guidelines, we do not reimburse providers for the cost of services attributable to those events and/or conditions identified as a Provider- Preventable Conditions (PPCs). In addition, members cannot be billed for these services.

PPCs are categorized as follows:

- Health Care Acquired Conditions (HCACs) – any condition identified on Medicare’s full list of Medicare’s hospital-acquired conditions (HACs).
- Other Provider-Preventable Conditions (OPPCs) – conditions that could apply in any health care setting, as follows:
  - Wrong surgical or other invasive procedure performed on a patient
  - Surgical or other invasive procedure performed on the wrong body part
  - Surgical or other invasive procedure on the wrong patient
- Events identified by the National Quality Forum (NQF) as Serious Reportable Events (SREs) found in Section 14.5.

For a complete list of PPCs and detailed reporting, billing and coding guidelines, please refer to reimbursement policy titled Provider Preventable Conditions and Serious Reportable Events available in the reimbursement policies section of our website at bmchp.org

4.15 ADA Guidelines

People living with disabilities

Health services must be accessible to all people living with disabilities. Providers must offer a level of service that allows people with disabilities full and equal enjoyment of services and access to facilities that are offered to its other customers. New and altered areas or facilities must be as accessible as possible to all customers. In the event that provider sites are not readily accessible, the provider must describe reasonable alternative methods for making the services accessible and usable. Providers must assure appropriate and timely health care to all members, including those with chronic illness and/or disabilities. Physical accessibility is not limited to entry to a provider office, but also includes access to services within the facility, such as exam tables and medical equipment.
4.16 Cultural Competency

We require BMCHP providers to be culturally competent in delivering care to members. Cultural and linguistic competency is defined as a set of congruent behaviors, attitudes and policies present among members and professionals that enables effective work in cross-cultural situations. We require BMCHP providers to be responsive to the linguistic, cultural, and other unique needs of any minority, homeless person, Enrollees with Special Health Care Needs, including individuals with disabilities, or other special populations.

“Culture” refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups including, but not limited to, ASL using deaf, hard-of-hearing and deaf blind person.

“Competence” implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities, as defined in the National Standards for Cultural and Linguistically Appropriate Services in Health Care.

We have a diverse membership with many linguistic abilities and cultural and ethnic backgrounds. To promote access to providers who have the ability to communicate with members in a linguistically appropriate and culturally sensitive manner, we use a number of methods to capture detailed linguistic, ethnic and cultural data on our members, including health assessment tools and querying members through contact with the Member Services department. As part of the credentialing process for individual clinicians, we assess a provider’s linguistic capabilities.

For access and availability assessment, the member’s self-reported primary language serves as a measure of their linguistic needs and preferences as well as a proxy for cultural and ethnic identity. The provider’s self-report of languages spoken serves as the measure of their linguistic ability and a proxy for cultural and ethnic backgrounds.

**BMCHP providers must ensure that:**

- Members know they have access to medical interpreters, signers, and TDD/TTY services or alternative formats, such as Braille, large font, audio tape, video tape, and Enrollee Information read aloud to an Enrollee by an Enrollee services representative; to facilitate communication, without cost to them.
- Care is provided with consideration for the member’s race/ethnicity, disability and language and how it impacts the member’s health or illness.
- Staff members with routine access to patients have cultural competency training and development.
- Staff responsible for data collection makes reasonable attempts to collect race and language-specific member information. Staff members explain ethnicity categories so members can identify themselves and their children.
- Treatment plans and clinical guidelines are followed with consideration of the member’s race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age,
gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.

- Office sites have posted and printed materials in English and Spanish, and any other required non-English language.
- A provider cannot rely on a member’s child to provide interpretive services. A provider cannot rely on the member’s family and/or friends to interpret unless the member requests.
- If a member refuses an interpreter, the provider makes an effort to explain possible consequences of proceeding without the assistance of an interpreter and documents the member’s declination.
- If the member speaks a language that is not prevalent in the community, BMCHP will provide telephonic language assistance services at the member’s request. The provider or member may call BMCHP’s Member Services department (see Important Contact Information). We will connect them to the appropriate interpreter telephonically.

### 4.17 Members Held Harmless for Charges

Except for collecting any applicable cost-sharing (copayments, coinsurance or deductibles), providers must look solely to BMCHP for reimbursement of furnished covered services in accordance with the provider’s contract with BMCHP. Providers agree that in no event, including but not limited to BMCHP non-payment, will the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the member for a BMCHP-covered service.

For Senior Care Options members, services that have not been pre-authorized by BMCHP SCO or meet limited exceptions for non-contracted providers will be denied as provider responsibility. Non-contract providers must sign a Waiver of Liability Statement, available at bmchp.org in order to appeal BMCHP’s denial.

### 4.18 Legal Notice

We are required under state law to provide the following notice:

This notice applies to any doctor of medicine, osteopathy, or dental science, or a registered nurse, social worker, doctor of chiropractic, or licensed psychologist, or an intern, or a licensed resident, fellow, or medical officer, or a licensed hospital, clinic or nursing home and its agents and employees, or a public hospital and its agents and employees ("Statutory Reporters"). Under M.G.L. c. 112, § 5F, Statutory Reporters are required to report to the Board of Registration in Medicine ("BORIM") any person they reasonably believe is in violation of M.G.L. c. 112, § 5, or any BORIM regulation, except as otherwise prohibited by law. This includes, but is not limited to, any physician who they have a reasonable basis to believe has fraudulently procured a certificate of registration, has violated a law related to the practice of medicine, whose conduct places into question the physician’s ability to practice of medicine, or is guilty of being impaired due to alcohol or drug use. Certain exemptions to this reporting requirement, as to a physician who is in compliance with
the requirements of a drug or alcohol program satisfactory to the BORIM, are described in the BORIM regulation 243 CMR 2.00.

For a list of Consumer Protections for Qualified Health Plan Products, please see the Addendum section at the end of this Provider Manual or click here.

4.19 Members with Special Health Care Needs

We require all BMCHP providers to ensure Members with Special Health Care Needs receive the appropriate level of care, including screening, identification, comprehensive assessments, care management, and an appropriate care plan.

Members with Special Health Care Needs are Members:

- with complex or chronic medical needs requiring specialized health care services, including multiple chronic conditions, co-morbidities, co-existing functional impairments, and physical, mental/substance use, and developmental disabilities;

- Who are children/adolescents with, or at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally;

- At high risk for admission/readmission to a 24-hour level of care within the next six (6) months;

- At a high risk of institutionalization;

- Diagnosed with a Serious Emotional Disturbance, a Severe and Persistent Mental Illness, or a substance use disorder, or otherwise have significant behavioral health needs;

- Who are chronically homeless;

- Are at high risk of inpatient admission or Emergency Department visits; or

- Receive care from other state agency programs.
Section 5: Provider Resources

5.1 Introduction

We are committed to partnering with you and supporting our entire network of providers, so together we can ensure the highest quality of care to our members.

Our website offers a variety of resources and tools to help you meet the medical needs of your patients, our members. For additional information or if you have questions, please contact your Provider Relations Consultant at 888-566-0008 or via email at provider.info@bmchp.org.

PCP offices participating in our network can access the following services:

- Support from Provider Engagement, Provider Service Center, Care Management, Community and Member Outreach teams
- Information on providers for the purposes of managing referrals and discharge planning

5.2 Secure Provider Portal

Our secure online provider portal offers you a convenient way to access information and resources. To comply with state and federal privacy laws and regulations, including HIPAA, we require a login and password to access member information and certain online provider Web functions. Because these features are protected, you must register for a secure portal Log-In ID request via our portal at provider portal and click on Provider Login.

Once you have requested your log-in ID, we will send you a link with instructions to set your permanent password. After acquiring your login credentials, you will be able to do the following within the portal:

- Check the status of a claim
- Check member eligibility
- Check PCP assignment
- View remittance history
- View reports such as an inpatient census

5.3 Additional Website Features

Our website, bmchp.org, offers convenient, dynamic features to save you time which helps you support and retain your patients.

‘Find a Provider’ tool

Our on-line provider look-up contains the most current provider listings for our MassHealth Senior Care Options, and commercial plans networks. Search results for PCPs, specialists (including behavioral health) and ancillary services providers contain the following demographic information:

- Location
- Hospital affiliation

Last updated May 9, 2018
• Specialty type
• Address and telephone number
• Whether PCPs are accepting only existing patients
• Languages spoken by provider or skilled medical interpreter at the site
• Whether a provider’s office is accessible to disabled members
• Our online Provider Directory also includes contracted pharmacies and hospitals

When searching for providers to arrange for appropriate care, please look under the correct network for the applicable member: MassHealth, Connector Care/QHP Silver (Silver Network), QHP Bronze/Gold/Platinum (Select Network) or Senior Care Options.

• **Enhancement for Prior Authorization Requests:** CPT & HCPCS Look-Up Tool that provides a quick and efficient method of verifying if your procedure or service requires prior authorization. Available on the Provider page of our website at bmchp.org.

• **Resources for claims submission:** To help you submit accurate claims and get paid faster, the website includes clinical editing guidelines and other reimbursement resources.

• **Network Notifications:** A list of important notices we have informed you about. Network Notifications are written notices that make changes to or update this Provider Manual and related BMCHP policies and procedures.

• **Provider notices:** Copies of the communications we email, postal mail or fax to you.

• **Provider-specific reports:** Requested available reports specific to inpatient census, member panels, member redetermination, and emergency department utilization. Speak to your Provider Relations Consultant for more information.

• **Other material available online:** Our website provides links to BMCHP’s policies, forms, information on electronic data interchange and other useful information. At your request, we distribute approved member and provider marketing literature, including brochures, posters and other collateral materials.

• **Online drug formulary:** Available on the Pharmacy page of our website at bmchp.org, allows access to verify coverage of a specific drug or an entire drug class.

### 5.4 Provider Engagement Department

The Provider Engagement Department is the liaison between the provider and BMCHP. Your dedicated Provider Relations Consultant will furnish you and your office with training and education regarding BMCHP and our processes. Our goal is to develop and maintain a mutually beneficial relationship.

Our dedicated Provider Relations staff members are assigned to assist you with any questions, to include, billing and reimbursement policies and guidelines, claims, credentialing, care management, etc. He/she is the person you contact when you have demographic changes, such as a change to group affiliation, tax identification number, address or phone change, or questions about working with us. Provider Relations
Consultants are experts in their field and know how important it is to be available to our providers to ensure satisfaction and to assist you in doing business with us.

Additionally, your dedicated Provider Relations Consultant:

- Orients and educates physicians, ancillary providers, vendors, administrative staff, hospital staff, and health center staff on our policies and procedures.
- Responds promptly to questions and concerns.
- Provides ongoing education and support.
- Is the point of contact for BMCHP.
- Helps you access reports (for example, inpatient census, member panel, emergency department utilization, and ad hoc data requests).

If you have any questions or concerns, call our Provider Service Center at 888-566-0008, or call your dedicated Provider Relations Consultant by visiting our website and choosing Find Your Provider Relations Consultant. Staff is available 8 a.m. to 5 p.m., Mon. – Fri. You may also call the provider line at 888-566-0008 and use the automated features to check member eligibility and enrollment at any time. The provider line is also available to provide you with the following information:

- General BMCHP policies and procedures
- Confirming a member’s current enrollment status (with capability available 24 hours a day, seven days a week)
- Determining a member’s benefit coverage based on the applicable program: MassHealth (MassHealth Standard, MassHealth Family Assistance, MassHealth CarePlus), Senior Care Options and Commercial plans’ benefit plans.
- Identifying a member’s PCP assignment and assisting with a transfer to another PCP panel if requested by the member
- Determining the network status of a provider
- Identifying your assigned Provider Relations Consultant
- Prior authorization or BMCHP notification of services (including medical/surgical services, and pharmacy services)
- Claims and billing matters (through the Claims Resolution Unit)

Provider training

We are committed to offering an in-service training within 30 days of our contract being executed. Among other things, this training will include:

- Member eligibility
- Provider responsibilities
- Understanding your provider reports
- Web portal training
• Care Management
• Billing and claims submission
• Cultural competency
• Administrative, Clinical and Reimbursement policies and procedures
• Fraud and abuse reporting

If you have a change in office staff, please contact your Provider Relations Consultant as he/she can schedule a time to visit with your new staff and conduct a training session for them. A member of our Provider Engagement team will visit your office on a routine basis. These meetings are designed to proactively identify and provide any additional training or assistance your office may require. Preferably these meetings will take place with the Office Manager or provider, as well as, with office staff.

**Care Management Department phone line**

• If you believe a member could benefit from our Care Management Services, please contact our Care Management department using the dedicated telephone number, 866- 853-5241. See [Section 11: Care Management](#) for additional information on our Care Management program.
• Behavioral health providers should call Beacon at 866-444-5155 for any behavioral health services or questions or issues they may have.
• Durable medical equipment, prosthetic, orthotic and medical supply (DMEPOS) providers should contact Northwood, Inc. (Northwood) at 866-802-6471 for any questions or issues they may have.

**5.5 Provider Service Center**

• Hours: 8 a.m. to 5 p.m., Monday – Friday
• Call: 888-566-0008 - Option 1 to access our automated claim status and eligibility verification system which is available 24 hours a day 7 days a week.

To improve services for our providers, we have a centralized team of Provider Service professionals to assist providers and resolve claims-related questions and payment issues from the provider’s first contact through the adjustment process.

**5.6 “Quick Reference” Charts and Code Lists**

There are a number of quick reference charts and lists described in this manual and below, and available on our website at [bmchp.org](http://bmchp.org). We encourage you to use these tools and distribute them to the staff responsible for implementing our contract at your practice site(s) and patient care areas. If you can’t access any of these documents on the website, ask your Provider Relations Consultant to mail or fax copies to you.

**BillingGuidelinesReferenceCharts**

• Our Oral Nutrition Dispensing Guide is available at [bmchp.org](http://bmchp.org).
• Summary of Billing Requirements for Medical/Surgical Services. Billing requirements - medical/surgical services in Section 9.

Medical/Surgical Prior Authorization Reference Charts
• Our Medical/Surgical Authorization Requirements Matrix is located on our website at bmchp.org. Choose the Provider tab, then Authorizations, and the Prior Authorization Requirements Matrix option.
• 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. Available on the Provider page of our website at bmchp.org
• DMEPOS services requiring prior authorization by either BMCHP or Northwood. See the prior authorization matrix available on our website at bmchp.org.
• Information regarding limitations on cosmetic procedures can also be found on our website at bmchp.org.

Member Information Reference Charts
• Chart of BMCHP Covered Benefits and Services, available on our website at bmchp.org
• in each member section.
• Instructions for verifying member eligibility. Section 2: Member Eligibility.
• Pharmacy Reference Charts See Section 13: Pharmacy Services.
• BMCHP Pharmacy benefits. bmchp.org/pharmacy/Providers. Also see Section 13: Pharmacy Services.

5.7 Provider Education and Communication

We will make our best effort to notify providers 60 days prior to the effective date of changes to this Provider Manual, medical or reimbursement policies and procedures. We will send written notice via postcard, email or other postal mailing, all of which will be posted to our website at bmchp.org.

Our staff educates network PCPs on how to access services for BMCHP members, assessment tools available to identify at-risk members in a timely manner, and methods of accessing network health providers. We collaborate with PCPs who prescribe medications for members with mental health or substance abuse diagnoses to ensure that treatment is furnished by behavioral health providers, when clinically appropriate. In addition, BMCHP staff educates PCPs on the importance of coordinating care with the member’s behavioral health provider and utilizing the Combined MCE Behavioral Health Provider/ Primary Care Provider Communication Form (after the member signs the appropriate consent form).

We develop and email “Provider News”, a newsletter for network providers, which is also posted to our website at bmchp.org. Sample topics include administrative and clinical guidelines, pharmacy news, quality initiatives and other information relevant to network providers. We welcome your ideas for newsletter topics. If you want to receive Provider News electronically, please provide your email address by contacting your Provider Relations Consultant, or email us at provider.info@bmchp.org.

Last updated May 9, 2018
5.8 Positive Provider/Member Relationship

Your relationship with your patient is vitally important to maintaining good health for a member, and we encourage this relationship in our communications with members. In the interest of good communication between you and our members, we tell each member to contact his or her PCP before seeking non-emergent healthcare services.

We provide PCPs with member panel report, which is a list of your assigned members. You can access this report via our secure provider portal at:

https://bmchp-wellsense.healthtrioconnect.com with a secure login and an arrangement with your Provider Relations Consultant. You should make your best efforts to schedule an initial appointment with every new member on your member panel. You may also obtain enrollment and PCP assignment information by calling our provider line at 888-566-0008 and selecting the member eligibility option.

5.9 Special Programs and Items for BMCHP Members

BMCHP members also benefit from the value-added services available to you, such as our clinical programs, access to a network of credentialed providers, and facilitation of a positive provider/member relationship. See section 6: Member Information for a description of additional value-added services and items that we offer to our members – beyond comprehensive healthcare benefits – including effective member outreach and communication, and excellent customer service.

5.10 Provider Complaints

Providers have the right to initiate a formal complaint regarding dissatisfaction with any Boston Medical Center HealthNet Plan or Well Sense Health Plan administrative policy or process.

This type of complaint may be filed:

**By Phone**    Please call your dedicated Provider Relations Consultant who will document and escalate your complaint. The main number to our Provider Services Department is 888-566-0008.

**By E-Mail**   Send your complaint to Provider.Info@BMCHP-wellsense.org

**In writing to**   Boston Medical Center HealthNet Plan

Attn: Provider Engagement Department

529 Main Street, Suite 500

Charlestown, MA 02129
Provider complaints will be reviewed by Boston Medical Center HealthNet Plan’s Network Management department leadership team.

You will receive confirmation of receipt of your complaint via phone or email within 1 business day and a response, via phone or email, will be provided within 7-10 days of our receipt of your call or written correspondence.

Section 6: Member Information

6.1 Member Information

We offer a variety of products to eligible Massachusetts residents and employer groups. Further information on BMCHP options are outlined under “Our Plans” starting on the home page of our website at bmchp.org.

6.2 Member Enrollment in BMCHP

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>MassHealth membership:</td>
<td>To become a member of BMCHP, a Massachusetts resident first must qualify through MassHealth or the Health Connector. Many community-based organizations, hospitals and community health centers will assist those seeking membership and help them apply through the electronic application. The law requires that an applicant provide the Commonwealth of Massachusetts with income information, an employment record, any disability or illness information, a list of family members, proof of citizenship, identity (e.g., government-issued identity card), or immigration status and additional details. The Commonwealth of Massachusetts will then notify the applicant if he or she is eligible for BMCHP. If is the Commonwealth determines that an applicant is eligible, he or she becomes a BMCHP member in one of the following ways: The individual chooses BMCHP; or MassHealth/the Health Connector enrolls the individual in BMCHP; or The individual is transferred to BMCHP from another managed care organization (MCO) or accountable care organization (ACO).</td>
</tr>
<tr>
<td>Qualified Health Plan – ConnectorCare plans only</td>
<td>Eligibility is determined on an individual basis. Members will be eligible as of the first of the month after their confirmed MCO selection. Once an individual is enrolled in BMCHP, s/he is typically a member for the remainder of the contract year (January 1 through December 31).</td>
</tr>
<tr>
<td>Qualified Health Plans (non- ConnectorCare plans):</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>QHP Platinum QHP Gold QHP Silver QHP Bronze</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligible Massachusetts residents may enroll in one of our QHPs through one of the following ways:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through the Health Connector: The Health Connector offers BMCHP QHP Plans to eligible individuals and their families, and to the employees (and their dependents) of small employer groups (1-50 employees). Eligibility determinations for QHPs are made by the Health Connector.</td>
</tr>
<tr>
<td>Directly through BMCHP: Eligible small groups (6-50 employees) may enroll directly through us into one of our QHP small group plans – known as “Employer Choice Direct” - by calling us directly. We will make eligibility determinations according to our eligibility and participation policies.</td>
</tr>
</tbody>
</table>

Last updated May 9, 2018
<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Care Options</td>
<td>Eligibility is determined on an individual basis. Members will be eligible as of the first of the month after they have enrolled in the SCO program. Members who disenroll are disenrolled at the end of the month.</td>
</tr>
</tbody>
</table>

### 6.3 MassHealth Membership - Overview

**MassHealth benefit categories and eligibility criteria for BMCHealthNet BMCHP membership**

We offer the following MassHealth benefit categories (further described below):

- MassHealth Family Assistance
- MassHealth Standard
- MassHealth CarePlus
- **MassHealth (not BMC HealthNet Plan) determines eligibility for all individuals applying for MassHealth benefits.** If an applicant meets eligibility criteria and the application is approved, MassHealth assigns the member to one of the benefit categories listed above based on the applicant's income level, age, and family status.

**MassHealth Family Assistance plan**

Members are eligible for MassHealth Family Assistance if their family's income before taxes and deductions is no more than 200% of the federal poverty level and if they meet one of the following standards:

- Are aged birth-18 years
- Are under age 65 and working, and are not eligible for MassHealth Standard or MassHealth CommonHealth
- Work for a qualified employer who participates in the Insurance Partnership
- Have employer-sponsored health insurance that meets MassHealth standards, and pay part of the cost of that health insurance, or are under age 65 and HIV positive and not eligible for MassHealth Standard or MassHealth CommonHealth
- Certain uninsured children may be eligible with income up to 300% of the federal poverty level.

**MassHealth Standard plan**

This benefit category includes both Standard Disabled and Standard Aid to Families with Dependent Children (AFDC) populations. Members are eligible for the MassHealth Standard plan if they meet the income standard and belong to one of the groups listed below:
• Pregnant women: at or below 200% of the federal poverty level
• Children under age one, at or below 200% of the federal poverty level
• Children aged one through 18, at or below 150% of the federal poverty level
• Parents or caretaker relatives of children under age 19, at or below 133% of the federal poverty level
• Disabled adults, at or below 133% of the federal poverty level

MassHealth CarePlus plan

MassHealth CarePlus includes MassHealth-eligible individuals who:
• Are uninsured childless adults ages 21-64 with incomes up to 133% of FPL
• Maintain non-Alien With Special Status (AWSS)
• Are not currently working
• Have not worked in more than one year or, if a person has worked, that person has not earned enough to collect unemployment
• Are not eligible to collect unemployment benefits

6.4 Qualified Health Plans (including ConnectorCare) - Overview

Qualified Health Plans (QHPs) are available to eligible individuals and groups through the state exchange, known as the Health Connector. Here are the QHPs offered through the Health Connector:

ConnectorCare plans

ConnectorCare plans are federal- and state-subsidized QHPs. There are three ConnectorCare plan types: I, II and III. These plans are offered only through the Health Connector to eligible individuals.

ConnectorCare plans use our “Silver Network.” ConnectorCare ID cards will reference “ConnectorCare” and have both BMCHP and the Health Connector logos.

Metallic QHPs

These are the metallic QHPs:

• Platinum
• Gold
• Silver
• Bronze

Each metallic QHP has different member cost-sharing obligations. Members purchasing these plans may be eligible for federal subsidies depending on income levels. The Platinum, Gold and Bronze plans use our “QHP Select Network.” The Silver plan uses our “Silver Network” and our “QHP Select Network” ID cards for these QHPs will reference the specific metallic plan and will contain both BMCHP and Health Connector logos.
Employer Choice Direct plans: In addition to the QHPs offered through the Health Connector, we also offer the same metallic QHPs (described above) directly to eligible groups (those with 6-50 employees). When these plans are made available to groups directly from BMCHP (not through the Health Connector), they are referred to as “Employer Choice Direct” plans. Employer Choice Direct ID cards will contain only our logo.

6.5 Qualified Health Plans – ConnectorCare: Membership Overview

ConnectorCare eligibility categories

We offer the following three ConnectorCare benefit plan types:

- ConnectorCare Plan Type I – For individuals who earn up to $12,060 yearly.
- ConnectorCare Plan Type II – For individuals who earn between $12,061 and $24,120 yearly.
- ConnectorCare Plan Type III – For individuals who earn between $24,121 and $36,180 yearly.

The Health Connector (not BMC HealthNet Plan) is responsible for all ConnectorCare eligibility determinations. If eligible for ConnectorCare, individuals self-select a managed care organization (MCO) participating in the ConnectorCare program. Once a member selects an MCO, he/she is locked-in for the remainder of the contract year (January 1 through December) and may switch MCOs only by obtaining a waiver from the Health Connector.

ConnectorCare eligibility criteria

Individuals are eligible for ConnectorCare if they meet all of the following criteria:

- Uninsured and ineligible for health insurance through Medicaid/Medicare, their employer or their spouse's employer for at least the last six months
- Income before taxes is at or below 400% of the federal poverty level
- U.S. citizen or a U.S. qualified alien or alien with special status
- Massachusetts residency
- Age 19 or older. (Some eligible persons under age 19 may be covered by MassHealth.
- BMCHP participates in both programs.)

6.6 Qualified Health Plans – Metallic Plans: Membership Overview

The Qualified Health Plans (QHPs) offered by BMCHP are:

- BMC HealthNet Plan Platinum
- BMC HealthNet Plan Gold
- BMC HealthNet Plan Silver A
- BMC HealthNet Plan Silver B
- BMC HealthNet Plan Bronze

Who is eligible for these QHPs?
**Individuals (Non-Group):** An Individual purchases insurance on his or her own without an employer contributing to the premium. The individual can cover all eligible family members. Individual, individual-plus-one, and individual-plus-family are all qualified coverage types for these QHPs. This category of eligibility is sometimes referred to as non-group coverage.

**Small businesses with 1 to 50 employees:** Small businesses from one (self-employed) through 50 employees and their eligible family members can participate in these QHP plans by enrolling through the Connector. Small businesses from 6-50 employees can also enroll in these QHPs directly with BMCHP into our Employer Choice Direct plan.

### 6.7 Senior Care Options (SCO) – Eligibility

The eligibility criteria for BMCHP’s SCO membership is:

- Must have or qualify for MassHealth Standard
- Must be age 65 or older
- Must not have ESRD as of the date of enrollment
- May also have Medicare Part A & B

### 6.8 Overview of BMCHP’s Benefits

**MassHealth and QHP Benefits Overview**

We offer comprehensive benefit packages for MassHealth, Qualified Health Plans (including ConnectorCare), and Employer Choice Direct members. Please see [Section 7: BMC HealthNet Plan Product Information](#) of this manual for information on the products available under BMCHP.

**Member self-referral services – for MassHealth, QHP, and Employer Choice** We do not require referral forms. However, in the interest of good communication between you and our members, we instruct each member to contact his or her PCP before seeking non-emergent healthcare services. BMCHP prior authorization requirements and compliance with clinical criteria still apply to certain member self-referral outpatient specialty services and inpatient admissions.

See our Members page at [bmchp.org](http://bmchp.org) for a list of medical/surgical services for which members may self-refer for care if delivered by a network provider. You can click on each product to view ‘covered services’.

A member may also self-refer for certain outpatient behavioral health services rather than being directed by his/her PCP if the service is delivered by a contracted Beacon participating provider. We contract with Beacon to manage our behavioral health program. Please direct all behavioral health inquiries to Beacon at [beaconhealthstrategies.com](http://beaconhealthstrategies.com) or call 866-444-5155.

Go to the [Members section of bmchp.org](http://bmchp.org) for information on the benefits available to BMCHP members.

**Special programs and items for members**

In addition to the clinical programs available to our members, we offer members several special programs and items that supplement their benefits.
For qualified **MassHealth** members, these extra programs and items include:

- Free infant and toddler car seats and child booster seats
- Free bicycle helmets for children
- Member Services department and Behavioral Health toll-free hotline to answer members’ questions
- Member newsletter
- Coordination of the MassHealth transportation benefit for qualified members
- Care management for special populations
- Free access to our Nurse Advice line
- Free access to our Audio Health Library
- Free dental kits, including toothbrush, toothpaste and floss (members age 4 and older)
- Reimbursements for Weight Watchers® and fitness club memberships

For **Qualified Health** (including ConnectorCare), and **Employer Choice Direct** members, these extra programs and items may include:

- Reimbursements for Weight Watchers® and fitness club memberships
- Member Services department and Behavioral Health hotline to answer members’ questions
- Care management for special populations
- Free access to our Nurse Advice Line
- Free access to our Audio Health Library

**Senior Care Options Benefits Overview**

We offer a comprehensive benefits package for SCO members.

**Member Referral Services – for SCO members**

We do not require referrals for members to see specialists. However, in the interest of good communication between you and our members, we urge members to contact his or her PCP before seeking non-emergent healthcare services. BMCHP prior authorization requirements and compliance with clinical criteria still apply to certain member outpatient specialty services and inpatient admissions.

Visit the [Members section](#) of our website at [bmchp.org](http://bmchp.org) for information on the benefits available to BMCHP members.

For **Senior Care Options** members, these extra programs and items include:

- Over-the-Counter Rewards Card - $75 per quarter to pay for covered over-the-counter drug store items
- Acupuncture – up to $500 annually for services not related to pain or nausea
- Vision – up to $200 annually for prescription eye glasses or sunglasses
• Reimbursement for healthy activities – One Weight Watchers program (online or in-person) and money back annually for fitness club memberships or classes such as yoga or water aerobics.

6.9 Member Eligibility
Always check member eligibility - before delivering services - on the date of service and daily during inpatient admissions. See Section 2: Member Eligibility for instructions on how to check member eligibility.

6.10 Primary Care Provider Selection and Assignment
We proactively assist and encourage each member to select his/her own PCP and other healthcare professionals, to the extent possible. For SCO members, this includes members of their Primary Care Team (PCT). We give information to each member to assist him/her with selecting a provider (e.g., physician specialty, geographic location and experience with special populations). When necessary, our Member Services department provides interpreter services for members when they call and/or if requested by the member. If we do not obtain a PCP selection from the member or the member’s designee, we assign an appropriate PCP immediately after the member's enrollment date in the BMCHP.

If a PCP assignment is required, the member is assigned to a participating PCP using the following criteria:

• If a member was previously enrolled in BMCHP, the PCP assignment will be the member's most recent PCP (if the assignment remains appropriate).
• If the member has not been enrolled in BMCHP before, we consider the following criteria when assigning a PCP to the member:
  • Geographic proximity of the PCP's site to the member's current residence
  • PCP site's accessibility to public transportation
  • PCP site's ability to accommodate the member's disability, if applicable
  • The member's age should be appropriate for the PCP's specialty and training:
    • Pediatrics - birth to age 21
    • Internal Medicine - age 18 or older
    • Family Medicine - all age categories
    • Geriatric Medicine – age 65 or older
• An obstetrician/gynecologist (OB/GYN) can serve as a PCP if selected by a female member, but BMCHP will not assign a member to an OB/GYN practice for primary care services without a member request.
• If the member does not select his/her own PCP, we will inform the member of the PCP assignment. Our member services department can also assist the member in scheduling an initial appointment with the PCP.

Request for PCP change
<table>
<thead>
<tr>
<th>Product</th>
<th>Timeframe for Requesting a PCP change</th>
</tr>
</thead>
<tbody>
<tr>
<td>MassHealth (including CarePlus) members</td>
<td>Any time</td>
</tr>
<tr>
<td>Qualified Health Plan (including ConnectorCare), and Employer Choice Direct members</td>
<td>Voluntary requests – up to three times a year</td>
</tr>
<tr>
<td>Senior Care Options (SCO) members</td>
<td>Any time</td>
</tr>
</tbody>
</table>

A member may request a change in his/her PCP assignment for any reason in any of the following ways:

- MassHealth and QHP members may complete, sign, and fax a Primary Care Provider Selection Form to our Enrollment department. SCO members may complete, sign, and fax a SCO PCP Selection Form to our Enrollment department Enrollment in the new PCP's member panel is effective the date the member signs the form.

- Call the Member Services department at 888-566-0010 (MassHealth, including CarePlus), 855-833-8120 (Qualified Health Plan, including ConnectorCare and Employer Choice Direct), or 855-833-8125 (SCO) between 8 a.m. and 6 p.m., Monday through Friday (except holidays). Enrollment in the new PCP's panel will be effective the next business day. However, we will transfer the member to the new PCP's panel the same day if the member states that he/she is in the PCP's office and wants the transfer to be effective immediately.

- For MassHealth and QHP members, login to the appropriate member portal at bmchp.org and submit the request online.

- For SCO members, login to the appropriate member portal at seniorsgetmore.org and submit the request online.

- If this is the member's first PCP selection, the PCP assignment will be effective on the member's enrollment date with BMCHP. Participating providers may assist members with a PCP selection or PCP transfer.

We monitor members' voluntary changes in PCP selections to identify members with frequent changes. We will re-educate members on the role of the PCP or direct members for additional services, if necessary. Also, we will identify opportunities for provider education and quality improvement if transfers are related to provider performance or administrative issues.

### 6.11 Continuity of Care for New and Existing BMCHP Members

#### New BMCHP members

When medically necessary, we will arrange for a new BMCHP member to continue receiving treatment from his/her current, non-network provider as further described below.
For new MassHealth (including CarePlus) members, this may occur for up to 60 calendar days from the member's BMCHP enrollment date if the member:

- has a life-threatening, degenerative, or disabling disease or condition;
- have significant health care needs or complex medical conditions;
- have autism spectrum disorder (ASD) and receive ABA Services;
- receive ongoing services;
- are hospitalized;
- are receiving treatment for behavioral health or substance use;
- are pregnant; or
- have received prior authorization for services, including scheduled surgeries; out of area specialty services; durable medical equipment (DME); prosthetics, orthotics, and supplies (POS); physical therapy (PT); occupational therapy (OT); speech therapy (ST); or nursing home admission.

For new members enrolling in a Qualified Health Plan (including ConnectorCare), or Employer Choice Direct plan, we cover services delivered by non-network physicians, nurse practitioners or physician assistants as follows.

For up to 30 days from the member's effective date of coverage if any of the following apply:

- The provider does not participate in any other health plan option offered by the member’s group (if applicable); and the provider is delivering an ongoing course of treatment or is the member's PCP.
- The member is pregnant, in which case we will cover through the member's first postpartum visit.
- The member has a terminal illness, in which case we will cover until the member's death.
- The member receives DME, POS, PT, OT, and/or ST previously authorized by MassHealth, a MassHealth-contracted MCO, or a MassHealth Accountable Care Partnership Plan.
- Other accommodations may be made for upcoming appointments, ongoing treatments or services, pre-existing prescriptions, scheduled and unscheduled inpatient care, and other medically necessary services.
- For new SCO members, this may occur for up to 30 calendar days from the member’s effective date of coverage if any of the following apply:
  - the provider does not participate in any other health plan option offered by the member’s group (if applicable); and the provider is delivering an ongoing course of treatment or is the member’s PCP.
  - The member has a terminal illness, in which case we will cover until the member’s death.
  - Additional conditions for coverage of continuity of care apply. Call us for further information.

Existing BMCHP members
When medically necessary, we will arrange for existing BMCHP members to continue receiving treatment from former BMCHP providers as further described below.

For existing MassHealth (including CarePlus) members, we may provide coverage for services delivered by recently terminated providers in the following circumstances. (In these cases the provider must not have been disenrolled from BMCHP due to fraud or quality of care issues.):

- We may allow affected members continued access to their terminated practitioner for up to 90 calendar days after the effective date of the practitioner’s termination from BMCHP if the member is undergoing active treatment for a chronic or acute medical condition. We will cover continued treatment through the current period of active treatment, or for up to 90 calendar days (whichever is shorter).
- We may allow members who are in their second or third trimester of pregnancy continued access to a terminated BMCHP practitioner whom they had been seeing in connection with their pregnancy through the postpartum period.

For existing Qualified Health Plan (including ConnectorCare), and Employer Choice Direct members, we may provide coverage for services delivered by recently terminated (former) network providers in the following circumstances (Note: in these cases the provider must not have been disenrolled from BMCHP due to fraud or quality of care issues.):

- We may allow affected members continued access to their terminated PCP for at least 30 days after the effective date of the PCP’s termination from BMCHP.
- If the member is undergoing active treatment for a chronic or acute medical condition, we cover continued treatment with the PCP or treating specialist through the current period of active treatment, or for up to 90 calendar days (whichever is shorter).
- We will allow members who are in their second or third trimester of pregnancy continued access, through the postpartum period, to a terminated BMCHP provider whom they had been seeing in connection with their pregnancy.
- We will allow members who are terminally ill continued access to an involuntarily terminated practitioner until the member’s death.

For existing SCO members, members are an integral part of the PCT and providers are key to educating members about their right to direct communication with BMCHP about requests for coverage. In most circumstances, the PCT participants, including ad hoc members, will collaborate together and with the member to formulate the Individualized Plan of Care (IPC). When the member desires an organization determination related to a request or service outside of the IPC, the provider should direct the member to contact Member Services to initiate a member request. To ensure the member’s right to request an organization determination is upheld, the provider should submit timely any clinical information requested by BMHCP for processing of the member’s request.

Additional conditions for coverage of continuity of care apply. Call us for further information.
6.12 Confidentiality and Provider Access to Member Information

We comply with all applicable state and federal laws and regulations pertaining to confidentiality of member medical and personal records. To ensure compliance, we will verify the identity of the provider or his/her designee seeking information that is considered member protected health information (PHI) under HIPAA, or personal information (PI) that is otherwise protected by law. The provider or his/her designee must give BMCHP acceptable authentication identifiers before BMCHP will release any PHI or PI.

6.13 Member Rights and Responsibilities

BMCHP members have rights concerning their health care and also certain responsibilities to their treating providers. We share this information with members and providers annually, or sooner, if policy changes occur. Please review these member rights and responsibilities as they are useful when explaining to members their responsibilities for adhering to certain BMCHP policies.

Providers are responsible for ensuring member rights, as applicable.

**Member Rights**

In general, all members, regardless of product, have the right to:

- Receive information about BMCHP, its services, our network providers, and member rights and responsibilities
- Be treated with respect and recognition of their dignity and right to privacy
- Participate with you in making decisions about their health care
- Candid discussions of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Voice complaints or appeals about BMCHP or the care arranged for by BMCHP
- Make recommendations regarding our member rights and responsibilities policies
- Receive information about any illnesses he or she has, presented in a manner appropriate to the member's condition and ability to understand
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand
- Participate in decisions regarding his or her health care, including the right to refuse treatment as far as the law allows, and to know what the outcomes may be
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- Freely exercise his or her rights without adversely affecting the way BMCHP and its providers treat him/her
- Request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526
- Be furnished with BMCHP covered services
- Request an interpreter when s/he receives medical care
- Request an interpreter when s/he calls or visits BMCHP offices (the Member Services department can provide an interpreter).
- Have any printed materials from BMCHP translated into his/her primary language, and/or to have these materials read aloud to him/her if member has trouble seeing or reading. Oral interpretation services will be made available upon request and free of charge.
- Choose his/her PCP and change the PCP assignment at any time by calling our Member Services department or by faxing a completed Primary Care Provider Selection form to our Enrollment Department.
- Receive medical care within the timeframes described in the Access to Care Guidelines in Section 4: Provider Responsibilities, Subsection 4.6 ‘Access to Care Standards’ for Medical/Surgical Services and to file an Internal Appeal if he/she does not receive care within those timeframes
- Receive behavioral health care according to Beacon standards described in Beacon's Provider Manual. BMCHP contracts with Beacon to manage BMCHP’s behavioral health program. Please direct all MassHealth or QHP behavioral health inquiries to Beacon at beaconhealthstrategies.com or call Beacon at 866-444-5155. SCO members should direct Beacon health inquiries to BMCHP at 855-833-8125.
- Ask for a second opinion about any medical care the member is advised by his/her PCP advises to have
- Receive emergency care 24 hours a day, seven days a week
- Receive medical treatment from BMCHP providers without regard to race, age, gender, sexual preference, national origin, religion, health status, economic status, or physical disabilities. No provider should engage in any practice, with respect to any BMCHP member, that constitutes unlawful discrimination under any state or federal law or regulation.
- Receive information about BMCHP, services, practitioners and providers and member rights and responsibilities.
- Expect healthcare providers to keep member records private, as well as anything members discuss with them. No information will be released to anyone without the member's consent, unless permitted or required by law.
- Make recommendations about our Rights and Responsibilities statement.

**Member Rights specific to MassHealth**

In addition to the member rights outline above, the following rights are specific to MassHealth members:

- Members receive the information required per BMCHP’s contract with the state.
- Have an open and honest discussion with you about appropriate or medically necessary treatment options for the member's medical conditions, regardless of cost or benefit coverage.
The member may be responsible for payment of services not included in the Covered Services list for his/her coverage type.

- Voice a complaint and file a grievance with BMCHP’s Member Services department and/or MassHealth Customer Service Center about services received from BMCHP or from a medical provider. The member also has the right to appeal certain decisions made by BMCHP. Member grievances and internal appeals are described in Section 10: Appeals, Inquiries and Grievances.

**Member Responsibilities**

Responsibilities of all BMCHP members, regardless of product, include the following:

- Supplying information (to the extent possible) that BMCHP and its network providers need in order to arrange for and provide care.
- Following plans and instructions for care that he/she has agreed on with any network providers.
- Understanding their health problems and participating in developing mutually agreed-upon treatment goals, to the degree possible.
- For all members other than SCO members, discussing with his/her PCP when a specialist’s services may be required or before he/she goes to the hospital (except in cases of emergencies or when s/he may self-refer for certain covered services). If a member self-refers to certain specialists, prior authorization may be required unless the specialist and the member’s primary care provider (PCP) are affiliated with the same hospital, or if the member is going to Boston Medical Center for specialty care.
- Keeping appointments, being on time, and calling in advance if he/she is going to be late or have to cancel.
- Notifying our Member Services department when he/she believes that someone has purposely misused BMCHP benefits or services.
- All members should notify our Member Services department (MassHealth members should also notify the MassHealth Customer Service Center) when a member changes his/her address or phone number.
- Paying for services not included in the Covered Benefits section of the EOC or handbook or the Covered Services list for MassHealth members.

**6.14 Member Outreach and Communication**

**Member Marketing**

We provide marketing materials to potential members who express interest in BMCHP membership. If contacted by potential members, BMCHP representatives inform them of eligibility guidelines, enrollment processes, role of the PCP, PCP selection process and covered benefits. BMCHP staff complies with all marketing standards established by MassHealth, the Health Connector, the Division of Insurance, the Massachusetts Executive Office of Health and Human Services, and the Centers for Medicare and Medicaid Services as these requirements relate to each program.
Providers may post approved marketing materials provided by BMCHP in provider offices. Senior Care Options providers are also allowed to promote their affiliation with BMCHP to their patients using an approved letter which we can provide upon request. Providers are otherwise prohibited from steering prospective members towards one specific health plan and must not engage in activities designed to influence patients to enroll with BMCHP. If you wish to make BMCHP materials available, you must first obtain approval from BMCHP as some materials may require regulatory approval. BMCHP is responsible for obtaining regulatory approval of all applicable materials.

Please note that this section does not affect communications with patients related to treatment and provision of services under BMCHP. For example, providers may talk to patients about benefits or services available from a managed care organization, including BMCHP, if the benefit or service relates to the patient's treatment needs. In addition, you may talk with our members about anything to do with their BMCHP membership, including extra items and services, choosing a PCP, how to get a new ID card, or other member questions.

**MemberServicesDepartment**

Our Member Services department is available to MassHealth and Qualified Health Plan members 8 a.m. to 6 p.m., Mon. – Fri. (except holidays). We are available to our Senior Care Options members 8 a.m. to 8 p.m., Mon. – Fri. from February 15 through September 30 and 8 a.m. to 8 p.m. 7 days a week from October 1 – February 14. Please refer to the Member Services telephone numbers available at [bmchp.org](http://bmchp.org) to determine which inquiry line is most appropriate for the member to call. If necessary, a Member Services Representative will arrange for another staff member to speak with a BMCHP member in his/her primary language, use an interpreter (free of charge), coordinate TTY/TDD services for members who are deaf or hearing-impaired, or use an alternative language device so the member can effectively communicate his/her needs to a Member Services Representative.

Member Services Representatives can answer member questions and/or direct members to appropriate resources at BMCHP, including the Behavioral Health and/or Pharmacy coverage hotline. The role of the Member Services representative is to:

- Conduct continuous member education on our administrative guidelines and benefits
- Serve as a liaison among BMCHP, you and the member
- Facilitate the member’s access to care
- Investigate, resolve, and respond to all member inquiries
- Assist members with PCP assignments or transfers to new PCPs, if requested by members

**Behavioral Health Hotline**

Our toll-free Behavioral Health provider hotline number is 866-444-5155 and is available 24 hours a day, seven days a week:

No referral is necessary in an emergency situation.
• MassHealth (including CarePlus) members can call 1-888-217-3501.
• Qualified Health Plan (including Connector Care), and Employer Choice Direct members can call 877-957-5600.
• Senior Care Options members can call 855-833-8125.

Nurse Advice Line

Members may call our toll-free Nurse Advice Line to speak with a trained registered nurse about health-related issues. The Nurse Advice Line is available to members 24 hours a day, seven days a week.

• Call:800-973-6273 (MassHealth and CarePlus members)
• 866-763-4695 (Qualified Health Plan, Connector Care, and Employer Choice Direct members)
• 844-971-1486 for Dual-eligible Senior Care Options members and 844-971-1485 for Medicaid only Senior Care Options members.

Following a set of established protocols, a registered nurse assesses a member’s symptoms, triages the member, and recommends services. This may include having the member contact his/her treating provider or PCP, administer self-treatment, and/or seek immediate help in an emergency department. We educate members that the Nurse Advice Line does not replace the member's PCP who provides primary care services and coordinates the member’s care.

New-Member Materials

We provide all new members with a member enrollment packet. This either contains the Member Handbook, the Evidence of Coverage (EOC), or directions on how to find the EOC for all programs. The Senior Care Options new member packet also contains a formulary.

All new members receive the following information in their enrollment packets:

• Information on accessing our online Provider Directory
• A description of BMCHP covered services and applicable copayments and other cost-sharing (such as deductibles and coinsurance)
• A description of the role of the PCP, and information on how members may select or change a PCP
• How members can obtain information about network providers
• How members can access medical/surgical and behavioral health services
• How members can get prescription drugs; and related pharmacy copayments
• How members can obtain emergency services, including guidelines on when to access emergency services directly, when to use 911 services, and how to access alternatives to emergency room care
• How members can obtain care and coverage when out of our service area
We make our best efforts to contact each new member by mail and MassHealth and Senior Care Options members by telephone. As part of this contact, we welcome him/her to BMCHP and provide an orientation to our administrative guidelines, covered benefits, role of the PCP, network composition and methods of communicating with us. We also urge all new MassHealth and QHP members to complete assessments, enabling us to follow up with members identified as high-risk or who may have a chronic medical condition. SCO members are scheduled to meet with their Care Manager who will perform a comprehensive assessment in person.

Our communication with high-risk members may include information related to:

- Signs and symptoms of common diseases and complications
- Early intervention strategies to avoid complications of illness (does not include SCO members)
- Risk-reduction strategies
- Treatment options to maintain optimal functioning
- Notifying a member if s/he is eligible for enrollment in a clinical program or community service based on his/her diagnosis, condition, or symptom(s)

**Ongoing Member Communications**

We maintain ongoing communication with our members as follows:

- We accept and answer member inquiries through written correspondence and calls made to our Member Services department.
- We mail member educational materials which may include information on the following topics: wellness reminders, preventive services, covered benefits, general BMCHP information, administrative guidelines, and answers to frequently asked questions.
- We periodically send mailings to members regarding important clinical and administrative issues. Additional copies of member ID cards, Evidences of Coverage, Member Handbooks and printed Provider Directories are also mailed to members, upon request.
- We contact MassHealth and QHP members to conduct Health Needs Assessments (HNAs) and contact Senior Care Options members to conduct the initial Minimal Data Set (MDS-HC) and HRA assessments.
- In addition, for all members we outreach to verify member information related to BMCHP membership or PCP assignment, investigate member complaints, follow-up on member questions, process appeals, and/or coordinate care management activities.
- We contact members to conduct member satisfaction surveys.
Section 7: BMC HealthNet Plan Product Information

This section describes the products we offer and some information specific to those products. For more information on the benefits available under each product, please visit the Member’s section of our website at [bmchp.org](http://bmchp.org) for our MassHealth and QHP members and [seniorsgetmore.org](http://seniorsgetmore.org) for our Senior Care Options (SCO) members.

7.1 MassHealth

Any MassHealth member who is eligible to enroll in a managed care organization (MCO) may enroll in BMC HealthNet Plan (BMCHP). Our members have a wide range of covered health care services available through BMCHP as well as services covered directly by MassHealth. Services covered directly by MassHealth are known as “wraparound” or “non-MCO” benefits. To review BMCHP-covered and excluded services and MassHealth wraparound benefits, please refer to the Covered and Excluded Services List for MCO or ACO and BMCHP’s MassHealth or ACO Member Handbook, all available in the Member’s section of our website at [bmchp.org](http://bmchp.org).

We offer the following MassHealth plans:

- Standard
- Family Assistance, and
- CarePlus

In addition:

- Members must select a PCP to direct and manage their care.
- Most services are not subject to cost-sharing except for prescription and over-the-counter drugs for members age 21 and older and in certain circumstances, such as when a member is enrolled in hospice care.
- Referral requirements must be followed for wraparound/non-MCO benefit coverage.
- Some services will require prior authorization from BMCHP.
- For services covered by BMCHP, you will need to follow the process for obtaining prior authorization described in Section 8: Utilization Management and Prior Authorization of this manual.
- For wraparound/non-MCO benefits, you will need to contact MassHealth to verify benefits and eligibility, and obtain pre-authorization for services. You must bill MassHealth directly for such services.
- Examples of wraparound/non-MCO benefits may include, but are not limited to routine dental services, Home Assessments and Participation in Team Meetings (Chapter 766), Keep Teens Healthy and coverage for eyeglasses, contact lenses and other visual aids.
Some services are not covered by either BMCHP or MassHealth. These are listed on the Covered and Excluded Services List available Member’s section of our website at bmchp.org. Some examples include:

- cosmetic services, devices, drugs and surgery except when they are prior authorized by BMCHP and are performed to correct or repair damage following an injury, illness or congenital deformity causing functional impairment, and/or to perform mammoplasty following mastectomy;
- diagnosis and treatment for infertility, reversal of voluntary sterilization and services or fees related to achieving pregnancy through a surrogate;
- over-the-counter prescription drugs not listed on BMCHP’s formulary and/or the provider has not given a prescription for the drug that meets all legal requirements for a prescription; experimental or investigational drugs; drugs not approved by the FDA; dietary and nutritional supplements; and drugs that have been deemed less- than-effective by the U.S. Food and Drug Administration.

7.2 Qualified Health Plans (including ConnectorCare plans)

We offer Qualified Health Plans (QHPs), which are made available to eligible individuals and groups through the state exchange, known as the Health Connector. QHPs offered through the Health Connector are as follows:

- ConnectorCare Plans: ConnectorCare plans are federal and state-subsidized QHPs.
- There are three ConnectorCare plan types: I, II and III. These plans are offered only through the Health Connector to eligible individuals. ConnectorCare Plans use our “Silver Network.”
- Metallic QHPs: Examples of these QHPs are as follows:
  - Platinum, Gold, Silver, Bronze (these may change from year to year so please see Member’s section of our website at bmchp.org.
  - Each metallic QHP has different member cost-sharing obligations. Members purchasing these plans may be eligible for federal subsidies – depending on their income levels. The Platinum, Gold and Bronze plans use our “QHP Select Network.” The Silver and ConnectorCare plans use our “Silver Network.”

**ID cards**: QHP ID cards indicate whether the member is enrolled in a ConnectorCare plan or the specific metallic QHP. These member ID cards have both BMCHP and Connector logos.

**Employer Choice Direct plans.** In addition to the QHP plans offered through the Health Connector, we also directly offer the same metallic QHPs (described above) to eligible groups of 6 – 50 employees. When these plans are made available to groups directly from us (not through the Health Connector), they are referred to as “Employer Choice Direct” plans. Employer Choice Direct ID cards have only our logo.

**PCPs and provider networks**: Each QHP plan requires members to choose (or be assigned) a PCP who is responsible for managing or providing the member’s care. PCPs must coordinate members’ care with other BMCHP participating providers in the Silver Network or QHP Select Network - depending on the
member’s plan enrollment. Except in an emergency or when authorized in advance by us, members enrolled in our QHPs (including ConnectorCare) must obtain all their covered health care services from our Silver Network or QHP Select Network as appropriate based on the member’s plan enrollment. If you have any questions about whether you participate in the Silver Network or the QHP Select Network, please call your dedicated BMCHP Provider Relations Consultant. To identify your Provider Relations Consultant, visit our website at bmchp.org > Find Your Provider Relations Consultant.

**Member cost sharing:** Most QHP covered services are subject to member cost-sharing: copayments, deductibles, and/or coinsurance. Please refer to the applicable Schedules of Benefits at bmchp.org for specific cost-sharing information related to the particular plan in which the member is enrolled.

- Office visit copayments may vary based on whether the care is provided by a PCP or specialist.
- In the course of receiving certain outpatient services (which may or may not be subject to cost-sharing), a member may also receive other covered services that require separate cost-sharing. For example, during a preventive health services office visit (no cost-sharing), a member may have a lab test that does require cost-sharing.
- Copayments are payable at the time of the visit.
- Providers should not bill our members for coinsurance and/or deductibles until the claim has processed. This will ensure that members are billed accurately. The Remittance Advice will reflect the member’s cost-share amount.
  - *Balance billing of covered services is not allowed* – except for applicable copayments, coinsurance and deductibles.
- Preventive services, as defined by the Affordable Care Act (ACA), are covered with no cost-sharing. For more information about which preventive services are included, see the Preventive Health Services on the member’s section of our website at bmchp.org or the federal government’s website at healthcare.gov.

**Prior authorization:** Some services require prior authorization by BMCHP. Please follow the process for obtaining prior authorization described in Section 8: Utilization Management and Prior Authorization of this manual.

**Newborns:** We cover routine nursery charges and well newborn care. If eligible, the newborn must be enrolled in BMCHP within 30 days of date of birth in order for us to cover any other medically necessary services rendered to the newborn.

**Covered and excluded services:** QHP covered (and excluded) services are described in the member’s Evidence of Coverage and associated Schedule of Benefits. Both can be found in the member’s section of our website at bmchp.org. Examples of services not covered by us include:

- Services that are not medically necessary
- Cosmetic services, devices, drugs and surgery except when they are prior authorized by BMCHP and are performed to correct or repair damage following an injury, illness or congenital deformity causing functional impairment, and/or to perform mammoplasty following mastectomy
• Reversal of voluntary sterilization and services or fees related to achieving pregnancy through a surrogate
• Please visit bmchap.org, or the Connector’s website at mass.gov > home > government > departments for more information on Qualified Health Plans (including ConnectorCare).

Cost-sharing terms and definitions applicable to the QHPs are as follows:

**Deductible:** The specific dollar amount a member may pay for certain covered services in a benefit year before BMCHP is obligated to pay for those covered services. Once a member meets his/her deductible, he/she pays either nothing, or the applicable copayment or coinsurance for those covered services for the remainder of the benefit year. Deductible amounts are in the member’s Schedule of Benefits posted on our website at bmchap.org.

**Copayment:** A fixed amount a member may pay for certain covered services.

Copayments are paid directly to the provider at the time the member receives care (unless arranged otherwise). Copayment amounts are in the member’s Schedule of Benefits posted on our website at bmchap.org.

**Coinsurance:** The percentage of costs a member may pay for certain covered services.

Coinsurance amounts are in the member’s Schedule of Benefits posted on our website at bmchap.org.

**Out-of-Pocket Maximum:** This is the maximum amount of cost-sharing a member is required to pay in a benefit year for most covered services. Out-of-pocket maximum amounts, if any, are in the member’s Schedule of Benefits posted on our website at bmchap.org.

### 7.3 Senior Care Options

We offer Senior Care Option plans to MassHealth seniors, age 65 and older who have MassHealth Standard. Many of these seniors are also enrolled in Medicare Part A and B, commonly known as the “Duals or dually eligible”. Seniors who have end stage renal disease (ESRD) are not eligible to join the SCO program.

**ID cards:** There are two different versions of the SCO ID cards. The ID card will have a BMCHP name reference being either Senior Care Options (SCO) for members who only have MassHealth, or Senior Care Options (HMO-SNP) for members who are dually eligible. Both member ID cards will have the BMCHP logo. Pictures of each ID card are available in Section 2: Member Eligibility of this manual.

**Website:** The SCO program has its own dedicated website for members, seniorsgetmore.org. Information for SCO providers may be found on bmchap.org.

**PCPs and provider networks:** The SCO program requires members to choose (or be assigned) a PCP who is responsible for managing or providing the member’s care. PCPs must coordinate member’s care with other BMCHP participating providers in the SCO network with the following exceptions as described in the member EOC:
  
  • Emergency or urgent care
• Out of area renal dialysis

If you have any questions about whether you participate in the Senior Care Options network, please call your dedicated BMCHP Provider Relations Consultant. To identify your Provider Relations Consultant, visit bmchp.org > Find Your Provider Relations Consultant.

**Member cost sharing:** Senior Care Options members do not have any co-payments, co-insurance or deductibles. **Balance billing of covered services is not allowed.**

**Prior authorization:** Some services require prior authorization by BMCHP. Please follow the process for obtaining prior authorization described in Section 8: Utilization Management and Prior Authorization of this manual.

Covered and excluded services: SCO covered (and excluded) services are described on our website at seniorsgetmore.org in the member’s Evidence of Coverage and associated Summary of Benefits.

**Examples of services not covered by us include:**

Services which are not medically necessary:

Cosmetic services, devices, drugs and surgery except when they are prior authorized by BMCHP and are performed to correct or repair damage following an injury, illness or congenital deformity causing functional impairment, and/or to perform mammoplasty following mastectomy.

Please visit seniorsgetmore.org for more information on BMCHP’s Senior Care Options program.
### 7.3 Services Managed by Our Vendor Partners

Note: Please refer to [Section 8: Utilization Management and Prior Authorization](#) for important authorization details. For questions, contact Member Services at 977-957-1300, option 1.

Some services provided to our members are managed by outside vendor partners, including:

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<th>Type of Service</th>
<th>Partner</th>
<th>Contact Information</th>
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| Outpatient Pharmacy Services           | EnvisionRx Options               | EnVision Rx Options, for Pharmacy Services:  
Call 877-957-1300  
Fax: See drug-specific prior authorization form for appropriate fax number. Fax forms are available at bmchp.org/providers/pharmacy.  
Visit: [https://www.bmchp.org/pharmacy/providers/drug-list](https://www.bmchp.org/pharmacy/providers/drug-list) to search covered drugs.  
EnvisionMail (formerly Orchard Pharmaceutical Services):  
• Call 1-866-909-5170 or TTY 711  
• Fax 1-866-909-5171  
Visit envisionpharmacies.com  
Mail 7835 Freedom Ave NW, North Canton OH 44720 |
| Mental Health and Substance Abuse Services | Beacon Health Strategies, LLC | MassHealth members call 888-217-3501  
Commercial and Qualified Health Plan (including ConnectorCare) members call 877-957-5600.  
Visit [beaconhealthstrategies.com](http://www.ctstransit.com/) or  
[https://www.bmchp.org/utility-nav/find-a-provider](https://www.bmchp.org/utility-nav/find-a-provider) |
| Non-Emergent Transportation Services for SCO Members | Coordinated Transportation Solutions, Inc. (CTS) | SCO Call Center: 866-444-7350  
Call the Provider Line: 800-492-9923  
| **Dental Benefits** | **DentaQuest** | **Call Provider Services:** 844-234-9829  
**Preventive dental services** for SCO members  
**Dental Benefits** | **Preventive dental services** for SCO members | **Visit** denclaims@dentaquest.com  
**Hours:** Mon. – Fri., 8 a.m. to 8 p.m. |
|----------------------|-------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|
|                      | **DentaQuest** | **Call Provider Services:** 844-234-9829  
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**Preventive dental services** for SCO members | **DentaQuest** | **Call Provider Services:** 844-234-9829  
**Preventive dental services** for SCO members | **Visit** denclaims@dentaquest.com  
**Hours:** Mon. – Fri., 8 a.m. to 8 p.m. |
|                      | **DentaQuest** | **Call Provider Services:** 844-234-9829  
**Preventive dental services** for SCO members | **DentaQuest** | **Call Provider Services:** 844-234-9829  
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**Hours:** Mon. – Fri., 8 a.m. to 8 p.m. |
Section 8: Utilization Management and Prior Authorization

8.1 General Information

Our Utilization Management (UM) program evaluates requests for covered services. The program determines medical necessity in accordance with Medicare coverage determinations (National Coverage Determinations and Local Coverage Determinations), where applicable, and through the use of nationally recognized criteria such as InterQual® and our internal medical policies (available at bmchp.org). Clinical criteria are:

- evidence-based and scientifically derived, if practicable
- developed in accordance with the standards created and adopted by nationally accredited organizations
- developed with input from BMCHP practicing physicians, external specialty consultants and advisory boards as needed
- developed in accordance with applicable contractual obligations and regulatory requirements
- applied in a manner that considers the individual clinical circumstances of the member
- used for making medical necessity decisions but are not a substitute for professional clinical judgment
- reviewed on an annual basis with input from appropriate actively practicing physicians and other specialists and updated as new treatments, applications and technologies are adopted as generally accepted professional medical practice
- approved for implementation by the Medical Policy, Criteria and Technology Committee and Quality Improvement Committee (QIC)

Providers can access BMCHP’s Medical Policy Criteria used or render decisions, available at bmchp.org or by calling the provider line at 888-566-0010.

Secure online provider portal

For information on accessing member information and online provider functions, please access our secure provider portal at bmchp.org.

Clinical review decisions

We require that qualified licensed health care professionals render or supervise all clinical review decisions. Under certain circumstances, non-clinical staff may authorize requests for coverage based on explicit instructions and coverage criteria. All utilization review decisions concerning coverage are made by qualified, licensed physicians or other licensed clinicians with the appropriate clinical expertise, as allowed by law. For example, pharmacy adverse determinations are rendered by licensed pharmacists. We conduct annual testing to ensure that criteria are applied in a consistent manner.
Our Medical Directors are available to providers by phone to discuss coverage denial determinations that were based on medical necessity. In addition, as required by applicable law, providers may request reconsideration of BMCHP’s initial or concurrent decision to deny coverage from a board-certified, actively practicing, clinical peer reviewer in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

You may access a copy of the medical policy criteria used by BMCHP to render a determination at bmchp.org or by calling the provider line at 888-566-0008. We conduct audits to ensure that the application of criteria is performed in a consistent manner. We do not reward practitioners, providers, or employees who perform utilization reviews, including delegated entities, for not authorizing health care services. No one is compensated or provided incentives to encourage denials or limit authorization or to discontinue medically necessary covered services. Adverse determinations are based on lack of medical necessity, failure to follow prior authorization or notification guidelines, or because a service is not a covered benefit. We also do not make decisions about hiring, promoting, or terminating our practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

Upon request from a member, a network provider, or MassHealth providers must furnish the medical necessity criteria used in the course of making organization determinations. Criteria are available from BMCHP upon request, and BMCHP’s internal medical policies and administrative policies are available online.

**Utilization Management Vendors**

We contract with the following vendors to perform authorization and utilization management:

**Beacon Health Strategies, LLC**, for behavioral health services:
- Call 866-444-5155 for help finding a network provider 24 hours/day, 7 days/week
- Visit beaconhealthstrategies.com

**Northwood, Inc.**, for durable medical equipment:
- Call 866-802-6471 8:30 a.m. to 5 p.m., Mon. – Fri
- Fax completed prior authorization forms to 877-552-6551
- Visit northwoodinc.com
- Provider Portal: https://providerportal.northwoodinc.com
- Email: provideraffairs@northwoodinc.com
- Write: P.O. Box 510, Warren, MI 48090

**DentaQuest** (for SCO only), for dental services:
- Call 844-234-9829 Mon. – Fri., 8 a.m. to 8 p.m.
- Visit dentaquest.com
- Fax 262-834-3450
- Clams/Payment Issues (Fax): 262-241-7379

Last updated May 9, 2018
• Claims to be Processed (Fax) 262-834-3589
• Claims Questions (Email): denclaims@dentaquest.com

EviCore Healthcare, for non-emergent, outpatient radiology services, such as MRIs/MRAs, CT/CTA, PET scans and nuclear cardiology studies:

• Call 888-693-3211
• Provider Call Center 800-467-6424
• Visit: https://www.evicore.com/
• Fax 888-693-3210
• Visit https://www.evicore.com/pages/providerlogin.aspx to complete and process a web-based submission form

8.2 Inpatient Utilization Management

The Inpatient Utilization Management team monitors and improves utilization efficiency and reduces costs, while managing health needs, clinical outcomes and member satisfaction. The team receives notification once members have been admitted to observation or inpatient level of care.

Through acute care coordination, BMCHP:

• Applies medical necessity determinations in accordance with Medicare coverage determinations (National Coverage Determinations and Local Coverage Determinations), where applicable, nationally recognized criteria such as InterQual® clinical criteria, or our internal medical policy criteria. Emergent acute inpatient admissions and continued stay for emergent or elective admissions are reviewed for medical appropriateness, as well as preadmission and continued stay in the acute rehabilitation and skilled nursing facility levels of care.
• Coordinates inpatient clinical services in the setting that is most appropriate for the member’s needs.
• Evaluates care to ensure that providers use resources appropriately and offer the highest quality of care possible.
• Develops and implements alternative and innovative services that enhance high-quality, cost-effective care.
• Engages a multi-disciplinary team for complex members to ensure appropriate planning for discharge from the medical inpatient setting to the community or a behavioral health setting.
• Collaborates with state agencies, as appropriate, to manage and coordinate members’ care across settings.

Acuteinpatienthospitalreview

BMCHP’s Inpatient Utilization (IUM) clinicians perform medical utilization management functions under the direction of a BMCHP Medical Director and licensed Clinical Manager. The staff works to ensure that the level of care during an inpatient stay is appropriate. They also work with hospital Case Managers,
Discharge Planners and attending physicians to facilitate a timely and appropriate transition between levels of care, through the following processes:

- Admission reviews
- Concurrent reviews
- Reviewing the appropriateness of discharge plans
- Providing BMCHP benefit information to assist with the planning of post-hospital services
- Ensure that non-covered services are not authorized as part of the admission
- Coordinating care linkages between providers and members by identifying hospital-based service users and ensuring PCP follow-up
- Identifying members who may benefit from post-hospital care management services and making referrals, as appropriate, to BMCHP’s Care Management staff

**Pre-Hospitalization Review**

Pre-hospitalization services must be authorized independently of the inpatient admission.

**Post-acute care review**

Our Inpatient Utilization Management Clinicians evaluate the medical necessity of admissions to and continued stay in acute rehabilitation facilities, skilled nursing facilities, and long-term care facilities using InterQual® clinical criteria. The clinician identifies the purpose, goals, and expected duration of the stay. For inpatient rehabilitation programs, the member must be able to actively participate in the treatment program.

**The Inpatient UM staff is responsible for:**

- Evaluating the proposed transfer from the acute care setting to the long-term care setting and validating that the level of care is appropriate for the member’s needs and condition(s).
- Notifying the long-term care facility of the availability of the member’s benefits.
- Requesting that the member be screened for admission to the appropriate institution.
- Coordinating the prior authorization process between BMCHP and the long-term care facility.

**8.3 Care Transitions Program**

The Care Transitions team comprises clinicians and non-clinicians. This team outreaches to members who are most at risk for readmission prior to an elective admission and after they have been discharged from the emergency department, or an inpatient setting. The purpose is to decrease 30-day, all-cause readmissions.

The CM serves as the lead and advocate in all member care transitions to ensure that the member’s safety and well-being are maintained across all health care settings. Communication with the member begins upon notification of an unscheduled admission or prior authorization for acute, SNF, or other inpatient level of care. Once the CM becomes aware of the admission, he/she contacts the member and/or family to discuss the admission to ensure that the member is involved in decision-making and planning. The CM
also contacts the Primary Care Team (PCT) to begin to discuss member’s condition and potential discharge plan. Discharge planning.

is initiated at this point, and the CM identifies any barriers that the member and/or caregiver could potentially face upon transition back to home or other health care setting. For scheduled admissions, the CM may schedule a home visit prior to the admission as part of the planning process. The CM may also visit the member in the hospital prior to their discharge and participate in hospital discharge planning and meetings. The CM works with the utilization staff, facility discharge planning personnel, BH CMs, the Member and the PCT to ensure a safe transition.

The CM works with the PCT to ensure that members have and understand their discharge instructions, have a follow-up PCP and/or specialist appointment, have and understand their medications, and have transportation to medical appointments. For certain individuals, especially those discharged on multiple medications or newly prescribed anticoagulants, a BMCHP pharmacist may outreach to the member and conduct medication reconciliation.

**The transition team or the Care Manager for SCO members:**

- Identifies ongoing health issues after discharge.
- Identifies cultural barriers that may impact their health and wellness.
- Contacts the PCP for specialist referrals or identified durable medical equipment needs.
- Assists with ordering visiting nurse or personal care attendant referrals.
- Refers to medical or behavioral health care management for ongoing coordination and educational needs.

The CM maintains ultimate responsibility throughout the transition process. The CM ensures that all care transition activities are completed across all healthcare settings. The CM collaborates with the Inpatient UM team to ensure a successful transition and that the Individualized Plan of Care (IPC) is modified based on the member’s condition and needs before, during, and after discharge. The CM also works with the member, facility staff, providers, and other PCT members to ensure that a comprehensive IPC is established as early as possible and revised as often as needed based on care transitions and other changes in the member’s status and healthcare needs. The BH vendor, Beacon, conducts the same type of transition planning to ensure continuity of BH services and communicates the plan to the CM. All documentation of these processes is maintained in the care management documentation systems to ensure that all staff members have access to the plan and communications at any point in the care transition.

Once the member has returned home after an inpatient stay, the CM contacts the member telephonically or in person within 48 hours of discharge. The CM uses motivational interviewing to educate the member and family/caregiver to ensure adherence with post-discharge regimens, improve self-management of chronic conditions, and perform medication reconciliation. The CM assesses the member for chronic health conditions and educational needs and conducts a depression screening.
Once the assessment is complete, the clinician discusses the assessment results with the member and creates or updates the existing IPC, in collaboration and in agreement with the member. For SCO members, the PCT is also included in this process and the process is completed for every member discharged to home regardless of the admission diagnosis. In all care transitions, the CM ensures a post-discharge appointment is made with the member’s PCP or specialist and evaluates the need for home health services, long term services and supports (SCO), DME, and transportation. He/she continues to follow members intensely post-discharge to home, collaborating with the member and PCT on an ongoing and as needed basis. The goal is to mitigate 30-day member readmissions and to ensure the member’s health care needs are maintained at the most appropriate level of care.

8.4 Prior Authorization

The Prior Authorization department conducts prospective reviews of coverage requests for certain services to ensure BMCHP medical necessity criteria are met and the service is available under the member’s health plan benefit.

The review process includes:

- Verification of member eligibility and benefits
- Validation of the servicing providers’ participation within the member’s plan.
- Entering the service requests and supporting information within BMCHP’s clinical documentation system in order to facilitate claims adjudication.
- Evaluation of medical appropriateness of the requested level and location of care for the member’s reported diagnosis and/or symptom(s).
- Evaluation of service requests using nationally recognized criteria such as InterQual® clinical criteria or BMCHP’s internal medical policy criteria.
- Secondary review by a Plan Medical Director or other qualified, licensed clinician when the initial review fails to meet BMCHP criteria identification of alternative coverage options.
- Communication of BMCHP’s coverage determination to providers and or members.
- Identification of members for referral to care management programs.

8.5 BMCHP Authorization Requirements

Below is an outline of our requirements for authorization. You can view the list of covered services and specific benefit exclusions or limitations in the member coverage page at bmchp.org.

To request prior authorization:

Our Prior Authorization (PA) staff is available 8:00 a.m. to 5 p.m., Monday - Friday (except holidays).

Providers may submit a BMCHP Medical Prior Authorization request Form available at bmchp.org or the Standard Prior Authorization Request Form available at hcasma.org. We are able to accept prior authorization requests via the Web, fax and standard mail.
Even if prior authorization has been obtained, providers must check eligibility on the date of service prior to delivering services. Providers must check the member’s eligibility daily for all inpatient admissions as MassHealth members’ eligibility may change from day to day. Eligibility changes on the first of the month for our QHP and SCO members however we still recommend that you verify eligibility prior to the date of service. Section 2: Member Eligibility for guidelines and step-by-step instructions on how to determine member eligibility in BMCHP. A provider may contact our Member Services team at any time to determine member benefits and eligibility, PCP assignment, and provider participation.

Once the prior authorization request is entered in our system, a reference number is assigned. Upon completion of the coverage decision, the submitting provider is notified of the decision by telephone or fax in accordance with the timeframes listed in this section. Our SCO members are also notified of the coverage decision. The reference number is assigned for tracking purposes and to inform you that we have received the request. The reference number does not guarantee approval of the request, or payment. Payment is contingent on whether the service is a covered service, is medically necessary, and the member’s eligibility on the date(s) of service. Submitting cost and pricing information on a prior authorization request does not guarantee payment at the submitted rate.

8.6 Authorization Requests: Requirements and Timeframes

Prior (pre-service) authorization request

A prior authorization request is a request for services or items that require BMCHP determination in advance of the service being rendered or the item being furnished.

Failure to follow the authorization requirements in this section will result in denial of claims payment. The provider will be liable for this service and the member may not be billed. Please see the prior authorization matrix at bmchp.org for specific requirements by service type.

If a service is denied for lack of prior authorization, please see Section 9: Billing and Reimbursement for further actions.

Prior authorization requirements for in-network specialty care

At the time a specialist visit is requested, providers should always verify that the specialist is in-network by checking the specialist’s and member’s PCP hospital affiliation within the product-specific online Provider Directory available at bmchp.org, or when applicable, the online Provider Directory of our vendors.

Prior authorization is not required for in-network specialty care when:

- the specialist is affiliated with Boston Medical Center; or the BMCHP-contracted specialist is affiliated with the same hospital as the member’s primary care provider PCP; or care is administered by BMCHP-contracted specialists affiliated with any BMCHP-contracted hospital not listed below.
• Excluding visits related to services identified in the Member Access to Care without Prior Authorization section, prior authorization is required for visits to BMCHP-contracted specialists affiliated with these hospitals (for our MassHealth and QHP products only):
  • Beth Israel Deaconess Medical Center – all locations
  • Carney Hospital
  • Saint Elizabeth’s Medical Center
  • Tufts Medical Center

When prior authorization is required, it will be granted for specialty care with specialists affiliated with the above hospitals when the specialty care is not available from a specialist affiliated with Boston Medical Center or from a BMCHP-contracted specialist affiliated with the same hospital as the member’s PCP.

Authorization requests may be submitted by the PCP or by the specialist using the prior authorization request form. Providers may also access BMC Connect, BMCHP’s specialty appointment service, directly at 877-781-4763.

Failure to follow prior authorization requirements will result in administrative denial of claim payment.

For information specific to behavioral health authorization of services, call 866-444-5155 or view the Provider Manual at beaconhealthstrategies.com.

Second opinions

We do not mandate a second opinion for any service or procedure, although all BMCHP members are entitled to a second opinion before commencing any recommended treatment plan or submitting to any diagnostic or surgical procedure. Upon request of the member, the PCP will initiate a consult with the second opinion physician and the member in collaboration with their treating physician(s) and will make the final decision about the course of treatment they want to pursue. We cover a second opinion from a qualified healthcare professional within our provider network, or we arrange for the member to obtain a second opinion outside the provider network at no cost to the member if an in-network health care professional is not available. Prior authorization is required for a member to obtain an out-of-network second opinion.

8.7 Member Access to Emergent and Urgent Services

Emergency and urgent services

We cover emergency care for all members. Determination of medical necessity for emergency services is based on the circumstances of the individual case and not on lists of diagnoses or symptoms. See Section 4: Provider Responsibilities for a description of a hospital’s responsibilities related to emergency care, BMCHP notification, and PCP communication guidelines.

An emergency medical condition is defined as a medical condition manifesting itself by symptoms of acute severity, including severe pain, whether physical or mental, in the absence of prompt medical attention, and could reasonably be expected by a prudent layperson who possesses an average
knowledge of health and medicine, in the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child), in serious jeopardy; (b) serious impairments to bodily function; or (c) serious dysfunction of any bodily organ or part.

Urgent care is medically necessary care that is required to prevent serious deterioration of a member’s health when they have an unforeseen illness or injury. It does not include emergency or routine care.
Out-of-area emergent (including post-stabilization) and urgent care

We recognize that members may have medical emergencies or require urgent care when they travel outside our service area.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Out of Area Coverage</th>
</tr>
</thead>
</table>
| Emergency Services (including Post Stabilization services) | BMCHP covers emergency services (including medications or procedures deemed necessary during the course of the emergency treatment) provided to members who are out-of-area when members cannot safely wait to obtain services from an in-network provider.  
  • MassHealth – coverage is provided if the emergent care occurs in the United States and its territories  
  • QHP – coverage is worldwide  
  • SCO – coverage is provided if the emergent care occurs in the United States and its territories |                                                                                                                                                                    |
| Urgent Care Services                    | BMCHP covers urgent care services that are provided out-of-area when: The illness or injury is unexpected; and the illness or injury requires medical care that cannot be delayed until the member returns home and the care must be received from an out of area provider.  
  • MassHealth – coverage is provided if the urgent care occurs in the United States and its territories  
  • QHP – coverage is worldwide  
  • SCO – coverage is provided if the urgent care occurs in the United States and its territories |
| Out of Area Renal Dialysis              | For our SCO members, out of area renal dialysis is covered.                                                                                                                                                               |
| BMCHP does not cover out-of-area non-emergent or non-urgent services, medications or procedures unless previously authorized. |

8.8 Utilization Management Timeframe Requirements

Timeliness of utilization review decisions and notifications

Our timeliness of utilization review decisions and notification policy includes decision and notification timeframes that:

• Are written in accordance with applicable regulatory requirements and accreditation standards
• Are established for standard, expedited, and retrospective requests for initial authorizations, extensions, limited authorizations, and denials of service requests.
• Apply to all utilization management requests received and processed by BMCHP or its designee
- Provide the necessary guidance for consistent triaging and processing of requests within departments
- Are intended to provide notice as expeditiously as the member’s health condition requires

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision Timeframes</th>
<th>Member and Provider Notification Timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Standard Non-Urgent Pre-Service Request</td>
<td>Medical service request: 14 calendar days from receipt of request (ROR).</td>
<td></td>
</tr>
<tr>
<td>Concurrent Non-urgent</td>
<td>Extension of decision for medical service requests: 14 calendar days of initial request.</td>
<td>Medical service requests:</td>
</tr>
<tr>
<td></td>
<td>BMCHP may extend the review period an additional 14 calendar days with request letter to the member and the provider.</td>
<td>No verbal notification required.</td>
</tr>
<tr>
<td></td>
<td>Decision will be made by the end of the 14 day extension.</td>
<td>Approvals: notification letter within 14 calendar days of ROR.</td>
</tr>
<tr>
<td></td>
<td>Pharmacy request: within 24 hours of ROR.</td>
<td>Denials: notification letter sent to member and provider within 14 calendar days of ROR.</td>
</tr>
<tr>
<td></td>
<td>*Receipt of Request (ROR) will be considered the date a fax is received or the received date stamp on a letter of medical necessity. For concurrent inpatient the “request date” will be considered the date of the request.</td>
<td>Extensions: denial notification letter to member and provider within 14 calendar days or 14-calendar day extension.</td>
</tr>
<tr>
<td>MassHealth Standard Non-Urgent Pre-Service Request / Concurrent Non-Urgent</td>
<td></td>
<td>Pharmacy requests: notification by telephone or fax within 24 hours of ROR.</td>
</tr>
</tbody>
</table>
| Qualified Health Plans (including ConnectorCare/Commercial Plans) Standard Non-Urgent Pre-Service Request and Concurrent No-Urgent Request | **For medical service requests:** within 2 business days of receipt of all needed clinical information but no later than 15 calendar days of receipt of request (ROR).  
**Pharmacy request:** within 2 business days of receipt of all needed clinical information but no later than 15 calendar days of receipt of request (ROR).  
No extensions permitted. | **Medical service requests:**  
**Approvals:** phone call to provider within 24 hours of decision- but no later than 15 calendar days from ROR.  
Approval notification letter to provider and member sent within 2 business days thereafter.  
**Denials:** phone call to provider within 24 hours.  
Denial notification letter sent to provider and member within 1 business day. |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expeditied or urgent pre-service request</strong></td>
<td><strong>Expeditied or urgent pre-service request</strong> is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination could either seriously jeopardize the life or health of the member, based on a prudent layperson’s judgment or in the opinion of a practitioner with knowledge of the member’s medical condition, would subject the member to severe pain or injury that cannot be adequately managed without the care or treatment that is the subject of the request.</td>
<td></td>
</tr>
</tbody>
</table>
| MassHealth Expedited or Urgent Pre-Service Request | **Medical service requests:** as expeditiously as the member’s health requires but no later than 72 hours of the ROR.  
**Pharmacy requests**: within 1 business day from ROR.  
**Extension:** decision will be made at end of 14-day extension. | **Approvals:**  
Approval notification letter within 72 hours.  
**Denials:** verbal notification to provider within 72 hours.  
Fax/letter to member and provider within 72 hours |
| Qualified Health Plans (including ConnectorCare/Commercial Plans) Expedited or Urgent Pre-Service Request | **Medical service requests:** as expeditiously as the member’s health requires but no later than 72 hours of the ROR.  
**Pharmacy request:** as expeditiously as the member’s health requires but no later than 72 hours of the ROR.  
No extensions permitted. | **Approvals:** notification letter within 1 business day of decision.  
**Denials:** notification letter sent to provider and member within 72 hours of ROR. |
**Continued Stay/Urgent Concurrent** is a review for an extension of a previously-approved ongoing course of treatment over a period of time or number of treatments meeting the expedited definition.

<table>
<thead>
<tr>
<th>MassHealth Continued Stay/Urgent Concurrent</th>
<th>Medical service requests: decisions within 24 hours of ROR. Pharmacy request: decisions within 24 hours of ROR</th>
<th>Medical service requests: Approvals: No verbal approval notification required. Notification letter sent within 24 hours. Denials: fax notification to provider within 24 hours. Notification letter to provider and member within 3 calendar days of ROR.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Health Plans (including ConnectorCare/Commercial Plans) Continued Stay/Urgent Concurrent Review</td>
<td>Medical service requests: As expeditiously as the member’s health requires but no later than 24 hours of ROR approvals. Pharmacy request: As expeditiously as the member’s health requires but no later than 24 hours of ROR approvals.</td>
<td>Approvals: Call to provider within 24 hours of decision. Notification letter to member and provider within 24 hours of decision, but no later than 72 hours from ROR. Denials: phone call to provider within 24 hours of ROR. Notification letter to provider and member within one business day.</td>
</tr>
</tbody>
</table>

**SCO Requests:**

<table>
<thead>
<tr>
<th>Type of Request</th>
<th>Decision Timeframes</th>
<th>Member and Provider Notification Timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Medical</td>
<td>As expeditiously as the member’s health condition requires, but no later than 14 calendar days after the ROR. Extensions do not apply for contracted providers.</td>
<td>Approvals/Denials: Notification letter of the organization determination sent to member and provider within 14 calendar days of ROR.</td>
</tr>
<tr>
<td>Pre-Service Medical Urgent/Expedited</td>
<td>As expeditiously as the member’s health condition requires, but no later than 72 hours after the ROR.</td>
<td>Approvals/Denials: Notification letter sent to member and provider within 72 hours of ROR. (Verbal notification may be provided with follow up written notification.). Note: In circumstances when the provider can reasonably be expected to have direct access to the member (for example – a hospitalized member awaiting determination regarding post-acute care), BMCHP may request that the provider deliver verbal and/or written notice of the determination on behalf of BMCHP.</td>
</tr>
<tr>
<td>Pre-Service Pharmacy Standard Non-Urgent</td>
<td>Within 72 hours of ROR.</td>
<td>Notification letter sent to member and provider within 72 hours of ROR. (Verbal notification may be provided with follow up written notification.)</td>
</tr>
<tr>
<td>Pre-Service Pharmacy Urgent/Expedited</td>
<td>Within 24 hours of ROR.</td>
<td>Verbal or written notification provided to member and provider within 24 hours of ROR. If only verbal provided within 24 hours of ROR notification letter will also be sent to member and provider within 3 business days of verbal notification.</td>
</tr>
</tbody>
</table>

### 8.9 Services that Require Plan Notification

We must be informed, as described below, about certain maternity related services a member has already received. This notification assists BMCHP in identifying those members who might benefit from care management involvement. Notification also allows us to monitor utilization and to initiate actions to improve service. The following maternity and newborn requirements apply to our MassHealth and QHP members.
Maternity Program related notification requirements

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Notification Instructions</th>
<th>Notification Timeframe</th>
<th>Party responsible for Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn Birth</td>
<td>Fax all newborn statistical information to the Enrollment department at 617-897-0838.</td>
<td>One business day of a newborn delivery.</td>
<td>Servicing facility.</td>
</tr>
<tr>
<td></td>
<td>Note: <a href="#">Section 2: Member Eligibility</a> for additional information related to notification of birth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirmed Pregnancy</td>
<td>Telephone or fax notification of confirmed pregnancy to the Prior Authorization department: Call: 888-566-0008. For initial notification, fax 617-951-3464 To submit additional clinical information, fax 617-951-3461.</td>
<td>3 business days for each confirmed pregnancy.</td>
<td>Obstetric provider.</td>
</tr>
</tbody>
</table>

Maternity related special circumstances

Third trimester pediatrician visits
We support the American Academy of Pediatrics [Prenatal Visit to the Pediatrician](#) initiative and will reimburse pediatric clinicians who provide this service to prenatal members. This service does not require BMCHP authorization.

Out-of-network exceptions for pregnant members
A BMCHP member who is pregnant must receive care from a BMCHP-contracted provider in the appropriate BMCHP network. However, we will consider exceptions to this policy if one of the following applies:

- The member was pregnant when she became a BMCHP member, and she has an established relationship with a non-participating obstetrical provider;
- The member’s BMCHP-participating provider becomes non-participating while the member is in her second or third trimester;
- The member speaks a language not spoken by any network obstetrician; or
- The member lives more than 30 miles away from any network obstetrician.

We must authorize all out-of-BMCHP maternity care, including delivery at the facility where the non-network obstetrician is affiliated.
Postpartum homecare visits BMCHP prior authorization is not required for an initial postpartum follow-up home care visit when mother and baby are discharged at the same time. This visit includes services for both the mother and newborn(s); therefore, a separate claim form or claim line cannot be billed for the newborn. Additional home care services rendered beyond the initial postpartum follow-up home visit require BMCHP prior authorization. This applies to both the mother and the newborn(s).

If the newborn is discharged after the mother, all newborn home care visits require prior authorization.

If during the postpartum visit it is determined that the newborn or mother requires urgent or emergent services, the home health provider should refer the member to the PCP and/or to an emergency room, whichever is clinically appropriate.

If during the postpartum visit it is determined that the newborn or mother requires immediate services, the home health provider is required to refer the member to the emergency department after first rendering appropriate care in anticipation of transport.

The home health provider is required to refer the member to the PCP, if it is determined that the newborn or mother require physician services during the initial postpartum visit.

Decision-making (triage) for referral and provision of care under the previous two clinical circumstances is included in the reimbursement for the postpartum follow-up visit.

### 8.10 New Technology, Experimental Diagnostics and Experimental Treatment

We evaluate new medical technologies and new uses for existing medical technology (including medical and behavioral health procedures, pharmaceuticals, and devices) to determine whether they should constitute a covered service. We do not cover experimental or investigational services except when required by law.

MassHealth defines experimental treatment as a service for which there is insufficient authoritative evidence that the service is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity.

For Qualified Health Plans/ConnectorCare, experimental or investigational treatment is defined as a treatment, service, procedure, supply, device, biological product or drug (collectively “treatment”) for use in diagnosing or treating a medical condition if any of the following is true:

- In the case of a drug, device, or biological product, it cannot be marketed lawfully without the approval of the U.S. Food and Drug Administration (“FDA”) and final approval has not been given by the FDA.
- The treatment is described as experimental (or investigational, unproven, or under study) in the written informed consent document provided, or to be provided, to the member by the health professional or facility providing the treatment.
- The authoritative evidence does not permit conclusions concerning the effect of the treatment on health outcomes.
• There is insufficient authoritative evidence that the treatment improves the net health outcome. (Improved net health outcome means that the treatment’s beneficial effects on health outcomes outweigh any harmful effects of the treatment on health outcomes.)

• There is insufficient authoritative evidence that the treatment is as beneficial as any established alternative. This means that the treatment does not improve net outcome as much as or more than established alternatives.

• There is insufficient authoritative evidence that the treatment’s improvement in health outcomes is attainable outside the investigational setting.

“Authoritative evidence,” as used in this definition, means only the following:

• Reports and articles of well-designed and well-conducted studies published in authoritative English-language medical and scientific publications that are subject to peer review by qualified medical or scientific experts prior to publication. In evaluating this evidence, we consider both the quality of the published studies and the consistency of results.

• Opinions and evaluations by national medical associations, other reputable technology assessment bodies, and healthcare professionals with recognized clinical expertise in treating the medical condition or providing the treatment. In evaluating this evidence, we consider the scientific quality of the evidence upon which the opinions and evaluations are based.

• The fact that a treatment is offered as a last resort does not mean that it is not an experimental or investigational treatment.

For our Senior Care Options members, BMCHP must maintain policies and procedures to evaluate the use of new medical technologies or new applications of established technologies including medical procedures, drugs, and devices specifically appropriate and effective for the geriatric population. The criteria and evaluation methods used in this process must be based on scientific evidence.

Our Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) regularly reviews information from clinically appropriate sources including peer-reviewed medical literature, professional societies, and regulatory agencies, and obtains expert opinions from specialist providers to determine whether a new or emerging technology is still investigational or whether it constitutes an accepted standard of practice.

The MPCTAC uses the following five criteria to evaluate the literature and reach a coverage decision:

The service or treatment must have final approval from the appropriate governmental regulatory bodies (e.g., the U.S. Food and Drug Administration), or any other federal governmental body with authority to regulate the technology. This applies to drugs, biological products, devices and other products that must have final approval to market the technology.

The scientific evidence utilizing peer-reviewed literature and evaluations by national medical associations must permit conclusions concerning the effect of the service or treatment on health outcomes.

• The service or treatment must improve the net health outcome and should outweigh any harmful effect.

• The service or treatment must be as beneficial as any established alternative.
• The outcomes must be attainable outside the investigational settings.
• The fact that a treatment is offered as a last resort does not mean that it is not an experimental or investigational treatment.
Section 9: Billing and Reimbursement

9.1 Overview
BMCHP is committed to efficiently and promptly reimbursing providers for covered services rendered to our members. In this section we outline the requirements that providers must follow when submitting a claim for reimbursement. It is important for providers to comply with these requirements in order to avoid delays in payment. Forms, guidelines, and policies that are referenced in this section can be found on our website at bmchp.org.

9.2 Provider Reimbursement
BMCHP will reimburse Providers for covered services and supplies furnished to members according to your provider agreement and this Provider Manual. The Provider Manual incorporates by reference, policies (administrative, reimbursement and clinical) that are posted at bmchp.org and include procedures that you must adhere to in addition to those in your agreements. Section 4: Provider Responsibilities, for administrative, coverage, and notification requirements for contracted providers and locum tenens physician services.

Submitting cost and pricing information does not guarantee payment at the submitted rate. Rates are based upon multiple factors that are set forth in your agreement and the Provider Manual, including:

- The contracted reimbursement rates in your participating agreement with BMCHP.
- Compliance with our administrative guidelines including Plan prior authorization and claim submission; see Section 8: Utilization Management and Prior Authorization for medical/ surgical services and pharmacy prior authorization guidelines.
- Verification of medical necessity.
- Verification that the service is a covered benefit.
- Eligibility of the member on the date of service.
- Adherence to proper CPT/HCPCS and other nationally recognized coding and billing guidelines.

9.3 Member Eligibility
Providers must check member eligibility before delivering services, on the date of service, and daily for inpatient admissions. Member eligibility may change from day to day for MassHealth members and on a monthly basis for Qualified Health Plan (including ConnectorCare) and Senior Care Options members. Note: Qualified Health Plan members are generally locked in to their respective plans for a full benefit year. However, a member’s or employer group’s failure to pay premium, or changes in a member’s employment status, may result in coverage termination at the end of any given month.

Terminations that occur retroactively due to failure to pay premiums or for other legitimate reasons will result in retroactive claims retractions. See below for special rules under the
AffordableCareAct. MassHealth members receive two ID cards at enrollment: a MassHealth member ID card and a BMCHP member ID card. Qualified Health Plan (including ConnectorCare) members receive only one BMCHP member ID card. Senior Care Options members receive one member ID card. See Section 2: Member Eligibility for guidelines and step-by-step instructions on how to confirm member eligibility in BMCHP.

**Cost-sharing (deductibles, coinsurance and copayments)**

Members are responsible to pay providers for the applicable cost-sharing dependent on the member’s product and benefit package as described below.

For the MassHealth program, the only service requiring copayment collection is pharmacy.

- Providers may not bill or refuse to provide services to MassHealth members for missed appointments.
- Providers should assist MassHealth members in keeping their appointments.
- Providers may not refuse to provide services to MassHealth members based on a member’s outstanding debt with you from a time prior to becoming a BMCHP member.

For Qualified Health Plan programs, many services require the collection of copayments, coinsurance, and deductibles. Senior Care Options members have no copayments, coinsurance, or deductibles. For complete information on cost sharing, please see the applicable Schedule of Benefits available on our website at bmchp.org.

**Please note the following for QHP members:**

- Office visit copayments may vary based on whether the care is provided by a PCP or specialist.
- In the course of receiving certain outpatient services (which may or may not be subject to cost-sharing), a member may also receive other covered services that require separate cost-sharing. For example, during a preventive health services office visit (no cost-sharing), a member may have a lab test that requires cost-sharing.
- Copayments are payable to the provider at the time of the visit.
- Providers should not bill members for coinsurance and/or deductibles until the claim has processed. This will ensure that members are billed accurately. The Remittance Advice will reflect the member’s cost-share amount.

**Prohibition on balance billing for covered services**

Balance billing for covered services, including emergency services, is *not* allowed – except for permitted copayments, coinsurance and deductibles (cost-sharing). For example, providers may not balance-bill for covered services in the following situations:

You deliver a covered service (not requiring prior authorization) to a member. Providers may collect permitted cost-sharing, but may not balance-bill.

You fail to get prior authorization from BMCHP before delivering a covered service requiring prior authorization (for example, speech therapy).
Providers may bill a member for the following:

Permitted cost sharing identified in the applicable Summary of Benefits at bmchp.org.

Non-covered services provided that, for MassHealth members, the requirements for billing non-covered services (as described below) are satisfied.

For SCO members, in order for a member to financially liable the member must request an organization determination. If after receiving denial of the organization determination, the member then receives the service, the member can be held financially liable.

Please refer to Section 4: Provider Responsibilities for information about SCO Organization Determination requirements.

**Billing MassHealth members for non-covered BMCHP services**

Providers may bill a MassHealth member for a service that is not covered by BMCHP or MassHealth only if all of the following conditions exist before the specific non-covered service is rendered:

- You have informed the member in advance that neither BMCHP nor MassHealth covers the service.
- The member decides to receive and pay for the non-covered service, and you tell the member that he/she will be responsible for payment of that service.
- The member consents in writing that he/she is financially responsible for the non-covered service in advance of the service.
- You have the member’s signed consent on file before the service is rendered.

See Section 9: Billing and Reimbursement for Non-Reimbursable Services guidelines on when you may bill a MassHealth member for a non-covered MassHealth service.

**Clean claims**

Our goal is to process clean claims and reimburse Providers within 30 calendar days of receipt of the claim.

To be considered clean, a claim must have all of the following characteristics:

- Contains no defect or impropriety.
- Includes all required substantiating documentation from contracted or non-contracted providers and suppliers.
- Includes all required substantiating documentation from contracted or non-contracted providers and suppliers.
- Includes all documentation substantiating and supporting any special treatment and/or complex procedure(s), including operative reports or use of an assistant surgeon.
- The claim or provider is not under investigation for fraud or abuse.
- Is properly submitted in the required format with all of the necessary data.
• Includes only valid HIPAA transaction codes
• Is ready for us to process immediately without the need to investigate information related to the claim. See Claim Guidelines available on our website at bmchp.org.

Clean claims late payment In connection with our Commercial and Qualified Health Plan programs, BMCHP, within 45 days after receipt of a clean claim for reimbursement for covered services, will either (i) make payment to the provider; (ii) notify the provider in writing of the reasons for nonpayment; or (iii) notify the provider in writing of what additional information or documentation is necessary to complete the claim form for reimbursement. For Senior Care Options members this timeframe is 30 days. There is no late payment penalty for MassHealth claims.

If BMCHP fails to comply with the paragraph above, it will pay interest at the rate of 1.5% per month, not to exceed 18% per year for QHP. This interest penalty will accrue beginning 45 days after BMCHP’s receipt of the clean claim for reimbursement. This interest penalty will not apply to claims that BMCHP is investigating because of suspected fraud/abuse.

For Senior Care Options the interest rate is currently 2.375% per year; the rate is subject to change on January 1 and July 1. The rate is set by the United States Department of Treasury. Interest accrued is equal to the number of days from date of payment minus 30 divided by 365 times the interest rate. This interest rate will not apply to claims which require additional development by BMCHP, denied claims and claims where no additional money is due.

**Affordable Care Act (ACA) grace period for delinquent premium payments**

**Qualified Health Plans**

As required by the Affordable Care Act, Qualified Health Plan members (purchasing coverage through the Massachusetts State Health Connector) who receive federal subsidies (in the form of advance payment of premium tax credits, or “APTCs”) must be given a 90-day grace period to make required premium payments. During this 90-day period, members cannot be terminated for non-payment of premium; therefore, these delinquent members are required to show as “eligible” on our systems. Members who fail to pay their required premium by the end of this 90-day period will have their coverage retroactively terminated by the Massachusetts State Health Connector and BMCHP retroactively to the first day of the second month of the 90-day grace period. Providers should understand these federal requirements because they directly affect your payments for covered services by BMCHP.

BMCHP will process and pay claims for covered services rendered during the first month of the grace period. BMCHP will also process and pay claims for covered services rendered in the second and third months of the grace period – but will give you required notice that these claims are subject to later denial and payment retraction by us if the member does not pay his/her premium by the end of the grace period. This notice will be in the Remittance Advice and the Electronic Remittance Advice (835). If the member does not pay the premium by the end of the grace period, the Massachusetts State Health Connector and BMCHP will terminate the member retroactively to the first day of the second month of the 90-day period. BMCHP will retract payment for all claims for services rendered during the second and third months of the 90-day grace period. (Retractions will begin for claims with dates of service no earlier
than February 1, 2015.) In this circumstance, Providers are entitled to bill the member for covered services rendered during the last two months of the grace period.

Please note that BMCHP cannot retroactively terminate a delinquent member until the Massachusetts State Health Connector providers BMCHP the notification. If the Massachusetts State Health Connector does not notify us by end of the 90-day grace period, services rendered to the member after the 90th day will be subject to the same retraction rules described above.

Pharmacy claims: Pharmacy claims with dates of service during the second and third months of the grace period will be processed in accordance with all BMCHP pharmacy rules, but not covered by BMCHP. During this time period, members will be responsible for 100% of the prescription cost. If the member pays his/her premium in full by the end of the 90-day grace period, the member may seek reimbursement from BMCHP’s pharmacy benefit manager.

Note: Under the Affordable Care Act, health plans are permitted to pend and later deny, rather than pay and later retract payment for claims for services rendered during the second and third months of the grace period. We reserve our right to pend such claims.

9.4 National Provider Identifier (NPI) and Tax ID Requirements

In order to receive reimbursement, providers must confirm that all National Provider Identifier (NPI) and tax ID numbers on electronic 837 formatted claims are valid and correct.

A Provider’s NPI number must match (have been registered with) an existing tax identification number (TIN) record on file. Even if the NPI number is valid, BMCHP will reject any claim that does not match its’ corresponding TIN. This additional data verification check enhances claims accuracy by eliminating claims payment to an incorrect or invalid provider.

BMCHP requires written notification of any TIN changes prior to claim submission, and no later than 30 calendar days prior to the effective date of the change. This will enable us to complete any necessary system changes and safeguard against payment disruption.

The NPI requirements described above are federally mandated. Questions regarding NPI or claims payments should be submitted, in writing, to NPI@bmchp.org.

Revenue codes

Revenue codes are four-digit codes that identify specific accommodation and/or ancillary charges. There are certain codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the National Uniform Billing Committee’s (NUBC’s) Official UB-04 Data Specifications Manual.

Taxonomy Codes

Providers must submit their billing taxonomy code for claims processing. Absence of a taxonomy code may result in an incorrect payment, delay in payment or claim denial. BMCHP-Specific Billing Guidelines by Service.
9.5 BMCHP-Specific Billing Guidelines by Service

Detailed information on coding and billing requirements are contained in our reimbursement policies and billing guidelines. See our Reimbursement Policies page at bmchp.org to view policies. Failing to bill according to these payment terms will cause your claim to be denied.

We also adopted the standards set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for service and business transactions, including billing codes, modifiers, units of service, and claims submission guidelines. See bmchp.org for the most up-to-date reimbursement policies and guidelines. To ensure accurate claims payment and encounter reporting, all claims must be submitted in compliance with HIPAA standards.

In addition to our Reimbursement Policies at bmchp.org, providers must follow the guidelines below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Billing guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing primary care services</td>
<td>BMCHP pays for primary care services if the member is assigned to the treating PCP’s panel or assigned to a PCP in the covering group. Physicians who provide specialty care services and also carry a primary care panel will need to use the appropriate modifier to identify specialty care services when billing us. We must approve and credential physicians with dual specialties in both specialties. In addition, providers must use a modifier when billing for primary care services delivered after hours. If you do not use the appropriate modifier, we will deny claims submitted for care rendered to members who are not part of the PCP’s panel or the PCP’s covering group.</td>
</tr>
<tr>
<td>Reimbursement for services provided by Mid-level clinician’s reimbursement</td>
<td>Please reference BMCHP’s mid-level clinician policy available at bmchp.org.</td>
</tr>
</tbody>
</table>

Modifiers

BMCHP complies with HIPAA billing guidelines and, therefore, mandate the use of HIPAA standardized modifiers. Modifiers are used to better define the service rendered to BMCHP members. When billing with the CMS-1500 Form, place the appropriate modifier(s) in block 24D

**When billing with the UB-04 Form, put the necessary modifier in block 44.** A narrative may not be used in place of the modifier. Invalid modifiers will be denied. Below is a description of certain modifiers by service type to clarify BMCHP guidelines in selected areas. Outlined below is a sample of modifiers recognized by BMCHP and not a comprehensive list of modifiers established by HIPAA and accepted by BMCHP. Please refer to the Reimbursement Policies available on our website at bmchp.org for appropriate use of modifiers.

**Ambulance Modifiers**
When billing for ambulance services, please include the appropriate modifier based on origination and destination. Please see our Transportation Reimbursement Policy available on at bmchp.org for detailed coding.

**Laboratory and Radiology Modifiers**

Providers delivering both the technical and professional components of laboratory or radiology services may bill with a global code. Bill the global code only if you are responsible for both the facility and professional overhead costs. Providers must use the appropriate modifier, TC or 26, when billing for only one component of the service. CMS guidelines are used to determine whether technical and professional components are applicable.

Modifier TC denotes the technical component (i.e., staff and equipment costs) of a laboratory or radiology procedure. You may use a TC modifier only if financially responsible for administrative overhead, staffing, equipment, or facility costs.

Modifier 26 denotes the professional component (i.e., the physician’s service) of a laboratory or radiological procedure. A physician may bill with this modifier if the professional service rendered is not going to be billed by any other entity (i.e., the facility where the service was rendered). If physicians are not paid directly by a facility for their professional services, they may bill the professional component.

Modifiers TC and 26 are only applicable for certain codes, as dictated by CMS. Please be sure to bill the TC and 26 modifiers with appropriate CPT codes, or the claim could deny as an invalid procedure/modifier code combination.

**Operative note required with modifier**

If you use modifier 22, we will conduct a clinical review to appropriately pay your claim with these modifiers.

**Primary Care modifiers**

BMCHP believes that the relationship between you and your patient is vitally important to maintain a member’s good health. Therefore, BMCHP will pay for primary care services provided only to a member who is on a PCP’s panel or on the panel of a physician in the PCP’s covering group. Providers must accurately communicate your covering arrangements with us.

A PCP who delivers after-hours care to members who are not assigned to the PCP’s covering group may bill using the TU modifier (for care rendered after hours) and/or the TV modifier (for care rendered on weekends and holidays), as appropriate.

**Exception:** Providers may continue to bill for services delivered to students within the school-based health center(s) that you staff, even if those students are not on your primary care panel. We recognize that these services are important extensions of the primary care relationship.

If Providers have a dual specialty approved and recognized by BMCHP and provide both specialty care services and have an assigned primary care panel, you will need to use the TS modifier to identify
specialty care services if the member you are treating is not on your primary care panel. If you do not use this modifier, we will deny your specialty care claims.

Only participating physicians will be paid for primary care services rendered to BMCHP members unless prior authorization is obtained prior to care being provided.

9.6 Compliance: Deficit Reduction Act and HIPAA requirements

BMCHP complies with the requirements of the Deficit Reduction Act of 2005 (DRA) and our obligations related to fraud and abuse under our applicable state sponsored programs. Under the DRA, any entity that receives more than $5 million per year in Medicaid and/or Medicare payments is required to provide information to its employees and contractors about the Federal False Claims Act, any applicable state False Claims Act, their rights be protected as whistleblowers, and BMCHP’s policies and procedures for detecting and preventing fraud, waste and abuse.

To ensure compliance with the DRA, BMCHP provides all its employees, provider network, contractors and agents with information about the False Claims Acts and published BMCHP Fraud and Abuse Policy internally as well as on the provider’s page of our website at bmchp.org.

BMCHP employees, contractors and providers are expected to immediately report any potential false, inaccurate or questionable claims or any other type of suspected fraud and/or abuse to our Fraud and Abuse Coordinator, or the Chief Compliance Officer or the Compliance hotline 888-411-4959 in accordance with BMCHP’s Fraud, Waste and Abuse Policy.

BMCHP is prohibited by law from retaliating in any way against anyone who reports, in good faith, a perceived problem, concern, fraud or abuse issue. Please review and adhere to the complete BMCHP Fraud, Waste and Abuse policy, available on our website at bmchp.org.

9.7 Remittance Advice

A remittance advice summarizes each processed item and lists the subsequent payment amount BMCHP has reimbursed. A remittance advice accompanies all BMCHP submitted claims. We produce one remittance advice that designates reimbursement amount for MassHealth, QHPs (including ConnectorCare) and SCO.

PDF versions of electronic remittance advices are available through bmchp.org. This environmentally friendly choice will help ensure a more efficient means of remittance advice delivery that will significantly reduce member privacy risks and ensure a reduced risk in proprietary information disclosures. Please note that we will continue to send paper check payments.

To retrieve your electronic remittance advices, you must have a login to our secure provider portal on our website, bmchp.org. If you currently do not have a website login ID, you must request one. You can do this through our website at bmchp.org or by contacting your dedicated Provider Relations Consultant or our provider line at 888-566-0008.

Each billed item on the remittance advice includes:

- Member name
• Member ID number
• Provider’s patient account number
• Billed codes (e.g., CPT-4, revenue code, HCPCS)
• Computed DRG or EAPG code
• Billed amount
• Allowed amount (BMHCP’s allowed fee)
• Adjustment or other insurance amount (amount for which other insurance is primary)
• Member cost sharing amount
• Amount paid (with the remittance)
• Disallow remarks (will provide brief descriptions of disallowable payments and the reasons for
  the reduction from charges or the line item denial)

9.8 Other Party Liability

MassHealth and participating managed care organizations (MCOs), such as BMC HealthNet Plan, are
payers of last resort. As a participating MCO, BMCHP will not pay for services until all other payment
sources have been exhausted. Further, we are required to notify MassHealth and CMS when it is
determined that a member has other coverage through a payer who may be liable for payment of a
healthcare expense.

For all other products, we may or may not be the primary payer in Other Party Liability situations.

Provider’s role:

Providers are required to perform “due diligence” to:

• Notify us of all instances of other party coverage by indicating the other carrier on the claim,
calling our Coordination of Benefits and Third Party Liability department at 617- 748-6188 or by
submitting a completed Coordination of Benefits indicator Form for MassHealth, or Coordination
of Benefits indicator Form for Senior Care Options both available on our website at bmchp.org.

• Obtain payment from all other liable parties prior to billing us. This includes billing the primary
carrier for previously paid claims when notified of the existence of other coverage by BMCHP.
NOTE: industry-standard COB procedures dictate that the filing limit for claim submission to the
primary insurance is based on the date the provider is notified that other insurance exists, and
not the date of service. Therefore, providers should not be penalized if claims are submitted in a
timely manner after such notification.

• Submit to BMCHP for consideration any balance when payment or denial is received from the
primary payer. When submitting the claim to BMCHP, include the explanation of benefits,
remittance advice, or denial letter from the other payer. You have 150 days to bill BMCHP after
receipt of the primary payer’s determination for MassHealth and SCO, and 90 days for QHP
(including ConnectorCare).
Role of our Other Party Liability Department

The Other Party Liability (OPL) Department consists of two units: Coordination of Benefits (COB) and Third Party Liability (TPL). The COB and TPL departments can be reached at 617-748-6188.

Coordination of Benefits (COB)

Coordination of benefits occurs when a member has other insurance. MassHealth is always the payer of last resort; any other insurance will always be primary over these programs. For all other programs, BMCHP will coordinate benefits as applicable to determine primary or secondary coverage.

When either a provider or independent source notifies BMCHP that COB exists, BMCHP will take the following action:

For the MassHealth program:

- Notify MassHealth that the member has other insurance. MassHealth will verify this information and update the Eligibility System (EVS). EVS may not always reflect COB information immediately and is not a guarantee of payment, especially if the member has another insurance that is primary.
- BMCHP will notify MassHealth providers by mail 60 days prior to adjusting any previously paid claims with dates of service during the effective dates of the other insurance.

For Senior Care Options

Notify BMCHP that a member has other insurance. Providers may mail COB information to BMC HealthNet Plan

PO Box 55282
Boston, MA 02205-5282

For all programs:

- Members who have other insurance that is primary will have claims adjusted within two years of the date of COB identification.
- BMCHP will deny any claims received subsequent to verification of COB if we are the secondary payer.

Third Party Liability (TPL)

TPL occurs when members are injured as a result of a liability accident. In these instances another party may be liable for the payment of the member’s medical claims. The most common types of TPL cases are motor vehicle accidents, workers’ compensation injuries, and slip-and-fall injuries. Auto insurance, worker’s compensation insurance and general liability insurance are the primary payers for all BMCHP members.
BMCHP members who are MassHealth and Senior Care Options members are entitled to $8,000 in Personal Injury Protection (PIP) benefits per automobile accident. Qualified Health Plan recipients are entitled to $2,000.

When a provider or independent source notifies BMCHP that TPL exists, BMCHP will take the following action:

- Deny any claims related to the incident received subsequent to verification of TPL.
- Adjust any previously paid claims related to the incident.

**9.9 Claims Submission**

Claims may be submitted on paper via mail, or electronically.

Before submitting a claim, please obtain any required prior authorization, as outlined in [Section 8: Utilization Management and Prior Authorization](#).

**Submitting a paper claim**

Paper claims may be submitted via U.S. mail to the address below for covered services rendered to BMCHP members. Sending claims via certified mail does not expedite claim processing and may cause additional delay.

- **BMC HealthNet Plan**
  - P.O. Box 55282
  - Boston, MA 02205-5282

- **SCO Only:**
  - P.O. Box 55991
  - Boston, MA 02205-5049

Providers must use the CMS-1500 Form to submit paper claims for professional services. The UB-04 Form must be used by providers to submit paper claims for facility services.

A computer-generated claim is defined as a claim form where all required data fields are completed in typed alphanumeric characters. An altered claim is defined as a computer-generated claim with some data fields completed in pen or pencil or crossed out; an altered claim is not considered a clean claim. Claims received with partial handwritten information or crossed-out lines will not be processed by BMCHP.

**Submitting an electronic claim**

BMCHP accepts and process electronically submitted claims in the standard HIPAA-compliant claims format using electronic data interchange (EDI). Submitting electronic claims provides many important benefits compared to paper claims submissions:

- Faster claim turnaround
• Quicker payments
• Fewer keying errors
• Reduced administrative costs for mailings
• Quicker notification of rejected claims

See the Providers page of our website at bmchp.org for more information on electronic claims submission.

When Providers must file a paper claim

In the following situations, a paper claim, instead of an electronic claim, must be filed:

• Your claim requires an attachment (e.g., transactions such as, invoices, or operative reports).
• You are filing a clinical and administrative appeal, even if the claim was originally submitted electronically.

Ways to submit claims electronically

There are two ways providers can submit claims electronically: directly to BMCHP or via a third party. We accept and processes claims electronically from five major clearinghouse entities:

• Capario (formerly known as MedAvant/ProxyMed/MedUnite)
• Emdeon (formerly known as WebMD/Envoy)
• RelayHealth (McKesson, Per-Se)
• The SSI Group
• NEHEN (New England Healthcare EDI Network)

If you or your billing agency uses one of these clearinghouses, you can begin sending electronic claims simply by contacting your clearinghouse representative or customer support line. Providers can also submit claims directly to us using the 837 format. BMCHP will work with you to coordinate electronic claims submission and testing before EDI implementation.

If you have any questions about submitting electronic claims, please contact your dedicated Provider Relations Consultant or call the provider line 888-566-0008 and select the provider services option. You can also get more information about electronic claims submission and detailed instructions for electronic data interchange (EDI) in BMCHP’s EDI Claims Companion Guide available with other EDI information on our website at bmchp.org.

When Providers must submit a claim to a vendor

The following claims must be submitted directly to our subcontract vendor and will not be accepted by BMCHP:

• Behavioral Health: Beacon Health Strategies, LLC - beaconhealthstrategies.com
• Durable Medical Equipment: Northwood, Inc.- northwoodinc.com
• Non-Emergent Transportation: Coordinated Transportation Solutions (CTS) - ctstransit.com
• Dental Services: Dental Services of Massachusetts (DentaQuest) (for SCO only) - dentaquest.com
Time limits on Claims

For MassHealth claims:

Providers must submit initial claims and encounters no later than **150 calendar days from the date of service**, unless you are awaiting a payment and remittance (or explanation of payment) from a primary insurer via coordination of benefits. The paper claim receipt date is the date that the claim is received in our Claims department.

If you receive payment or documentation from another insurer more than 150 days after the date of service, you must send your claim/encounter form and the primary insurer’s remittance advice to us within 150 days of receipt of the remittance advice from the other insurer. Include the Explanation of Benefits or remittance with any claims submitted to BMCHP.

For Qualified Health Plan (including ConnectorCare) claims:

You must submit initial claims and encounters no later than **90 calendar days from the date of service**, unless you are awaiting a payment and remittance (or explanation of payment) from a primary insurer via a coordination of benefits. The paper claim receipt date is the date that the claim is received in our Claims department.

If you receive payment or documentation from another insurer more than 90 calendar days after the date of service, you must send your claim/encounter form and the primary insurer’s remittance advice to us within 90 calendar days of receipt of the remittance advice from the other insurer. Include the Explanation of Benefits or remittance with any claims submitted to us.

If you receive payment from both BMCHP and another payer, you must contact BMCHP’s Coordination of Benefits department regarding any repayment obligations.

Claims submitted for an administrative appeal must be received by BMCHP’s Provider Appeals Unit within the timeframe specified in Section 9: [Timeframes for administrative appeal determination](#). Retrospective adjustment beyond this time period is considered at BMCHP’s discretion, but the adjustment may not exceed **one year from the date of service**.

For Senior Care Options claims:

Providers must submit initial claims and encounters no later than **150 calendar days from the date of service**, unless you are awaiting a payment and remittance (or explanation of payment) from a primary insurer via coordination of benefits. The paper claim receipt date is the date that the claim is received in our Claims department.

If you receive payment or documentation from another insurer more than 150 days after the date of service, you must send your claim/encounter form and the primary insurer’s remittance advice to us within 150 days of receipt of the remittance advice from the other insurer. Include the Explanation of Benefits or remittance with any claims submitted to BMCHP.
9.10 Resubmitting a Claim

A resubmission is any previously filed claim that is resubmitted due to incorrect claims processing by us, or previously denied for additional documentation such as medical records, invoice or itemized bill. For MassHealth and SCO claims, we must receive resubmitted claims no later than 300 days from the date of service. For Qualified Health Plans claims, we must receive resubmitted claims no later than 180 days from the date of service.

Reasons for a resubmission include:

- Failure to match authorization
- Incorrectly keyed line item details
- Incorrectly keyed provider ID number
- Incorrectly keyed member ID number
- Incorrect eligibility dates
- Incorrectly keyed claim coding
- Serial denials or rejections
- Request for itemized bill
- Request for medical records
- Request for invoice

If a claim is considered a resubmission, please indicate at the top of the claim and enclose a copy of the remittance advice with the error highlighted. If you dispute the payment amount of a claim and a discrepancy cannot be identified on the remittance, please contact Provider Services by calling the provider line at 888-566-0008 and selecting the claims option. Contract-related issues should be directed to your designated Provider Relations Consultant.

Payment retraction or adjustment

Payment retractions or adjustments are necessary for many reasons, including when the provider makes an error on a claim, or when BMCHP makes an error during the processing of a claim. We follow industry-standard protocols related to payment retractions and adjustments. If you identify an error, we request that you process the remittance advice and deposit the associated check as payment for those claims processed correctly on the remittance advice. For incorrectly processed claims, please submit the remittance to BMCHP and highlight only those claims that have been processed in error. Providers should note the incorrect payment on the remittance advice. BMCHP will adjust all incorrectly processed claims and retract the overpayments from future remittances. (Please note that if you issue a refund check or return the check issued by us, it will result in delayed payment for you.) If you believe we have underpaid for covered services, you must notify Provider Services or contact your dedicated Provider Relations Consultant regarding a contract or fee schedule dispute. See also, Section 9.3: Affordable Care Act (ACA) grace period for delinquent premium payments – Qualified Health Plans, for Affordable Care Act standards related to retraction of payments for certain Qualified Health Plan members who fail to pay required premium by the end of the payment grace period.

Last updated May 9, 2018
Rejected/denied claims

BMCHP accepts only standard diagnosis and procedure codes in compliance with HIPAA transaction code set standards. Claims containing old codes that have been replaced or deleted will deny and will require resubmission.

Providers must use current CPT-4, place of service, revenue, bill type, and healthcare common procedure coding system (HCPCS) codes in combination with current modifiers. BMCHP will deny any outpatient facility claim submitted with a revenue code if there is no corresponding HCPCS code where required by the National Uniform Billing Committee (NUBC).

The reference number generated during our prior authorization process is not a guarantee of payment. See the guidelines in this section on resubmitting a claim.

The following table summarizes processes related to rejected and denied claims.

<table>
<thead>
<tr>
<th>Rejected Claim</th>
<th>A claim that was not properly submitted cannot be processed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible reasons:</td>
<td></td>
</tr>
<tr>
<td>• The NPI is incorrect, is not listed on the claim or does not match the recorded tax identification number registered in our system. See NPI outlined in this section.</td>
<td></td>
</tr>
<tr>
<td>• BMCHP member’s ID number, name or date of birth are invalid on the claim.</td>
<td></td>
</tr>
<tr>
<td>• The original claim number is not included on a void, replacement or corrected claim.</td>
<td></td>
</tr>
<tr>
<td>• EDI void and replacement requests that do not include the required information, such as the original claim number.</td>
<td></td>
</tr>
<tr>
<td>• Provider Taxonomy code submitted is invalid. See Payment retraction or adjustment in Section 9 (this section) for information on submitting a corrected claim.</td>
<td></td>
</tr>
<tr>
<td>See Payment retraction or adjustment in Section 9 (this section) for information on submitting a corrected claim.</td>
<td></td>
</tr>
</tbody>
</table>
### Denied Claim

After processing properly submitted claims, a claim maybe denied for several reasons, including:

- Is not a clean claim.
- Duplicate claim.
- Claim is filed after the claims submission time limits.
- Member is ineligible for BMCHP benefits at the time of service.
- Procedure code cannot be billed separately from a primary procedure already paid.
- Prior authorization was not obtained for all dates of service or service type.
- Late notification or non-notification of admission.
- Set of invalid or inappropriate procedure, diagnosis and place of service codes, or other required clinical information is not provided.
- Time of admission and/or time of discharge are not provided for inpatient admissions and targeted outpatient services.
- Procedure or instruction is not a covered benefit for the member.
- Invalid procedure and modifier combination is used.
- Billing for newborn is under the incorrect member ID number. See newborn billing guidelines under Section 9: Billing requirements - medical/surgical services. Claim does not meet clinical editing guidelines.

### Administrative Appeals of denied claims

Submit a Request for Claim Review Form available on our website at bmchp.org in writing to BMCHP’s Provider Service Center to the attention of the Provider Appeals department.

For questions about Administrative Appeals, please see Section 10: Appeals, Inquiries and Grievances or call the Provider Service Center at 888-566-0008.

Monday - Friday (except holidays), 8 a.m. to 5 p.m.
Submit a corrected claim
Any previously filed paid or denied claim a provider resubmits with changed or corrected information,

<table>
<thead>
<tr>
<th>BMCHP must receive all corrected claims as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MassHealth and SCO within 150 days of the original</td>
</tr>
<tr>
<td>process remit date, not to exceed 300 days from the</td>
</tr>
<tr>
<td>date of service</td>
</tr>
<tr>
<td>QHP-within 90 calendar days of the original process</td>
</tr>
<tr>
<td>remit date, not to exceed 180 days from the date of</td>
</tr>
<tr>
<td>service.</td>
</tr>
<tr>
<td>Corrected claims are related to one or more of the</td>
</tr>
<tr>
<td>following: Incorrect provider name</td>
</tr>
<tr>
<td>Incorrect member name or member ID number</td>
</tr>
<tr>
<td>Incorrect line item details (e.g., procedures, modifier,</td>
</tr>
<tr>
<td>units, or charges)</td>
</tr>
<tr>
<td>Incorrect place of service</td>
</tr>
<tr>
<td>Providers may not re-submit a claim that was</td>
</tr>
<tr>
<td>rejected for a missing NPI number as a corrected</td>
</tr>
<tr>
<td>claim. Provider must re-bill such claim as a new claim</td>
</tr>
<tr>
<td>with updated information.</td>
</tr>
<tr>
<td>Claims that have been previously denied and are</td>
</tr>
<tr>
<td>being resubmitted with requested information such</td>
</tr>
<tr>
<td>as itemizations, invoices or operative notes, should</td>
</tr>
<tr>
<td>not be submitted as corrected claims. These can</td>
</tr>
<tr>
<td>simply be resubmitted with the additional</td>
</tr>
<tr>
<td>documentation.</td>
</tr>
<tr>
<td>Items submitted for reconsideration of timely filing</td>
</tr>
<tr>
<td>denials, clinical edit denials, or partial payment</td>
</tr>
<tr>
<td>denials are considered Appeals and must be</td>
</tr>
<tr>
<td>submitted with appropriate documentation using the</td>
</tr>
<tr>
<td>Administrative Appeals process outlined in</td>
</tr>
<tr>
<td>Section 10: Appeals, Inquiries and Grievances.</td>
</tr>
<tr>
<td>If a claim is considered a corrected claim, please</td>
</tr>
<tr>
<td>indicate this at the top of the claim and include</td>
</tr>
<tr>
<td>BMCHP claim number, which can be found on the</td>
</tr>
<tr>
<td>remittance advice. Additionally, all corrected claim</td>
</tr>
<tr>
<td>information should be circled when the claim is</td>
</tr>
<tr>
<td>resubmitted. Corrected paper claims that are not</td>
</tr>
<tr>
<td>submitted in this manner may have delays in</td>
</tr>
<tr>
<td>processing.</td>
</tr>
<tr>
<td>The claims submission address for corrected paper</td>
</tr>
<tr>
<td>claims is:</td>
</tr>
<tr>
<td>BMC HealthNet Plan</td>
</tr>
<tr>
<td>P.O. Box 55282</td>
</tr>
<tr>
<td>Boston, MA 02205-5049</td>
</tr>
<tr>
<td>Corrected claims only apply to claims that were</td>
</tr>
<tr>
<td>previously submitted and paid or denied. They do</td>
</tr>
<tr>
<td>not apply to original or first-time submissions.</td>
</tr>
<tr>
<td>The corrected claims must:</td>
</tr>
<tr>
<td>Include the original claim number</td>
</tr>
<tr>
<td>Include an indication of the item(s) needing</td>
</tr>
<tr>
<td>correction</td>
</tr>
<tr>
<td>Not have handwritten changes</td>
</tr>
<tr>
<td>Be submitted within the stated guidelines not</td>
</tr>
<tr>
<td>include any correction fluid on the paper claim.</td>
</tr>
<tr>
<td>EDI can process replacement claims, which allow</td>
</tr>
<tr>
<td>correction of most billing items. For member and/or</td>
</tr>
<tr>
<td>provider changes, however (provider name, NPI</td>
</tr>
<tr>
<td>number, member name, or member ID number),</td>
</tr>
<tr>
<td>process such a change as a void claim with a new</td>
</tr>
<tr>
<td>submission.</td>
</tr>
</tbody>
</table>
### Electronic claims are processed automatically.

Providers should use the “replacement” and “void” options for claims originally submitted to BMCHP electronically, which will help avoid the need to submit corrected claims on paper. Both void and replacement requests must include BMCHP’s original claim number in specified locations as an electronic void or replacement request. Without this information, the claim will be rejected.

### EDI voids and replacements are not accepted in the following situations:

The claim is not at the finished status. Finished claims are those printed on a remittance advice with an assigned claim number, or those claims in the claims inquiry section on the Administrative Resources page at bmchp.org with a status of “finished.” Claims identified with a status of “in process” or “adjudicated” are not considered finished.

The claim is “split” (e.g., a request for a claim that crosses a calendar year span).

EDI void or replacement transactions do not apply to Clinical Appeals, Administrative Appeals, or requests for a claim adjustments (i.e., disputes regarding the original handling of the claim).

Questions should be directed to your assigned Provider Relations Team or BMCHP’s EDI department.

Please refer to the [EDI Guidelines](https://www.bmchp.org) or complete an online request, both available on our website at bmchp.org.

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### Rejected Claim

**A claim that was not properly submitted cannot be processed.**

**Possible reasons:**

- The NPI is incorrect, is not listed on the claim or does not match the recorded tax identification number registered in our system. See NPI outlined in this section.
- BMCHP member’s ID number, name or date of birth are invalid on the claim.
- The original claim number is not included on a void, replacement or corrected claim.
- EDI void and replacement requests that do not include the required information, such as the original claim number.
- Provider Taxonomy code submitted is invalid.

**See Payment retraction or adjustment in Section 9 (this section) for information on submitting a corrected claim.**
9.11 Administrative Appeals

This section applies to all BMC HealthNet Plan products.

If Providers wish to appeal a claim we have denied, submit a Request for Claim Review Form available on our website at bmchp.org. If you have a question about an Administrative Appeal, call the provider line at 888-566-0008 and select option 2 to speak with a Provider Services representative. Staff is available from 8:30 a.m. to 5 p.m., Monday through Friday, except holidays. Providers may submit an administrative appeal to BMCHP if you are requesting that a previously denied claim be overturned due to circumstances outlined below. Providers may request that we review and reconsider an authorization or claim that was denied for an administrative reason rather than for medical necessity of services. The administrative appeal process is only applicable to claims that have already been processed and denied. An administrative appeal cannot be requested for services rendered to a member who was not eligible on the date(s) of service, or for benefits that are not administered or covered by BMCHP. We provide a thorough, timely and unbiased review of an administrative appeal for:

- Claims received outside of the timely filing limit
- Claims denied for not following BMCHP authorization/referral process
- Member eligibility limitation
- Member benefit limitation
- Coding or clinical edit denials

An administrative appeal does not include:

- Standard and expedited internal member appeals.
- Claim adjustment or corrected claim - any previously filed claim that is resubmitted with information that has been changed by the provider.
- Claim resubmission - Any previously filed claim that is resubmitted due to incorrect claim processing by BMCHP.
- Coordination of benefits, motor vehicle accident, and workers compensation appeal.

Level one and level two administrative appeals

We offer two levels of internal administrative review to providers. If the initial review (level one) results in an administrative denial, you have the opportunity to file a second administrative appeal (level two) to us. The Administrative Appeals Committee will review all level-two appeals. All second level administrative appeal decisions rendered by the Administrative Appeals Committee are final decisions by BMCHP.

Information required for administrative appeals

Required documentation

To request an administrative appeal, you must submit the following information within the applicable filing timeframe specified in this section.
• Providers must submit a completed Request for Claim Review Form available on our website at bmchp.org and the form must include an explanation describing the issue related to the administrative appeal submission.

• A separate provider Request for Claim Review Form available on our website at bmchp.org must be supplied for each appeal and may include claims for only one member.

• Providers must submit to BMCHP the required documentation and relevant information related to the administrative appeal. Mail the documents and information to the following address:
  BMC HealthNet Plan
  Attn: Provider Appeals
  P.O. Box 55282
  Boston, MA 02205

BMCHP will reject and return all incomplete appeal submissions.

Required data elements for administrative appeals

The following data elements must be present on the Request for Claim Review Form available on our website at bmchp.org and must be legible:

• Provider name
• BMCHP-assigned provider identification (ID) number/NPI
• Contact name
• Contact telephone number
• Member name
• Member ID number
• Claim number
• Date of service
• Procedure code being appealed
• Charge amount
• Total claim charges
• Denial code

Timeframes for filing an Administrative Appeal

Administrative appeals must be filed with us within 150 calendar days from the original denial date and no later than 300 calendar days from the date of service for our MassHealth and SCO products. The filing limit for claims submission to us is 150 calendar days from either the date of service, the date of hospital discharge or, in the case of multiple insurers, the date of the primary insurer’s explanation of benefits (EOB). An administrative appeal filed after these timeframes will be denied, and BMCHP will be held harmless. Retrospective adjustments (beyond the maximum 300 calendar days) will be denied or considered at BMCHP’s discretion.
Please Note: For QHP Plans, 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. The 90 calendar days are from either the date of service, the date of hospital discharge or, in the case of multiple insurers, the date of the primary insurer’s explanation of benefits (EOB). An Administrative Appeal filed after these timeframes will be denied, and BMCHP will be held harmless. Retrospective adjustments (beyond the maximum 180 calendar days) will be denied or considered at BMCHP’s discretion.

**Recommended documentation for administrative appeals**

To avoid processing delays, BMCHP recommend that providers submit as much documentation as possible that supports the administrative appeal. Additionally, each denial requires specific documentation to substantiate an appeal. Examples of such documentation may include copies of one or more of the following:

- Original explanation of payment (EOP) or remittance advice
- Proof of timely claims submission
- BMCHP reference number
- Surgical/operative notes
- Office visit notes
- Pathology reports
- Medical invoices (e.g., invoices for durable medical equipment or pharmaceuticals)
- Medical record entries

**Documentation checklist sorted by type of administrative appeal**

**Reimbursement appeal**

- Submit a written explanation of the requested change(s) on Request for Claim Review Form available on our website at bmchp.org.
- Attach the remittance advice and identify the claim we should review.
- Attach all supporting documentation in the form of invoices, operative notes, office notes, or any necessary medical record information.

**Claim denied for lack of BMCHP authorization**

- Submit a completed Request for Claim Review Form available on our website at bmchp.org detailing all pertinent information with the necessary clinical documentation;
- Attach a copy of the claim and the remittance advice.
- Authorization-related appeals must demonstrate medical necessity and identify any additional clinical information to us that was not previously provided or used in the initial decision.
- If prior authorization was required but not obtained, you must supply a written explanation of an extenuating circumstance that prevented you from contacting us for prior authorization or extending an existing authorization to cover the date(s) of service for a member’s treatment.
• If prior authorization was required and obtained, you must supply proof to us that you followed our prior authorization procedure. Proper supporting documentation includes a copy of your original information faxed/submitted to us and relevant medical records. Also, please include the reference number received verbally or in writing from us.

BMCHP reviews claims denied for lack of authorization in these situations:

• The member was added retrospectively to BMCHP after the service was rendered.
• The member was added retrospectively to BMCHP during a course of continuing treatment.
• The member has been referred for same day services.
• Gaps in authorization exist for ongoing or continuing outpatient services and when extenuating circumstances exist.
• A service was provided (e.g. by a non-participating provider) that was urgent or emergent in nature and the service is covered by BMCHP. However, there was an auto or manual administrative denial issued. Submit the medical documentation that supports the justification that the requested service was either urgent or emergent.

Other cases that support extenuating circumstances and retrospective review are appropriate.

If one of these criteria is met, BMCHP will review the case and, if approved, we will adjust the claim. Only those services that meet medical necessity criteria which were in place on the date of service will be approved. This applies to all provider requests that do not meet medical necessity review criteria, level-of-care criteria, or medical policy to a BMCHP medical director. When the service is determined to be not medically necessary, the claim denial will be upheld.

Claim denied for submission over the filing limit

An administrative appeal submitted to us due to a claim denial for filing limit violations needs to include a completed Request for Claim Review Form available on our website at bmchp.org and proof of a prior claim submission. The administrative appeal must include one of the following or the appeal will be returned unprocessed:

If the initial claim submission is after the filing limit and the circumstance for the late submission was beyond your control, you may appeal by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing limit. Please include the original claim form. You must send us the appeal within the timeframe specified in this section.

If the member did not identify him/herself as a BMCHP member, you must supply proof to BMCHP that the member had been billed within our timely filing limit.

A provider who submits paper claims must attach the following to be considered acceptable proof of prior submission.

• Computer printout of patient account ledger
• EOB from primary insurer
• Proof that another insurance carrier was billed
A provider who submits electronic claims (either through a clearinghouse or directly to BMCHP) must attach the applicable electronic data interchange (EDI) transmission report. The EDI transmission report will provide proof of prior-submission and indicate that we did not reject the claim.

<table>
<thead>
<tr>
<th>Method of EDI Submission</th>
<th>EDI Transmission Report(s)</th>
<th>EDI Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>WebMD</td>
<td>Submitter Daily Summary and Provider Daily Summary</td>
<td>Claims submitted to WebMD. Claims rejected at WebMD with reject reason.</td>
</tr>
<tr>
<td>Medunite</td>
<td>Claims Audit Report</td>
<td>Claims accepted or rejected at Medunite with reject reason.</td>
</tr>
<tr>
<td>SSI</td>
<td>Report Type Level 1 – EDI Data Center Confirmation</td>
<td></td>
</tr>
<tr>
<td>Directly To BMCHP</td>
<td>Claims Acceptance Acknowledgement</td>
<td>Claims accepted or rejected by BMCHP with reject reason.</td>
</tr>
</tbody>
</table>

NEHEN (New England Health EDI Network) has been added as a vendor specializing in electronic solutions.

Claim denied because member ineligible on the date of service

- Submit a written explanation of the requested change(s) on a completed
- [Request for Claim Review Form](http://bmchp.org) available on our website at bmchp.org.
- If a member becomes retroactively eligible or loses BMCHP eligibility and is later determined to be eligible, the 150-calendar day timely filing deadline begins on the date the member is enrolled in BMCHP.
- Attach the remittance advice and written evidence that the member was eligible for the time period covered by the date(s) of service. A printout from MassHealth EVS or a printout from another agency or organization that is approved to provide eligibility information can suffice as written evidence of eligibility.

Claim denied for coding and clinical editing

Submit a completed [Request for Claim Review Form](http://bmchp.org) available on our website at bmchp.org, detailing all pertinent information, including RA denial code and identify the specific procedure code(s) being appealed, and provide the necessary clinical documentation; E/M encounters require documentation of history, exam, and medical decision-making; documentation must support the levels billed. If you bill for two separate services or procedures, the documentation for each service must be able to stand alone and support that charge. This includes:

- A clear statement of the reason for the encounter
- Appropriate history and physical examination
- Review of any labs, X-rays and other ancillary services
• The reason for and results of diagnostic tests
• Relevant health risk factors
• The member’s progress, including response to treatment, change in treatment, and member’s noncompliance
• Assessment plan of care including treatments and medications (specify frequency and dosage), referrals and consults, member/family education, specific instructions for follow-up, and discharge summary and instructions
• You must attach a copy of the claim and the remittance advice.

**Timeframes for administrative appeal determination**

An appeals coordinator ensures all necessary information is attached to the appeal. Once we reach a decision, we will send you a written notice of determination. If the original claim denial is upheld, a letter will be sent with the reason(s) for the determination. If a claim denial is overturned, your Remittance Advice Summary will indicate that the claim has been adjusted. An Administrative Appeal decision is based on the information available at the time of the review and will **usually be rendered within 30 calendar days of receipt of the appeal.**
9.12 Claims Payment

Inquiring about the status of a claim

Our Provider Services staff is ready to help you with payment issues. Provider Services is a centralized team of highly trained professionals who work with providers to resolve claims-related questions from your first contact through the adjustment process. If you have a claim-related question or payment issue, call the provider line at 888-566-0008 and select the claims status inquiry option.

Online claims status inquiry and remittance advice

It’s easy and fast to find out the status of a claim with your provider login at bmchp.org. Providers will be able to get the following important information on individual claims:

- Claims status inquiry — A printer-friendly version of a claims status inquiry. Once you have entered the claim number and received results on that claim, you can print out a properly formatted document with complete information about the specific claim.
- Remittance advices — An image of the remittance advice. The payment reference ID number will be shown as a link that you can click on to view that remittance. Claim payment remittance images are on file for as far back as 365 days. The remittance advice images can sometimes be large; however, you can use the FIND function within Acrobat Reader to find a specific claim by its claim number, member ID number, or member name. In order to view the remittance advice image, you must have Adobe Acrobat Reader installed on your computer. If you don’t already have this application, you can get a free copy of it from the Adobe website, adobe.com. To access this information online, a provider must have a BMCHP-assigned login ID number and password to ensure that HIPAA privacy standards are maintained for BMCHP members. See Section 5: Provider Resources for information on how a contracted provider may obtain a website login ID number and password. This section also includes a list of additional website features available to participating providers.

Clean Claims Payment

Our goal is to process clean claims and reimburse you within 30 calendar days of receipt of the claim. BMCHP will mail the check to the treating provider who submitted the bill, or issue an electronic funds transfer (EFT) if the provider is enrolled in BMCHP’s EFT program.

Electronic funds transfer (EFT)

EFT is an optional service that permits direct electronic deposit of a BMCHP claims payment. The program is easy, free and saves you time and money. We automatically issue reimbursement directly into the bank account designated by the contracted provider. EFT methods are faster and more secure for moving funds than paper checks. Since our payments are deposited electronically with EFT, there are no deposit slips for you to prepare. Advantages of EFT include:

- Prompt payment – no waiting for checks to clear
- Improved cash flow
• No lost checks or postal delays
• Savings of administrative and overhead costs
• Simplified record keeping
• Reduced paperwork

How to Request payment by EFT

To become an EFT provider, complete an Electronic Funds Transfer Form (EFT) available on our website at bmchp.org. You may also obtain a sample form from your Provider Relations Consultant. Fill out the EFT-1 form and submit it with one of the following forms of documentation from the account in which you wish to receive BMCHP payments:

• Voided check
• Letter from your practice’s bank confirming the ABA transit number and account number
• Letter from you on your practice’s letterhead, signed by an authorized signer, explaining the reason why a voided check cannot be supplied, and confirming the ABA transit number and account number to be used for EFT.

Please be sure all necessary information is legible, and return the documents to your Provider Relations Consultant. After we receive the EFT-1, your Provider Relations Consultant will contact you to verify that the information is complete and correct. You will begin to receive payments via EFT approximately seven to 10 calendar days after this verification has been completed. If you have not begun receiving your payments within 14 calendar days or two check cycles, whichever is later; contact your Provider Relations Consultant.

Providers who enroll in BMCHP’s EFT program will continue to view their remittance advices via BMCHP’s secure online provider portal indicating member names, dates of service, services rendered, and amounts of BMCHP payments. Your bank statement will continue to reflect deposited amounts and dates of deposit.

9.13 Provider Audit

Our Provider Audit department conducts periodic claim audits, which may be conducted onsite at a provider’s location or via desk audit at BMCHP. The purpose of our audits is to:

• Ensure the appropriateness and accuracy of provider billing practices, including but not limited to, consistency between medical record documentation, procedure code selection, where relevant, and provider Charge Description Master (“CDM” “charge master”);
• Evaluate BMCHP and provider compliance with contract rights and obligations related to claims, including, but not limited to, adherence to medical and reimbursement policies;
• Verify the financial accuracy of claims payment

In performing these audits, BMCHP subscribes to the third-party payer bill audit guidelines in the National Health Care Billing Audit Guidelines developed by the American Health Information Management Association, American Hospital Association, Association of Healthcare Internal Auditors,
Blue Cross Blue Shield Association, Healthcare Financial Management Association, and Health Insurance Association of America, unless otherwise specified below or in your contract.

Our policies, including but not limited to medical, authorization, eligibility, claims administration and reimbursement, apply to all audits. In the event we do not maintain a policy regarding a specific subject, we reserve the right to utilize policies or guidance promulgated by such organizations as MassHealth, Centers for Medicare and Medicaid Services (national or local), American Medical Association, American Hospital Association, National Uniform Billing Committee, World Health Organization, Food and Drug Administration, national professional medical societies, and/or recognized anti-fraud organizations.

Further, we conduct DRG Validation Audits, either directly or via a contracted audit agent. The purpose of these audits is to validate the physician’s order for inpatient status, the accuracy of diagnoses and procedure coding, their sequencing and the subsequent DRG assignment, accuracy of discharge disposition, presence/absence of provider preventable conditions, and other factors that may impact DRG assignment and/or payment. The roles of the provider and BMCHP or our contracted audit agent, as described below, are applicable to DRG Validation Audits.

**Provider’s role**

Upon notification by BMCHP of our intent to audit, you are required to do all of the following:

- Designate someone with relevant knowledge and experience to coordinate audit activities.
- Respond to the notification, providing preparatory information such as the itemized bill and/or other documentation requested within the designated time period.
- Notify us at least 10 working days in advance if an onsite audit must be rescheduled or if you are unable to provide documentation for a desk audit within the designated time period. Any such cancelled audits must be rescheduled within 45 days of the initial audit date.
- Provide full, complete clinical (medical) records and any additional documentation that supports the claim(s) in question or helps our auditors understand the exact nature of charges and charge description masters spanning the service dates of the claims at a mutually agreed upon time and location for onsite audits or in the documentation packet for desk audits. Such additional documentation could include, but is not limited to, signed and dated ancillary department records/logs, signed and dated charge tickets, descriptions and provider’s cost of any services, supplies, or implants billed as “miscellaneous” items and, upon request, provider’s inflators (i.e., “mark-up” rates), and policies developed, adopted, and periodically reviewed by clinical staff, as evidenced by dates of implementation and review and signatures of policy owner(s).
- Identify and present, at the beginning of an onsite audit or in the documentation packet of a desk audit, any charges omitted from the final bill or billed in insufficient quantity on the final bill that you would like considered for payment. Under-billed or unbilled charges not presented at the beginning of an audit will not be reviewed or considered for payment.
- Provide a suitable work area for onsite audits.
• Attend an exit conference or, per mutual agreement, receive audit results at the conclusion of an on-site audit or receive audit results via regular or electronic mail at the conclusion of a desk audit.

Respond to initial audit findings within 30 days of the initial Audit Summary Report date, unless otherwise agreed upon in writing in advance.

Submit late charge type bills for any agreed upon previously unbilled or under-billed charges directly to BMCHP’s auditor within 30 days of the initial Audit Summary Report date. Do not submit corrected claims or late charge bills via the usual claims submission process or through Provider Appeals.

**Our Provider Audit Department’s role**

We use a variety of criteria to identify claims for review. We may categorize audits as generic (generally consisting of claims for a variety of services) or focused (generally consisting of claims related to a specific service). In no circumstance does BMCHP pay a fee to conduct an audit or for the copying of records associated with an audit.

**In the performance of these audits, we will:**

• Identify the audit sample using internal criteria and random sampling methodology.

• Select claims for audit with a final bill-paid date that is not more than two years prior to the proposed audit date (unless otherwise agreed to in your contract), except in the case of suspected fraud, waste or abuse, in which case there is no restriction on the look-back period.

• Notify you in writing of our intent to audit not less than 30 days prior to the proposed audit date, providing sufficient information regarding the nature of the audit and the specific claims to be audited as is required to allow you to comply with your responsibilities as described above.

• Employ auditors knowledgeable in clinical practice, coding and billing and possessing the highest degree of integrity and professionalism.

• Verify service descriptions and prices against the charge description master (CDM) in effect on the date of service.

• Accept all documentation that contains sufficient information to identify both the member receiving the service(s) and the individual(s) completing the documentation along with his/her credentials as evidence that a specific service was provided. However, we will not accept amended/altered medical records that are either unsigned, lacking credentials, and/or undated. We will not accept medical records or other documentation amended/altered more than 30 days after the date of service.

• Give you written results at the conclusion of the audit for each claim reviewed, either as an individual initial Audit Summary Report for each claim reviewed on-site or as a combined Audit Summary Report individually detailing the findings for all claims reviewed by desk audit.

• Allow you a response period of 30 days for all claims with audit discrepancies, unless otherwise agreed upon in writing at the time of audit.
• Accept late charge bills submitted within 30 days of the initial Audit Summary Report for any agreed upon previously unbilled or under-billed services/items you identified at the beginning of an onsite audit or submitted with the documentation packet for a desk audit.
• Provide a final Audit Summary Report, one for each claim for which an individual initial Audit Summary Report was presented at the conclusion of an onsite audit or a combined final Audit Summary Report for all claims for which a combined initial Audit Summary Report was presented at the conclusion of a desk audit.

BMCHP’s contracted audit agent’s role
When we utilize a contracted audit agent to conduct DRG validation audits the provider’s role is as described above.

In the performance of these audits, the contracted audit agent will:
• Identify the audit sample using internal criteria and receive approval from us to proceed with the audit.
• Select claims for audit with a final bill-paid date that is not more than two years prior to the proposed audit date (unless otherwise agreed to in your contract) except in the case of suspected fraud, waste or abuse, in which case there is no restriction on the look-back period.
• Notify providers in writing of the agent’s intent to audit no less than 30 days prior to the proposed audit date, providing sufficient information regarding the nature of the audit and the specific claims to be reviewed.
• Employ auditors with expertise in inpatient coding and billing and the highest degree of integrity and professionalism.
• Accept all documentation containing sufficient information to identify both the member receiving the services and the individual completing the documentation and his/her credentials as evidence those specific services were provided. However, the agent will not accept amended/alterned medical records that are either unsigned, lacking credentials and/or undated. The agent will not accept medical records or other documentation amended/alterned more than 30 days after the date of service.
• Provide preliminary written results to providers at the conclusion of the audit.
• Allow providers a response period of 30 days for all claims with audit discrepancies.
• Provide final written results to providers at the conclusion of the 30 day response period.
• Escalate to our Provider Audit department any appeals of the contracted agent’s final response.

In connection with an audit, whether conducted directly by BMCHP or by a contracted agent, we may:
• Expand the scope of the audit if additional areas of concern are identified during the course of an audit.
• Extrapolate findings of an audit sample to a designated universe of claims.
• Adjust or retract claim payments, as indicated on the final written report, via offset of future claims’ payment, identifying audit-related retractions and/or claim adjustments on the remittance advice, or, upon written mutual agreement, accept refund of overpayments.

• Issue a technical denial and retract payment(s) when a provider fails to respond to a request for medical records.

• Escalate the audit to the Special Investigations Unit for further review.

If you dispute the audit findings on a final written report, you may submit an appeal directly to the Provider Audit Department (do not submit as an administrative appeal) within 30 days of the date of the final written report. Your appeal, which must be submitted in writing and identified as a second level appeal, must be accompanied by all clinical documentation related to the audit citation in question, any relevant policies, date-relevant CDM documentation, etc., as previously described, and any other supporting information you would like us to consider. Provider Audit senior management will review your appeal, research the issue(s), and consult BMCHP clinicians and other subject matter experts, as necessary. We will make best efforts to review the appeal and notify you in writing of the final determination within 60 days of receipt of the appeal, provided, however, that we reserve the right to extend the review period if necessary to complete a full and final review. If the review period is extended beyond 60 days, we will notify you in writing of the extension. Our appeal determinations are final. We will process any claim adjustments resulting from the final determination of an appeal within 30 days of the final appeal determination.

9.14 Special Investigations Unit

To combat fraud, waste and abuse (FWA), the Special Investigations Unit (SIU) examines claims data to detect aberrant billing patterns and investigates these patterns as well as referrals made by providers, members and employees, the Provider Audit department, and external sources. Investigations may be conducted as desk reviews or on-site at a provider’s location(s) and such on-site investigations may be announced or unannounced. In all cases, providers agree to cooperate with the investigation including, but not limited to, providing medical records and other documentation or access to them. Neither SIU investigations nor the final determinations of such investigations are subject to limited look back periods or other processes or procedures described elsewhere in this Provider Manual including, but not limited to, administrative or medical necessity appeals.

9.15 Credit Balance

A credit balance occurs when payment for a claim exceeds the contracted rate for that claim. Common overpayment reasons include payments for services for which another payer is primary, incorrect billing, and claim processing errors such as duplicate payments.

Provider’s role

Providers are required to perform due diligence to identify and refund overpayments to BMCHP within 60 days of receipt of the overpayment. Credit balances are usually discovered through a review of your credit balance report and Aged Trial Balance (ATB) report. Providers may either:
• Self-report credit balances by using the Credit Balance Refund Data Sheet available on our website at bmchp.org. All refund and adjustment requests should be directed to the Credit Balance department at:
  BMC HealthNet Plan Credit Balance Department
  529 Main Street, Suite 500
  Boston, MA 02129
  Fax: 617-897-0811

• Or, contact our Credit Balance department at 617-748-6229 to schedule an on-site review of your credit balance reports to identify any overpayments.

Role of our Credit Balance Department
When Providers notify us of an overpayment, we will adjust the claim(s) to reflect the correct payment.

When an onsite credit balance review takes place, whether performed by BMCHP staff or a contractor on behalf of BMCHP, we will take the following steps:

• Review all findings with your designated representative.
• Allow you a 30 day response period.
• Retract any overpaid claims after 30 days in the absence of a response.

9.16 Forms and Instructions
Billing requirements - medical/surgical services:

Providers should reference our Reimbursement Policies for additional details regarding coding specifications, modifiers, payment rules, and other processing rules that may apply to the services and provider types identified below. Failure to follow the terms within these policies may result in full or partial claim denials. Our field level billing requirement for UB-04 and CMS-1500 are available on our website at bmchp.org.

Aging Services Access Points (ASAPs)

ASAPs are non-profit agencies that manage the State’s Home Care Program with delegated authority from the Executive Office of Elder Affairs. ASAPs are responsible for Information & Referral, Screening and Assessment, Service Plan Development, Case Management and Vendor Oversight for the SCO program.

BMCHP reimburses contracted ASAP agencies for Geriatric Support Services Coordination and delivery of services that are approved by the Care Team.

Participating ASAPs may submit electronically per instruction in Section 9.9 or may submit an excel spreadsheet on a monthly basis to Boston Medical Center HealthNet Plan. The excel spreadsheet must be
submitted without any missing or incomplete fields. Incomplete information will cause the claim to be rejected or processed incorrectly. The data fields within the excel spreadsheet include the following:

- ASAP Name
- ASAP Tax ID #
- ASAP NPI
- Billing Date
- Medicaid ID
- Member ID
- First Name
- Last Name
- DOB
- Service From Date
- Service To Date
- Place of Service
- Service Type
- Vendor Name
- Diagnosis Code
- Procedure Code
- Units
- Charge
- Total Charge

Email excel spreadsheets to ASAPBilling@BMCHP.org

If you have any questions about submitting the excel spreadsheet, please contact BMCHP ASAP Program Manager at ASAPBilling@BMCHP.org.

**Ambulatory surgery center – freestanding**

Freestanding ambulatory surgery centers must bill with the outpatient bill type and must bill only those procedures identified in their contractual fee schedule.

**Ambulance transportation**

BMCHP is responsible for the payment of covered emergency transportation.

**Anesthesia services**

Anesthesiologists must bill using the appropriate anesthesia CPT-4 or HCPCS codes and an anesthesia modifier. For anesthesia services, providers should bill using the total number of minutes for the service(s) performed (base units should not be reported); the minutes should be indicated in the units field of the
CMS-1500 Form. Surgeons performing anesthesiology services should bill using CPT-4 codes for anesthesia services.

**Dental services ADA**

Dental Claim Form

BMCHP has partnered with DentaQuest to manage preventive dental service for SCO. Providers are encouraged to use the web portal at [dentaquest.com](http://dentaquest.com) to submit claims; however DentaQuest will also allow claims via clearinghouse and paper. Providers must submit paper claims on an ADA approved claim form. For Dentaquest’s billing information, see the Important Contact Information [Important Contact Information](http://bmchp.org) available on our website at [bmchp.org](http://bmchp.org).

**Durable medical equipment (DME) and medical supplies**

CMS-1500 form

BMCHP has partnered with Northwood, Inc. to manage durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provided by the following provider types for all BMCHP members:

- Breast prosthesis providers
- Durable medical equipment providers
- Emergency response system providers
- Home care providers*
- Home infusion providers*
- Medical supply providers
- Mobility providers
- Ocular prosthetic providers
- Orthotics/prosthetics providers
- Oxygen/respiratory equipment providers
- Pharmacy providers (who distributes/dispenses DMEPOS)
- Sleep study providers**
- Specialty pharmacy providers*
- Speech generating device providers
- Wig providers

*Exception: When these provider types bill for medical supplies and equipment related to infusion, parenteral and tube fed nutrition, BMCHP is responsible to manage and pay for those supplies, equipment and claims. All such claims should be submitted directly to BMCHP and must follow BMCHP’s billing requirements for these services and products.

**Exception: When this provider type bills for professional services supporting sleep studies, BMCHP is responsible for managing and paying for those professional services.

Northwood is responsible for the following services related to DMEPOS when provided by the above provider types:
• Claims processing and adjudication
• Data reporting
• Member and provider services related to DMEPOS requests
• Prior authorization of DMEPOS
• Provider contracting, credentialing and management
• Provider inquiries, grievances and appeals
• Exception: For the SCO products grievances and appeals are managed by BMCHP

Northwood claims submission address can be found in our Important Contact Information sheet, available on our website at bmchp.org.

Early and periodic screening, diagnoses and treatment (EPSDT)  CMS-1500 form

To identify EPSDT services, providers should bill according to BMCHP’s EPSDT Reimbursement Policy at bmchp.org. For behavioral health screenings, use code 96110 with the identified modifiers.

Emergency services  CMS-1500 form or UB-04 form
Family planning services  CMS 1500 form Home health and home infusion services

If home health services are billed on a UB-04 Form, the provider must include the appropriate outpatient bill type for postpartum home visits. The postpartum home visit billing must include the appropriate diagnosis code (V240 to V242), and the service must be billed under the mother’s member ID number.

Inpatient facility services  UB-04 form

Appropriate ICD procedure, diagnosis and current bill type codes are required for proper processing for all inpatient billing. All inpatient and outpatient services billed on a UB-04 form must include a valid revenue code. Most but not all outpatient services must include a corresponding CPT-4/HCPSC code as required by National Uniform Billing Committee rules and specifications. Professional/physician services should be excluded from the UB-04. These services should be billed on a CMS 1500 form.

Laboratory services (free-standing)  CMS-1500 form

Modifiers are required when billing for the technical or professional component of laboratory services unless billing the service globally.

Medications  UB-04 form/CMS-1500 form

See Medication Reimbursement Policy available on our website bmchp.org.

Newborn billing  UB-04 form/CMS-1500 form

Within 24 hours of delivery, all newborn statistical information should be faxed to BMCHP’s Enrollment Department. All completed Notification of Birth (NOB) forms, which are available at bmchp.org, must be faxed to BMCHP’s Enrollment Department at 866-335-9317 (not to the Prior Authorization Department).
For the MassHealth program, the Enrollment Department will create a temporary, BMCHP- specific member ID number (T-number) for the newborn and will fax this information back to the hospital for billing purposes within two business days. The T-number will be the only number required for billing purposes. This will expedite the payment of newborn claims if BMCHP receives all required information. For the Commercial and Qualified Health Plan (including ConnectorCare) programs, a T-number will not be issued; therefore providers must wait for the permanent member ID number to bill for newborn services. See Section 8: Utilization Management and Prior Authorization for authorization guidelines for more information.

**Observation stays**
UB-04 form

See clinical policies for observation services at bimchp.org.

**Occupational therapy**
CMS-1500 form

See reimbursement policies available at bimchp.org to access billing procedures for occupational therapy.

**Optometry services**
CMS-1500 form

VSP Vision Care manages vision benefits for MassHealth BMCHP members. Please forward all claims and find reimbursement information directly from VSP. See the Important Contact Information sheet available on our website at bimchp.org.

**Note:** For Qualified Health (including ConnectorCare) members, VSP will manage BMCHP’s discount program for vision hardware. Please note that VSP is not managing the vision medical benefit. BMCHP’s medical network will be used for the vision medical benefit. See the Important Contact Information sheet available on our website at bimchp.org.

**Note:** For Senior Care Options members vision benefits including vision hardware are managed by BMCHP.

**Physical therapy**
CMS-1500 form

See reimbursement policy available at bimchp.org for billing procedures for physical therapy.

**Podiatry services** (includes foot orthosis)
CMS-1500 form

**Primary care services**
CMS-1500 form

Primary care providers must follow industry standard coding for new and established patient billing, as specified by CPT. Refer to BMCHP’s reimbursement policies on general billing and coding, claim editing and payment accuracy, and general reimbursement for further billing guidance.

**Radiology services (free-standing)**
CMS-1500 form

A modifier is required when billing separately for the technical or professional component of radiology services. Refer to for additional details.

Speech, language and hearing services
CMS-1500 form
Unlisted codes

For procedures with an unlisted code, providers are required to provide an operative note upon billing BMCHP for review, in order for the claim to be paid.

Vaccine and immunization administration

All claims for reimbursement of immunization administration must include the specific antigen code in order for payment to be made. If the antigen is state supplied (SL), use the SL modifier. If the vaccine is not state-supplied, follow the guidelines in BMCHP’s Immunization Reimbursement Policy available at bmchp.org. When billing for multiple vaccine administrations, a provider must use the appropriate administration codes and number of units. BMCHP cannot reimburse higher for a state-supplied vaccine administration than is permitted under federal regulations. See the Immunization Reimbursement policy for billing and reimbursement guidelines for immunizations and vaccines both available at bmchp.org.

CMS-1500 claim form requirements

Providers must bill professional charges, including charges for DME or supplies, on a CMS-1500 Form. Submit claim/encounter forms for all services rendered. Providers can bill multiple dates of service and/or procedures on a single CMS-1500 Form.

The following information is required for every CMS-1500 form submitted for payment:

- Member’s name, address, and BMCHP member ID number.
- Individual servicing provider’s name, address, phone, tax ID number and NPI number.
- Claims submitted without a valid NPI will be returned unprocessed. The provider/facility/supplier NPI number must be placed in block 33 of the CMS-1500 Form.
- Current ICD-10 diagnosis/procedure coding, CPT-4 and/or HCPCS codes, place-of-service codes and units.
- If billing BMCHP as a secondary payer, include a copy of the primary carrier’s explanation of benefits, remittance advice or letter of denial of service.

For additional details on what is necessary for proper claim submission, please see the guidelines outlined above for CMS-1500 form.

Providers must include the required claim data elements identified in the Billing Requirements for Institutional Claims and Billing Requirements for Professional Claims available on our website at bmchp.org.
Section 10: Appeals, Inquiries and Grievances

This section describes our member appeal, inquiry and grievance processes.

10.1 Overview

We have processes for receiving and promptly resolving member inquiries, grievances and appeals, as well as provider requests for clinical reconsiderations of member responsibility denials and administrative appeals (provider appeals). The member appeals process includes the right of a member, or person acting on behalf of the member (Authorized Representative) to use our member appeals and grievances processes. All references to the Office of Medicaid Board of Hearings (BOH) refer to external appeals for MassHealth members. Qualified Health Plans and Commercial plan members must pursue external appeals via the Office of Patient Protection. Under certain circumstances, Senior Care Options members may appeal externally to organizations contracted with the Center for Medicare and Medicaid Services (CMS) and/or the Office of Medicaid Board of Hearings. Member/consumer protections (inquiries, grievances and appeals) differ between MassHealth, Qualified Health Plans/Commercial plans and our Senior Care Options products. This manual section describes these differences.

10.2 MassHealth Appeals: Related Definitions

Below are some definitions to help you understand our processes for certain inquiries, grievances, appeals and other MassHealth-related communications. For example, these definitions are referred to in connection with the following:

- Provider reconsideration requests
- Clinical right to discuss an Adverse Action
- Provider appeals
- Administrative appeal of a previously denied claim (level one and level two)
- Member inquiries
- Member grievances
- Member appeals
- Standard appeal (level one and level two)
- Expedited appeal (level one)
- Medicaid Board of Hearings (BOH) appeal

Authorized Representative

An Authorized Representative is any individual that BMCHP can document has been authorized by the member, in writing, to act on the member’s behalf with respect to a grievance, internal appeal or BOH external appeal. This authorization may remain permanently on file but can be revoked at any time by the member. An Authorized Representative may also include the legal representative of a deceased member’s estate. Providers may act as Appeal Representatives but cannot independently bring standard
internal or BOH external appeals. A provider may request an expedited appeal without the written consent of the member. An Authorized Representative may be a family member, agent under a power of attorney, health care agent under a health care proxy, a healthcare provider, attorney or any other person appointed, in writing, to represent the member in a specific grievance or appeal. We may require documentation that an Authorized Representative meets one of the above criteria.

A member appeal is a request by a member or Authorized Representative for review of an Adverse Action.

**Appeals and Grievances Specialist**

Our Appeals and Grievances Specialist is responsible for coordinating, investigating, documenting and resolving all appeals and grievances. For member appeals, this Specialist acts as a liaison between BMCHP and Office of Medicaid's Board of Hearing for external review appeals.

**Adverse action**

An adverse action is an occurrence that falls into one of the following categories:

- The failure of a provider to deliver BMCHP-covered services in a timely manner in accordance with the access to care guidelines and waiting time standards.
- A BMCHP denial or limited authorization of a requested service, including the determination that a requested service is not a covered service.
- BMCHP reduction, suspension or termination of a previous authorization for a service.
- BMCHP’s failure to act within the required timeframes described in the utilization management timeline policy available on our website at [bmchp.org](http://bmchp.org).
- BMCHP’s failure to act within the required timeframes for reviewing an internal appeal and issuing a decision.
- The denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue. Procedural denials for requested services do not constitute Adverse Actions. These include but are not limited to denials due to the provider’s failure to:
  - follow BMCHP prior authorization procedures
  - follow BMCHP referral rules
  - file a timely claim
  - follow other BMCHP guidelines

**Board of Hearings (BOH)**

The Board of Hearings (BOH) is within the Executive Office of Health and Human Services’ Office of Medicaid and is responsible for reviewing external member appeals.

**Board of Hearings (BOH) Appeal**

An external appeal is available to members who have exhausted our internal appeals process and are requesting an external review. A BOH appeal is a written request to BOH by a member or the member’s Authorized Representative to review a final, internal appeal decision made by BMCHP.
Continuing services
Covered services that we previously authorized and are the subject of an internal appeal or BOH appeal involving a decision by BMCHP to terminate, suspend or reduce the previous authorization. We provide continuing services pending the resolution of the internal appeal or a BOH appeal. Continuing services will be provided if the request is made within 10 calendar days from the date of the Adverse Action.

Date of action
The effective date of an Adverse Action.

Expedited internal appeal
An internal appeal that has been expedited because BMCHP determines, or a physician on behalf of a member asserts, that taking the time for a standard resolution could seriously jeopardize the member’s life or health, or the member’s ability to attain, maintain, or regain maximum function. There is only one level of internal review for expedited appeals.

Final internal appeal
A final internal appeal is a second-level review of a standard internal appeal; or, for a member who waives the second-level internal appeal, it is the first-level BMCHP review of a standard internal appeal.

First-level standard internal appeal
The first-level review of a request by a member or member’s Authorized Representative for review of an Adverse Action.

Grievance
A grievance is any expression of dissatisfaction by a member or an Authorized Representative about any action or inaction by BMCHP other than an Adverse Action. Possible subjects for grievances include, but are not limited to, quality of care of services provided, aspects of interpersonal relationships such as rudeness of a provider, office staff or BMCHP employee, or failure to respect the member’s rights.

Inquiry
An inquiry is any oral or written question by a member to BMCHP’s Member Services Department regarding an aspect of BMCHP’s operations that does not express dissatisfaction about BMCHP.

Provider
Provider refers to an appropriately credentialed and licensed individual, practitioner, physician, healthcare professional, vendor, or facility, agency, institution, organization or other entity that has an agreement with BMCHP for the delivery of services. This manual uses the term “you” synonymously with “provider.”
10.3 Qualified Health Plans (including ConnectorCare) Appeals: Related Definitions

Below are definitions to be used for the Qualified Health Plans (including ConnectorCare) plans sections of this manual.

**Adverse determination**

A BMCHP determination, based on a review of information provided, to deny, reduce, modify or terminate an admission, continued inpatient stay or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness. These are often known as medical necessity denials because in these cases BMCHP has determined that the service is not medically necessary for a member.

**Authorized Representative**

An Authorized Representative is any individual that BMCHP can document has been authorized, in writing, by the member to act on the member’s behalf with respect to all grievances, internal appeals or external appeals. Such standing authorization may be revoked by the member at any time. A member may verbally authorize a practitioner to act on his/her behalf to initiate an appeal, and you may request an expedited appeal without the written consent of the member. A member may be represented by anyone he/she chooses, including an attorney or a provider. An Authorized Representative may be a family member, agent under a power of attorney, healthcare agent under a healthcare proxy, a healthcare provider, attorney or any other person appointed in writing to represent the member in a specific grievance or appeal. We may require documentation that an Authorized Representative meets one of the above criteria.

**Appeals and Grievances Specialist**

Our Appeals and Grievances Specialist is responsible for coordinating, investigating, documenting and resolving all appeals and grievances. For member appeals, the specialist acts as a liaison between BMCHP and the Office of Patient Protection for external review appeals.

**Appeal**

A member appeal is a formal complaint by a member or member’s Authorized Representative about a denial of coverage. There are two types of denials which may be appealed:

**Benefit denial** – A BMCHP decision, made before or after the member has obtained services, to deny coverage for a service, supply or drug that is specifically limited or excluded from coverage in the Qualified Health Plan (including ConnectorCare) member’s applicable Evidence of Coverage (EOC).

**Adverse determination** – A BMCHP decision, based on a review of information provided, to deny, reduce, modify or terminate an admission, continued inpatient stay or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care or effectiveness. These are often known as medical necessity denials because in these cases BMCHP has determined that the service is not medically necessary for the member.
Grievance

A grievance is any formal complaint, oral or written, submitted by a member or member's Authorized Representative, regarding:

BMCHP administration (how BMCHP is operated): Any action taken by a BMCHP employee, any aspect of BMCHP’s services, policies or procedures, or a billing issue.

Aspects of interpersonal relationships such as rudeness of a provider or a provider staff member.

Quality of care: The quality of care a member received from one of our participating providers.

Inquiry

An inquiry is a communication by or on behalf of a member to BMCHP that has not been the subject of an adverse determination and that requests redress of an action, omission or policy of BMCHP. It is any communication by a member to BMCHP asking us to address a BMCHP action, policy or procedure. It does not include questions about adverse determinations, which are BMCHP decisions to deny coverage based on medical necessity.

Office of Patient Protection (OPP)

The office within the Commonwealth’s Health Policy Commission established by M.G.L. c. 111 §217 responsible for the administration and enforcement of M.G.L. c. 176O §§ 13, 14, 15 and 16, and 958 CMR 3.000.

Provider

Provider refers to an appropriately credentialed and licensed individual, practitioner, physician, healthcare professional, vendor, or facility, agency, institution, organization, or other entity that has an agreement with BMCHP for the delivery of services. This manual uses the term “you” synonymously with “provider”.

10.4 Senior Care Options Appeals: Related Definitions

Below are some definitions to help you understand our processes for certain inquiries, grievances, appeals and other Senior Care Options-related communications.

Adverse Action

An Adverse Action is when any one of the following actions or inactions by BMCHP occurs:

- the failure to provide Covered Services in a timely manner in accordance with the accessibility standards;
- the denial or limited authorization of a requested service, including the determination that a requested service is not an Covered Service;
- the reduction, suspension, or termination of a previous authorization by the Contractor for a service;
• the denial, in whole or in part, of payment for a service, where coverage of the requested service
is at issue, provided that procedural denials for requested services do not constitute Adverse
Actions, including but not limited to denials based on the following:
  • failure to follow prior authorization procedures;
  • failure to follow referral rules;
  • failure to file a timely claim;
• the failure to act within the timeframes for making authorization decisions; and
• the failure to act within the timeframes for reviewing a BMCHP Appeal and issuing a decision.

Appeal of Part C Services (Part C appeal)
An appeal of Part C Services is defined as any of the procedures that deal with the review of adverse
organization determinations on the health care services a member believes he or she is entitled to
receive, including delay in providing, arranging for, or approving the health care services (such that a
delay would adversely affect the health of the member), or on any amounts the member must pay for a
service as defined in 42 CFR 422.566(b). These procedures include reconsideration by BMCHP, and if
necessary, an independent review entity (IRE), hearings through the Board of Hearings at EOHHS,
hearings before Administrative Law Judges (ALJ), review by the Medicare Appeals Council (MAC), and
judicial review.
Disputes involving optional supplemental benefits offered by BMCHP will be treated as appeals.

Appeal of Part D Services (Part D appeal)
An appeal of Part D Services is defined as any of the procedures that deal with the review of adverse
coverage determinations made by BMCHP on the benefits under a Part D plan the member believes he or
she is entitled to receive, including a delay in providing or approving the drug coverage (when a delay
would adversely affect the health of the member), or on any amount the member must pay for drug
coverage, as defined in 42 CFR 423.566(b). These procedures include redeterminations by BMCHP,
reconsiderations by the independent review entity (IRE), hearings through the Board of Hearings at
EOHHS, Administrative Law Judge (ALD) hearings, reviews by the Medicare Appeals Council (MAC), and
judicial reviews.

Appeals and Grievances Specialist
Our Appeals and Grievances Specialist is responsible for coordinating, investigating, documenting and
resolving all appeals and grievances. For member appeals, this Specialist acts as a liaison between BMCHP
and the external review organizations.

Authorized Representative
An Authorized Representative is any individual appointed by a member or other party, or authorized
under State or other applicable law, to act on behalf of a member or other party involved in an Appeal or
Grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of a
member or party in obtaining an Organization Determination, Coverage Determination, filing a grievance,
or in dealing with any of the levels of the appeals.
process, subject to the applicable rules described in Sections 2.8 and 2.9 or the SCO Contract and at 42 CFR Part 405.

**Board of Hearings (BOH)**

The Board of Hearings (BOH) is within the Executive Office of Health and Human Services’ Office of Medicaid and is responsible for reviewing external member appeals.

**Board of Hearings (BOH) Appeal**

An external appeal is available to members who have exhausted our internal appeals process and are requesting an external review. A BOH appeal is a written request to the BOH by a member or the member’s Authorized Representative to review a final, internal appeal decision made by BMCHP.

**Complaint Concerning Part C Services**

A Complaint is any expression of dissatisfaction to a BMCHP, provider, facility or Quality Improvement Organization (QIO) by a member made orally or in writing. This can include concerns about the operations of providers of BMCHP such as: waiting time, the demeanor of health care personnel, the adequacy of facilities, the respect paid to members, the claims regarding the right of the member to receive services or receive payment for services previously rendered. It also includes BMCHP’s refusal to provide services to which the member believes he or she is entitled. A complaint can be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate Grievance and/or Appeal process.

**Complaint Concerning Part D Services**

A complaint may involve a grievance, coverage determination, or both. A complaint also may involve a late enrollment penalty (LEP) determination. Every complaint must be handled under the appropriate process.

**Coverage Determination for Part D Services**

A Coverage Determination is any decision made by or on behalf of BMCHP regarding payment or benefits of Part D benefits to which a member believes he or she is entitled.

**Date of action**

The effective date of an Adverse Action.

** Expedited Reconsideration (Appeal) of Part C Services**

An Expedited Appeal is an internal review by BMCHP of a request by a member or Authorized Representative that has been expedited because BMCHP determines, or a physician on behalf of a member asserts that, taking the time for a standard resolution could seriously jeopardize the member’s life or health, or the member’s ability to attain, maintain, or regain maximum function. The timeframe to review and resolve an Expedited Appeal is 72 hours from the time it is received at BMCHP, unless an extension of up to 14 calendar days is necessary.
Expedited Redetermination (Appeal) of Part D Services

An Expedited Appeal is an internal review by BMCHP of a request by a member or Authorized Representative that has been expedited because BMCHP determines, or a physician on behalf of a member asserts that, taking the time for a standard resolution could seriously jeopardize the member’s life or health, or the member’s ability to attain, maintain, or regain maximum function. The Expedited Redetermination timeframe is 72 hours from receipt at BMCHP.

Fast Track Appeal

A Fast Track Appeal is an Expedited Appeal review process conducted by the QIO when a member disagrees that their covered skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) services should end, or when member disagrees with their discharge from an inpatient hospital stay. CMS contracts with Quality Improvement Organizations (QIOs) to conduct fast-track appeals.

Grievance – Part C Services (Part C Grievance)

A Part C Grievance is any complaint or dispute, other than an Organization Determination, expressing dissatisfaction with the manner in which BMCHP or delegated entity provides health care services, regardless of whether any remedial action can be taken. A member or their Authorized Representative may make the complaint or dispute, either orally or in writing, to BMCHP, provider, or facility. An expedited grievance may also include a complaint that BMCHP refused to expedite an Organization Determination or reconsideration, or invoked an extension to an Organization Determination or reconsideration time frame. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Grievance – Part D

A Part D grievance is any complaint or dispute, other than a Coverage Determination or a late determination penalty (LEP) determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D plan sponsor, regardless of whether remedial action is requested. A grievance may also include a complaint that a Part D sponsor refused to expedite a Coverage Determination or redetermination. Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.

Types of Part C and D Grievances

- **Administrative Grievance**: a member Grievance related to billing issues or a member’s dissatisfaction with BMCHP’s staff, policies, processes or procedures or involuntary disenrollment by BMCHP.
- **Expedited Administrative Grievance**: a member Grievance related to BMCHP’s extension of timeframes for Organization Determinations or Reconsiderations (Appeals) or the refusal of BMCHP to grant a request for an expedited Organization Determination, Reconsideration (Appeal), Coverage Determination or Redetermination (Part D Appeal).
- **Clinical Grievance (i.e. Quality of Care Grievance):** a member Grievance regarding the health care and/or services that a member has received or is trying to receive.

- ** Expedited Clinical Grievance (i.e. Expedited Quality of Care Grievance):** a member Grievance regarding a clinical issue of such an urgent nature that it is deemed that a delay in the review process might seriously jeopardize 1) the life and/or health of the member, and/or 2) the member’s ability to regain maximum functioning, or 3) is an issue that poses an interruption in the ongoing immediate treatment of the member.

**Independent Review Entity**

An independent entity contracted by CMS to review BMCHP’s adverse reconsiderations of organization determinations or the denials of coverage determinations.

**Inquiry**

An inquiry is any oral or written request to BMCHP, a provider or facility, without an expression of dissatisfaction, e.g., a request for information or action by a member.

**Medically Necessary Services**

(per Medicare):

- that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y.

(per MassHealth):

- that are provided in accordance with MassHealth regulations at 130 CMR 450.204;

- which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and

- for which there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly. Medically Necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

Services must be provided in a way that provides all protections to the member provided by Medicare and MassHealth.

**Organization Determination**

An Organization Determination is any determination made by BMCHP with respect to the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
• Payment for any other health services furnished by a provider other than BMCHP that the member believes are covered under Medicare, or if not covered under Medicare, should have been furnished, arranged for, or reimbursed by BMCHP.

• BMCHP’s refusal to provide or pay for services, in whole or in part, including the level of services, that the member believes should be furnished or arranged for by BMCHP.

• Reduction, or premature discontinuation of a previously authorized ongoing course of treatment.

• Failure of BMCHP to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.

Provider

Provider refers to an appropriately credentialed and licensed individual, practitioner, physician, healthcare professional, vendor, or facility, agency, institution, organization or other entity that has an agreement with BMCHP for the delivery of services. This manual uses the term “you” synonymously with “provider.”

Quality Improvement Organization (QIO)

A Quality Improvement Organization is an organization comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare members. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for members receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.

Reconsideration

A Reconsideration is a member’s first step in the Part C appeal process after an adverse organization determination; BMCHP or Independent Review Entity may reevaluate an adverse organization determination, the findings upon which it was based, and other evidence submitted or obtained.

Redetermination

A Redetermination is a member’s first step in the Part D appeal process, which involves BMCHP reevaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.

Standard Appeal

A Standard Appeal is an internal Reconsideration or Redetermination by BMCHP of a request by a member or Authorized Representative to review an adverse Organization or Coverage Determination. The timeframe to review and respond is anywhere from 7 to 30 calendar days from date of receipt at BMCHP. Extensions are only allowed for Reconsiderations.
10.5 Clinical Right of a Provider to Discuss an Adverse Action/Determination

Our Medical/Surgical Prior Authorization, Pharmacy Prior Authorization and Inpatient Utilization Management staff are responsible for processing pre authorization (pre-service) requests for all products and concurrent and retrospective authorization requests (when guidelines are met) for MH and QHP products. The staff refers all provider requests that do not meet medical necessity review criteria, level-of-care criteria, or medical policy to BMCHP’s medical director or clinical licensed pharmacist for pharmacy requests for review and determination. Adverse Actions/ Determinations (i.e., authorization denials) resulting from a determination of medical appropriateness or necessity are made by BMCHP’s medical director or clinical pharmacist for pharmacy requests.

At your request and with appropriate documentation, a BMCHP medical director, clinical pharmacist or designee will be available to discuss the adverse action/determination with you. All requests to discuss the adverse action should be sent to us in writing to the attention of the medical director or his/her designee, with any additional clinical information that was not previously provided or used in our decision; this information should be received by our medical director prior to the discussion. Call our provider line at 888-566-0008, and select the appropriate department based on the type of service to be discussed (i.e., Medical Prior Authorization Department, Care Management Department, or Pharmacy Department). This process is not required prior to the member or Authorized Representative filing an internal appeal. The medical director or clinical pharmacist will communicate any recommendation(s) to you for alternative care or an alternative treatment plan for the member, when appropriate.

10.6 MassHealth Member Inquiries, Grievances and Appeals

We have an effective process to respond to member inquiries and grievances, and resolve member appeals in a timely manner. If the inquiry deals with medical necessity or a service coverage issue, we offer the member assistance and inform him/her of the appeals process. If the inquiry cannot be resolved immediately or within one business day, the issue is addressed as a grievance. A member or a member’s Authorized Representative has the right to file a grievance or appeal with us or MassHealth. You may assist in resolving a member issue by furnishing documentation and other information that we request, and may be appointed as an Authorized Representative by the member to act on the member’s behalf regarding a grievance, internal appeal or BOH appeal.

A member or member’s Authorized Representative may submit three types of appeals for Adverse Actions related to medical/surgical and/or pharmacy services covered by BMCHP.

- Standard internal appeal—Level one and level two
- Expedited internal appeal—Level one only
- BOH appeal

An appeal of an Adverse Action is a standard internal appeal or an expedited internal appeal filed with BMCHP by a member or a member’s Authorized Representative. An external review appeal is directed to the BOH and can only be filed after exhausting BMCHP’s internal appeal process and a final internal
appeal decision has been rendered by BMCHP. **Member internal appeals must be submitted to BMCHP within 30 calendar days of the notice of Adverse Action to the member.** We may reject as untimely any BMCHP appeals submitted later than 30 calendar days after the notice of an Adverse Action.

**How a member submits an inquiry, grievance or appeal**

When a member has a concern about the care, service or access to service provided by BMCHP or a participating provider, the member or member’s Authorized Representative may submit an inquiry, grievance or appeal in any of the following ways:

- The member or member’s Authorized Representative may make oral inquiries or file an oral appeal or grievance by calling our Member Services Department at 888-566-0010 or dial 711 for Telecommunications Relay Service. Use of language services is free of charge to the member or member’s Authorized Representative. See [Section 6: Member Information](#) for information on the Member Services Department, including hours of operation and services provided.
- If a minor is able (under the law) to consent to a medical procedure, that minor can request an appeal of the denial of such treatment without parental/guardian consent.
- The member or member’s Authorized Representative may send written appeals and/or grievances to us via fax at 617-897-0805 or by mail to:
  
  BMC HealthNet Plan
  
  Member Appeals and Grievances 529 Main Street, Suite 500
  
  Boston, MA 02129

- The member or member’s Authorized Representative may submit a grievance or appeal to a BMCHP representative in person at a BMCHP office location during regular business hours, 8:30 a.m. to 5 p.m., Monday through Friday (except holidays).
- The member or member’s Authorized Representative may call a health benefits advisor at the MassHealth Customer Service Center. The MassHealth Customer Service Center is available Monday through Friday, 8 a.m. to 5 p.m. (except holidays). See the [Important Contact Information sheet](#) available on our website at [bmchp.org](http://bmchp.org) for the telephone numbers for MassHealth.
- The member or member’s Authorized Representative may submit an external appeal request to the BOH after exhausting the BMCHP’s internal appeal process and only a final internal appeal decision has been rendered by BMCHP. This section provides an overview of the BOH appeals process.
- We will send written acknowledgement of the receipt of any grievance or internal appeal to members and/or Authorized Representatives, if applicable, within one business day of receipt by BMCHP.

We will provide instructive materials and forms to assist a member who submits a grievance or appeal. If the member requests it, we will give him or her reasonable assistance completing the forms and following procedures applicable to the internal appeals process. This includes, but is not limited to,
providing interpreter services free of charge and toll-free numbers with TTY/TDD and interpreter capability.

We will complete the resolution of grievances and send written notice to affected parties, no more than 30 calendar days from the date BMCHP received the grievance. See below for notice of resolution for appeals.

**Monitoring grievances**

We maintain reports of all grievances for trending and analysis. These reports include the following information:

- Member name and ID number
- Date of grievance (when the event occurred)
- Date grievance reported/received by BMCHP
- Type and nature of grievance
- Staff responsible for follow-up
- Date Appeal and Grievance Specialist was contacted
- How grievance was addressed
- Date of correspondence/communication with provider/practitioner
- Resolution
- Date resolution letter sent to member or Authorized Representative
- What, if any, corrective action taken
- Grievance resolution date

We review these data and our grievance policies annually and make any necessary modifications or improvements.

**Monitoring member appeals**

We maintain reports of all Member appeals (including both internal appeals and external appeals submitted to the BOH). These reports include the following information:

- Type and nature of the appeal
- How each appeal was addressed
- Outcome of the appeal
- What, if any, corrective action was taken related to the appeal
- The provider involved in the appeal
- If the service was denied or approved after review of the appeal

We review these data and our appeals policies annually, and make any necessary modifications or improvements.
Standard internal appeal

We offer two levels of internal review for standard appeals. First and second level appeal reviews are conducted by healthcare professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action, and who have not been involved in any prior review or determination of the particular internal appeal and who are not the subordinate of someone who was involved. During the appeal review process, we will consult, if appropriate, with the same or similar board-certified specialty providers who typically treat the medical condition, perform the procedure or provide the treatment involved in the appeal. Information regarding the internal appeal process and the BOH appeal process is included in any notice following the resolution of an Adverse Action or internal appeal. Appeals must be filed by the member or member's Authorized Representative within 30 calendar days of the notice of the Adverse Action or notice of our decision following an appeal. We will not take punitive action against providers who support a member's internal appeal.

Our standard internal appeal process and written notice to affected parties will conclude no more than 40 calendar days from the date we received the member's request for a first-level internal appeal (unless the timeframe is extended). This timeframe excludes the time the member took to file the second-level internal appeal.

We will allow a member or member's Authorized Representative, before and during the internal appeals process, the opportunity to examine the member's case file, including medical records, and any other documentation and records considered during the internal appeals process. We will also allow reasonable opportunity for a member or member's Authorized Representative to present evidence and allegations of fact or law in person as well as in writing.

The timeframe for the standard appeal may be extended for up to fourteen (14) calendar days if the member or member's Authorized Representative requests the extension, or BMCHP can justify to MassHealth, upon request, that:

- The extension is in the member's interest; and
- There is a need for additional information where there is a reasonable likelihood that receipt of this information would lead to approval of the request, if received; and this outstanding information is reasonably expected to be received within five calendar days.

For any extension not requested by the member or member's Authorized Representative, BMCHP will provide the member or member's Authorized Representative with written notice of the reason for the delay. The member or member's Authorized Representative has the right to file a grievance regarding an extension decision made by BMCHP.

We will provide the member with continuing services, if applicable, pending resolution of the first or second-level review of an internal appeal, if the member submitted the request for the first or second level internal appeal within 10 calendar days of the Adverse Action, unless the member specifically indicates that he or she does not want to receive continuing services. If the decision is to uphold the Adverse Action denial, the member may have to pay MassHealth for the cost of the continuing services.
**Expedited internal appeal**

A member or member's Authorized Representative may request an expedited internal appeal after receiving notification of an Adverse Action for urgent or time-sensitive care. See the definitions section above for a definition of an urgent or time-sensitive case eligible for an expedited appeal. We do not require written permission from the member for providers to file expedited appeals on the member's behalf, and we will not take punitive action against providers who request an expedited resolution on behalf of a member.

We offer one level of internal review for an expedited appeal. The review is conducted by a healthcare professional who has the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the adverse action. A determination will be made within 72 hours of the receipt of the expedited internal appeal unless this timeframe is extended as outlined below.

We will allow reasonable opportunity for a member or member's Authorized Representative to present evidence and allegations of fact or law in person as well as in writing. We will also remind a member or member's Authorized Representative of the limited time available for this opportunity in the case of an expedited appeal.

We may reject the request of a member or member's Authorized Representative for an expedited appeal. In the event the request is rejected, BMCHP will:

- Transfer the internal appeal to the timeframe for standard internal appeal resolution, and
- Make reasonable efforts to give the member or member's Authorized Representative oral notice of the denial, and will send written notice within two calendar days.

We may only reject a provider's request on behalf of a member for an expedited appeal if we determine that the request is unrelated to the member's health condition.

The timeframe for the expedited appeal determination may be **extended for up to 14 calendar days** if the member or member's Authorized Representative requests the extension, or if we can justify to MassHealth, upon request, that:

- The extension is in the member’s interest; and
- There is a need for additional information where there is a reasonable likelihood that receipt of this information would lead to approval of the request, if received, and this outstanding information is reasonably expected to be received within 14 calendar days.

For any extension not requested by the member or member's Authorized Representative, we will provide the member or member's Authorized Representative with written notice of the reason for the delay. The member or member's Authorized Representative has the right to file a grievance regarding an extension decision made by BMCHP.

We will provide the member with continuing services, if applicable, pending resolution of the expedited appeal if the member submitted the request for the expedited appeal within 10 calendar days of the
Adverse Action, unless the member specifically indicates that he or she does not want to receive continuing services.

We will notify the member, member's Authorized Representative (if applicable) and treating provider by telephone and in writing of our decision related to the expedited internal appeal. A member or member’s Authorized Representative may submit an external appeal request to the BOH after the resolution of an expedited internal appeal with us.

**Board of Hearings (BOH) appeal**

A member may request an external appeal review with the BOH after we have rendered an internal appeal decision, standard or expedited. The member must file a hearing request within 30 calendar days of BMCHP’s notification of a standard internal appeal denial. Requests for expedited hearings must be filed within 20 calendar days from the date of the BMCHP’s expedited internal appeal denial. We will include the BOH Fair Hearing Application and other instructive materials that the member or member's Authorized Representative may need to complete to request a fair hearing with the BOH. We will assist the member in submitting the BOH appeal request and completing the BOH form if an external appeal is requested by the member or member’s Authorized Representative.

If the member or member’s Authorized Representative does not understand English and/or is hearing or sight impaired, the BOH will make sure that an interpreter and/or assistive device is available at the hearing.

We will make best efforts to ensure that a provider, acting as an appeal representative, submits all applicable documentation to the BOH, the member and BMCHP within five business days prior to the date of the hearing, or if the BOH appeal is expedited, within one business day of being notified by the BOH of the date of the hearing. Applicable documentation will include, but will not be limited to, any and all documents that will be reviewed upon at the hearing.

We will provide the member with continuing services, if applicable, pending resolution of the BOH appeal if the following occurs: the member or member's Authorized Representative submits the request for the BOH appeal within 10 calendar days from the date of the decision on the member's first or second level standard internal appeal of expedited internal appeal. This is unless the member specifically indicates that he or she does not want to receive continuing services. If the BOH appeal decision is to uphold BMCHP’s denial of coverage, the member may have to pay MassHealth for the cost of the continuing services.

We will allow a member or member's Authorized Representative access to the member's appeal files during the BOH appeal process, and we will implement the BOH appeal decision immediately if our decision is overturned.

**Member or Authorized Representative pharmacy copayment appeal process**

A member or member's Authorized Representative may submit a pharmacy copayment appeal to BMCHP if he/she believes that the copayment cap is met earlier than documented by BMCHP. If the member does not agree with our decision, the member or member's Authorized Representative may appeal to BMCHP using the standard internal appeal process outlined in this section (or the expedited internal appeal process also outlined in this section, if necessary criteria are met). A member or member's Authorized
Representative may also request another level of appeal through the BOH. A description of the BOH appeal process is outlined above.

10.7 Qualified Health Plans (including ConnectorCare) Member Inquiries, Grievances and Appeals

Internal inquiry process

An inquiry is any communication the member makes to BMCHP asking us to address a BMCHP action, policy or procedure. An inquiry is a communication by or on behalf of a member to us that has not been the subject of an adverse determination and that requests redress of a BMCHP action, omission or policy. It does not include questions about adverse determinations, which are BMCHP decisions to deny coverage based on medical necessity.

The internal inquiry process is an informal process used to resolve most inquiries. Members or their Authorized Representatives can initiate this process by calling the Member Services Department at 877-492-6967 Qualified Health Plan (including ConnectorCare) members.

The internal inquiry process is not used to resolve concerns about the quality of care received by members or an adverse determination (coverage denial based on medical necessity). If a concern involves the quality of care received from a provider, Member Services will refer the concern directly to its internal grievance process. If a concern involves an adverse determination, Member Services will refer the concern directly to our internal appeals process (see below).

Member Services will review and investigate inquiries and respond to a member or Authorized Representative by phone within three working days. When communicating the findings, Member Services will determine whether the member is satisfied with the outcome. If the member or the member’s Authorized Representative is not satisfied, or BMCHP was unable to resolve the inquiry within three working days, we will offer to start a review of the concern through our formal internal grievance or appeal process (see below). The process used depends on the type of inquiry. If a decision is made not to start a grievance or appeal during BMCHP’s call with the member or Authorized Representative, BMCHP will send the member or the Authorized Representative a letter explaining the right to file a grievance or appeal.

Internal grievance process

We do not use the internal grievance process to resolve complaints about a denial of coverage. We address complaints relating to Adverse Determinations through the internal appeals process. We categorize internal grievances as follows:

- **Administrative Grievances (how BMCHP operates):** Grievances related to billing issues or a member’s dissatisfaction with our staff, policies, processes or procedure that have no impact on the member’s medical care or access to medical care.

- **Clinical Grievances (Quality of Care Grievances):** Grievances relating to the healthcare and/or services that a member received from a BMCHP participating provider or is trying to receive.
**Expedited Clinical Grievances (Expedited Quality of Care Grievances):** Grievances relating to clinical issues of an urgent nature such that it is deemed that a delay in the review process might seriously jeopardize:

- the life and/or health of the member, and/or
- the member’s ability to regain maximum functioning, or is an issue that poses an interruption in the ongoing immediate treatment of the member.

The preferred way for a member or member’s Authorized Representative to file a grievance is to put it in writing and send it to us by postal mail or fax. A grievance also may be delivered in person to one of our offices or may be submitted orally by calling the Member Services Department at 877-492-6967 (Qualified Health Plan, including ConnectorCare, members). If the grievance is filed orally, the Appeals and Grievances Specialist will write a summary of his/her understanding of the grievance and send a copy to the member or member’s Authorized Representative within 48 hours of receipt (unless the time limit is extended by mutual written agreement). This summary will serve as both a written record of the grievance as well as an acknowledgment of our receipt of it. These time limits may be extended by mutual written agreement.

Written grievances should include name, address, BMCHP ID number, daytime telephone number, detailed description of the grievance (including relevant dates and provider names), and any applicable documents that relate to the grievance (such as billing statements). Written grievances should be faxed to 617-897-0805 or postal mailed to:

- BMC HealthNet Plan
- Member Appeals and Grievances 529 Main Street, Suite 500
- Boston, MA 02129

A grievance may be filed any time within 180 days of the date of the applicable event, situation or treatment. We encourage the member or member’s Authorized Representative to file grievances as soon as possible.

Once the written grievance is filed, we send a letter (“acknowledgement”) to the member or member’s Authorized Representative explaining that we have received the grievance. We send this letter within 15 working days of the receipt of the grievance.

If the grievance requires us to review medical records, a signed **Consent Form for the Release of Medical Information**, available at [bmchp.org](http://bmchp.org) must be submitted to us. When signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided. If a **Consent Form for the Release of Medical Information** is not included with the grievance, we will promptly send a blank form to the member or member’s Authorized Representative. If we do not receive this form within 30 calendar days of the date of the grievance, we may respond to the grievance without having reviewed relevant medical information. In addition, if we receive the form but a provider does not give us the medical records in a timely fashion, we will ask the member or Authorized Representative to agree to extend the time limit for us to respond to the grievance. If we cannot reach agreement on a timeline extension, we may respond to the grievance without having reviewed relevant medical information.
All grievances will be processed by an Appeals and Grievances Specialist. Reviews will be performed by appropriate healthcare professionals who are knowledgeable about the type of issues involved in the grievance. Responses will be based on the terms of the Qualified Health Plans Evidence of Coverage, BMCHP’s clinical policies and guidelines, the opinions of the treating providers, the opinions of BMCHP’s professional reviewers, applicable records provided by providers, and any other relevant information available to BMCHP.

We will send a written response to the member or member’s Authorized Representative within 30 calendar days of receipt of the grievance. The 30 calendar day period begins as follows:

If the grievance requires BMCHP’s review of medical records, the 30 calendar day period does not begin until BMCHP receives a signed Authorization to Consent Form for the Release of Medical Information.

If the grievance does not require a BMCHP review of medical records, the 30 calendar day period begins on the next working day following the end of the three working day period for processing inquiries through the internal inquiry process, if the inquiry was not addressed within that time period, or on the day BMCHP was notified of the member’s lack of satisfaction with the response to the inquiry.

These time limits may be extended by mutual written agreement between the member or member’s Authorized Representative and BMCHP. Any extension will not exceed 30 calendar days from the date of the mutual agreement. If BMCHP does not respond to a grievance that involves benefits within the timeframes described in this section, including any mutually agreed upon written extension, the grievance will be deemed decided in the member’s favor. Our written response to a grievance will describe other options, if any, for further BMCHP review of a grievance.

We will not consider a grievance received until it is actually received by us at the appropriate address or telephone number listed. Members are entitled to free access to and copies of any of their medical information related to their grievance that is in BMCHP’s possession and under BMCHP’s control.

Member or Authorized Representative Qualified Health Plan (including ConnectorCare) pharmacy copayment grievance process

A member or member’s Authorized Representative may submit a pharmacy copayment grievance to BMCHP if he/she believes that the copayment cap is met earlier than documented by BMCHP. If the member does not agree with our decision, the member or Authorized Representative may file a grievance with us using the internal grievance process.

Internal appeals process

The preferred way for a member or member’s Authorized Representative to file an appeal is to put it in writing and send it to us by postal mail or fax. The appeal may also be delivered in person to one of our offices or may be submitted orally by calling our Member Services department at 877-492-6967 (Commercial and Qualified Health Plan, including ConnectorCare, members). If a written appeal has been filed, we will send a letter (“acknowledgment”) to the member or member’s Authorized Representative explaining that the appeal has been received. We send this letter within 15 working days of receipt of the appeal. If the appeal is filed orally, the Appeals and Grievances Specialist will write a summary of the
appeal and send a copy to the member or member’s Authorized Representative within 48 hours of receipt (unless the time limit is extended by mutual written agreement). This summary will serve as both a written record of the appeal as well as an acknowledgment of BMCHP’s receipt. These time limits may be extended by mutual written agreement.

Written appeals should include the member’s name, address, BMCHP ID number, daytime phone number, detailed description of the appeal (including relevant dates and provider names), any applicable documents that relate to the appeal, such as billing statements, and the specific result that has been requested. Written appeals can be faxed to 617-897-0805 or mailed to:

BMC HealthNet Plan
Member Appeals and Grievances 529 Main Street, Suite 500
Boston, MA 02129

To submit an appeal in person, a member may go to any of BMCHP’s office locations. Locations are listed in Section 1: General Information of this Provider Manual.

An appeal can be filed at any time within 180 days of the date of the original coverage denial. We encourage members and their Authorized Representatives to file any appeals as soon as possible.

**Release of medical records:** If the appeal requires us to review medical records, a signed Authorization to Consent Form for the Release of Medical Information available on our website at bmchp.org must be submitted to us. This form authorizes providers to release medical information to us. It must be signed and dated by the member or member’s Authorized Representative. If the Consent Form is not included with the appeal, the Appeals and Grievances Specialist will promptly send a blank form to the member or member’s Authorized Representative. This form must be signed and dated by the member or member’s Authorized Representative. When signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided. If we do not receive this form within 30 calendar days of the date of receipt of the appeal, we may respond to the appeal without having reviewed relevant medical information. In addition, if we receive the form but a provider does not give the medical records to us in a timely fashion, we will ask the member to agree to extend the time limit for a response.

All appeals will be processed by an Appeals and Grievances Specialist. Appeal reviews will be performed by appropriate individuals who are knowledgeable about the issues relating to the appeal. Appeals regarding Adverse Determinations will be reviewed by health care professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Determination, who have not been involved in any prior review or determination of the particular appeal and who are not the subordinate of someone who was involved. During the appeal review process, BMCHP will consult, if appropriate, with same or similar, board-certified specialty providers who typically treat the medical condition, perform the procedure, or deliver the treatment involved in the appeal. Decisions will be based on the terms of the member’s Evidence of Coverage, the opinions of the member’s treating providers, the opinions of our professional reviewers, applicable records provided by the member or providers, and any other relevant information available to us.
We will send a written response within 30 calendar days of receipt of the appeal. The 30 calendar day period begins as follows:

If the appeal requires us to review a member’s medical records, the 30 calendar day period does not begin until we receive a signed [Consent Form for the Release of Medical Information](#).

If the appeal does not require us to review a member’s medical records, the 30 calendar day period begins on the next working day following the end of the three working day period for processing inquiries through the internal inquiry process, if the inquiry was not addressed within that time period, or on the day BMCHP was notified that the member was not satisfied with the response to the inquiry.

These time limits may be extended by mutual written agreement. Any extension will not exceed 30 calendar days from the date of the mutual agreement.

No appeal will be considered received by us until it is actually received at our appropriate address or telephone number listed above.

Written responses to Adverse Determinations will explain further avenues of appeal for the member, such as the member’s right to request an External Review from an Independent External Review Agency through the Massachusetts Health Policy Commission/Office of Patient Protection.

If we don’t respond to the appeal within the timeframes described in this section, including any mutually agreed upon written extension, the appeal will be deemed decided in the member’s favor. Members are entitled to free access to and copies of any of their medical information related to their appeal that is in our possession and under our control.

**Expedited internal appeals process**

An expedited appeal is a faster process for resolving an appeal. This faster process can be used when there has been a denial of coverage involving immediate or urgently-needed services. Examples of appeals that are eligible for the expedited appeals process are appeals involving substantial risk of serious and immediate harm; inpatient care; certain durable medical equipment; and terminal illness. Expedited appeals will not be used to review a benefit denial, which is a denial of coverage for a service, supply or drug that is specifically limited or excluded as outlined in the member’s Qualified Health Plans (including ConnectorCare) EOC.

An expedited appeal will be reviewed and resolved within 48 hours if it includes a signed certification by a physician that, in the physician’s opinion, the service is medically necessary; a denial of such service would create a substantial risk of serious harm; and the risk of serious harm is so immediate that the provision of such service should not await the outcome of the standard internal appeals process. The Appeals and Grievances Specialist will make reasonable attempts to notify the member, member’s Authorized Representative, and treating provider orally of decisions involving expedited appeals. The Appeals and Grievances Specialist will also send written resolution to the member and/or member’s Authorized Representative within 48 hours of the request.

**Inpatient care:** The appeal will be expedited if the member is an inpatient in a hospital and the appeal concerns an Adverse Determination by us that inpatient care is no longer medically necessary. This means
we will review and resolve the expedited appeal before discharge. If our decision continues to deny coverage of continued inpatient care, we will send a written decision to the member upon discharge. The Appeals and Grievances Specialist will also make reasonable attempts to orally notify the member, member’s Authorized Representative, and treating provider. If the member is inpatient, a health care professional or a hospital representative may be the member’s Authorized Representative without the member having to complete an Authorized Representative Form.

**Durable medical equipment (DME) needed to prevent serious harm:** The appeal will be expedited if it includes a signed certification by a physician that, in the physician’s opinion: the DME is medically necessary; a denial of the DME would create a substantial risk of serious harm to the member (and describes the harm that will result to the member absent action within a 48 hour period); and the risk of serious harm is so immediate that the provision of the DME should not await the outcome of the standard internal appeals process. The certification must also specify a reasonable time period, not less than 24 hours, in which BMCHP must provide a response. This means we will review and decide the expedited appeal and send a written decision within less than 48 hours of receipt of this certification. The Appeals and Grievances Specialist will also make reasonable attempts to orally notify the member, member's Authorized Representative, and treating provider.

**Terminal illness:** The appeal will be expedited if the member has a terminal illness (an illness likely to cause death within six months) and the member, member’s Authorized Representative, or treating provider submits an appeal for coverage of services. This means we will provide a written resolution within five working days of receipt of the appeal. If our decision continues to deny coverage, the member may request a conference with us to reconsider the denial. We will schedule the conference within 10 days of receipt of the request. If the member’s physician, after consulting with our medical director, decides that the effectiveness of the proposed service would be materially reduced if not furnished at the earliest possible date, we will schedule the hearing within five working days. The member or member’s Authorized Representative may attend the conference. Following the conference, we will issue a written decision. The Appeals and Grievances Specialist will also make reasonable attempts to orally notify the member, member’s Authorized Representative and treating provider.

We will decide all other expedited appeals within 48 hours of receipt. If we do not respond to the expedited appeal within these timeframes, including any mutually agreed upon written extension, the expedited appeal will be deemed in the member’s favor.

If an appeal concerns the termination of ongoing coverage or treatment, the disputed coverage remains in effect at our expense through the completion of the standard internal appeals process or expedited internal appeals process (regardless of the outcome of the process) if all of the following are true:

- the appeal was filed on a timely basis
- the services were originally authorized by BMCHP prior to the member or member's Authorized Representative filing an appeal (except for services sought due to a claim of substantial risk of serious and immediate harm)
- the services were not terminated due to a specific time or episode related exclusion in the member’s EOC
the member continues to be an enrolled member

Reconsideration of a final Adverse Determination

We may offer the member or member's Authorized Representative the opportunity for reconsideration of its final appeal decision on an Adverse Determination. We may offer this when, for example, we received relevant medical information too late for us to review it within the 30-calendar-days’ time limit for standard appeals, or we did not receive it but expect it to become available within a reasonable time following our written decision on the member’s appeal. If the member or member’s Authorized Representative requests reconsideration, the member or member's Authorized Representative must agree, in writing, to a new review time period not to be more than 30 calendar days from the agreement to reconsider the appeal.

Independent external review process

External review process for your appeal: The External Review process allows the member to have a formal independent review of a final Adverse Determination made by us through our standard internal appeals process or expedited internal appeals process. Only final Adverse Determinations are eligible for external review. BMCHP benefit denials (i.e., denials based on coverage limitations and specific exclusions) are not eligible for external review.

External reviews are performed by an independent organization under contract with the Office of Patient Protection (OPP) of the Commonwealth of Massachusetts Health Policy Commission. Members can request the external review or can ask for an Authorized Representative, including a healthcare provider or attorney, to act on the member’s behalf during the external review process. A member may be represented by anyone he or she chooses, including an attorney.

How to request an external review: To request external review, the member or member's Authorized Representative must file a written request with the OPP within four months of receipt of BMCHP’s written notice of the final appeal decision. A copy of the OPP’s external review forms and other information will be enclosed with our notice of its decision to deny a member’s appeal.

Expedited external review: The member or member’s Authorized Representative can request an expedited external review. To do so, a physician must submit a written certification explaining that a delay in providing or continuing the health services that are the subject of the appeal would pose a serious and immediate threat to the member’s health. If the OPP finds that such a serious and immediate threat to the member’s health exists, it will qualify the request as eligible for an expedited external review.

A member or Authorized Representative may file a request for an expedited external review either (1) after receipt of BMCHP’s final written decision on their expedited internal appeal; or at the same time as the member files a request for an expedited internal appeal.

Requirements for an external review: The request must be submitted on the OPP’s application form called External Review Form available on the OPP’s website at mass.gov. We will send the form with the appeal denial response letter. Copies of this form may also be obtained by calling our Member Services
Department at 877-492-6967 (Qualified Health Plans (including ConnectorCare) plans), by calling the OPP at 800-436-7757, or from the OPP’s website at mass.gov/hpc/opp.

- The form must include the member or member's Authorized Representative's signature consenting to the release of medical information.
- A copy of our final appeal decision must accompany the form.

**Coverage during the external review period:** If the subject of the external review involves termination of ongoing services (outpatient or inpatient), the member or member’s Authorized Representative may apply to the External Review Agency to seek the continuation of coverage for the service(s) during the period the review is pending. Any request for continuation of coverage must be made to the review panel before the end of the second working day following the receipt of our final decision about the appeal. The review panel may order the continuation of coverage if it finds that substantial harm to the member’s health may result from termination of the coverage or for such other good cause as the review panel shall determine. The continuation of coverage will be at BMCHP’s expense regardless of the final external review decision.

**Access to information:** The member or member’s Authorized Representative may have access to any medical information and records related to the external review that are in BMCHP’s possession or under BMCHP’s control.

**Review process:** The OPP will screen requests for external review to determine whether the member’s case is eligible for external review. If the OPP determines that the case is eligible for external review, it will be assigned to an External Review Agency that contracts with the OPP. OPP will notify the member, the member’s Authorized Representative (if applicable) and the BMCHP of the assignment. The External Review Agency will make a final decision and send it in writing to the member, member’s Authorized Representative (if applicable), and BMCHP. For non-expedited external reviews, the decision will be sent within 60 calendar days of receipt of the case from the OPP. For Expedited External Reviews, the decision will be sent within four working days from receipt of the case from the OPP. The decision of the External Review Agency is binding on BMCHP.

If the OPP determines that a request is not eligible for external review, the member or member's Authorized Representative will be notified within 10 working days of receipt of the request or, in the case of requests for expedited external review, within 72 hours of the receipt of the request.

How to reach the Office of Patient Protection (OPP):

**Health Policy**

**Commission Office of**

Patient Protection Two
Boylston Street, 6th
Floor Boston, MA 02116

Telephone: 800-436-7757 Fax:-617-624-5046

Last updated May 9, 2018
10.8 **Senior Care Options Complaints, Grievances and Appeals**

We have an effective process to respond in a timely manner to member complaints, grievances, and appeals. If the complaint deals with medical necessity or a coverage issue, we offer the member assistance and inform him/her of the appeals process. You may assist in resolving a member issue by furnishing documentation and other information that we request, and may be appointed as an Authorized Representative by the member to act on a the member’s behalf regarding a grievance, internal or external appeal.

**Member Grievance Process**

The member grievance process begins upon BMCHP receipt of a verbal or written complaint. Members can also file quality of care grievances with the QIO as well as BMCHP.

The preferred way for a member or the member's Authorized Representative to file a grievance is to put it in writing and send it to us by postal mail or fax. A grievance also may be delivered in person to one of our offices or may be submitted orally by calling the SCO Member Services Department at 855-833-8125.

Written grievances should include name, address, BMCHP ID number, daytime telephone number, detailed description of the grievance (including relevant dates and provider names), and any applicable documents that relate to the grievance (such as billing statements). Written grievances should be faxed to 617-897-0805 or postal mailed to:

- **Boston Medical Center HealthNet Plan Senior Care Options**
- **Member Grievances Department 529 Main Street, Suite 500**
- **Boston, MA 02129**

Members, or their Authorized Representatives, may also file a Grievance at any time with CMS.

In addition, whenever BMCHP disapproves a member or an Authorized Representative’s request for an expedited Organization Determination, expedited Coverage Determination, expedited Appeal, or extends the times for resolving an Organization Determination or Reconsideration (Appeal), members or their Authorized Representatives can file an Expedited Grievance.

Grievances are considered according to the following process:

- An Appeals and Grievance specialist acknowledges the receipt of the grievance in writing.
- Grievances are reviewed within thirty (30) calendar days (or within twenty-four (24) hours if the grievance is expedited). Under certain circumstances, grievances may be extended up to 14 calendar days.
- Reviews will be performed by appropriate healthcare professionals who are knowledgeable about the type of issues involved in the grievance.
• If a Grievance is related to the quality of a Provider’s office, BMCHP may conduct an office site visit based on the severity of the issue or if the office site has had two or more similar Grievances within three (3) months or three (3) or more Grievances within six (6) months of the Grievance receipt date.

It is the expectation of BMCHP that you kindly respond to our requests for information relating to grievances in a timely manner.

Member Appeals

Fast Track Appeals

A fast track appeal is when a member disagrees with the coverage termination decision from a SNF, HHA, CORE or upon discharge notification from an inpatient hospital. To initiate a fast track appeal, a member must make their request timely to the QIO, Livanta, LLC, authorized by Medicare to review the aforementioned services. Members and/or Authorized Representatives are given instructions in their discharge notification about how to contact Livanta to initiate the fast track appeal process.

When a member files a Fast Track Appeal, the QIO will notify BMCHP, and BMCHP will notify the facility that the member, or their Authorized Representative, has filed the Appeal. BMCHP will then require a copy of the Notice of Medicare Non-Coverage (NOMNC) or Important Message (IM) and the member’s entire medical record from the facility or agency. Once the information is received it will be reviewed by an appropriate health care professional who will prepare the appropriate response letter being either a Detailed Explanation of Non-Coverage (DENC) or Detailed Notice of Discharge (DNOD). BMCHP will fax to the QIO the applicable notices and complete the medical record the day the Fast Track Appeal is received or by close of business the day before the member is due to be discharged from services. BMCHP may request provider assistance in delivery of the response letter to the member (DENC or DNOD).

Standard and Expedited Reconsideration (Appeal) for Part C Services

BMCHP’s Standard Reconsideration Process is inclusive of one level of appeal and the process may not exceed more than 30 calendar days from the date BMCHP receives the member’s or Authorized Representative’s request for Appeal, unless the timeframe is extended. A Standard Appeal will be considered a final level of internal review. Members or their Authorized Representative may request Standard Appeals. If a member grants permission, a provider may file a Standard Appeal on behalf of the member.

BMCHP’s Expedited Reconsideration Process consists of one level of review and will conclude no more than 72 hours from the time BMCHP received the member’s or Authorized Representative’s request for expedited appeal, unless the timeframe is extended. An Expedited Appeal will be considered a final level of internal review.

Timeframes for Standard and Expedited Reconsideration may be extended for up to 14 calendar days. Extensions may only be granted if:

• The member and/or Authorized Representative requests or voluntarily agrees to the extension, or
• BMCHP can justify (upon request) that the extension is in the member’s interest, and
• There is a need for additional information where:
• There is a reasonable likelihood that receipt of such information would lead to approval of the request, and
• Such outstanding information is reasonably expected to be received within 14 calendar days.

For any extension not requested by the member and/or Authorized Representative, BMCHP shall provide the member and/or Authorized Representative written notice of the reason for the extension. It should be noted that members have the right to file an Expedited Grievance on an extension decision made by BMCHP.

If an Appeal does not qualify for an extension, BMCHP must make the appeal decision within the allotted time frame based on the information available.

BMCHP may dismiss a Standard or Expedited Reconsideration if:

• A person other than the member files the Appeal on the member’s behalf and the member does not submit written authorization for that person to serve as their Authorized Representative prior to the deadline for resolution of the Appeal, or
• BMCHP becomes aware that the member has obtained the service before BMCHP completes its Appeal review
• The member or Authorized Representative filed Standard or Expedited Appeal beyond the 60 calendar day filing limit (60 days from when BMCHP provided the Member notice of the adverse Organization Determination), unless the member shows good cause.

**Standard and Expedited Redetermination (Appeal) for Part D Drugs**

BMCHP’s Standard Redetermination Process is inclusive of one level of appeal and the process may not exceed more than 7 calendar days from the date BMCHP receives the member’s or Authorized Representative’s request for Appeal, unless the timeframe is extended. A Standard Appeal will be considered a final level of internal review.

BMCHP’s Expedited Redetermination Process consists of one level of review and will conclude no more than 72 hours from the time BMCHP received the member’s or Authorized Representative’s request for expedited appeal. Redeterminations may not be extended. An Expedited Appeal will be considered a final level of internal review.

Depending upon play type and service(s) requested, members may be eligible for certain external appeal options. For example, SNP members may be eligible for external appeals through the MassHealth BOH or the CMS IRE, Maximus, or both. The member’s reconsideration and redetermination letters will provide specific instructions on their options and how to proceed if members and/or their Authorized Representative wish to file an external appeal.
10.9 Provider Reviews Related to Inquiries, Grievances, and Appeals

Monitoring provider performance

We monitor the performance of physicians, hospitals and other participating healthcare providers related to member inquiries, grievances, and appeals by:

- Conducting concurrent and retrospective chart reviews
- Reviewing utilization patterns
- Analyzing results of member satisfaction surveys
- Compiling information from member inquiries, grievances, and appeals

Provider quality issues

We routinely send you feedback on a case-by-case basis as we identify quality issues. When we determine that a quality issue exists, the following procedure applies:

- Our quality manager or a BMCHP medical director notifies you of the issue. You must respond orally or in writing to us within 30 calendar days of the notification. Your response is reflected in the final determination of the severity level. The severity rating ranges from “no quality of care issue was identified” to “a quality of care issue with confirmed significant adverse impact to the member.”
- Upon receipt of your response, the medical director and/or the clinician reviewer, in conjunction with you, determines if a corrective action plan is required. Decisions are based on the severity level of the issue and your response.
- The medical director and/or clinician reviewer collaborates with you to develop, implement and evaluate the corrective action plan. Modifications to the plan are made, as appropriate. If you do not comply with the final plan, the medical director may take further action to resolve the concern.
- Based on the severity of the quality of care issue, the medical director may require the Credentialing Committee to conduct an off-cycle review of your practice.

We place documentation in your credentialing file, which we review when re-credentialing you.

For further details about this process, please review Section 14: Quality Management, or call your designated Provider Relations Consultant.
Section 11: Care Management

*Important contact information*

For assistance or to refer a member to our Care Management Program, please call 866-853-5241.

Staff answers and returns calls from 8:30 a.m. to 5 p.m., Monday –Friday. A voicemail box is available for messages, and there are faxing capabilities after hours and on holidays. The Care Management line allows providers to access care management services for members who require medical care management.

For additional information on our Care Management Program, visit bmchp>members>care management program.

We contract with Beacon Health Strategies to manage our behavioral health program. Please direct behavioral health inquiries to **Beacon Health Strategies**:

- Call 855-834-5655 for help finding a network provider 24 hours a day.
- Call the TTY/TDD line at 866-727-9441.
- Visit [beaconhealthstrategies.com](http://beaconhealthstrategies.com) or
- Visit [bmchp.org](http://bmchp.org) and search the provider network.

11.2 Overview of Care Management Services

We understand that a fragmented approach to a member’s health needs does not always provide the best level of care. That’s why our Care Management Model integrates physical, behavioral health services, pharmacy management and wellness programs, enabling us to work with providers to fully respond to all of a member’s healthcare needs.

This collaborative approach helps ensure that we fully assess the member’s overall health status, facilitating coverage for medically necessary services, and advocating for the member as he or she navigates the healthcare system.

**Who is involved?**

The program involves the member, his or her health care provider and the Plan working together so members can reach optimal health. Our care managers and/or Beacon care managers for behavioral health will reach out to members to check on their progress and help coordinate care with all necessary health care providers.

The Care Management staff includes registered nurses, licensed social workers and trained Care Management specialists. We work with members to ensure they understand and can access the right services and information to manage their condition and be as healthy as possible.

**Care Management Services**

BMCHP’s priority is to help members with all their health-related needs. The goal is for members to regain optimum health or improved functional capability and aims to proactively identify and engage
our members, their families and significant supports in a way that integrates CM with medical, social, environmental, behavioral health and community support. We focus on what matters to members, the provider’s care and coordination of services, other Plan resources and departments (Utilization Management, Pharmacy, Member Services, Provider Relations) and maximize value through the most efficient use of available resources and technology, resulting in better health, better experience and better health outcomes. Clinical and/or non-clinical professionals use a multi-disciplinary approach, providing goal oriented and culturally competent services to members. With an emphasis on prevention, self-management, and care coordination across providers and health settings, the approach ensures necessary services by primary care physicians, licensed professionals, agencies and care givers.

11.2 Components of the Care Management Program

BMCHP’s Care Management Program consists of the following components:

- Care coordination for medical, behavioral, and social needs
- Support of patient-centered medical homes and health homes
- Non-emergency medical transportation
- Wellness and prevention programs
- Chronic care management programs
- High cost/high risk member management programs
- Coordination and integration with social services and community care

Identifying members for enrollment in care management

Care Management identifies members for enrollment through different methods, including algorithms based on analysis of medical, pharmacy, radiology, and/or laboratory claims, as well as health risk assessments or referrals from providers. Members are also identified by Plan staff, such as inpatient Utilization Management clinicians, Prior Authorization clinicians, Beacon Health Strategies staff, Northwood staff or member/care-giver self-referral.

Assessing members’ medical, social, and behavioral health needs

Members who agree to participate in care management are assigned a Care Manager and/or community health worker and an assessment is conducted with the member either by phone or in person. The assessments provide direction to develop an individualized and comprehensive person centered plan. Care management collaborates with providers in developing the care plan. This may include interdisciplinary provider and Plan care management meetings with or without the participation of the member.

Individual and comprehensive person-centered care plans include identifying problems, interventions, and goals unique to the individual to meet his/her health needs, with interventions identified through available benefits to the member and community based services. Providers may collaborate in developing the care plan along with the member and primary caregivers.
11.3 Care Management Levels of Intervention and Members Targeted

Our Care Management program includes three levels of intervention:

I. Care management education and wellness

II. Low to moderate risk care management and disease management

III. Complex medical care management

We also have a Senior Care Options program, which provides targeted interventions to members over 65 which we will discuss in the next section.

I. Care management education and wellness

This level of care offers educational coaching and information that helps members successfully manage illness and stay healthy. We coach members and share culturally and linguistically appropriate materials, tools and resources that promote wellness and disease prevention.

Educational initiatives include:

- Smoking cessation program information
- Childbirth education classes
- Nutritional counseling
- Stress management
- The importance of physical activity and self-care training, including self-examination.
- Education on taking over-the-counter and prescribed medications appropriately and how to coordinate these medications.
- Members and caregivers receive personalized information regarding signs and symptoms of common diseases and conditions - such as stroke, diabetes and depression - and their and potential complications. The program focuses on teaching patients the importance of self-managing their own health, along with working with their healthcare provider, in order to accomplish their health-related goals. We emphasize that early intervention and risk reduction strategies can help avoid complications that occur with disability and chronic illness.

As a partner in fostering the health of our members, BMCHP works with providers to integrate health education, wellness and disease prevention into member’s care.

II. Low to moderate risk care management and disease management

This level of care offers population management (disease management), an intermediate-level care management program with a focus on helping members develop self-management skills, arranging services and providing health education for members with specific medical, behavioral and social needs. It level offers a more involved approach where Care Managers work directly with members, either by telephone or in person. They assess a member’s condition, coordinate care and review available benefits.
The Care Manager can help set up services such as family support and community resources. Additionally, the Care Manager develops and implements individualized care plans for each member, emphasizing psychosocial and socioeconomic support, self-management goals, care coordination, ongoing monitoring and appropriate follow-up. The Care Managers assist in coordinating physical, social, and behavioral health services and benefits that will help maintain a member’s optimum health.

Targeted conditions include:

- Asthma (disease management)
- Diabetes (disease management)
- Heart failure
- Chronic obstructive pulmonary disease
- Obesity
- Hypertension
- Depression
- Severe and persistent mental illness (SPMI)
- Severe emotional disturbance (SED)
- Substance Use Disorder

III. Complex medical care management

The complex level of intervention addresses the needs of the highest risk members, who are the most complex members of the Plan’s disease management program. They typically have comorbidities and psychosocial and socioeconomic needs that can significantly diminish their quality of life. They also may be unable to adhere to treatment plans designed by their providers. Care Management staff members use a multidisciplinary approach to comprehensively assess members’ conditions. They conduct face-to-face meetings if appropriate, and with the member’s cooperation, coordinate care through the health care continuum, which helps determine benefits and needed resources, including family and community resources.

An individualized care plan is developed and implemented for each member, emphasizing psychosocial support, socioeconomic support, self-management goals, care coordination, coordinating with staff in other agencies, or community service organizations. The plan also identifies barriers to meeting goals, assesses the member’s ability to comply with treatment goals, provides ongoing monitoring, performs appropriate follow-up and modifies the plan as needed. Care Managers and coordinators work with and educate members to navigate the health care system. Members are provided with information relevant to their needs and stage of readiness, with a goal of averting the need for more intensive medical services.

Medical conditions that may be appropriate for a care management referral include, but are not limited to:

- Cancer
- Bariatric Surgery
- HIV
- CVA or other degenerative neurologic or neuromuscular disorders
- Spinal cord injury/traumatic brain injury/anoxic brain injury
- Members younger than one year old and on synagis or discharged from a NICU or Level II
- Nursery with complex or serious ongoing medical problems.
- Neonatal abstinence syndrome/shaken baby syndrome
- Members with congenital anomalies of the nervous system; encephalopathies, central nervous system tumors or other mass lesions, traumatic brain injury, spinal cord injury, neuromuscular disorders, degenerative neurological, metabolic, or genetic diseases, cerebral vascular accident, advanced/active AIDS, COPD, certain rare diseases such as multiple sclerosis, hemophilia, sickle cell, Parkinson’s, rheumatoid arthritis, myasthenia gravis, Gaucher’s, lupus, dermatomyositis, polymyositis and amyotropic lateral sclerosis.

Indications that a member may benefit from a referral to complex care management for any medical condition (including one managed through a population based program) include, but are not limited to:

- Members who show evidence of having certain functional impairments that impact personal skills and/or clinical needs.
- Members with a high risk score, who are also high cost and/or who have high emergency department, inpatient or pharmacy usage.
- Members who are homeless.
- An illness or event that has caused a change or decline in ability to self-manage.
- 5 or more different specialists.
- An acute inpatient stay with LOS >7 days.
- Multiple admissions/readmissions.

**Maternal and Child Health**

We also offer a comprehensive maternal child health program. This program focuses on prevention through early identification of problems, education and coaching on the expectations of delivering a complex newborn, coordination of prenatal and parenting programs, prenatal and postpartum physician appointments, and coordination of psychosocial and socioeconomic needs. The Care Management team monitors the member’s care during pregnancy and the postpartum period for high risk pregnancies and coordinates care for the complex newborn through the first year of life. This includes providing a care manager nurse for the family who helps determine benefits and needed resources, including family and community resources.

The program also advises members about Plan “extras” such as car seats for infant/toddler MassHealth members, and electric breast pumps, with a prescription for MassHealth members. MassHealth members who complete their postpartum visits between 21 and 56 days are eligible to receive a free box of diapers.
Provider practices must notify our Prior Authorization department of every confirmed member pregnancy in order for members to benefit from participating in the program. For those who receive postpartum visits, if it is determined that the newborn or mother requires urgent or emergent services, the home health provider is required to refer the member to the emergency department after first rendering appropriate care in anticipation of transport. The home health provider is required to refer the member to the PCP if it is determined that the newborn or mother requires physician services during the initial postpartum visit. Decision making (triage) for referral and provision of care under these circumstances is included in the reimbursement for the postpartum follow-up visit.

11.4 Care Management Process
Our Care Management Program uses the care management process with clinical, social, and behavioral health care managers, community health works and coordinators who handle:

1. Assessment
2. Planning
3. Implementation
4. Evaluation

11.5 Community Service Resource Support
Our Care Management Program coordinates access for our members to appropriate community resources such as food stamps, housing and clothing, as well as medically necessary transportation services.

11.6 Contacting the Care Management Staff
BMCHP encourages Providers to contact our Care Management Department during business hours Monday-Friday at 866-853-5241 if you feel a member could benefit from Care Management services.

11.7 Care Transition Team
Comprised of clinicians and non-clinicians, the Care Transitions Team outreaches to members after they are discharged from any setting through the healthcare continuum (acute inpatient, post-acute facilities). The Care Transitions Program aims to meet the goal of reducing inpatient readmission within 30 days for specific targeted conditions showing high rates of readmission. Through the member assessment and individualized plan of care, the program also aims to provide available benefit services and resources to keep the member in the least restrictive setting. The Plan uses evidence-based guidance from the Agency for Healthcare Research and Quality (AHRQ) and Truven Medicaid specific data for the targeted readmission triggers. The team supports member transitions for 31 to 45 days or longer, per member need, by ensuring that members receive and understand their discharge instructions, have a follow-up PCP and/or specialist appointment, have and understand their medications and have transportation to medical appointments. For certain individuals, especially those
discharged on eight or more medications or newly prescribed anticoagulants, a Plan pharmacist may outreach to the member and conduct medication reconciliation. The transition team also:

- Identifies ongoing health issues after discharge.
- Identifies cultural barriers which may impact their health and wellness.
- Contacts the primary care physician for specialist referrals or identified durable medical equipment needs.
- Assists with ordering visiting nurse or personal care attendant referrals.
- Refers to medical, social, or behavioral health care management, or a community health worker for ongoing coordination and educational needs.

11.8 Senior Care Options – Care Management

Overview of the Model of Care

BMC HealthNet Plan (BMCHP) has designed a model of care that enables us to provide comprehensive, coordinated care which integrates Medicare and Medicaid services for individuals age 65 and older. The core elements of the model of care include:

Model of Care Core Elements

- Target population
- Measurable goals
- Primary care teams
- Provider network that address unique needs of target population
- Model of care training for personnel and provider network
- Health Risk Assessment
- Individualized Plan of Care
- Communication network
- Caring for vulnerable populations element
- Performance and health outcome measurement

Goals of the Model of Care

- Increase access to essential services, such as medical, mental health and social services;
- Improve access to affordable care;
- Improve coordination of care through an identified point of contact, improving seamless transitions of care across healthcare settings, providers and health services;
- Improve access to preventative health services;
- Assure appropriate utilization of services;
• Improve beneficiary health outcomes; and
• Facilitate access to Long-Term Support Services.

Senior Care Options Program Description

The Senior Care Options Program is a comprehensive health plan which coordinates both the delivery of Medicare and Medicaid services. Our goal is to provide enhanced care that reduces health disparities, improves health and functionality and supports a person-centered approach to healthcare.

BMC HealthNet Plan’s SCO program addresses the unique and complex needs of each individual, age 65 and older by combining health services with social support services. BMCHP does this by coordinating care and specialized geriatric support services, long term care services, along with respite care for families and caregivers.

Each member who joins BMC HealthNet Plan’s SCO program receives an Individualized Plan of Care (IPC), as well as a devoted team – their Primary Care Team (PCT) -- to manage their specific needs. Our program begins with an individual assessment of each member which forms the basis for the creation of the member’s patient-centered IPC. BMCHP’s SCO Care Manager (CM) convenes the member’s PCT and is responsible for ensuring communication across the team, coordinating relevant information to the Members’ plan of care and including the Member in PCT discussions.

The Primary Care Team

Each member’s specific needs and priorities determine the composition of their PCT. The PCT is responsible for the assessment, coordination and monitoring of a member’s care. The PCT consists of the member, their designated caregivers, BMCHP’s SCO CM, the member’s primary care provider, the member’s long term geriatric support service coordinator (“GSSC“) and other professionals and para-professionals as needed.

Primary Care Provider Role

The PCP and the PCT play a central role in the coordination and provision of care to members. Each BMCHP SCO member has a PCT with the following responsibilities:

• Maintaining the health and wellness of the member;
• Engaging the personnel necessary to support person-centered care;
• Supporting the member’s strengths and expressed preferences and needs; and
• Collaborating to create and execute the member’s Individualized Plan of Care leading to informed decision-making and quality outcomes.

In collaboration with the member’s SCO CM, the PCP is ultimately responsible for organizing and convening the PCT. At any time, if the PCP determines that a member’s health or status requires a reassessment or a change in their care plan, the PCP may convene the PCT by contacting the member’s SCO CM. PCT meetings may range from a single direct conversation between the PCP and the SCO CM (with or without their GSSC), to a conversation between the SCO CM and the GSSC with the member in his or her home. If circumstances warrant, a full meeting convening all of the member’s PCT may occur.
The SCO CM will ensure the convening of all required members of the PCT including for periodic assessments and transitions from one care setting to another.

**Other Members of the Primary Care Team**

The composition of the member’s PCT will vary depending on his or her specific needs, priorities expressed by the member or their caregivers/family, and information provided by the key assessments, the Minimum Data Set (MDS) Plan Health Risk Assessment (HRA), and other sources. Centered around the member, the PCT always includes the PCP, the SCO Care Manager, the member, the member’s primary caregiver/natural support, if applicable, the GSSC, a practice-based care coordinator (if available), and, as appropriate, the SCO Social Work Care Manager, and Behavioral Health Care Manager(s). The SCO CM or the care coordinator is responsible for ensuring communication across the team, coordination of materials, and inclusion of the member in PCT discussions.

Depending on the member’s needs, preferences and priorities, other team members may include: a geriatrician, a registered nurse, a physician assistant, specialists, pharmacists, home care providers, friends/family/informal caregivers, a behavioral health provider, a personal care attendant (PCA), nutritionist, transportation personnel, advocates, State agency and other care managers, and any other person the member wishes to have as part of the team. BMCHP and Beacon medical directors (medical and behavioral health) become ad hoc members of the PCT and provide clinical consultation and guidance to the team. The member can make changes to the members of the PCT at any time.
Participants of the Primary Care Team

- Behavioral Health Care Manager
- Member's Primary Caregiver/Natural Support
- Behavioral Health Medical Director
- Practice-based Care Coordinator
- UM Staff
- SCO Care Manager
- Primary Care Provider
- Pharmacist
- SCO Medical Director
- Geriatric Support Services Coordinator
- Community Relationships & Supports
<table>
<thead>
<tr>
<th>Primary Care Team Member</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>Provide information, advise selection of team members, learn about his or her condition(s) and self-management, participate in Individualized Plan of Care (IPC) development, prioritize goals and adhere to the IPC, as well as bringing any barriers to the attention of the PCT.</td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>Provide care (preventative, acute, chronic), coordinate and arrange care, facilitate communication and information exchange among the member’s various treatment providers and participate on the PCT as a source of information regarding needs, barriers, treatment planning and progress toward goals, care plan development and interaction with the member.</td>
</tr>
</tbody>
</table>
| SCO Care Manager (medical, behavioral, or social) | • Perform or arrange member initial assessment and reassessments.  
• Coordinate, implement, and manage the member’s IPC, work with the member and his or her PCP to facilitate care from specialty, ancillary and tertiary providers, behavioral health providers, and coordinate the member’s Medicare and MassHealth benefits.  
• Facilitate member access to psychosocial supports.  
• Monitor services for quality, appropriate utilization and efficacy and coordinate transitions across the continuum of settings.  
• Foster communication between all PCT parties, including the member. Determine IPC review frequency, which must occur at least every six months.  
• Research and share community resources with members and peers.  
• Promote and encourage member collaboration with the primary care provider, PCT, other health care providers and social services agencies.  
• Assist members in developing wellness strategies and self-management skills to effectively access and use services.  
• Assist the member, when necessary, in placing calls, completing applications, and advocating for available supports/services.  
• Monitor for gaps in care. |
<table>
<thead>
<tr>
<th>Primary Care Team Member</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s Primary Caregiver/Natural Support</td>
<td>Provide information, learn about the member’s condition and its management, participate with the PCT in the development of the IPC and engage with the member and other PCT members to best represent the members’ wishes and preferences.</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>Provide medication reconciliation, member outreach, recommendations to the PCT on member medication management and oversight of the Medication Therapy Management Program, with notification to the PCT.</td>
</tr>
<tr>
<td>Geriatric Support Services Coordinator (GSSC)</td>
<td>Oversee the evaluation, assessment and plan of care functions to ensure that services and supports are delivered and achieve the intended outcomes.</td>
</tr>
<tr>
<td>Community Relationships and Supports</td>
<td>Participate as ad hoc members of the PCT and the member’s IPC to fulfill community-based resources and supports for the member.</td>
</tr>
<tr>
<td>BMCHP’s Medical Directors</td>
<td>Provide ongoing support, which may include clinical consultation, communication facilitation with providers and clinical guidance to the PCT, utilization review and prior authorization determinations.</td>
</tr>
<tr>
<td>Utilization Management (UM) Staff</td>
<td>Provide medical necessity admission review, prior review and authorization of services, where indicated.</td>
</tr>
<tr>
<td>Behavioral Health Medical Director</td>
<td>Provide ongoing support, which may include behavioral health and substance use disorder (SUD) consultation, communication facilitation with providers and behavioral health and SUD guidance to the PCT.</td>
</tr>
<tr>
<td>Other</td>
<td>Other specialists, based on the member’s specific needs and preferences, may include a registered nurse, physician assistant, BH provider, home health nurse or a medical specialist.</td>
</tr>
</tbody>
</table>
Initial Assessment and Individualized Plan of Care

All members residing in a community setting will receive an initial assessment within 30 calendar days of enrollment. Members residing in an institution or for whom institutional placement is pending, will receive their assessments within five (5) business days of enrollment. Ideally, members will be evaluated in their homes because it is the optimal way to develop a holistic understanding of their needs, goals and preferences. Community-dwelling members who decline an in-home evaluation will be offered evaluation at their PCP’s office, adult day center, or other community setting. Members residing in institutional settings will be evaluated in their institution of residence.

BMCHP uses the Minimum Data Set-Home Care (MDS-HC) and a BMCHP-developed Health Risk Assessment (HRA) to assess community-dwelling members. Members residing in institutional settings are evaluated using the Minimum Data Set-3.0 (MDS-3.0).

The PCP is also responsible for completing a medical history, physical exam and evaluation to provide current diagnoses, medications and a medical treatment plan. When combined with the member’s MDS/HRA, the PCT will have a complete set of information on which to develop the member’s IPC. A member’s individual plan of care is developed within 30 calendar days of the completion of their assessments. Once the member’s IPC is developed, it must be agreed to and signed by the member or their designated representative. The member or their designated representative will receive a copy of the signed IPC.

Members will be assessed and their IPC updated at least every six months, or more frequently as needed to include when the member experiences a major change that is:

a) Not temporary;

b) Impacts more than one area of health status; and

c) Requires interdisciplinary review or revision of the IPC.

Members with Alzheimer’s/Dementia, Chronic Mental Illness and who are Nursing Home Certifiable or at end of life will be assessed quarterly and have their IPC updated. Specific attention will be paid to member assessments, member/caregiver feedback, and IPC progress on reaching member goals. Additional assessments and potential changes in a member’s IPC are triggered by changes in enrollment status, hospital admission or other transition, or at the request of the PCP, any member of the PCT, or the Member/family. These comprehensive initial and ongoing assessments are a key part of BMCHP’s efforts to identify and meet the member’s care needs.

Member IPCs are available electronically to the member and to their PCT through BMCHP’s Centralized Enrollee Record. Members may also call the customer concierge line at BMCHP to have a copy of their IPC mailed or faxed to them.

Who is responsible for care coordination?

BMCHP’s SCO care manager holds primary responsibility for care coordination of the member and will ensure the coordination of all communication with the member’s PCT. Care Managers are licensed
Registered Nurses. The BMCHP CM will work collaboratively with the Behavioral Health CM, the Social CM, GSSC, practice-based CM (if one exists), UM staff, care coordinator, and all members of the PCT to ensure all needs of the member’s IPC are coordinated.

11.9 Care Management Process

Care management is an on-going process.

- The PCT is used through the assessment and reassessment process and during PCT meetings, to coordinate the Member’s care.

- The Care Manager is responsible for ongoing communication between PCT meetings, for coordinating with providers and programs needed to support the Member. When socioeconomic needs are identified as part of the IPC, the CM may use a BMCHP Social CM to support members in overcoming barriers to include working with housing organizations in placing members into permanent housing. In the event behavioral health issues are the primary concern for the member, the behavioral health Care Manager may assume responsibility for coordinating care across all behavioral health and SUD providers and programs. The BH care managers will provide the ongoing coordination of the behavioral health goals, interventions, and provider contact when needed, documenting the coordination between the PCP, PCT and the behavioral health providers. Recommended treatment referrals will be coordinated with the BMCHP CM, Member, caregiver/family, and members of the PCT.

Members have continual access to their IPC and can contact a PCT member directly at any time about their IPC, or work more centrally through their Care Manager or PCP. BMCHP’s BH Care Manager may use community outreach workers to support Members in non-clinical ways, such as regular meetings with transient members at homeless shelters or community centers.

Members who refuse involvement or cannot be reached

Some members may refuse care coordination and/or care management services or cannot be reached, despite our best efforts. In these instances, each member will still have an IPC developed by collecting information from providers, prior authorization information, and medical, behavioral health and pharmacy claims data. The IPC will be developed and communicated to the member’s PCP and other PCT members.

Coordination with Community Care Facilities

Based on the individual needs of each member, the PCT will work with Social CMs and others to tailor services to individual needs and ensure we reach individuals who may be transient. This includes nursing homes, long-term care facilities, substance abuse treatment program and mental health facilities. If a member’s IPC calls for coordination with community care facilities, professionals from those facilities may be part of the PCT as necessary.
Section 12: Behavioral Health Management

Helpful contact information
We contract with Beacon Health Strategies (Beacon) to manage our behavioral health program. For more information:

- Refer to the Beacon-BMC HealthNet Plan Policy and Procedure Manual available from Beacon at beaconhealthstrategies.com > providers > provider tools. Under “plan name” enter “BMCHP” > bulletins & manuals > provider manual; or
- Call Beacon at 866-444-5155.

Providers should contact our behavioral health service line – staffed by Beacon representatives

- at 866-444-5155 for the following:
  - prior authorizations
  - concurrent reviews (MassHealth, QHP)
  - care management
  - reporting behavioral health adverse Incidents 24 hours a day, seven days a week.
  - Behavioral health services
  - Beacon-BMC HealthNet Plan policy and procedure manual
  - Detailed description of each level of care
  - Level of care clinical criteria
  - All claims submission information, including companion guides, information on eServices and EDI services.

12.1 Overview
Beacon is responsible for managing all aspects of our behavioral health program for all members, including:

- provider credentialing and contracting
- claims processing and adjudication
- quality management and improvement
- medical management/utilization review
- member grievances and appeals (except for Senior Care Options which are managed directly through BMCHP See Section 10: Appeals, Inquiries and Grievances
- member services
- management of CBHI services (for MassHealth members only)
Behavioral health providers must contract with and be credentialed **by Beacon** in order to provide services to our members. Providers may access the Beacon-BMC HealthNet Plan Policy and Procedure Manual by visiting beaconhealthstrategies.com > Providers > Provider Tools > Under “Plan Name,” enter “BMC HealthNet Plan” > Bulletins and Manuals > Provider Manual.

We and Beacon have designed a Behavioral Health Management Program to guide and support providers in delivering and coordinating care for our members. This program is part of our Health Services Program described above.

**Beacon’s contact information**

<table>
<thead>
<tr>
<th>Beacon’s website</th>
<th>Visit beaconhealthstrategies.com.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health provider line</td>
<td>Call 866-444-5155</td>
</tr>
<tr>
<td>Behavioral health preauthorization</td>
<td>Call 866-444-5155</td>
</tr>
<tr>
<td>Behavioral health CBHI team</td>
<td>Call 866-444-5155 (MassHealth only)</td>
</tr>
<tr>
<td>Behavioral health member lines</td>
<td>Call 888-217-3501 (MassHealth, CarePlus)</td>
</tr>
<tr>
<td></td>
<td>Call 877-957-5600 (Qualified Health Plans, including Connector Care)</td>
</tr>
<tr>
<td>Behavioral health member TTY/TDD line</td>
<td>Call 711</td>
</tr>
</tbody>
</table>

Forms: The [Combined MCE Behavioral Health Provider/Primary Care Provider Communication form](#).

For emergency behavioral health services, contact your local Emergency Services Program, listed Section 12:4 Emergency Service Program (ESP) Providers, 24 hours/day:

**BehavioralHealthDepartment activities**

A range of emotional, social and behavioral issues pose a major threat to the overall health and quality of life of some BMCHP members. Therefore, our behavioral health program, managed by Beacon, plays a central role in overseeing and managing the mental health and addiction treatment needs of members, as well as coordinating these needs with medical services. Behavioral health activities focus on:

- Evaluating behavioral health services based on clinical criteria.
- Coordinating effective and efficient care through our continual review process if additional behavioral health services are required beyond those given prior authorization by Beacon.
- Using care management approaches to tailor services to our members’ needs, considering their medical and behavioral health conditions.
• Ensuring that our members’ care is provided in a context of cultural and linguistic competency to the greatest extent possible.
• Monitoring members closely whose level of acuity and/or utilization patterns suggest a need for additional assistance and care coordination.
• Developing and maintaining contractual arrangements with available community resources and providers that represent a full continuum of mental health and substance abuse care.
• Working collaboratively with providers to coordinate members’ care; and providing timely and accurate information in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
• Utilization management decision-making is based on the appropriateness of care and service, and the applicable member benefits. Neither BMCHP nor Beacon provides financial or other types of incentives to providers, practitioners, employees or other individuals for issuing denials of coverage or services.

PLEASE NOTE: All inpatient and outpatient behavioral health services rendered by non-participating providers require prior authorization from Beacon, except for emergency services.

**BMCHHealthNetPlan requirements by categories of care**

BMCHP notification, prior authorization, coordination of care, and discharge planning are essential elements of care management, and are described in detail in the Beacon-BMC HealthNet Plan Policy and Procedure Manual available via Beacon at beaconhealthstrategies.com. Our behavioral health program covers the following major categories of care:

• Inpatient/diversionary services for mental health
• Inpatient/diversionary services for addiction treatment
• Outpatient mental health and addiction services
• Psychiatric consultation on medical units
• Emergency services
• Children’s Behavioral Health Initiative (CBHI) (for MassHealth members only)

Each category of care requires effective and timely discharge planning by the treating provider. We review all clinical decisions using our behavioral health clinical criteria. For additional information, including a detailed description of each level of care in the behavioral health system and the level of care clinical criteria, please refer to the Beacon–BMC HealthNet Plan Policy and Procedure Manual available from Beacon at beaconhealthstrategies.com, or contact Beacon directly at 866-444-5155.

### 12.2 Communication and Coordination of Member Treatment

BMCHP and Beacon collaborate with you to manage the care of members and ensure that each member’s needs are met in the setting most clinically appropriate, considering both behavioral and medical needs. We are committed to improving the quality of care delivered to our members. Toward that end, for SCO if
applicable, the Behavioral Health providers would be part of the care team as described in Section 11: Care Management. For MassHealth, Care Plus and QHP we have joined with the other managed care organizations in Massachusetts to develop a joint Combined MCE Behavioral Health Provider/Primary Care Provider Communication form to increase the frequency and the quality of the content of communication between behavioral health clinicians and PCPs. With informed member consent, this form can be used by PCPs and by behavioral health providers to communicate with one another. The advantages of using only one form include:

- Less administrative burden for providers—one form limits the time needed to locate the correct form and link to the member’s health plan.
- Consistency in the provision of information shared between behavioral health providers and PCPs.
- Clear and consistent information request and exchange, resulting in timely collaboration
- The “two-way” communication form can be faxed (along with appropriate documentation from the member for release of information) and can be easily placed in the member’s record.

Access the Combined MCE Behavioral Health Provider/Primary Care Provider Communication form available on our website at bmchp.org.

### 12.3 Beacon – Claims and Provider Contracting

#### Claims

Claims for behavioral health services rendered to our members must be submitted directly to Beacon within 60 days of the date of service as follows:

Through Beacon’s EDI Gateway and eService’s electronic transaction portal, available at beaconhealthstrategies.com > For Providers > e-Services.

For all information for claims submission, including companion guides, information on eServices and EDI services, visit beaconhealthstrategies.com Providers > Claims.

#### Contracting and Credentialing

Providers interested in joining the Beacon provider network to provide services to our members must contact Beacon’s Provider Relations department directly to inquire about credentialing and other network participation requirements, including execution of a Provider Service Agreement. Call Beacon’s Provider Relations department at 781-994-7556.

### 12.4 List of Emergency Services Programs (ESPs)

The following is the most up-to-date listing of behavioral health Emergency Services Programs (ESPs) in Massachusetts. Office hours may differ but services are available 24 hours a day, seven days a week.
Emergency Service Program (ESP) Providers

No prior authorization is needed in an emergency situation. If a member is having a mental health crisis or emergency, contact one of the ESP’s listed below by region:

<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Operating Hours</th>
<th>Cities/Towns in Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>BEST Community-Based Location 85 E. Newton Street Boston, MA 02118 Call 617-414-8336 Fax 617-414-8333</td>
<td>7 a.m. – 11 p.m. weekdays 9 am. – 5 p.m. weekends</td>
<td>Boston (Dorchester, South Boston, Roxbury, West Roxbury, Jamaica Plain, Mattapan, Roslindale, Hyde Park, Lower Mills), Brighton, Brookline, Charlestown, Chelsea, East Boston, Revere and Winthrop.</td>
</tr>
<tr>
<td>BEST- Community-Based Location 25 Staniford Street Boston, MA 02114 Call 617-523-1529 Fax 617-523-1207</td>
<td>7 am. – 5 p.m. weekdays</td>
<td></td>
</tr>
<tr>
<td>Best/Boston Medical Center 818 Harrison Ave Boston, MA 02118 Call 617-414-7612 Fax 617-414-4209</td>
<td>24/7</td>
<td></td>
</tr>
<tr>
<td>BEST/Mass General Hospital 55 Fruit Street Boston, MA 02114 Call 617-726-2994 Fax 617-724-3727</td>
<td>24/7</td>
<td></td>
</tr>
</tbody>
</table>
### BEST Community Crisis Stabilization Program

**Address:**
- 20 Vining St.
- Boston, MA 02118

**Contact Information:**
- Call: 617-371-3000
- Fax: 617-516-5070

**Operating Hours:** 24/7

### BEST Community Crisis Stabilization Program

**Address:**
- 85 E. Newton Street Boston, MA 02118

**Contact Information:**
- Call: 617-371-3000
- Fax: 617-414-8319

**Operating Hours:** 24/7

### METRO BOSTON

**Area:** Cambridge/Somerville

**ESP Provider:** Boston Medical Center/Cambridge Somerville Emergency Services Team (C.S.E.S.T.)

**24-hour access number:** 800-981-4357

<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Operating Hours</th>
<th>Cities/Towns in Area</th>
</tr>
</thead>
</table>
| CSEST Community-Based Location 660 Broadway Somerville, MA 02145 | 7 a.m. – 11 p.m. weekdays  
11 am. – 7 p.m. weekends | |
| CSEST/Cambridge Hospital 1493 Cambridge Street Cambridge, MA 02139 | 24/7 | |
## CSEST Community Crisis Stabilization Program

660 Broadway  
Somerville, MA 02145  
Call 617-616-5472  
Fax 617-623-1817

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### METRO BOSTON

**AREA: Norwood**  
**ESP Provider: Riverside Community Care**  
**24-hour access number: 800-529-5077**

<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Operating Hours</th>
<th>Cities/Towns in Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Riverside Community Based Location</td>
<td>8 a.m. – 8 p.m. weekdays</td>
<td>Canton, Dover, Foxboro, Medfield, Millis, Needham, Newton, Norfolk, Norwood, Plainville, Sharon, Walpole, Wellesley, Weston, Westwood and Wrentham.</td>
</tr>
<tr>
<td>190 Lenox Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norwood, MA 02062</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 781-769-8674</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 781-440-0740</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Riverside Community Based Location</td>
<td>8 a.m. – 8 p.m. weekdays</td>
<td>24 hours weekends</td>
</tr>
<tr>
<td>15 Beacon Ave</td>
<td>24 hours weekdays</td>
<td>Canton, Dover, Foxboro, Medfield, Millis, Needham, Newton, Norfolk, Norwood, Plainville, Sharon, Walpole, Wellesley, Weston, Westwood and Wrentham.</td>
</tr>
<tr>
<td>Norwood, MA 02062</td>
<td>24 hours weekends</td>
<td></td>
</tr>
<tr>
<td>Call 781-769-8674</td>
<td>24 hours weekends</td>
<td></td>
</tr>
<tr>
<td>Fax 781-769-6072</td>
<td>24 hours weekends</td>
<td></td>
</tr>
<tr>
<td>Riverside Community Crisis Stabilization Program</td>
<td>24/7</td>
<td></td>
</tr>
<tr>
<td>15 Beacon Ave</td>
<td>24/7</td>
<td>Canton, Dover, Foxboro, Medfield, Millis, Needham, Newton, Norfolk, Norwood, Plainville, Sharon, Walpole, Wellesley, Weston, Westwood and Wrentham.</td>
</tr>
<tr>
<td>Norwood, MA 02062</td>
<td>24/7</td>
<td></td>
</tr>
<tr>
<td>Call 781-769-1342</td>
<td>24/7</td>
<td></td>
</tr>
<tr>
<td>Fax 781-769-0197</td>
<td>24/7</td>
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</tr>
<tr>
<td>Service Locations</td>
<td>Operating Hours</td>
<td>Cities/Towns in Area</td>
</tr>
<tr>
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</tr>
<tr>
<td>354 Waverly Street Framingham, MA 01702</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 508-872-3333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 508-875-2600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocates-Community Based Location</td>
<td>24/7</td>
<td></td>
</tr>
<tr>
<td>28 Mill Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marlboro, MA 01752</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 508-786-1584</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 508-786-1585</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocates-Community Based Location</td>
<td>24/7</td>
<td></td>
</tr>
<tr>
<td>675 Main Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waltham, MA 02451</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 781-893-2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 508-647-0183</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocates Community Crisis Stabilization Program</td>
<td>24/7</td>
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<tr>
<td>28 Mill Street</td>
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<td></td>
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<tr>
<td>Marlboro, MA 01752</td>
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<td></td>
</tr>
<tr>
<td>Call 508-786-1580</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Central Massachusetts Area: North County
**ESP Provider:** Community HealthLink, Inc.  
**24-hour access number:** 800-977-5555

<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Operating Hours</th>
<th>Cities/Towns in Area</th>
</tr>
</thead>
</table>
| Community HealthLink, Inc - Community-Based Location  
40 Spruce Street  
Leominster, MA 01453  

### Central Massachusetts Area: Worcester
**ESP Provider:** Community HealthLink, Inc.  
**24-hour access number:** 866-549-2142

<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Operating Hours</th>
<th>Cities/Towns in Area</th>
</tr>
</thead>
</table>
| Riverside Community-Based Location  
32 Hamilton Street  
Milford, MA 01757  
Call 508-634-3420  
| Riverside Community-Based Location  
206 Milford Street  
Upton, MA 01568  
Call 508-529-7000  
Fax 508-529-7001 | 8 a.m. – 5 p.m. weekdays | |
| Riverside/Harrington Memorial Hospital  
100 South Street  
Southbridge, MA 01550  
Call 508-765-3035  
Fax 508-764-2434 | 8 a.m. – 8 p.m. 7 days/week | |
<table>
<thead>
<tr>
<th>Riverside Community-Based Location</th>
<th>TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td>GB Wells Center 29 Pine Street</td>
<td></td>
</tr>
<tr>
<td>Southbridge, MA 01550</td>
<td></td>
</tr>
<tr>
<td>Call 508-765-9167</td>
<td></td>
</tr>
<tr>
<td>Fax 508-764-2434</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Riverside Community Crisis Stabilization Program</th>
<th>24/7</th>
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</thead>
<tbody>
<tr>
<td>32 Hamilton Street</td>
<td></td>
</tr>
<tr>
<td>Milford, MA 01757</td>
<td></td>
</tr>
<tr>
<td>Call 508-634-3420</td>
<td></td>
</tr>
<tr>
<td>Fax 508-422-9644</td>
<td></td>
</tr>
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**Central Massachusetts Area: Worcester**  
**ESP Provider: Community HealthLink, Inc.**  
**24-hour access number: 866-549-2142**

<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Operating Hours</th>
<th>Cities/Towns in Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community HealthLink, Inc. Community-Based Location</td>
<td>24/7</td>
<td>Auburn, Boylston, Grafton, Holden, Leicester, Millbury, Paxton, Shrewsbury, Spencer, West Boylston and Worcester.</td>
</tr>
<tr>
<td>72 Jaques Ave</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thayer Building, 2nd Floor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worcester, MA 01610</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 508-860-1283</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 508-856-1695</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UMASS Memorial Medical Center</td>
<td>24/7</td>
<td></td>
</tr>
<tr>
<td>55 Lake Avenue North</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worcester, MA 01655</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 508-334-3562</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 508-856-1695</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Locations</td>
<td>Operating Hours</td>
<td>Cities/Towns in Area</td>
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<td>---------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Community HealthLink Community Crisis Stabilization Program</td>
<td>24/7</td>
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</tr>
<tr>
<td>72 Jaques Ave</td>
<td></td>
<td>Worcester, MA 01610</td>
</tr>
<tr>
<td>Thayer Building, 2nd Floor</td>
<td></td>
<td>Call 508-860-1283</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax 508-856-1695</td>
</tr>
<tr>
<td><strong>Northeastern Massachusetts Area: North Essex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ESP Provider: Northeast Behavioral Health</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>24-hour access number: 866-523-1216</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Service Locations</strong></td>
<td><strong>Operating Hours</strong></td>
<td><strong>Cities/Towns in Area</strong></td>
</tr>
<tr>
<td>Lahey/NBH Community-Based Location</td>
<td>24/7</td>
<td>Amesbury, Beverly, Boxford, Danvers, Essex, Georgetown, Gloucester, Groveland,</td>
</tr>
<tr>
<td>60 Merrimack Street</td>
<td></td>
<td>Hamilton, Haverhill, Ipswich, Manchester by the Sea, Marblehead, Merrimac,</td>
</tr>
<tr>
<td>Haverhill, MA 01830</td>
<td></td>
<td>Middleton, Newbury, Newburyport, Peabody, Rockport, Rowley, Salem, Salisbury,</td>
</tr>
<tr>
<td>Call 978-521-7777</td>
<td></td>
<td>Topsfield, Wenham and West Newton</td>
</tr>
<tr>
<td>Fax 978-521-7767</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lahey/NBH Community-Based Location</td>
<td>24/7</td>
<td></td>
</tr>
<tr>
<td>41 Mason Street, Unit #4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salem, MA 01970</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 978-744-1585</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 978-744-1379</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lahey/NBH/Salem Hospital-North Shore Medical Center</td>
<td>24/7</td>
<td></td>
</tr>
<tr>
<td>81 Highland Avenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salem, MA 01970</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 978-354-4550</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 978-745-9021</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Lahey/NBH Community Crisis Stabilization Program  
41 Maston Street, Unit #4  
Salem, MA 01970  
Call 978-744-1585  
Fax 978-744-1379

**Northeastern Massachusetts Area:**  
**Lawrence**  
**ESP Provider:** Northeast Behavioral Health  
**24-hour access number:** 877-255-1261

<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Operating Hours</th>
<th>Cities/Towns in Area</th>
</tr>
</thead>
</table>
| Lahey/NBH Community-Based Location  
12 Methuen Street, 2nd Floor Lawrence, MA 01841  
Call 978-620-1250  
Fax 978-682-9333 | 8 a.m. – 12 a.m.  
7 days/week | Andover, Lawrence, Methuen and North Andover. |
| Lahey/NBH Community Crisis Stabilization Program  
12 Methuen Street, 2nd Floor Lawrence, MA 01841  
Call 978-620-1250  
Fax 978-682-9333 | 24/7 |  |
**Northeastern Massachusetts Area:**

**Lowell**

ESP Provider: Northeast Behavioral Health

24-hour access number: 800-830-5177

<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Operating Hours</th>
<th>Cities/Towns in Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lahey/NBH Community-Based Location 391 Varnum Ave Lowell, MA 01854 Call 978-455-3397 Fax 978-459-9096</td>
<td>8 a.m. – 12 a.m. 7 days/week</td>
<td>Billerica, Chelmsford, Dracut, Dunstable, Lowell, Tewksbury, Tyngsboro and Westford.</td>
</tr>
<tr>
<td>Lahey/NBH Community Crisis Stabilization Program 391 Varnum Ave Lowell, MA 01854 Call 978-455-3397 Fax 978-459-9096</td>
<td>24/7</td>
<td></td>
</tr>
</tbody>
</table>

**Northeastern Massachusetts Area:**

**Tri-City**

ESP Provider: Eliot Community Services

24-hour access number: 800-988-1111

<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Operating Hours</th>
<th>Cities/Towns in Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eliot Community-Based Location 95 Pleasant Street Lynn, MA 01901 Call 781-596-9222 Fax 781-581-9876</td>
<td>8 a.m. – 8 p.m. weekdays 9 a.m. – 6 p.m. weekends</td>
<td>Everett, Lynn, Lynnfield, Malden, Medford, Melrose, Nahant, North Reading, Reading, Saugus, Stoneham, Swampscott and Wakefield.</td>
</tr>
</tbody>
</table>
### Southeastern Massachusetts Area: Southern Coast

**ESP Provider:** Child and Family Services of New Bedford  
**24-hour access number:** 877-996-3154

<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Operating Hours</th>
<th>Cities/Towns in Area</th>
</tr>
</thead>
</table>
| Child and Family Services Community-Based Location  
543 North Street  
New Bedford, MA 02740  
Call 508-996-3154  
| Child and Family Services Community-Based Location  
118 Long Pond Road, Suite 102  
Plymouth, MA 02360  
Call 508-747-8833  
Fax 508-747-8835 | 24/7 | |
| Child and Family Services Community Crisis Stabilization Program  
543 North Street  
New Bedford, MA 02740  
Call 508-996-3154  
Fax 508-991-8082 | 24/7 | |
## Western Massachusetts Area: Berkshires

**ESP Provider:** The Brien Center for Mental Health and Substance Abuse

**24-hour access number:** 800-252-0227

<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Operating Hours</th>
<th>Cities/Towns in Area</th>
</tr>
</thead>
</table>
| The Brien Center Community-Based Location  
34 Pomeroy Ave  
Pittsfield, MA 01201  
Call 413-499-0412  
| The Brien Center Community-Based Location  
66 West Street Pittsfield, MA 01201  
Call 413-499-0412  
Fax 413-499-0995 | 8 a.m. – 12a.m.  
7days/week |  |
| The Brien Center Community-Based Location  
124 Americal Legion Drive North Adams, MA 01247  
Call 413-664-4541  
Fax 413-662-3311 | 9 a.m. – 5 p.m. weekdays |  |
| The Brien Center Community-Based Location  
60 Cottage Street  
Great Barrington, MA 01230  
Call 413-664-4541  
Fax 413-528-8187 | 9 a.m. – 5 p.m. weekdays |  |
<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Operating Hours</th>
<th>Cities/Towns in Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical &amp; Support Options Community-Based Locations</td>
<td>24/7</td>
<td>Ashfield, Athol, Bernardston, Buckland, Charlemont, Colrain, Conway, Deerfield, Erving, Gill, Greenfield, Hawley, Heath, Leverett, Leyden, Millers Falls, Montague, New Salem, Northfield, Orange, Petersham, Phillipston, Rowe, Royalston, Shelburne, Shutebury, Sunderland, Turners Falls, Warwick, Wendell and Whately.</td>
</tr>
<tr>
<td>140 High Street</td>
<td>8 a.m. – 8 p.m. weekdays</td>
<td></td>
</tr>
<tr>
<td>Greenfield, MA 01301</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 413-774-5411</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 413-773-8429</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical &amp; Support Options Community-Based Location</td>
<td>24/7</td>
<td></td>
</tr>
<tr>
<td>491 Main Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Athol, MA 01331</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 978-249-9490</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 978-249-3139</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical &amp; Support Options Community Crisis Stabilization Program</td>
<td>24/7</td>
<td></td>
</tr>
<tr>
<td>140 High Street</td>
<td></td>
<td></td>
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<tr>
<td>Greenfield, MA 01301</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 413-772-0249</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 413-773-8429</td>
<td></td>
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</tbody>
</table>
### Western Massachusetts Area: Pioneer Valley

**ESP Provider:** Behavioral Health Network

**24-hour access number:** 800-437-5922

<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Operating Hours</th>
<th>Cities/Towns in Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Network Community-Based Locations</td>
<td>24/7</td>
<td>Agawam, Belchertown, Blandford, Bondsville, Chester, Chicopee, East Longmeadow, Granby, Granville, Hampden, Holyoke, Huntington, Indian Orchard, Longmeadow, Ludlow, Monson, Montgomery, Palmer, Russell, South Hadley, Southampton, Southwick, Springfield, Thorndike, Three River, Tolland, ware, Westford, West Springfield and Wilbraham.</td>
</tr>
<tr>
<td>417 Liberty Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Springfield, MA 01104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 413-733-6661</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 413-733-7841</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carson Center 77 Mill Street</td>
<td>24/7</td>
<td>Agawam, Belchertown, Blandford, Bondsville, Chester, Chicopee, East Longmeadow, Granby, Granville, Hampden, Holyoke, Huntington, Indian Orchard, Longmeadow, Ludlow, Monson, Montgomery, Palmer, Russell, South Hadley, Southampton, Southwick, Springfield, Thorndike, Three River, Tolland, ware, Westford, West Springfield and Wilbraham.</td>
</tr>
<tr>
<td>Westfield, MA 01085</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 413-568-6386</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 413-572-4144</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77 Mill Street</td>
<td></td>
<td></td>
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<tr>
<td>Westfield, MA 01085</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 413-568-6386</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 413-572-4144</td>
<td></td>
<td></td>
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<tr>
<td>40 Bobala Road</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holyoke, MA 01104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call 413-532-8016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax 413-532-8205</td>
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</tbody>
</table>
Section 13: Pharmacy Services

13.1 Pharmacy contacts for providers

In addition to the pharmacy information in this manual, we have a Pharmacy section on our website at bmchp.org. It provides additional information and resources.

<table>
<thead>
<tr>
<th>Information needed</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up-to-date medication coverage information</td>
<td>View the Pharmacy formulary at bmchp.org.</td>
</tr>
<tr>
<td></td>
<td>For MassHealth, Commercial and Qualified Health Plan (QHP) members: Call BMCHP at 888-566-0008.</td>
</tr>
<tr>
<td>Over-the-counter (OTC) formulary</td>
<td>View the OTC formulary at bmchp.org.</td>
</tr>
<tr>
<td></td>
<td>For MassHealth and Qualified Health Plan (QHP) members: Call BMCHP at 888-566-0008.</td>
</tr>
<tr>
<td>Prior authorization forms and clinical guidelines</td>
<td>View Prior authorization forms and clinical guidelines at bmchp.org.</td>
</tr>
<tr>
<td></td>
<td>For MassHealth and Qualified Health Plan (QHP) members: Call BMCHP at 888-566-0008.</td>
</tr>
<tr>
<td>Mail Order Pharmacy Program</td>
<td>View the Mail Order Pharmacy Program at bmchp.org</td>
</tr>
<tr>
<td></td>
<td>For MassHealth and Qualified Health Plan (QHP) members: Call BMCHP at 888-566-0008.</td>
</tr>
<tr>
<td>To verify medications which are available or excluded from the Mail Order Pharmacy Program</td>
<td>View the Pharmacy formulary at bmchp.org. Call EnvisionPharmacies at 866-909-5170 to enroll in the</td>
</tr>
<tr>
<td>Office administered drugs (i.e., injectables) that require prior authorization</td>
<td>View the Pharmacy formulary bmchp.org. View the Prior Authorization form and clinical guidelines at bmchp.org</td>
</tr>
<tr>
<td>Excluded medications</td>
<td>View the Pharmacy formulary at bmchp.org.</td>
</tr>
<tr>
<td>List of Drugs restricted to Specialty Pharmacy</td>
<td>View the Specialty drug list at bmchp.org.</td>
</tr>
</tbody>
</table>
13.2 General Information

To ensure that members receive quality, affordable healthcare, we contract with a pharmacy benefit manager (PBM) to provide a pharmacy network and manage the pharmacy benefits offered to members. In addition, the pharmacy program offers a comprehensive utilization management program.

Pharmacy and Therapeutics Committee

We maintain a Pharmacy and Therapeutics Committee (P&T Committee) composed of both internal and external physicians, pharmacists and other practitioners who are actively practicing in the community. This committee develops and manages our drug formulary to reflect current evidence-based clinical practice. It also helps to maintain compliance with all applicable legal, regulatory and accreditation standards.

In addition, the P&T Committee evaluates the most current medical literature and consults with appropriate practitioners to develop clinical coverage criteria used to administer our pharmacy utilization management programs. These programs include prior authorization, step-therapy edits, and quantity limitations. Clinical coverage criteria are updated annually and approved by the P&T Committee.

The P&T Committee may also advise BMHCP on other pharmacy-related issues as needed to enhance our ability to provide a comprehensive pharmacy benefit to our members and to improve the quality of the pharmacy management program.

Drug Utilization Evaluation Program

Pursuant to our Drug Utilization Evaluation Policy as approved by the P&T Committee, Pharmacy Services can evaluate physician prescribing patterns, pharmacist dispensing activities, and member use of medications. This involves a comprehensive review of members’ prescription medication data before, during and after dispensing to ensure appropriate medication decision-making and positive member outcomes. We then may recommend interventions to physicians, pharmacists and members, as necessary. To determine effectiveness, the P&T Committee also monitors utilization and compliance with the identified interventions.

13.3 Prescription Drug Monitoring Program

The Prescription Drug Monitoring Program (PDMP) identifies a member population at risk for inappropriate use of medications that have potential for abuse, including schedule II-IV controlled substances and high risk non-controlled substances. Members are automatically enrolled into the program if they are identified through algorithms that incorporate pharmacy claims and medical service utilization data.

The program incorporates both automatic interventions and clinical pharmacist review of member cases for interventions depending on the specific algorithm triggered. All cases referred into the program by internal staff or providers are evaluated by a Clinical pharmacist. As part of the review process, the clinical pharmacist evaluates the member’s medical history including emergency room visits, patterns of
medication use, and gaps in coordination of care among prescribers to determine the appropriate intervention(s) to be completed, if any.

Intervention actions may include direct provider communication, restriction of medication access through a single pharmacy and/or physician (physician group), as well as referrals to our fraud and abuse team for further evaluation. The goal of the program is to assist health care providers be better informed of their patients’ medication use patterns and to promote proactive management to minimize the potential for medication misuse.

In addition to regularly identifying individuals for enrollment, the PDMP also enrolls members through provider referrals. To learn more or to enroll a member, call the provider line at 888-566-0008 and select the “pharmacy” option.

Members enrolled in the Senior Care Options (SCO) program, are monitored through the Opioid Overutilization Monitoring Program. Members are identified for a pharmacist review through internal reports as well as reports provided by the Centers for Medicare and Medicaid (CMS). SCO members are not enrolled in the PDMP program.

13.4 Medication Therapy Management Program

The Senior Care Options program offers a medication therapy management (MTM) programs to dually eligible members who have multiple chronic diseases, take a number of different medications, and have high annual drug costs. Members who meet the qualifying criteria are automatically enrolled in the program each year and are eligible for extra education regarding their medications and a comprehensive review with a pharmacist or other qualified healthcare professional. The goal of the program is to improve medication use and reduce adverse drug events. Any identified medication recommendations or interventions may be directly communicated to providers.

13.5 Pharmacy Benefits

Pharmacybenefitmanager (PBM)

The pharmacy benefit manager (PBM) administers our prescription drug benefits. This includes making a comprehensive network of retail pharmacies available to our members. Use the Find a Pharmacy search tool at bmchp.org to access a list of retail pharmacies affiliated with the PBM.

Our formulary

Our formulary is the primary source of information on medications available through the prescription pharmacy benefit. The formulary contains information on medication coverage, applicable pharmacy program and copayment tier status. Please use the formulary as a reference when prescribing medications to BMCHP members. We regularly update the formulary with new medications and medication coverage changes. Changes to the formulary are posted to bmchp.org and are also mailed to our provider network as needed.

Over-the-counter formulary
Over-the-counter (OTC) coverage includes many commonly used OTC medications and select medical devices that are available through the retail pharmacy network for specific BMCHP members; coverage may vary by plan type. For covered OTC items, see the OTC formulary available at bmchp.org. A prescription must be written for the covered item so that it can be processed as a pharmacy claim.

13.6 Pharmacy Utilization Management Programs

The Pharmacy Utilization Management (UM) programs are designed to manage the utilization of drugs that can be obtained through retail pharmacies, specialty pharmacies, or in a provider setting. These programs include prior authorization, step therapy, quantity limitations, mandatory generic substitution, new-to-market medication program, and the medication exceptions process. Medications managed with any of these programs require submission of a Prior Authorization Request Form available at bmchp.org. A utilization review decision will be rendered on the coverage of the requested medication. These programs are updated regularly based on BMCHP’s P&T Committee’s recommendations and reflect the ever-changing field of pharmaceuticals.

If we deny a pharmacy prior authorization request, the member and/or his or her authorized appeal representative have the right to appeal the decision. If appealing the decision, the member or representative may submit any additional information for consideration during the internal appeal process. An internal appeal must be submitted within 30 calendar days of the denial letter for MassHealth, within 180 calendar days for Qualified Health Plans, and within 60 calendar days for Senior Care Options. See Section 10: Appeals, Inquiries and Grievances for additional information.

PharmacyUtilizationManagement(UM)ProgramDescriptions

Pharmacy Prior Authorization (PA) Program

We use clinical guidelines/criteria for coverage of certain medications that are not considered first-line therapy by clinical practice guidelines, have specific indications for use or are subject to use for non-FDA approved indications. Medications managed under the PA program require prior approval for coverage.

If a provider feels it is medically necessary for a member to take a drug managed under our pharmacy programs, an appropriate Prior Authorization Request form available at bmchp.org, should be submitted to the fax number on the form. A clinician will review the request, and we will notify the provider of the decision in accordance with applicable regulatory and accreditation standards. See Section 8: Utilization Management and Prior Authorization for our timeframe requirements.

See our Prior Authorization Forms and Clinical Guidelines Prior Authorization Forms and Clinical Guidelines available at bmchp.org to access a listing of medications that are in the PA Program.

Step Therapy Program

The Step Therapy Program is a form of prior authorization. It generally requires the use of cost-effective or first-line medication(s) before approval of a second-line medication is granted. If the required therapeutic benefit is not achieved using the first-line medication, the prescriber may request the use of a second-line medication and submit a prior authorization request. See BMCHP’s Prior Authorization Forms and Clinical Guidelines available at bmchp.org.
Quantity Limitation Program

The Quantity Limitation program ensures the safe and appropriate use of a select number of medications by covering only a specified amount of the medication to be dispensed at any one time. Prior authorization is required when requesting quantities greater than what BMCHP allows. Please see quantity limitation guidelines and Pharmacy Prior Authorization Request Form available on our website at bmchp.org.

Mandatory Generic Medication Program

The US Food and Drug Administration (FDA) has determined certain generic medications to be therapeutically equivalent (“AB rated”) to their brand counterparts. This means that these generic medications are as effective as the brand. The state of Massachusetts requires the interchanging of “AB rated” generics unless the practitioner indicates that the brand medication is medically necessary. In addition, coverage for most brand medications with generic equivalents is subject to our prior authorization requirements. See the Mandatory Generic Substitution Program Policy at bmchp.org.

New-to-Market Medication Program

BMCHP reviews all new-to-market drugs before adding them to the formulary or covering them under our pharmacy benefit. The P&T Committee evaluates these drugs to determine whether the new-to-market medications are safe for prescribing to members and to determine the coverage status. For guidelines, see New to Market Medication Program Policy at bmchp.org.

Medication exception process

The medication exception process allows a provider the ability to request coverage of a non-covered medication for a member based upon medical necessity. Medications specifically excluded from coverage by federal or state regulations (such as Medicaid or Medicare), and those specifically excluded in the Commercial plans Evidence of Coverage are not subject to this policy.

The provider must submit a letter of medical necessity or a completed Pharmacy Prior Authorization Request Form available on our website at bmchp.org, along with any corresponding documentation relevant to the medical necessity of the non-covered medication to BMCHP for review.

13.7 Pharmacy Networks Affiliated with BMCHP

Retail Pharmacy

Our members may fill prescriptions at any retail pharmacy in our pharmacy network. The network includes more than 250 pharmacies throughout Massachusetts. To find the location and contact information of a specific retail pharmacy, use the Find a Pharmacy search tool available at bmchp.org.

Specialty pharmacy

We contract with a select network of specialty pharmacies that have experience managing the dispensing of specific medications used to treat certain complex conditions. Our specialty pharmacies mail members’ specialty prescriptions directly to their homes, doctor’s office, or other designated address. Visit the Pharmacy Programs page at bmchp.org to access the Specialty Pharmacy Guide.
Mailorder pharmacy

We offer a mail order pharmacy program that allows members to fill 90-day supplies of maintenance medications through our mail order pharmacy, Envision Pharmacies. Members save time and money by filling prescription in bulk supplies. Some medications are not available through this benefit, such as over-the-counter products, controlled substances, and specialty medications provided by our specialty pharmacies.

For more information regarding the Mail Order Pharmacy Program, visit bmchp.org or to enroll in the program call Envision Pharmacies at 866-909-5170.

13.8 Pharmacy Copayments

Member cost sharing amounts

MassHealth members are charged a copayment for medications with the exception of the following:

- The member is under the age of 19.
- The member is pregnant (members must notify their doctor to submit a BMCHP Medical Prior Authorization Form, available at bmchp.org).
- The member’s pregnancy ended in the last 60 days (members must notify their doctor to submit a Medical Prior Authorization Form).
- The member is in hospice care.
- The member is a Native American or Alaska Native from a federally recognized tribe.
- The member is receiving care as an inpatient in an acute hospital, nursing facility, chronic disease hospital, rehabilitation hospital, or intermediate-care facility for the developmentally delayed.

Qualified Health Plan members are charged copayments, coinsurance and/or deductibles for medications, and may have special pharmacy deductibles – depending on the applicable benefit package in which they are enrolled.

Senior Care Options member have no copayments, coinsurance and/or deductibles for covered medications.

Section 6: Member Information for additional details regarding copayment amounts.

Annual cost-sharing caps

MassHealth members are responsible for paying copayments for all dispensed medications, including retail, specialty and mail-order, until they have reached their annual copayment “cap” or maximum. Members become exempt from paying copayments once they have reached the maximum. See Section 7: BMC HealthNet Plan Product Information for details.

Qualified Health Plan members also may have out-of-pocket maximums that may include deductibles, copayments or coinsurance paid by the member for medications.

We will send a letter to each member notifying him/her when the annual or benefit year maximum has been reached.
Senior Care Options members have $0 cost share for all covered medications throughout the benefit year.

**Pharmacy copayment compliance**

We expect all pharmacies to comply with the cost-sharing rules applicable to all plans.

For Qualified Health Plan members: Pharmacies must collect the required deductible, copayment and/or coinsurance. For clarification, please see information about Prescription Copayments available at bmchp.org.

**Pertaining to MassHealth members, please note the following:** In accordance with 130 CMR 450.130, providers, including pharmacies, may not refuse services or withhold prescriptions if the member reports he/she is unable to pay the copayment at the time of service/receipt of prescription.

**BMCHP action with non-compliant pharmacies for MassHealth members**

Our Pharmacy staff will immediately follow up with any pharmacy that denies a medication to a MassHealth member based on the member’s reported inability to pay the pharmacy copayment at the time of service/receipt of prescription. Our standard operating procedure includes:

- Outreach to the member who was denied the medication to ensure that he or she receives the needed medication in a timely manner.
- Inform the pharmacy that denying prescription drugs to MassHealth members based on a member’s inability to pay his/her copayment at the time of service/receipt of prescription is a violation of MassHealth regulations and federal Medicaid law.
- Provide MassHealth with a list of pharmacies that demonstrate a pattern of inappropriately denying prescription drugs to members, and document steps BMCHP takes to resolve the situation. If necessary, take disciplinary action against a noncompliant pharmacy.
Section 14: Quality Management

14.1 General Information

Our Quality Management Program helps ensure that we and our participating providers deliver quality services to members. Providers are required to participate in the program as part of their agreement with us.

Providers may be asked to participate in clinical programs (e.g. to increase HEDIS rates), surveys, (e.g., appointment lead times), or other initiatives aimed at improving quality of care or member satisfaction. We develop these programs and initiatives to meet contractual, regulatory and accreditation requirements and to address opportunities for improvement identified through the analysis of available data (e.g. HEDIS and CAHPS). Some of these programs, such as HEDIS, involve the use of practitioner data.

14.2 Scope of the Quality Improvement Program

Through the Quality Improvement Program (QIP), we monitor and oversee the following aspects of medical and behavioral health care and service:

- Ongoing evaluation of the quality of care and service (including integration and coordination of care and access and availability to quality clinical care)
- Continuous quality improvement
- Clinical standards and care coordination guidelines
- Member safety
- Member satisfaction, including evaluating complaints and appeals
- Utilization management
- Care management, disease management and population health
- Continuity and coordination of care
- Credentialing
- Network management

14.3 BMCHP Quality Improvement Goals

Our QIP identifies the key areas of focus for each year in our annual Quality Improvement (QI) work plan. We consider many factors when deciding on QI initiatives or projects for the annual plan. Some of these factors include those projects that:

- Support our mission and strategic goals
- Were identified through monitoring quality metrics, evaluating previous QI work plans, and input from practitioners and/or members
- Improve the overall health, well-being and safety of members
• Improve member and provider satisfaction
• Improve member access to health care
• Fulfill accreditation, contract and other legal/regulatory requirements

BMC HealthNet Plan:
• Collects information and data relevant to objectives and measures of QI goals
• Implements well-designed, innovative, targeted and measurable interventions to achieve objectives
• Evaluates the effectiveness of interventions
• Plans and initiates processes to sustain achievements and continue improvements

Examples of QI goals include:

• Identifying members with asthma and continuously improving processes to facilitate managing this population; increasing appropriate asthma medication utilization; and decreasing emergency department and inpatient hospital utilization by members identified with persistent asthma.
• Identifying members with diabetes; continuously improving processes to facilitate managing this population; and improving the care and knowledge of these members with the goal of preventing or delaying development of complications of diabetes and promoting self-management.
• Assessing children’s and adolescents’ primary care visits and promoting age-appropriate preventive care visits in compliance with the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical protocol and periodicity schedule. We provide updates on progress toward QI goals to members and providers.

14.4 Healthcare Effectiveness Data and Information Set Guidelines (HEDIS)
HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, asthma and diabetes. HEDIS also includes the standardized survey of consumers’ experiences that evaluates a plan’s performance in areas such as customer service and access to care. The survey is called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA), which defines standards for accreditation of health plans in the U.S. CAHPS is sponsored, supported and maintained by the Agency for Healthcare Research and Quality (AHRQ). The HEDIS performance measures are reported to certain regulatory bodies on an annual basis according to state and federal requirements.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
CAHPS is a nationally recognized member satisfaction survey tool for managed care used by NCQA and the Centers for Medicare and Medicaid Services (CMS). CAHPS is a component of HEDIS and is used by BMCHCP to assess the member’s subjective experience when accessing health care.
HEDIS methods
HEDIS and other performance measurements are operational requirements for BMCHP and are used for a variety of care assessments. Wherever possible, we use administrative data captured in our claims transaction systems. There are, however, occasions when we must rely on the review of a member’s actual medical record to show the breadth of services actually performed. For example, we conduct medical record reviews to determine how many diabetic members are controlling their blood glucose within specific limits.

A typical HEDIS cycle will require our staff to request and review approximately 5,000 medical records. Our medical record review must be a comprehensive evaluation of all clinical information related to a member’s care.

We will work with provider sites to securely access electronic medical records, coordinate faxing or mailing of the needed information to a secure location or schedule on-site visits to review medical records. Electronic submission of medical records on password protected, encrypted flash drives is also acceptable.

<table>
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<tr>
<th>HEDIS medical record data collection timeframes</th>
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<tbody>
<tr>
<td>Record requests distributed to providers</td>
</tr>
<tr>
<td>Record reviews conducted</td>
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<tr>
<td>Required submission date for fax or mailed records</td>
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We strive to make these reviews as easy as possible for providers and rely on the cooperation of providers to make these reviews successful. Providers’ prompt attention and response to requests for chart information is critical and is appreciated and eliminates rework.

Provider profiling
We may collect and report necessary data for developing an improvement strategy for us, and give providers important feedback on quality of care guidelines. We may evaluate provider performance using clinical, administrative and member satisfaction quality indicators in the following manner:

- Develop reports to identify performance by specific provider and/or provider group
- Develop and use benchmarks to measure quality indicators
- Provide feedback regarding performance results and compare it to overall network performance
- Collect feedback from providers regarding disseminated reports, and use this feedback to revise reports as necessary
- Identify opportunities for improvement and work with providers to establish quality improvement goals and action plans
- Periodically measure providers’ progress in achieving the goals specified in the action plans.
14.5 Provider Reporting of Serious Reportable Events (SREs), Provider Preventable Conditions (PPCs) and Adverse Incidents

Providers must report all serious reportable events (SREs) and provider preventable conditions (PPCs) within seven days of the event, and adverse incidents related to a BMCHP member within a reasonable timeframe. (See below for definitions of these terms.) You must report as follows.

- For SREs/PPCs/adverse events unrelated to behavioral health care, call our Quality Department at 617-478-3704 to report the event.
- For SREs/adverse events related to behavioral health care, call our partner, Beacon Health Strategies (Beacon), at 866-444-5155 (TTY/TDD line at 866-727-9441) to report the event. Learn more Section 12: Behavioral Health Management.

Provider preventable conditions: Under Section 2702 of the Affordable Care Act (ACA) and federal regulations at 42 CFR 447.26, Medicaid providers must report PPCs to Medicaid agencies, and Medicaid agencies are prohibited from paying providers for PPCs in violation of the federal requirements. PPCs are conditions that meet the definition of a “Health Care Acquired Condition” or an “Other Provider Preventable Condition” as defined by CMS (see federal regulations at 42 C.F.R. 447.26(b)). These must be reported to BMCHP within seven days and a follow up report is required within 30 days.

Serious reportable event (SRE): An event that occurs on premises covered by a hospital’s license, office based practice, ambulatory surgery center, or skilled nursing facility that results in an adverse patient outcome, is clearly identifiable and measurable, usually or reasonably preventable, serious in their consequences (such as resulting in death or loss of a body part, injury more than transient loss of a body function or assault). These events are also characterized as adverse in nature, represent a clear indication of a health care provider’s lack of safety systems and/or, are events that are important measures for public credibility or public accountability as established by guidelines issued by the National Quality Forum (NQF) as Serious Reportable Events (SREs). These must be reported to BMCHP within seven days and a follow up report is required within 30 days.

Adverse event: An adverse event is an unexpected occurrence that results in or has the potential to result in serious harm to the well-being of a member who is receiving services managed by us or has recently been discharged from services managed by us.

Examples of adverse events include:

- Unexpected death
- Death which was not anticipated as a significant possibility 24 hours before the death OR where there was a similarly unexpected deterioration in the patient’s condition leading to or precipitating events which led to death
- Death not expected as the outcome from progression of an illness or disease
- Death from a condition not present on admission and/or caused by medical management rather than due to the patient’s underlying disease
- Death related to a surgical or invasive procedure
- Fetal death at > 24 weeks
- Newborn death
- Intrapartum maternal death
- Death within one week of an elective ambulatory procedure
- Serious bodily injury, permanent loss of function or life threatening situation not expected as foreseeable outcomes of member’s condition/treatment
- Any other event during the member’s care or treatment that results in or has the potential to result in serious harm to the member.

**Critical Incident:** An incident that occurs in the community on the premises of an Adult Day Health, Group Adult Foster Care, Adult Foster Care (including where Adult Foster Care services may be provided, such as a private residence setting), Transitional Living or Day Habilitation facility that is sudden or progressive and requires immediate attention and decisive action to prevent or minimize any negative impact on the health and welfare of one or more SCO members.

We review all reported SREs, PPCs, critical incidents and non-behavioral health adverse incidents. We collect, document, evaluate, report, and monitor these incidents in a timely manner. We believe that the frequency of these events may be reduced by examining the settings in which they occur. We collaborate with providers to identify system changes to reduce the likelihood of similar occurrences in the future. Our Chief Medical Officer or his/her designee and/or Vice President of Quality and Clinical Program Oversight or his/her designee reviews all non-behavioral health adverse incidents.

### 14.6 Medical Record Charting Standards

This internal program systematically assesses medical record documentation of patient care against standards as required in our medical record documentation policy (QI 5.001).

This approach is designed to objectively assess the structure, content and management of patient records at the time of the review while minimizing any impact of the review process on practitioner operations. The intent of the assessment is to offer feedback to help providers to continuously meet standards and to ensure continuity, efficiency and quality of care for members.

Medical records must be legible, documented accurately and comprehensively, and accessible to healthcare practitioners. This includes the transfer of medical information when a member changes to another provider. Providers and BMCHP must work together to ensure that member records are treated as confidential and in full compliance with state and federal laws and regulations.

**Medical record charting standards— all providers**

We expect providers to maintain medical records according to industry standard practice, and we will periodically monitor charting practices. The following summarizes the components of charting practices that we evaluate during site audits.

- Provider site has a systematic method to retrieve medical records. Electronic medical record systems should be secure and password or otherwise protected.
• Charts are available and retrievable.
• Charts are stored and accessed according to the Health Insurance Portability and Accountability Act (HIPAA), such as requesting identification from auditors. All staff members receive periodic training on member confidentiality.
• Hard copy medical records, if applicable, are stored securely in a separate area or room and accessible only to authorized personnel. Records area should be locked, if feasible.
• There is a documented location of any and all BMCHP member patient files retrieved from the filing system.
• Electronic medical record systems should have the ability to track staff members who have accessed the medical record.
• Standard formats and forms are used consistently in hard copy and electronic records.
• All medical records are legible.
• All medical record entries are signed with name, title and date.
• Counter-signature by the supervising physician should be used when required by state or federal law or facility (e.g., countersignature by supervising physician is documented for interns and residents (42 CFR 415.170)).
• Patient name, date of birth and identification number should be on each page of the chart.
• Medical records are organized by individual patient in a logical manner that is current, detailed and organized and facilitates effective patient care, utilization and quality review.
• Individual patient charts are organized in chronological order. In electronic records, documentation copied and pasted from previous visits can be easily distinguished from documentation of current services.
• Each file contains a data sheet with basic demographic and contact information, also including patient’s, race, ethnic background, preferred spoken and written language, and any disabilities.
• Medical records include documentation of problem list, medications, history (including serious accidents, operations and illnesses), physical exam, preventative services/age appropriate risk screening (including cigarettes, alcohol and substance abuse), documentation of clinical findings and evaluation at each visit.
• Working diagnoses are consistent with findings.
• All diagnoses, conditions, complications, and treatment plans, goals and outcomes are documented; this includes radiology, laboratory work and consultation results. All abnormal subjective and objective findings are appropriately addressed; unresolved problems from previous visits have documentation of a follow-up plan including return visits, telephone calls or other medium with the timeframe designated.
• Treatment plans are consistent with diagnoses.
• Laboratory, radiology and consult notes are filed in the chart; reviewed, signed and dated by the ordering provider or a member of his/her practice team at the time of receipt. In addition, documentation exists for follow-up for abnormal findings.
• Provider site has policies and procedures for consent.
• Records include prominent display of allergy and adverse reactions or documentation of no known allergy.
• There should be documentation for any member over age 18 whether they have executed an advance directive; if pertinent, records should include a prominent display of advance directives indicating patient wishes regarding treatment, where appropriate.
• For members up to age 21, there is evidence that preventive screening and services are offered in accordance with EPSDT Periodicity Schedule.
• For members beginning at age 21, treatment is in accordance with preventive and disease management, evidence-based clinical guidelines from recognized professional associations endorsed by BMCHP. As noted, these can be found at bmchp.org.
• There is no evidence that members are placed at inappropriate risk by a diagnostic or therapeutic procedure.
• There should be appropriate notation of under- or over-utilization of specialty services or pharmaceuticals.
• Records include prominent display of advance directives indicating patient wishes regarding treatment, where appropriate.
• All contacts with state agencies are documented or filed in the chart.
• All contacts with the member’s family, guardians or significant others are documented.

Providers must retain medical records for the period of time specified in all applicable state and federal laws and regulations and in BMCHP’s contracts.

Preventive care charting standards

In addition to the medical record charting standards outlined above, PCPs are required to document recommendations or examinations for the following:

• All services provided directly by the PCP.
• All ancillary services and diagnostic tests ordered by the practitioner with results as noted in the charting section.
• All diagnostic and therapeutic services for which a member was referred by a practitioner that includes but is not limited to home health nursing reports, specialty physician reports, hospital discharge reports and physical therapy reports as noted in the charting section.

Preventive care services must include documentation of mammograms, Pap smears, adult and pediatric immunizations, risk screening, anticipatory guidance and any other preventive health standards adopted by BMCHP.

Pediatrics charting standards

In addition to the medical record charting standards for preventive care, pediatric charting must include the following:
- Flow sheet for immunizations
- Growth and development chart
- BMI percentile or BMI plotted on a percentile graph
- Anticipatory guidance documentation
- Appropriate physical and social/emotional developmental screenings and referrals as needed

**Behavioral health services charting standards**

We contract with Beacon Health Strategies (Beacon) to manage our behavioral health program. Please contact Beacon at beaconhealthstrategies.com or call Beacon at 866-444-5155 for charting standards for behavioral health services.

**Inpatient medical/surgical hospitalization charting standards**

- Identification of the member
- Name of the member’s physician
- Date of admission
- Plan of care required under 42 CFR 456, which must include diagnoses, symptoms, complaints and complications indicating the need for admission, a description of the functional level of the member, any orders for medications, treatments, restorative and rehabilitative services, activities, social services and diet. Plans for continuing care and discharge, as appropriate, must be documented.
- Initial and subsequent continued stay review dates described under 42 CFR 456.128 and 456.133
- Date of operating room reservation, if applicable
- Justification of emergency admission, if applicable
- Reason and plan for continued stay, if the attending physician believes continued stay is necessary
- Other supporting material that our Utilization Management staff believe appropriate to be included in the record

### 14.7 Medical Record Audits

Provider sites utilizing paper charts selected for medical record audits must participate in and cooperate with medical record audits. These audits are necessary to ensure compliance with our medical record standards and with criteria we periodically develop and distribute to providers. Criteria for these chart audits may be checked during the annual HEDIS project or other medical record review projects during the year. Providers must make medical records or copies of records available to us, CMS or its agents, or other state or federal government agencies, and any authorized external quality review organization (e.g., NCQA) for purposes of assessing the quality of care rendered. Medical record reviews of diagnostic information are also conducted to assess completeness of coding and insure accurate risk stratification.

**Medical record audits for PCPs**
We may conduct a retrospective sample audit of medical records at selected PCP sites with a panel size of 100 or more members as part of the network quality management process.

**Our medical record audit process is as follows:**

- We perform the audit using our basic charting standards and any medical care evaluation audit tools that might be relevant to provider practices (e.g., we might use the audit tool for evaluating the treatment of adult members with hypertension in an internal medicine practice). If deficiencies are identified during the audit, we communicate the results of audits to the practitioner. Any practitioner not meeting the goal of 90% will be asked for a corrective action plan.

- Providers are required to provide access to the office or practice site and the members’ medical records or to send copies of members’ medical records to our Clinical Informatics Department when requested by us.

**Medical record audits for specialists**

We conduct onsite chart audits of participating medical/surgical specialists, when necessary. These audits follow the same basic process used for PCPs, where pertinent. An additional focus for specialty service and behavioral health medical record audits is the level of communication between the specialist and the PCP (i.e., coordination of care).

**14.8 Provider Communication**

Providers may freely communicate with members about their treatment options, including medication treatment options, regardless of benefit coverage limitations.

**14.9 Clinical Practice Guidelines**

We have endorsed several preventive and disease management, evidence-based clinical guidelines, including those for asthma, diabetes, pregnancy and abuse and neglect identification. We encourage providers to refer to these guidelines to assist them in delivering quality care to our members. Links to the Clinical Practice Guidelines are available at bmchr.org. If providers need a printed copy of these guidelines, please call our Provider Service Center at 888-566-0008.

**14.10 Clinical Documentation and Medicare Risk Adjustment**

**Clinical Documentation Processes**

**Required Medical Record documentation**

The Centers for Medicare & Medicaid Services (CMS) uses a risk adjustment system to account for medical expenses and care coordination costs for beneficiaries with special needs. As part of that system, CMS requires BMCHP providers to maintain substantive documentation in their medical records on all relevant diagnoses for a member. CMS may audit providers at any point for compliance with documentation standards.
The definition of “substantive documentation” is that each diagnosis billed must be supported by three items in the medical record:

- An evaluation for each diagnosis
- Assessment of relevant symptoms and physical examination findings at time of visit
- A status for each diagnosis For example:
  - Stable, progressing or worsening, improving
  - Not responding to treatment or intervention
  - A treatment plan for each diagnosis
  - Observation or monitoring for exacerbation, responses to treatment, etc.
  - Referrals to specialists or services (e.g. cardiologist or PT)
  - Continuations or changes to any related medications

**Coding Compliance**

BMCHP encourages providers to code to the most appropriate level of specificity as a general standard of practice (CPT, ICD10). BMCHP and/or CMS may audit the provider at any point for over-coding and/or similar billing practices related to Fraud, Waste, and Abuse.

**Educational Resources**

Providers are encouraged to contact BMCHP Provider Relations at -617-748-6308 to request education about coding and documentation compliance.

**Medicare Risk Adjustment: General Guidelines and Recommendations**

In order for the findings and coding of clinical encounters to be accepted by CMS for risk adjustment purposes, a clinical encounter must be in the form of a face-to-face visit by a physician or advanced practice clinician (such as an NP, PA, LICSW, OT, or PT). Moreover, all active diagnoses must be documented during a face-to-face encounter at least once per calendar year in order for the diagnoses to count for risk adjustment purposes. All diagnoses, meeting the “substantive documentation” standards listed above must be submitted on a claim and sent to BMCHP for that date of service. Submission of all diagnoses on a claim is the best way to insure an accurate risk adjustment calculation for each member.

**Annual Assessment Process**

BMCHP encourages providers to adopt the practice of an annual comprehensive assessment to ensure that all active conditions are reviewed at least once during the calendar year. The process of reviewing active conditions may be tied to an annual wellness exam or an annual physical exam.

The documentation and coding compliance practices and general risk adjustment guidelines described above should be adhered to in documenting and coding the findings of an annual comprehensive assessment visit.
14.11 Star Ratings

The Centers for Medicare and Medicaid Services (CMS) uses the Five-Star Quality Rating System to determine compensation for Medicare Advantage plans and educate consumers on health plan quality. The Star Ratings system consists of over 50 measures from six different rating systems. The cumulative results of these measures make up the Star rating assigned to each health plan.

The Star Rating of 50 + measures are derived from six different rating systems:

- **HEDIS** – Healthcare Effectiveness Data and Information Set is a set of performance measurements in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plan performance to other plans as well as to national or regional benchmarks. For example, this allows the health plan and CMS to determine how many members have been screened for high blood pressure.

- **CAHPS** - Consumer Assessment of Health Care Providers and Systems is a patient/member survey rating health care experiences.

- **CMS** - Centers for Medicare and Medicaid Services rates each plan on administrative type metrics, such as, beneficiary access, complaints, call center hold times, and percentage of customers choosing to leave a plan.

- **PDE** - Prescription Drug Events is data collected on various medications related events, such as high-risk medications, medication adherence for chronic conditions e.g. hypertension, and pricing.

- **HOS** - Health Outcomes Survey is a survey that uses patient-reported outcomes over a 2.5-year time span to measure health plan performance. The goal of HOS is to gather valid, reliable, and clinically meaningful health status data in the Medicare Advantage (MA) program for use in quality improvement activities, pay for performance, program oversight, public reporting, and improving health. All managed care organizations with Medicare contracts must participate.

- **IRE** - an Independent Review Entity is an independent entity contracted by CMS to review Medicare health plans’ adverse reconsiderations of organization determinations. Medicare Advantage plans are required to process enrollee appeals (reconsiderations) timely and submit all denied appeals to the IRE.

Star Ratings also have a significant impact on the financial outcome of Medicare Advantage health plans by directly influencing the bonus payments and rebate percentages received. CMS awards quality-based bonus payments to high performing health plans based on their Star Ratings performance. For health plans with a four star (ratings 1-5 stars with 5 highest performing plans) or more rating, a bonus payment is paid in the form of a percentage (maximum of five percent) added to the county benchmark.

The methodology used by CMS is subject to change and final guidelines are released each fall.

**The Star Rating methodology was developed to:**

- Help consumers choose plans on medicare.gov
• Strengthen CMS’ ability to distinguish stronger health plans for participation in Medicare Parts C and D
• CMS may penalize consistently poor performing health plans
• Strengthen beneficiary protections
Addendum

Massachusetts Consumer Protections for Qualified Health Plan Products

As part of its compliance with Massachusetts laws and regulations, the Plan is required to distribute to providers the following provisions of certain Massachusetts managed care consumer protection requirements. These requirements apply only to the Plan’s Qualified Health Plan products. They do not apply to the Plan’s Medicaid products.

1. According to M.G.L. c. 175 §47U(b) (or M.G.L. c. 176G §5(b), M.G.L. c. 176A §8U(b) and M.G.L. c. 176B §4U(b)), carriers shall provide coverage for emergency services provided to insureds for emergency medical conditions. After an insured has been stabilized for discharge or transfer, a carrier may require a hospital emergency department to contact a physician on call designated by the carrier or its designee for authorization of post-stabilization services. The hospital emergency department shall take all reasonable steps to initiate contact with the carrier or its designee within 30 minutes of stabilization. However, such authorization shall be deemed granted if the carrier or its designee has not responded to the call within 30 minutes. In the event the attending physician and the on-call physician do not agree on what constitutes appropriate medical treatment, the opinion of the attending physician shall prevail and such treatment shall be considered appropriate treatment for an emergency medical condition, provided that such treatment is consistent with generally accepted principles of professional medical practice and is a covered benefit under the policy or contract.

2. According to M.G.L. c. 175 §47U(c) (or M.G.L. c. 176G §5(c), M.G.L. c. 176A §8U(c) or M.G.L. c. 176B §4U(c)), a carrier may require an insured to contact either the carrier or its designee or the primary care physician of the insured within 48 hours of receiving emergency services, but notification already given to the carrier, designee or primary care physician by the attending physician shall satisfy this requirement.

3. According to M.G.L. c. 176O §10(c), “[a] carrier or utilization review organization shall conduct an annual survey of insureds to assess satisfaction with access to specialist services, ancillary services, hospitalization services, durable medical equipment and other covered services . . . [and c]arriers that utilize incentive plans shall establish mechanisms for monitoring the satisfaction, quality of care and actual utilization compared with projected utilization of health care services of insureds.”

4. According to M.G.L. c. 176O §12(b), “[a] carrier or utilization review organization shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information . . . [a]n the case of a determination
to approve an admission, procedure or service, the carrier or utilization review organization shall notify
the provider rendering the service by telephone within 24 hours, and shall provide written or electronic
confirmation of the telephone notification to the insured and the provider within two working days
thereafter. In the case of an adverse determination, the carrier or utilization review organization shall
notify the provider rendering the service by telephone within 24 hours, and shall provide written or
electronic confirmation of the telephone notification to the insured and the provider within one working
day thereafter.

5. According to M.G.L. c. 176O §12(c), “[a] carrier or utilization review organization shall make a concurrent
review determination within one working day of obtaining all necessary information. In the case of a
determination to approve an extended stay or additional services, the carrier or utilization review
organization shall notify by telephone the provider rendering the service within one working day, and
shall provide written or electronic confirmation to the insured and the provider within one working day
thereafter. A written or electronic notification shall include the number of extended days or the next
review date, the new total number of days or services approved, and the date of admission or initiation
of services. In the case of an adverse determination, the carrier or utilization review organization shall
notify by telephone the provider rendering the service within 24 hours, and shall provide written or
electronic notification to the insured and the provider within one working day thereafter. The service
shall be continued without liability to the insured until the insured has been notified of the
determination.”

6. According to 211 CMR 52.08(6), “[t]he written notification of an adverse determination shall include a
substantive clinical justification therefor that is consistent with generally accepted principles of
professional medical practice, and shall, at a minimum: (a) identify the specific information upon which
the adverse determination was based; (b) discuss the insured’s presenting symptoms or condition,
diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the
relevant medical review criteria; (c) specify any alternative treatment option offered by the carrier, if
any; (d) reference and include applicable clinical practice guidelines and review criteria; and (e) include a
clear, concise and complete description of the carrier’s formal internal
grievance process and the procedures for obtaining external review pursuant to 105 CMR 128.400.”

7. According to M.G.L. c. 176O §12(e),”[a] carrier or utilization review organization shall give a provider
treating an insured an opportunity to seek reconsideration of an adverse determination from a clinical
peer reviewer in any case involving an initial determination or a concurrent review determination. Said
reconsideration process shall occur within one working day of the receipt of the request and shall be
conducted between the provider rendering the service and the clinical peer reviewer or a clinical peer
designated by the clinical peer reviewer if said reviewer cannot be available within one working day. If
the adverse determination is not reversed by the reconsideration process, the insured, or the provider
on behalf of the insured, may pursue the grievance process established pursuant to [M.G.L. c. 176O, §§]
13 and 14. The reconsideration process allowed herein shall not be a prerequisite to the formal internal grievance process or an expedited appeal required by [M.G.L. c. 176O, §] 13.”

8. According to M.G.L. 176O §16(a) “[t]he physician treating an insured, shall, consistent with generally accepted principles of professional medical practice and in consultation with the insured, make all clinical decisions regarding medical treatment to be provided to the insured, including the provision of durable medical equipment and hospital lengths of stay. Nothing in this section shall be construed as altering, affecting or modifying either the obligations of any third party or the terms and conditions of any agreement or contract between either the treating physician or the insured and any third party.”

9. According to M.G.L. 176O §16(b) “[a] carrier shall be required to pay for health care services ordered by a treating physician if (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. A carrier may develop guidelines to be used in applying the standard of medical necessity, as defined herein. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed with input from practicing physicians in the carrier’s or utilization review organization's service area; (ii) developed in accordance with the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured.”

10. According to M.G.L. 176O §16(c) “[w]ith respect to an insured enrolled in a health benefit plan under which the carrier or utilization review organization only provides administrative services, the obligations of a carrier or utilization review organization created by this section and related to payment shall be limited to recommending to the third party payor that coverage should be authorized.”

11. According to 958 CMR 3.501, “[c]arriers shall allow any female insured who is in her second or third trimester of pregnancy and whose provider in connection with said pregnancy is involuntarily disenrolled for reasons other than those related to quality or fraud, to continue treatment with her provider, consistent with the carrier’s evidence of coverage, for a period up to and including the insured’s first postpartum visit.”

12. According to 958 CMR 3.502, “[c]arriers shall allow any insured who is terminally ill, and whose provider in connection with the treatment of the insured’s terminal illness is involuntarily disenrolled for reasons other than those related to quality or fraud, to continue treatment with the provider, consistent with the terms of the carrier’s evidence of coverage, until the insured’s death.”
13. According to 958 CMR 3.503(1), “[a] carrier shall provide coverage for health services to a newly insured provided by a provider who is not a participating provider in the carrier’s network for up to 30 days from the effective date of coverage if: (a) the insured’s employer only offers the insured a choice of carriers in which said provider is not a participating provider; and (b) said provider is providing the insured with an ongoing course of treatment or is the insured’s primary care provider.”

14. According to 958 CMR 3.503(2), “[w]ith respect to an insured pregnant woman who is in her second or third trimester, coverage pursuant to 958 CMR 3.503(1) shall apply to services rendered through the insured’s first postpartum visit.”

15. According to 958 CMR 3.503(3), “[w]ith respect to an insured with a terminal illness, coverage pursuant to 958 CMR 3.503(1) shall apply to services rendered until the insured’s death.”

16. According to 958 CMR 3.504(1), “[a] carrier may condition coverage of continued treatment by a provider under 958 CMR 3.500 through 3.502, upon the provider’s agreeing: (a) to accept reimbursement from the carrier at the rates applicable prior to the notice of disenrollment as payment in full; (b) to not impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; (c) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and, (d) to adhere to such carrier’s policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing treatment pursuant to a treatment plan, if any, approved by the carrier.”

17. According to 958 CMR 3.504(2), “[a] carrier may condition coverage of treatment by a provider under 958 CMR 3.503 upon the provider’s agreeing: (a) to accept reimbursement from the carrier at the rates applicable to participating providers as payment in full; (b) to not impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider participated in the carrier’s network; (c) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and (d) to adhere to the carrier’s policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing treatment pursuant to a treatment plan, if any, approved by the carrier.”

18. According to 958 3.504(3), “[n]othing in 958 CMR 3.500 through 3.502 or 3.504 shall be construed to require the coverage of benefits that would not have been covered if the provider involved had remained a participating provider. Nothing in 958 CMR 3.503 shall be construed to require coverage of benefits that would not have been covered if the provider involved was a participating provider.”

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19. According to 958 CMR 3.505(1), “[a] carrier that requires an insured to designate a primary care provider shall allow such a primary care provider to authorize a standing referral for specialty health care, including mental health care, provided by a health care provider participating in such carrier’s network when: (a) the primary care provider determines that such referrals are appropriate; (b) the provider of specialty health care agrees to a treatment plan for the insured and provides the primary care provider with all necessary clinical and administrative information on a regular basis; and (c) the health care services to be provided are consistent with the terms of the carrier’s evidence of coverage.”

20. According to 958 CMR 3.505(2), “[n]othing in 958 CMR 3.505 shall be construed to permit a provider of specialty health care who is the subject of a referral to authorize any further referral of an insured to any other provider without the approval of the insured’s carrier.”

21. According to 958 CMR 3.505(3), “[f]or purposes of 958 CMR 3.505, “specialty health care” means health care services rendered by a provider other than a primary care provider.”

22. According to 958 CMR 3.506(1), “[n]o carrier that requires an insured to obtain referrals or prior authorizations from a primary care provider for specialty care shall require an insured to obtain a referral or prior authorization from a primary care provider for the following specialty care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in such carrier’s health care provider network: (a) annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse midwife or family practitioner to be medically necessary as a result of such examination; (b) maternity care; and, (c) medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions.”

23. According to 958 CMR 3.506(2), “[n]o carrier shall require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such insureds in the absence of a referral from a primary care provider.”

24. According to 958 CMR 3.506(3), “[c]arriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse-midwives or family practitioners to communicate with an insured’s primary care provider regarding the insured’s condition, treatment and need for follow-up care.”
25. According to 958 CMR 3.506(4), “[n]othing in 958 CMR 3.506 shall be construed to permit an obstetrician, gynecologist, certified nurse midwife or family practitioner to authorize any further referral of an insured to any other provider without the approval of the insured’s carrier.”

26. According to 958 CMR 3.506(5), “[f]or the purposes of 958 CMR 3.506, the term “specialty care” is limited to those services that are medically necessary and consistent with the terms of the carrier’s evidence of coverage.”

27. According to 958 CMR 3.506(6), “[n]othing in 958 CMR 3.506 shall be construed to prohibit a carrier from applying all other applicable health plan requirements for preauthorization or other prior approval for admission to a facility or specific procedures for specialty care provided by an obstetrician, gynecologist, certified nurse-midwife or family practitioner.”