

# Commercial Provider Manual



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# Section 1

## Member Information

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## Section 1

# Member Information

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### Member Plans

Mass General Brigham Health Plan lines of business include Commercial, Qualified Health Plan (QHP) and My Care Family (see My Care Family provider manual).

New members receive a Mass General Brigham Health Plan member identification card, and a welcome guide with information about how to use the plan. Mass General Brigham Health Plan also attempts to contact newly enrolled members to welcome them to the plan and provide education about their benefits and perks, and when applicable, the role of the PCP in managing his or her care.

#### Commercial/Qualified Health Plan (QHP)

Mass General Brigham Health Plan commercial plans are available in all segments of the market, the merged market, and large groups.

HMO members are required to obtain a referral from their PCP for most specialty visits prior to services rendered or any supplies provided. Some exceptions apply. Mass General Brigham Health Plan PPO Plus members are not required to have a PCP, nor obtain referrals for specialty visits. Please see the Prior Authorization, Notification and Referral Guidelines at [Provider.MGBHP.org](https://Provider.MGBHP.org), and the “Utilization Management” section of this manual for more information on the services subject to referral and prior authorization. Failure to obtain the required Mass General Brigham Health Plan approvals may result in claim denials.

Mass General Brigham Health Plan names are based on the type of network the plan follows:

**Complete:** Full access to all providers in Mass General Brigham Health Plan network.

**Choice:** Full access to all providers in Mass General Brigham Health Plan network at different tiered member cost sharing levels for certain services.

#### Large Group Plans

Mass General Brigham Health Plan offers a portfolio of HMO and PPO products and plans offering large group employers a range of plan design and cost sharing options.

To be eligible, employer groups must be based within the Mass General Brigham Health Plan service area and have 51, or greater, eligible full-time equivalent employees.

#### Merged Market Plans

ACA compliant Merged market commercial plans offer quality health care coverage to individuals, families, and small employer groups.

These plans are available to small groups who are based within the Mass General Brigham Health Plan service area (with 50 or fewer eligible full-time equivalent employees) and non-group (individuals and families) who reside within the Mass General Brigham Health Plan service area.

#### Mass General Brigham Employee Plans

Mass General Brigham Health Plan administers health benefits for more than 100,000 Mass General Brigham employees and their covered dependents. Mass General Brigham plans include Plus PPO and Select (EPO).

#### Massachusetts Health Connector (QHP)

Mass General Brigham Health Plan is one of a select number of health insurance plans in Massachusetts that has received the Massachusetts Health Connector’s Seal of Approval to offer a range of product options, including ConnectorCare, available through the state Exchange— the Massachusetts Health Connector. When purchasing through the Health Connector, individuals and groups can

choose from a selection of Mass General Brigham Health Plan product offerings.

### Medicare Balance

Medicare Balance is a product that frees the participant from worrying about deductibles, copays, or coinsurance for any Medicare-covered service with a provider that accepts Medicare. Medicare Balance provides secondary coverage to Medicare—all members are required to have both Medicare Parts A and B.

Medicare Balance does not have a provider network, so members may choose to see any doctor, anywhere in the nation, who accepts Medicare. Medicare Balance members don't need a referral to see a specialist.

For billing purposes, Medicare should be listed as the member's primary coverage and Medicare Balance as their secondary coverage. Also, Medicare Balance pays the entire balance on member deductibles and coinsurance costs for services charged at the Medicare-allowed amount. So, you don't have to collect any out-of-pocket fees from your patients.

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## Member Enrollment

*Member enrollment and eligibility changes are posted daily at our Provider portal at [Provider.MGBHP.org](https://Provider.MGBHP.org). Look for the "Check Eligibility" button on the home screen. Once a member is identified, click on the name to find their Schedule of Benefits (SOB)—the SOB is where you'll find their coverage and eligibility information.*

### Enrollment Activities

Through [MGBHP.org](https://MGBHP.org), primary care sites are notified daily of HMO enrollment activity specific to their practice. This information is provided to assist primary care sites in their own patient outreach efforts.

Currently available information includes:

- *Member Roster* reports listing all active Mass General Brigham Health Plan members
- Transaction reports listing member enrollment activities
  - New members who have chosen the practice as their primary care site
  - Existing members who have transferred from another primary care site
  - Member initiated PCP changes
  - Members terminated by the plan
  - Members active with Mass General Brigham Health Plan but who have elected to get their primary care elsewhere within the Mass General Brigham Health Plan network
- *Provider Roster* reports listing all credentialed or enrolled clinicians.

To ensure proper reimbursement, providers are strongly encouraged to monitor enrollment activity regularly and to notify Mass General Brigham Health Plan Provider Service of any discrepancies.

- To enroll in the Provider portal, please visit [MGBHP.org](https://MGBHP.org) and follow the easy registration instructions—or consult with your site's appointed User Administrator.
- For additional assistance with the Provider portal, email Mass General Brigham Health Plan at [HealthPlanPRWeb@mgb.org](mailto:HealthPlanPRWeb@mgb.org).

### Primary Care Assignments

All Mass General Brigham Health Plan HMO members must select a primary care provider at the time of enrollment.

However, family members may choose different primary care providers. PPO Plus members are not required to select a PCP.

PCPs should make their best efforts to contact newly assigned members to provide an overview of the practice (such as hours and available services). PCPs should also assess any medical needs and, when applicable, schedule an initial appointment.

Mass General Brigham Health Plan provider portal allows providers to update missing or discrepant PCP assignment information, including members transferring their care to another PCP.

Members can also update their PCP via the Member portal.

### Mass General Brigham Health Plan Customer Service

Mass General Brigham Health Plan's highly skilled Customer Service Professionals are available to assist providers and answer questions on eligibility, benefits and policies, or procedures. Customer Service can be contracted as follows:

#### *Providers*

Phone 855-444-4647  
Monday – Friday, 8:00 AM–6:00 PM  
Closed 12:00 to 12:45 pm

#### *Members*

Phone 866-414-5533 (TTY: 711)  
Monday – Friday  
8:00 AM–6:00 PM  
Thursday, 8:00 AM–8:00 PM

Customer Service Professionals can also assist members with updates to their demographics, PCP and other information. Provider requests for updates to a member's PCP information must be submitted through [Provider.MGBHP.org](https://Provider.MGBHP.org).

For Limited English Proficiency (LEP) members, Customer Service Professionals can facilitate a connection with contracted interpreters in over 200 languages.

### The Member Welcome Guide

All new members receive a welcome guide in

- A welcome guide
- Member-specific benefits and coverage information
- Member education materials

### The Welcome Call

New members receive a welcome call to provide an introduction to Mass General Brigham Health Plan and explain how to access services. When appropriate, this call is conducted in the member's primary language to ensure their full comprehension.

Topics covered during the welcome call include:

- Confirmation of demographics and language preference
- Explanation of the role of the PCP, when applicable
- Overview of Mass General Brigham Health Plan benefits, covered services, discounts and perks
- Overview of Mass General Brigham Health Plan's Care Management programs from requiring any member cost sharing. Please refer to Preventive Services Provider Payment Guidelines for a full list of services and codes that are not subject to cost sharing on our commercial plans with a network provider.

### Member Identification (ID) Cards

Each Mass General Brigham Health Plan member is issued an ID card\* with information as shown in the below samples:

[Product reference | Mass General Brigham Health Plan](#)

\*A Mass General Brigham Health Plan ID card itself does not indicate an individual is currently enrolled in the Plan

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## Member Eligibility and Identification

All Mass General Brigham Health Plan members receive a member identification card. A Mass General Brigham Health Plan card itself does not guarantee coverage.

Providers are responsible for verifying eligibility daily, including but not limited to while a member is hospitalized. Mass General Brigham Health Plan will only reimburse for covered services rendered to a member eligible on the date of service and when all other authorization and payment requirements are met.

Except in emergencies, a member's coverage and eligibility should be verified prior to rendering services. The provider portal offers around-the-clock access to member information and other administrative functions. Eligibility information for Mass General Brigham Health Plan members is also available via NEHEN.

### Cost Sharing

Members are fully liable for their corresponding cost sharing (copayment, coinsurance, and deductible amounts), and providers are strongly encouraged to bill Mass General Brigham Health Plan first, then bill the member for the corresponding copayment, coinsurance and/or deductible amounts.

Members are responsible to pay any applicable copayments, coinsurance, and deductibles. In addition, the Patient Protection and Affordable Care Act (PPACA) exempts certain preventive services.

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## Patient Relations

### Member Rights and Responsibilities

Mass General Brigham Health Plan members are entitled to specific rights,

including accessing and correcting medical records information, as shown below.

Members must be allowed to freely apply these rights without negatively affecting how they are treated by providers and/or Mass General Brigham Health Plan. In addition, Mass General Brigham Health Plan providers must treat Mass General Brigham Health Plan members with fairness, honesty, and respect, including refraining from any biases based on income status, physical or mental condition, age, gender, gender identity, sexual orientation, religion, creed, race, color, physical or mental disability, personal appearance, political affiliation, national origin, English proficiency, ancestry, marital status, genetic information, medical history, receipt of health care, veteran's status, occupation, claims experience, duration of coverage, pre-existing conditions, actual or expected health status, need for health care services, evidence of insurability, ultimate payer for services, status as a member, or geographic location within Mass General Brigham Health Plan service areas.

### **Member Rights**

Our valued Mass General Brigham Health Plan members have the right to:

- Receive information about Mass General Brigham Health Plan, our services, our providers, and practitioners, covered benefits, and the rights and responsibilities as a Member of Mass General Brigham Health Plan.
- Receive documents in alternative formats and/or oral interpretation services free of charge for any materials in any language.
- Have their questions and concerns answered completely and courteously.
- Be treated with respect and with consideration for their dignity.
- Have privacy during treatment and expect confidentiality of all records and communications.
- Discuss and receive information regarding treatment options, regardless of cost or benefit coverage, with their Provider in a way which is understood by the member. They may be responsible for

payment of services not included in the Covered Services list for their coverage type.

- Be included in all decisions about their health care, including the right to refuse treatment and the right to receive a Second Opinion on a medical procedure at no cost to the member.
- Change Primary Care Providers.
- Access Emergency Care twenty-four (24) hours a day, seven (7) days a week.
- Access an easy process to voice the member's concerns and expect follow-up by Mass General Brigham Health Plan.
- File a Grievance or Appeal if the member has had an unsatisfactory experience with Mass General Brigham Health Plan or with any of our contracted Providers, or if the member disagrees with certain decisions made by Mass General Brigham Health Plan.
- Make recommendations regarding Mass General Brigham Health Plan's Member rights and responsibilities.
- Create and apply an Advance Directive, such as a will or a health care proxy, if the member is over 18 years of age.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Freely apply the member's rights without negatively affecting the way Mass General Brigham Health Plan and/or the member's Provider treats them.
- Ask for and receive a copy of the member's health record and request that it be changed or corrected, as explained in the Notice of Privacy Practices in the Member Handbook.
- Receive the Covered Services the member is eligible for as outlined in the Covered Services list enclosed with the Member Handbook.

### ***Member Responsibilities***

Members of Mass General Brigham Health Plan also have the responsibility to:

- Choose a Primary Care Provider, the Provider responsible for their care.
- Call their Primary Care Provider when they need health care.
- Tell any health care Provider that they are a Mass General Brigham Health Plan Member.
- Give complete and accurate health information that Mass General Brigham Health Plan or their Provider needs in order to provide care.
- Understand the role of their Primary Care Provider in providing their care and arranging other health care services that they may need.
- To the degree possible, understand their health problems and take part in making decisions about their health care and in developing treatment goals with their Provider.
- Follow the plans and instructions agreed to by the member and their Provider.
- Understand their benefits and know what is covered and what is not covered.
- Call their Primary Care Provider within forty-eight (48) hours of any Emergency or Out-of-Network treatment. If they experienced a Behavioral Health Emergency they should contact their Behavioral Health Provider, if they have one.
- Notify Mass General Brigham Health Plan of any changes in personal information such as address, telephone, marriage, additions to the family, eligibility of other health insurance coverage, etc.
- Understand that they may be responsible for payment of services they receive that are not included in the Covered Services list for their coverage type.



## Assistance with Interpretation/Communication

Mass General Brigham Health Plan contracted practices must provide interpreter services free of charge when necessary, including but not limited to over the phone communication, to Limited English Proficiency (LEP) members. This requirement is in keeping with Title VI of the Civil Rights Act of 1964 that requires recipients of federal financial assistance to provide translation or interpretation services as a means of ensuring that their programs and activities normally provided in English are accessible to LEP persons and thus do not discriminate on the basis of national origin. The provision of translation or interpreter services must comply with applicable state and federal mandates and consider relevant guidance issued by the Department of Health and Human Services Offices of Civil Rights Minority Health, as well as the Massachusetts Office of Health Equity.

Additional resources to assist providers in meeting this obligation include [US Department of Health and Human Services Office of Minority Health](#) and the [Limited English Proficiency](#) websites.

Mass General Brigham Health Plan contracted providers must have the capacity to communicate with members in languages other than English, communicate with individuals with special health care needs (including with those who are deaf, hard-of-hearing, or deaf blind), and make materials and information available in alternative formats.

## Privacy Rights

Mass General Brigham Health Plan believes strongly in safeguarding the personal and health information of our members and expects all Mass General Brigham Health Plan providers to fully comply with all applicable state and federal regulations regarding confidentiality of health information, including but not limited to the privacy and security regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

It is important that privacy regulations do not impact patient treatment or quality of care. Absent specific authorization from the member, HIPAA allows for the exchange of information needed for treatment, payment, and health care operations. Examples that are applicable to the relationship between Mass General Brigham Health Plan and our providers include but are not limited to:

- *Payment* - The exchange of information needed to ensure that appropriate payment is made for services provided to members, including fulfilling authorization requirements, rendering payment, and conducting retrospective audits.
- *Health care operations* - The collection of information for quality assessment and improvement activities such as Healthcare Effectiveness Data and Information Set (HEDIS) audits, medical record reviews, the investigation of grievances, quality of care issues or suspected fraud and abuse. The exchange of information that enables the coordination of medical care for a Mass General Brigham Health Plan member by our team of Care Managers or the provision of information to our providers concerning their patients' utilization of medical services.

Mass General Brigham Health Plan members are informed of their privacy rights, including how Mass General Brigham Health Plan uses their information, by distribution of our Notice of Privacy Practices.

### Treatment of Minors (Privacy)

State law allows minors, under certain circumstances, to consent to medical treatment without parental consent. In such situations, the minor would be able to initiate an appeal or designate an appeal representative with respect to that medical treatment without parental consent. In such circumstances, the minor may need to consent to the release of information concerning that medical treatment, even to the parent(s).

Providers are encouraged to seek legal counsel about minors' consent to medical treatment and about patient confidentiality and privacy.

More information about consent of minors for medical treatment can be found at: [bc.edu/schools/law/jrap/](https://bc.edu/schools/law/jrap/).

Providers with questions or concerns about Mass General Brigham Health Plan's privacy practices can contact Mass General Brigham Health Plan Privacy Officer at 800-433-5556 or [HealthPlanQualityandCompliance@mgb.org](mailto:HealthPlanQualityandCompliance@mgb.org).

### Accessing Emergency Services

Mass General Brigham Health Plan members are covered for care in emergencies. Members can go to any emergency room of any hospital. The hospital does not have to be in the Mass General Brigham Health Plan provider network.

Coverage includes use of an ambulance and post-stabilization care services related to an emergency.

An emergency is a health condition a member believes will put their health in serious danger if immediate medical attention is not received.

Examples of emergencies are:

- Chest pain
- Poisoning
- Trouble breathing
- Severe bleeding
- Convulsions
- Having thoughts of hurting yourself or others

If a member believes their health problem is an emergency and needs immediate attention, the member should be instructed to call 911 at once or go to the nearest emergency room right away to be examined and stabilized before being discharged or transferred to another hospital.

If a member is experiencing a behavioral health emergency, the member should call 911, go to the nearest emergency room, or contact the emergency services program (ESP) in their area.

A list of emergency rooms in all areas of the state can be found in the Mass General Brigham Health Plan Provider Directory.

Members should contact their PCP within 48 hours of any emergency visit to coordinate any needed follow-up care. Members who experience a behavioral health emergency should be instructed to contact their behavioral health provider if they have one.

Mass General Brigham Health Plan members are also covered for emergency care 24 hours a day, seven days a week, even when outside of the Mass General Brigham Health Plan service area.

**Emergency Service Providers (ESP)** Emergency Service Programs (ESP) can offer community-based behavioral health services when a hospital emergency department visit may not be required. Readily available services include crisis assessment, interventions, and referrals to appropriate services and are available to Mass General Brigham Health Plan members.

While some circumstances may necessitate a behavioral health crisis evaluation in an emergency department setting, there are many times when an individual can best be served by having a crisis evaluation conducted at the member's home, ESP office or a community-based location, such as the PCP's office.

PCPs should consider contacting a local ESP for Mass General Brigham Health Plan members presenting with the following:

- Complaints of feeling depressed or having suicidal thoughts
- Deteriorating mental status brought on by recent noncompliance with psychotropic medications or reactions to changes in medical regime
- Inability to utilize usual coping strategies when in crisis

ESPs are available 24/7 and should respond within 60 minutes of being contacted. Additional information about ESPs is available from the National Alliance on Mental Illness at [namimass.org/crisis/who-to-call-for-help](http://namimass.org/crisis/who-to-call-for-help).

A listing of ESPs in all areas of the state is available via Mass General Brigham Health Plan's Provider Directory, by contacting the Statewide Directory for Behavioral Health Emergency Services Program or by calling Optum at 844-451-3518.

### **Mass General Brigham Health**

**Plan/Optum** Mass General Brigham Health Plan has contracted with Optum to partner in managing the delivery of behavioral health services for all members.

Mass General Brigham Health Plan delegates these areas of responsibility to Optum:

- Claims processing and claims payment
- Member connections and Customer Service
- Provider contracting and credentialing
- Quality management and improvement
- Service authorization
- Utilization management/case management

### **Advance Directives**

Mass General Brigham Health Plan members have the right to execute advance directives such as health care agents and health care proxies, living wills and organ donation cards to inform health care providers what to do if they become unable to make decisions about their care.

Mass General Brigham Health Plan actively attempts to increase awareness of its adult members, participating providers, and Mass General Brigham Health Plan staff of the importance of members executing an advance directive.

When applicable, providers should discuss advance directives as part of office visits. The discussion should be documented in the patient's medical record and updated regularly, including whether, or not, the patient chooses to execute an advance directive. If a patient establishes a written advance directive, it is advised that the provider maintain a copy of this in the patient's medical records. Additional information is available at [caringinfo.org](http://caringinfo.org).

### **Communicating with Patients**

Effective patient-provider communication is vital to good health outcomes and patient satisfaction.

Limited English Proficiency, low literacy and/or a patient's medical and emotional health can compromise his/her understanding despite

the clinician's best efforts and affect communication between patients and medical practice staff. Many patients struggle with understanding, and those with limited health literacy are more likely to be hospitalized or frequently use emergency services. Patients should be educated on the first visit as to what to expect from providers and office staff. Information such as practice policies, Patient Rights and Responsibilities, turnaround for returning phone calls and the process for filling prescriptions must be covered early on to ensure a mutual understanding of expectations. The patient must receive a clear explanation (preferably in writing) of what is and isn't acceptable behavior to proactively enhance patient-provider interactions. Office staff should receive adequate training for dealing with patients up to and including:

- Respect for the Patient Bill of Rights
- Avoiding using the caregiver status as a threat to the patient
- Incorrect assumptions about contributing factors to patient behaviors
- Dismissive verbal or body language that can fuel anger
- Adequate communication of acceptable and unacceptable patient behavior
- Depersonalizing patient behavior

### Escalating Protocols

Partnering with the patient in his or her care is key to effective patient-provider relationships. It is recommended that clinicians start by building a rapport with the patient, asking for his or her goal in seeking care and understanding the impact of the illness on the patient's life. Conveying empathy verbally and non-verbally, delivering the diagnosis in terms of his or her original concerns and educating the patient are key to successfully completing an office visit.

If communicating with non-English-speaking patients, using trained medical interpreters (versus a minor, family

member, or non-trained personnel) can result in a more accurate diagnosis, greater patient compliance and, in some cases, a bridge to address patient-provider cultural gaps. Ideally this need is determined at the time of registration so that an interpreter can be involved early on and be scheduled for all of the patient's appointments. Otherwise, an interpreter should be called immediately when the need is discovered.

There should be a brief discussion between the interpreter and the clinician beforehand to clarify the goals of the visit. On meeting with the patient, clinicians should speak directly to the patient and not to the interpreter. A trained medical interpreter should use the first person, thus speaking as the doctor and the patient. For effective interpretation, sentences should be kept short and simple, avoiding use of complicated medical terminology, and repeating critical information such as medication names and/or dosage as requested.

When dealing with patients, understanding factors affecting their behavior can help greatly in developing a care management plan. It is sometimes possible to predict patients who may become easily agitated, irrational, or violent, depending on their medical condition. Some patients also struggle with feeling let down by their ailing bodies or feeling spiritually betrayed.

Rushing through a visit can be counterproductive. Providers are encouraged to pay close attention to the patient's words, voice, or attitude to pick up anger signs or levels that might express fear, anger, or violence.

Providers should also watch for overly compliant behavior, which could suggest that the patient has lost his or her identity. Providers should directly address their patient's underlying feelings, making eye contact at all times, and addressing the patient as "Mr." or "Miss/Ms./Mrs." in a friendly manner. When appropriate, obtaining assistance from relatives may help break any isolation the patient may feel and create solutions while also providing support.

## Terminating a Patient from Your Practice

Mass General Brigham Health Plan recognizes the critical importance of a positive therapeutic relationship and is committed to working with provider practices in developing and maintaining strong patient relationships. However, we recognize that at times the relationship may be jeopardized by the actions of a member and that on rare occasions, a provider may contemplate terminating a member from the practice. A patient's behavior isn't always indicative of being angry at their health care providers.

Validating a patient's frustration and concerns may go a long way in improving therapeutic relationships. Termination from a practice while a member is in an emergent or urgent care situation, in the latter stages of pregnancy or is not mentally competent, is rarely justifiable.

Medical office staff should be trained to maintain a professional demeanor and when appropriate, leave the room after conveying empathy with the patient's situation, giving them time to think about what is happening.

Mass General Brigham Health Plan is committed to collaborating closely with the provider and the member. This includes but is not limited to:

- Facilitating access to behavioral health treatment and community resources
- Participating in case conferences
- Providing intensive care management.

Providers are expected to make every effort to resolve incompatible patient relationships and to proactively notify Mass General Brigham Health Plan of unresolved patient issues as they are identified by emailing Provider Services at [HealthPlanProvidersService@mgb.org](mailto:HealthPlanProvidersService@mgb.org). The notification to the health plan must include the patient's name and date of birth, a summary of the issues and supporting documentation, including copies of

documented attempts made to address the patient's behavior prior to reaching the decision. Mass General Brigham Health Plan will acknowledge receipt, and the provider will be contacted directly if additional information is needed to review the request. As part of our thorough review of these cases, MGBHP may request additional and/or missing information, including a copy of the practice's patient rights and responsibilities or code of conduct policy, when applicable.

If it is jointly determined that issues cannot be addressed to the satisfaction of both parties, and a decision is made that the only alternative is terminating the patient relationship, the decision should not be communicated to the member until after jointly coordination with Mass General Brigham Health Plan. This will ensure effective continuity of care and that these decisions are made in an objective and fair manner.

### Notification to Member

The provider is responsible for communicating, in writing, to the member and to Mass General Brigham Health Plan the reason for the decision and the effective date of termination. Except in instances of imminent danger, the member must be provided with at least 30-days advance notice to transition their care to another provider.

At a minimum, the letter should include:

- The reason for the decision
- The effective date of termination
- A summary of attempts made by the provider's practice to work with the patient prior to reaching the decision
- The option of continuing care for at least 30 days while the patient makes other arrangements
- The process for the transfer of medical records
- Instructions to contact Mass General Brigham Health Plan Customer Service with questions about their new Primary Care Provider

## Section 2

# Covered Services

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Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.

## Section 2

### Covered Services

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#### Overview

Mass General Brigham Health Plan's lines of business include Commercial (HMO and PPO Plus plans), Qualified Health Plans (QHP) and My Care Family (see the My Care Family Provider Manual). It is important for providers to confirm a member's eligibility and coverage upon arrival for an appointment as coverage for certain services varies by plan.

Important details about your Mass General Brigham Health Plan patient's coverage and eligibility are found at [Provider.MGBHP.org](https://Provider.MGBHP.org). Look for the "Check Eligibility" button on the home screen. Once a member is identified, click on their name to find their Schedule of Benefits—home to all their plan's coverage information.

Some benefits have limits, and it is important to note each plan's definition of "benefit period."

- Commercial plans may have a plan year or calendar year; please log into [Provider.MGBHP.org](https://Provider.MGBHP.org) or call Mass General Brigham Health Plan's Provider Service for additional information.
- Additionally, some services may be covered on a rolling period (for example, a routine eye exam may be covered once every 12 months). This would require the next appointment is booked 12 months and 1 day after the current appointment.

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#### General Coverage Requirements

To be covered by Mass General Brigham Health Plan, all health care services and supplies must be:

Provided by or arranged by the Member's primary care provider (PCP) or a Mass General

Brigham Health Plan in-network provider\*

- A Referral has been obtained (most specialty care requires a Referral for HMO plans)
- Prior Authorized when required
- Medically Necessary
- A Covered Health Care Service under the benefit plan of the member
- Provided to an eligible Member enrolled in a Mass General Brigham Health Plan

Detailed coverage information is available at [Provider.MGBHP.org](https://Provider.MGBHP.org) or by calling Mass General Brigham's Health Plan's Provider Service.

\*Exceptions: Members can access emergency services as noted in Section 1, "Access to Emergency Services—Out-Of-Area."

#### Commercial/Qualified Health Plan (QHP) HMO Plans

For a listing of covered services, please check [Provider.MGBHP.org](https://Provider.MGBHP.org) or call Mass General Brigham Health Plan's Provider Service.

- Some custom Commercial plans do not include Pharmacy coverage.
- Commercial plan coverage may include member cost sharing including deductibles, copays, and coinsurance.

Mass General Brigham Health Plan will cover the medically necessary Covered Health Services listed in Section 7 of member handbooks during the period of the clinical trial that they are a Member of Mass General Brigham Health Plan, as long as they meet certain requirements.

Members must qualify to participate in an approved clinical trial for the treatment of cancer or other life-threatening medical condition and have been referred to the clinical



trial by a Network Provider or have provided medical and scientific information to Mass General Brigham Health Plan proving they meet the conditions for participation in the clinical trial. An approved clinical trial is defined as having been funded or approved by at least one of the following entities: National Institutes of Health (NIH); Center for Disease Control and Prevention; Agency for Health Care Research and Quality; Centers for Medicare & Medicaid Services; a cooperative group or center of any of the above or the Department of Defense, Veterans Affairs or the Department of Energy; or a qualified non-governmental research entity identified in NIH guidelines for grants; or (b) a study or trial under a Food and Drug Administration approved investigational new drug application; or (c) a drug trial that is exempt from investigational new drug application requirements.

Mass General Brigham Health Plan coverage during approved clinical trials excludes the investigational item, device or service; items and services solely for data collection and analysis; and services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. Coverage is provided when services are rendered by Network Providers; prior authorization must be obtained in order to receive coverage of services rendered by Out-of-Network Providers.

Mass General Brigham Health Plan Commercial/QHP members are not covered for the following unless specifically noted in the plan's *Schedule of Benefits* or *Member Handbook*:

- Acupuncture
- Benefits from other sources
- Biofeedback
- Blood and related fees except as specified in the *Member Handbook*
- Charges for missed appointments
- Chiropractic Care, except as noted in the individual plan's Schedule of Benefits

Cosmetic Services and Procedures, unless medically necessary or mandated by state law:

- Custodial or Rest level of care services
- Dental Care
- Dentures
- Diet foods
- Educational testing and evaluations
- Exams required by a third party
- Experimental Services and procedures
- Eyewear/Laser Eyesight Correction, except as noted in the *Member Handbook*
- Foot Care, except as noted in the *Member Handbook*
- Fitness Program Benefit or Reimbursement, except as noted in the individual plan's Schedule of Benefits
- Hearing aids for adults (22 and older), except as noted in the *Member Handbook*
- Long term care
- Massage therapy
- Other non-covered services as noted in the *Member Handbook*
- For HMO members, services received from an Out-of-Network Provider, excluding urgent or emergency services and those which have been prior authorized
- Non-emergency care when traveling outside the United States
- Personal comfort items
- Planned Home Births
- Private-duty nursing
- Reversal of voluntary sterilization
- Services covered under other sources, such as Workers Compensation or veteran's benefits
- Self-monitoring devices, except as noted in the *Member Handbook*
- Weight Loss Program Benefit, except as noted in the individual plan's Schedule of Benefits
- Wilderness Therapy



### Commercial PPO Plus Plans

Members with a Mass General Brigham Health Plan PPO Plus Plan do have coverage for services with out of network providers as outlined in their Schedule of Benefits, member handbook and amendments. A Prior Authorization to receive services out of network is not required in the PPO plan; however, services that require Prior Authorization to confirm medical necessity in network also require Prior Authorization out of network.

- The individual rendering the service may be a Physician, Nurse Practitioner, Physician Assistant, Registered Nurse, Licensed Practical Nurse or Medical Assistant certified in the application of fluoride varnish.

- The individual rendering the service must complete the Oral Health Risk Assessment Training or equivalent.
- The provider must meet all claim submission requirements including use of valid procedure codes.
- The member is under the age of 18.
- The service is medically necessary as determined by a Caries Assessment Tool (CAT).

PCP sites that do not have providers or staff certified in the application of fluoride varnish must direct patients in need of fluoride varnish to Mass General Brigham Health Plan's Customer Service team for help finding a certified provider.

## Section 3

# Provider Management

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## Section 3

### Provider Management

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#### Provider Recruitment

The various ways providers can join a Mass General Brigham Health Plan provider network include:

- A provider may submit a request in writing to Mass General Brigham Health Plan Provider Network Operations
- Mass General Brigham Health Plan may recruit providers in geographic areas where there is a deficit of specific provider types
- Mass General Brigham Health Plan may respond to requests from employer groups or primary care sites seeking to access providers within a given service area

#### Becoming a Participating Provider

Participation in a Mass General Brigham Health Plan provider network requires the execution of a provider agreement. This agreement contains the provisions that govern the relationship between Mass General Brigham Health Plan and the provider.

A clinician or group will be considered a participating provider only upon successful execution of a provider agreement. The provider must notify Mass General Brigham Health Plan of any changes to the information submitted in the initial application request to contract. Material omissions and/or misstatements in the application request to contract will deem the contract voidable.

The contract will be effective as of a date determined by Mass General Brigham Health Plan, and the provider will be notified accordingly. Mass General Brigham Health Plan will not reimburse for any services provided prior to the effective date of the contract.

When applicable, credentialing requirements must be met before becoming a contracted provider.

Some changes in a provider's practice may require reconsideration by Mass General Brigham Health Plan, up to and including re-application for continued participation as a network provider.

These changes include but are not limited to:

- Change in practice location to a different state
- Change in practice specialty
- Change in ownership
- Entering or exiting from a group practice
- Changes in hospital privileges
- Change in insurance coverage
- Disciplinary and/or corrective action by a licensing or federal agency
- Material changes in the information submitted at the time of contracting

When in doubt, please send an email\* to [HealthPlanPEC@mgb.org](mailto:HealthPlanPEC@mgb.org).

\* Please do not send Protected Health Information (PHI) through unsecured email.

#### Board Certification Requirement

Mass General Brigham Health Plan requires board certification for PCPs and specialty physicians to ensure that the percentage of board-certified PCPs and specialty physicians participating in Mass General Brigham Health Plan's provider networks, at a minimum, is approximately equivalent to the community average for PCPs and specialty physicians. Participating physicians are required to be either board-certified or board-eligible and to be actively pursuing board certification to participate with Mass General Brigham Health Plan.

During the initial credentialing process and then every two years, Mass General Brigham Health Plan will validate a participating physician's

board certification status. If the participating physician is not board-certified, he/she must provide written documentation that they are board-eligible and are actively pursuing board certification within the required time as defined by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).

Any provider that is not board-certified and not appropriately board-eligible must receive approval to be added to a Mass General Brigham Health Plan provider network.

### Primary Care Provider Group (PCPG)

A primary care provider group (PCPG) is an entity whose practice is in general/internal medicine, pediatrics, family practice, or OB/GYN and is contracted with Mass General Brigham Health Plan to provide and coordinate comprehensive health care services to all assigned members. A PCPG may be a health center, hospital ambulatory care clinic, or other physician practice and can consist of one or more clinicians and/or locations.

### Role of the Primary Care Provider

The primary care provider (PCP) provides or manages first-contact, continuous and comprehensive health care services for a defined group of assigned members at his/her primary care site. The PCP is responsible for providing, arranging for, and coordinating the provision of covered services to his or her Mass General Brigham Health Plan patients.

A PCP can be an individual physician, a registered nurse practitioner, or a physician assistant eligible to practice one of the following specialties:

- Family practice
- Internal medicine
- OB/GYN
- Pediatrics

### Specialty Providers

A specialty provider is responsible for the provision of covered specialty care services working in collaboration with the member's PCP. Mass General Brigham Health Plan's specialty provider networks include specialists in over 120 specialties.

### Role of the Specialty Provider

Mass General Brigham Health Plan expects specialty providers to communicate their findings in a timely manner to the PCP and when applicable, other referring providers. A consultation is not considered complete until the specialist's provision of a written report to be incorporated by the PCP's office into the patient's medical record.

### Concierge Providers

If any provider intends to offer certain amenities or special service not considered covered services in exchange for payment of any additional fee or charges by the member, he or she must notify Mass General Brigham Health Plan in writing at least 90 days before charging such fee to any Mass General Brigham Health Plan member.

The provider must also give the following information in writing to all Mass General Brigham Health Plan members receiving care from such provider:

- A copy of the member notification and decision to charge a fee
- The amount and frequency of the fee
- Benefits and relevant services covered in the fee
- A statement indicating that Mass General Brigham Health Plan is not responsible for the payment of the fee and is only responsible for payment of medically necessary services covered by Mass General Brigham Health Plan

Written requests should be emailed to Mass General Brigham Health Plan at [HealthPlanPEC@mgb.org](mailto:HealthPlanPEC@mgb.org).

Continuity of care must be provided to any member who is unable or chooses not to pay this fee. 90 days must be provided for continuity of care. Whenever possible, information regarding patient reassignment to other providers and support for the patients through this transition should be provided.

Upon submission of this request to Mass General Brigham Health Plan, Mass General Brigham Health Plan will notify the DOI as required. Mass General Brigham Health Plan's Provider Directory will be updated to reflect concierge status for your practice to inform members of potential fees.

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## Credentialing

Mass General Brigham Health Plan has a full credentialing delegation agreement with Andros Technologies, Inc.

Credentialing is a process used to ensure that providers who intend to participate and practice in a Mass General Brigham Health Plan network meet a level of quality compared to established standards. Mass General Brigham Health Plan uses the National Committee on Quality Assurance (NCQA) guidelines in the credentialing process. Mass General Brigham Health Plan continuously strives to expand the capacity of its provider networks through the credentialing process to have multilingual practitioners available to members who are responsive to linguistic, cultural, ethnic, and other unique needs of minority groups or special populations and who do not unlawfully discriminate based upon state or federal laws and regulations. The credentialing application collects information on a practitioner's languages spoken.

Mass General Brigham Health Plan expects that all credentialed practitioners obtain the required Continuing Education Units in their practice areas as recommended by their applicable licensing board. Unless based on

access requirements where exceptions are granted, all credentialed physicians must be board-certified in their medical specialty or be in the process of achieving initial certification in a time frame relevant to guidelines established by their respective medical specialty board. In some cases, Mass General Brigham Health Plan retains the right to contract and enroll providers who are not board certified if there is a shortage of providers in that specialty. Upon receipt of a physician's new certification status, the physician is required to notify Mass General Brigham Health Plan of his or her new certification status. Mass General Brigham Health Plan monitors all non-board-certified physicians' board certification at least every two years or at the time of the physician's re-credentialing cycle.

At a minimum, all medical doctors (MDs), doctors of osteopathy (DOs), doctors of optometry (ODs), doctors of chiropractic medicine (DCs), doctors of podiatric medicine (DPMs) and any independently licensed and practicing practitioner must be credentialed by Mass General Brigham Health Plan. Doctors of dental medicine (DMDs) and doctors of dental surgery (DDSs) must be credentialed to be participants in Mass General Brigham Health Plan's network. Allied professionals such as physical therapists (PTs), occupational therapists (OTs), and speech and language therapists (SLTs) are also subject to credentialing requirements at a group level. Nurse practitioners (NPs) and physician assistants (PAs) (acting in the role of a PCP), and certified nurse midwives (CNMs) are also eligible for credentialing and billing under their corresponding National Provider Identifier (NPI) number.

A nurse practitioner or a physician assistant, practicing within the scope of his or her license, including all regulations requiring collaboration with a physician, may choose to enroll as a PCP subject to member assignments.

Re-credentialing occurs in a two-year cycle

consistent with the practitioner’s birth month and year.

Hospital-based physicians with specialties in pathology, emergency room, anesthesiology, and radiology (also known as HERAP providers) practicing exclusively in a facility setting or facility-based emergency room are not credentialed by Mass General Brigham Health Plan. That list would also include NPs (specialists), Covering providers, Locum Tenens, Urgent Care providers, and Critical Care Medicine specialists. However, they are reviewed and privileged through their respective licensed institutions, which includes review of their credentials. Behavioral health practitioners are credentialed by Mass General Brigham Health Plan’s behavioral health benefits manager, Optum.

### The Credentialing Committee

The Credentialing Committee is Mass General Brigham Health Plan’s peer review body with responsibility for oversight of the credentialing and re-credentialing functions. The committee also meets monthly or on an as-needed basis to review other applications and includes consultants actively practicing in some of the same specialties as those practitioners credentialed by Mass General Brigham Health Plan.

Mass General Brigham Health Plan’s Chief Medical Officer, or designee, is responsible for oversight of the credentialing program. Portions of the credentialing process may be delegated. However, Mass General Brigham Health Plan retains the right to approve new clinicians and to terminate or suspend existing clinicians.

At each meeting the Credentialing Committee makes one of the following credentialing decisions about inclusion in or exclusion from Mass General Brigham Health Plan’s provider networks:

- Approve
- Conditionally approve (with a corrective

action plan and follow-up)

- Table for more information and further review
- Decline/deny

### Practitioner Rights

Mass General Brigham Health Plan does not discriminate against any qualified applicant for practitioner network membership solely because of race, color, national origin, ancestry, age, sex, religion, disability, sexual orientation or type of procedure or patient served.

Mass General Brigham Health Plan’s credentialing policies do not discriminate against clinicians who service “high-risk” populations or who specialize in conditions or procedures requiring costly treatment.

Practitioner rights in the credentialing and re-credentialing processes include:

- The right to review information submitted to support their credentialing application (except National Practitioner Data Bank [NPDB] reports, as required by law)
- The right to correct erroneous information
- The right to be informed of the status of their credentialing or re-credentialing application, upon request.

For more information, contact Mass General Brigham Health Plan Provider Service at 855-444-4647 or email [HealthPlanPEC@mgb.org](mailto:HealthPlanPEC@mgb.org).

### Sanctioned Providers

To ensure a quality network and the safety of enrolled members, Mass General Brigham Health Plan reserves the right to alter a contractual relationship when a practitioner fails to meet Mass General Brigham Health Plan’s quality standards.

Mass General Brigham Health Plan monitors the

following activities on an ongoing basis as a part of the re-credentialing and re-licensure process:

- Sanctioned providers
- Adverse events
- Complaints

Decisions about altering a practitioner's relationship with Mass General Brigham Health Plan are guided by patient care considerations and based on information submitted by the practitioner as well as other objective evidence.

If at any time a practitioner's license is suspended or terminated, that practitioner becomes ineligible for providing services to any member. Mass General Brigham Health Plan will not reimburse such excluded practitioners/providers for services furnished, directed, or prescribed by such a practitioner.

An appeal process is available for practitioners who are not offered network participation after initial credentialing or re-credentialing. Notification of their right to appeal a credentialing decision and a description of the appeal process is included in Mass General Brigham Health Plan's letter to the practitioner at the time they are notified of the adverse credentialing or re-credentialing decision. Practitioners have the right to review information submitted to support their credentialing and re-credentialing application (excluding NPDB information) at any time. The practitioner may request to review his or her credentialing or re-credentialing file in writing, verbally or electronically, and a member of Mass General Brigham Health Plan's Credentialing staff will contact him or her to schedule a mutually agreed upon time to review the file. If desired by the practitioner, copies of the file can be forwarded to the practitioner by certified, returned receipt mail.

Practitioners have the right to correct erroneous information submitted to Mass General Brigham Health Plan in support of their credentialing or re-credentialing application.

Mass General Brigham Health Plan reports all terminations of network practitioners for quality of care reasons to the appropriate authorities, including the NPDB and the state licensing board. Reporting of practitioners terminated for quality reasons occurs within 15 calendar days of the practitioner's final appeal outcome in accordance with the regulations governing the NPDB and the procedures set forth below. The provider always can appeal any negative credentialing decision.

If there is a negative report, disciplinary action, sanction, or other evidence of serious quality deficiencies regarding a practitioner, an objective assessment of the practitioner's practice is undertaken by the Mass General Brigham Health Plan Credentialing Committee to determine whether the practitioner's status or contract should be reduced, suspended, or terminated. Events leading to a change in the practitioner's participation status with Mass General Brigham Health Plan include but are not limited to:

- Sanctions rendered by a state or federal agency
- Refusal to comply with Mass General Brigham Health Plan, local, state, or federal requirements, or regulations on clinical or administrative practices
- A pattern of practice that falls below applicable standards and expectations
- Failure to maintain full and unrestricted licensure in the Commonwealth of Massachusetts
- Failure to comply with accepted ethical and professional standards of behavior

When any of the following situations comes to the attention of Mass General Brigham Health Plan staff, the information regarding the practitioner, as well as all available historical credentialing and performance information, is presented for review by the chairperson of the Credentialing Committee, or his or her designee:

- The practitioner's application for staff

privileges or membership with any group/facility is denied or rejected for disciplinary cause or reason

- The practitioner's staff privileges, membership, or employment with any group/facility is terminated or revoked for disciplinary cause or reason
- The practitioner voluntarily accepts, or restrictions are imposed on, staff privileges, membership, or employment with any group/facility for disciplinary cause or reason
- Malpractice complaints
- Any sanction imposed by the Massachusetts Board of Registration in Medicine, Board of Nursing, the Office of the Inspector General, or any state or federal agency
- A pattern of practice that falls below applicable standards and expectations
- Failure to maintain full and unrestricted licensure in the Commonwealth of Massachusetts
- Failure to comply with accepted ethical and professional standards of behavior
- Refusal to comply with Mass General Brigham Health Plan, local, state, or federal requirements or regulations on clinical or administrative practices

The chairperson, or his or her designee, will make an immediate and temporary decision on whether to suspend or reduce the practitioner's participation status with Mass General Brigham Health Plan. A decision to immediately suspend or curtail a practitioner's participation status is made when the event indicates that a practitioner may be a threat to the health and/or safety of his or her patients and/or is in a situation where the practitioner cannot serve the health needs of his or her patients appropriately.

Where a determination that the seriousness of the deficiency warrants an immediate alteration of a practitioner's participation status, the practitioner is notified in writing that a

professional review action has been brought against him or her, including the reasons for the action and a summary of the consideration process and appeal rights.

The practitioner is invited to attend a meeting within 30 calendar days to have his or her case heard and provided with the corresponding date, time, location, and other relevant information.

The practitioner may present appropriate materials supporting his/her case. After full consideration of the facts, the committee will decide as follows:

- Continued full participation
- Continued participation with supervision
- Continued participation with mandatory education, counseling and/or training
- Continued participation with limits
- Reduction or restriction of participation privileges
- Suspension from the network for a given time period or until conditions for full participation are met
- Termination from a Mass General Brigham Health Plan provider network

The practitioner is notified by registered mail within 10 business days of the Credentialing Committee's determination. When applicable and depending on the decision, the notification may include the following information:

- That a professional review action has been brought against the practitioner, reasons for the action and a summary of the appeal rights and process
- That the practitioner is allowed to request an appeal hearing no later than 30 calendar days from the date of the letter
- That the practitioner may be represented by an attorney or another person of his or her choice during the appeal proceedings
- That if an appeal is requested by the practitioner, Mass General Brigham Health Plan will appoint a panel of individuals to review the appeal and



notify the practitioner in writing of the appeal decision and reasons.

Mass General Brigham Health Plan Provider Service and other relevant staff are notified of any change in the practitioner's relationship with Mass General Brigham Health Plan, along with notification to the Executive Office of Health and Human Services, applicable state licensing boards, the National Practitioner Data Bank, and other applicable entities of any reportable incidents. Updates to Mass General Brigham Health Plan's online provider directory are made immediately.

If the practitioner is a PCP, the practitioner's member panel will be closed, and arrangements will be made for the transfer of the membership to another credentialed primary care network provider.

### Appeals Process

If a practitioner chooses to appeal a network participation decision made by Mass General Brigham Health Plan, the request must be made in writing within 30 calendar days from Mass General Brigham Health Plan's notification. The notification should include whether the practitioner will bring an attorney or another person of his or her choice.

Pending the completion of the appeal process and unless specified otherwise, the initial decision of the Credentialing Committee remains in full force and effect.

Upon timely receipt of the request, a meeting is scheduled with Mass General Brigham Health Plan's Appeals Panel to review the appeal. The Appeals Panel consists of: Mass General Brigham Health Plan's Vice President of Provider Network Management, Mass General Brigham Health Plan's Chief Medical Officer or designee, Director of Enrollment and Legal Regulatory and Compliance. Each panel member can appoint a designee of his or her choice, and Mass General Brigham Health Plan's

legal counsel will be present when deemed appropriate.

The practitioner is notified of the Appeals Panel decision in writing, including the specific reasons for the decision.

### Reporting to Appropriate Authorities

After a final determination has been made resulting in a practitioner's termination, a letter is issued to the practitioner advising him or her of Mass General Brigham Health Plan's determination, including its responsibility to report such termination to the NPDB, EOHHS and appropriate state board licensing entities. The practitioner may dispute the language of the NPDB or state reports. A dispute can be based upon any one of the following reasons:

The factual accuracy of the report

- Whether the report was submitted in accordance with the NPDB or other state guidelines
- Mass General Brigham Health Plan's eligibility as an NPDB reporting entity
- Upon receipt, Mass General Brigham Health Plan will review the applicable reason(s) and determine as to whether any changes should be made. When applicable, necessary changes are processed.

Subsequent notification to the practitioner, the NPDB, applicable state board licensing entities and EOHHS is made indicating one of the following actions:

- Void of the initial report
- No action
- Correction to the language reported

When no appeal is initiated by the practitioner within 30 calendar days following notice of the Mass General Brigham Health Plan decision, or when an appeal is upheld, the practitioner's name remains removed from Mass General Brigham Health Plan's provider directory. When applicable, arrangements are made by Mass General Brigham Health Plan staff to have

affected members assigned to another contracted provider.

### Credentialing Requirements

To participate in a Mass General Brigham Health Plan provider network and, where applicable, be listed in Mass General Brigham Health Plan’s provider directories, practitioners must be credentialed by Mass General Brigham Health Plan. Providers listed in the provider directory are those who a member can choose when accessing care.

Mass General Brigham Health Plan does not recognize interim or provisional credentialing or providers still in training. Providers must be fully credentialed before they can be compensated for care rendered to Mass General Brigham Health Plan members.

Practitioners seeking enrollment with Mass General Brigham Health Plan and who work for a Mass General Brigham Health Plan contracted group must first submit a request through Mass General Brigham Health Plan Provider Enrollment Portal. Alternatively, the group can also submit a completed HCAS Enrollment Form to Mass General Brigham Health Plan with preliminary information about the practitioner and his or her practice.

The form may be sent to:

Address: Mass General Brigham  
Health Plan  
Credentialing Department  
399 Revolution Drive, Suite 810  
Somerville, MA 02145

Fax 617-526-1982

Email [HealthPlanPEC@mgb.org](mailto:HealthPlanPEC@mgb.org)

Shortly after receipt and processing of the enrollment request, the practitioner or his or her credentialing administrator will receive a welcome packet with instructions for completing the initial credentialing submission process by registering with Council for Affordable Quality Healthcare (CAQH) that contains a replica of the Integrated Massachusetts Application (IMA). Those

practitioners submitting an enrollment request but already registered with CAQH and who have authorized release of their CAQH information to Mass General Brigham Health Plan will not receive a welcome packet but may receive an email requesting that they re-attest to their data. Provided that the attestation is current, Mass General Brigham Health Plan will then initiate the credentialing process.

Mass General Brigham Health Plan’s (Andros’) credentialing process involves accumulating and verifying many elements of a practitioner’s professional history including licensure, training, hospital privileges and malpractice history. At a minimum, Mass General Brigham Health Plan is required to:

- Check each applicant with the National Practitioner Data Bank (NPDB)
- Verify licensure to practice, DEA (as applicable), and malpractice insurance coverage of \$1,000,000 per occurrence and \$3,000,000 aggregate
- Determine if an applicant has any pending Medicare or Medicaid sanction
- Where applicable, verify that an applicant has clinical privileges in good standing at a licensed facility designated by the applicant as the primary admitting facility. If an applicant does not have admitting privileges, the applicant must have a coverage relationship with a Mass General Brigham Health Plan credentialed provider.

Mass General Brigham Health Plan has a process in place to provide ongoing performance monitoring of practitioners between credentialing and re-credentialing cycles. In addition to monitoring practitioner performance through member complaints and grievances, at least twice a month Mass General Brigham Health Plan’s Credentialing staff checks state licensing boards’ disciplinary action lists for license restrictions/sanctions and the Office of the Inspector General’s latest Exclusion and Reinstatement Lists of individuals and

organizations excluded from Medicare/Medicaid/federal programs. Complaints received by Mass General Brigham Health Plan and sentinel events regarding practitioners are also compiled periodically for review.

If a credentialed, contracted practitioner has been disciplined, excluded, or is shown to have other performance issues after his or her initial credentialing, Mass General Brigham Health Plan will immediately take appropriate actions to address the issue, in accordance with its policies and procedures. Possible actions taken may range from establishing corrective action plans with close monitoring for compliance until the issues are resolved to reconsideration of the credentialing decision, up to and including termination from the network. Mass General Brigham Health Plan also has a process in place to notify applicable state licensing boards and the National Practitioner Data Bank of any reportable incidents.

### The Credentialing Process

Mass General Brigham Health Plan is a member of [Healthcare Administrative Solutions, Inc.](#) (HCAS). This non-profit entity was founded in 2007 with collaboration from several Massachusetts health plans to streamline the credentialing and re-credentialing processes.

Submission of those elements of the credentialing and re-credentialing transactions that are common to participating HCAS health plans can occur through a centralized database. The CAQH allows providers to submit credentialing information once into its Universal Credentialing Data Source to be used by all HCAS health plans in which the practitioner participates or is in the process of contracting.

As part of the full delegation agreement with Andros Technologies, Inc., Mass General Brigham Health Plan is committed to the turn-around of completed credentialing applications submitted by Medical Doctors (MDs), Doctors of Osteopathy (DOs) and other PCPs within 30

days of receipt of a completed application. Upon completion of the credentialing process, providers are notified within four business days of the Credentialing Committee decision and are included in the Mass General Brigham Health Plan provider directory. Providers who do not meet the credentialing standards are given an opportunity to appeal the decision.

### Andros Credentialed Providers

Mass General Brigham Health Plan has a full delegated credentialing agreement with Andros Technologies, Inc. for both their initial credentialing and re-credentialing process.

### The Re-credentialing Process

Re-credentialing occurs in a two-year cycle consistent with the practitioner's birth month and year.

A practitioner who has been successfully credentialed by Mass General Brigham Health Plan, and either leaves the practitioner network voluntarily or has been terminated by Mass General Brigham Health Plan for any reason with a break in service greater than 30 calendar days, must go through Mass General Brigham Health Plan's initial credentialing process again prior to reinstatement in the network.

### Locum Tenens

Mass General Brigham Health Plan defines locum tenens as a physician covering for another physician temporarily for six months or less and not subject to full credentialing.

Providers must specifically indicate that the physician is being enrolled in a locum tenens capacity. Enrollment for these clinicians require completion of request in Mass General Brigham Health Plan's Provider Enrollment Portal or an HCAS Enrollment Form, and malpractice information as well as hospital privileges or covering arrangements otherwise. Locum tenens providers are not eligible to render and bill for services until written

confirmation from Mass General Brigham Health Plan of their successful enrollment and are held to the same expectations of all other Mass General Brigham Health Plan providers.

If the locum tenens physician will be in place beyond six months, Mass General Brigham Health Plan must be notified at least 45 days ahead of time such that Mass General Brigham Health Plan can initiate the abbreviated credentialing process. Failure to timely notify Mass General Brigham Health Plan will result in claim denials and the retroactive processing of any denied claim cannot be considered.

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## Provider Enrollment

Mass General Brigham Health Plan requires that, when applicable, all providers be credentialed or enrolled prior to rendering care. Mass General Brigham Health Plan does not recognize interim or provisional credentialing of practitioners still in training. Services rendered prior to a practitioner's enrollment by Mass General Brigham Health Plan cannot be honored. Practitioners seeking enrollment with Mass General Brigham Health Plan, and employed by a Mass General Brigham Health Plan contracted group, must submit a request through Mass General Brigham Health Plan's Provider Enrollment Portal or a completed [HCAS Enrollment Form](#) to Mass General Brigham Health Plan with preliminary information about the practitioner and his/her practice.

Provider sites can review a list of all Mass General Brigham Health Plan enrolled clinicians, including original effective dates of the affiliation via the Provider Roster reports available from our provider portal, [Provider.MGBHP.org](#). For new Mass General Brigham Health Plan providers, the practitioner is notified (by letter) of his/her ability to begin rendering care upon approval for network participation by Mass General Brigham Health Plan's Credentialing

Committee.

For questions on a clinician's enrollment status, email Mass General Brigham Health Plan at [HealthPlanPEC@mgb.org](mailto:HealthPlanPEC@mgb.org) or contact Mass General Brigham Health Plan Provider Service at 855-444-4647.

## Provider Enrollment Changes

To keep accurate network provider information, Mass General Brigham Health Plan must be promptly notified *in writing* of relevant changes pertaining to a provider's practice. The primary way to notify Mass General Brigham Health Plan of enrollment changes is through the Provider Enrollment Portal. The Provider Enrollment Portal gives you easy access to submit requests such as the following:

Enroll a new provider into your group

- Terminate an existing provider from your group
- Open and close your panels
- Submit demographic changes
- Generate a complete HCAS form

The Provider Enrollment Portal gives you real time status information of your enrollment request, as well as send you an email notification when your request has been completed.

Providers can also submit provider enrollment changes on the Standardized Information Change Form or with a signed document on the provider's stationery. Completed forms should be emailed to [HealthPlanPEC@mgb.org](mailto:HealthPlanPEC@mgb.org). Verbal requests and/or those submitted by third parties or billing agents not on record as authorized to act on a provider's behalf cannot be accepted.

## Provider Terminations

For providers terminating from a practice, Mass General Brigham Health Plan requires written notification at least 60 days *prior to* the practitioner's termination date unless otherwise agreed upon.

The notification must be submitted through the Provider Enrollment Portal on [Provider.MGBHP.org](https://Provider.MGBHP.org), on the [Standardized Provider Information Change Form](#), on the Provider Termination Request Form, or using a similar document on the provider's stationery that includes at a minimum:

- The provider's name
- National provider identification (NPI) number
- Effective date of termination
- Reason for termination
- If PCP, panel re-assignment instructions
- Signature and title of the person submitting the notification

Upon receipt of the notification, Mass General Brigham Health Plan's staff will work with affected members, the provider's office, and when applicable, specialty providers, to ensure continuity of care.

Involuntary terminations (those initiated by Mass General Brigham Health Plan) will include notification to the provider and the practice as needed.

Except when a provider's termination is based upon quality related issues or fraud, Mass General Brigham Health Plan may allow continuation of treatment for covered services for:

- Up to 30 days following the effective date of the termination if the provider is a PCP
- Up to 90 days for members undergoing active treatment for a chronic or acute medical condition; or through the lesser of the current period of active treatment with the treating provider

Members in their second or third trimester of pregnancy with the provider treating the member in conjunction with said pregnancy through the initial post-partum visit.

- Services for members who are terminally ill until their death.

The provider must accept payment at the applicable fee schedule as payment in full and must not seek any payment from the member for covered services, except for any applicable copayments, deductibles, or coinsurance. The provider must adhere to Mass General Brigham Health Plan's quality assurance programs and other Mass General Brigham Health Plan policies and procedures including, but not limited to, procedures regarding prior authorization and notification.

For members who will continue receiving care from the provider, Mass General Brigham Health Plan Clinical staff will contact the provider to obtain more information including confirmation of any scheduled services to be authorized on an out-of-network basis, with the provider being notified accordingly.

Claims for members who continue to see a terminated provider without Mass General Brigham Health Plan's knowledge will be automatically denied. Disputes in these cases can be addressed through Mass General Brigham Health Plan's administrative appeals process and, depending on the outcome, the provider will be reimbursed for services rendered at the applicable fee schedule.

### Panel Changes

Panel closure notification does not apply to specialty providers. Mass General Brigham Health Plan requires that a practice maintain at least 50 percent of PCP panels open at all times. A PCP panel may not be closed to an existing patient who has transferred to Mass General Brigham Health Plan from another health plan.

PCPs may not close their panels to a specific Mass General Brigham Health Plan product. When a PCP's panel reaches 1,500 members, the provider must request to close his or her panel by providing Mass General Brigham Health Plan with 30-days advance written notice. The PCP may decline new or additional



Mass General Brigham Health Plan members only if his or her panel is also closed to all other health plans.

Members who had selected the PCP prior to Mass General Brigham Health Plan's notification must be allowed assignment to his/ her panel. Other exception requests for PCPs with closed panels will be discussed with the PCP's office and processed only upon obtaining verbal approval.

PCPs are required to notify Mass General Brigham Health Plan through the Provider Enrollment Portal of any changes in their panels. The PCP can also submit a notification letter that must include the effective date of the panel closure and whenever possible, the anticipated duration of such closure. The PCP's panel status will be reflected accordingly in the Mass General Brigham Health Plan Provider Directory. A Mass General Brigham Health Plan Provider Relations Manager reviews rosters at each provider visit as additional confirmation of panel status, to monitor the duration of closed panels, and to ensure accuracy of provider enrollment information and adequate access.

Through [Provider.MGBHP.org](https://Provider.MGBHP.org), Mass General Brigham Health Plan provides updated PCP assignment information daily to PCP offices. Discrepancies in a member's PCP information can be systematically corrected by the PCP office without assistance from Mass General Brigham Health Plan.

- This option is limited to PCP changes within the same site, to a PCP with an open panel.
- Changes to a member's PCP and Primary Care Site must be initiated by the member calling Mass General Brigham Health Plan Member Service or by submitting the request through [Provider.MGBHP.org](https://Provider.MGBHP.org) and attesting to obtaining the member's consent.

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## Behavioral Health Care Integration

Mass General Brigham Health Plan and its designated behavioral health contractor, Optum, are committed to fully integrating Mass General Brigham Health Plan members' medical and behavioral health care. Mass General Brigham Health Plan recognizes the importance of working collaboratively to create a coordinated treatment system where all providers work together to support the member in a seamless system of care. To this end, Mass General Brigham Health Plan has worked closely with Optum to develop specific programs and provider procedures that standardize communication and linkage between Mass General Brigham Health Plan members' primary care and behavioral health providers. Linkage between all providers (primary care, mental health, and substance abuse providers, as well as state agencies) supports member access to medical and behavioral health services, reduces the occurrence of over-and-underutilization, and provides coordination within the treatment delivery system.

Communication among providers also improves the overall quality of both primary care and behavioral health services by increasing the early detection of medical and behavioral health problems, facilitating referrals for appropriate services, and maintaining continuity of care.

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## Provider Rights and Responsibilities

Mass General Brigham Health Plan does not prohibit or restrict network providers acting within the lawful scope of practice from advising or giving treatment options, including any alternative treatment.

To ensure effective relationships, and to be consistent with our joint commitment to enhance the quality of life for all Mass General

Brigham Health Plan members, we require network providers to:

- Accept Mass General Brigham Health Plan members as patients to the extent other health plan members are accepted.
- Make members aware of all available care options, including clinical care management
- Treat Mass General Brigham Health Plan members as equals to all other patients.
- Be active participants in discharge planning and/or other coordination of care activities.
- Comply with medical records requirements relative to proper documentation and storage, allowing access for review by individuals acting on Mass General Brigham Health Plan's behalf and supporting appropriate medical record information exchange at a provider and/or member's request.
- Comply with patient access standards as defined within this manual.
- Remain in good standing with local and/or federal agencies.
- Be responsive to the cultural, linguistic, and other needs of Mass General Brigham Health Plan members.
- When applicable, inform members of advanced directive concurrent with appropriate medical records documentation.
- Coordinate care with other providers through notification of findings, transfer of medical records, etc., to enhance continuity of care and optimal health.
- Report findings to local agencies as mandated and to Mass General Brigham Health Plan when appropriate.
- Promptly notify Mass General Brigham Health Plan of changes in their contact information, panel status, and other relevant information.
- To remain active in Mass General Brigham Health Plan provider directories, providers must submit data and attest in CAQH (<https://proview.caqh.org/Login>) at least every 90 days. Examples of information

that providers need to collect and update in CAQH include:

- provider race and ethnicity
- open/closed patient panel status
- ages and genders treated
- cultural groups and special populations treated
- telehealth modalities
- practice group name and location
- appointment scheduling telephone number
- practice email address
- hospital affiliations
- website address
- Respect and support Mass General Brigham Health Plan Members Rights and Responsibilities.

Of equal importance, Mass General Brigham Health Plan providers have the right to:

- Receive written notice of network participation decisions.
- Exercise their reimbursement and other options as defined within this manual and/or the Mass General Brigham Health Plan Provider Agreement.
- Communicate openly with patients about diagnostic and treatment options. Expect Mass General Brigham Health Plan adherence to credentialing decisions as defined herein.

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## Member Complaints and Grievances

Mass General Brigham Health Plan is strongly committed to ensuring member satisfaction and the timely resolution of reported concerns regarding a member's experience with a health care provider.

For more information on Mass General Brigham Health Plan's processes for inquiries, complaints, and grievances, please see the "Appeals & Grievances" section of this manual.

## Access and Availability Requirements

Mass General Brigham Health Plan's Provider Network Management staff regularly evaluates access and availability and the comprehensiveness of Mass General Brigham Health Plan's provider networks.

Access and availability of acute care facilities, PCPs and obstetricians/ gynecologists are evaluated at least quarterly. Access and availability of high-volume specialty care practitioners is evaluated at least annually. High-volume specialties are defined as the top five specialties based on claim volume.

Mass General Brigham Health Plan strives to ensure the availability of practitioners who are multilingual, understand and comply with state and federal laws requiring that practitioners assist members with skilled medical interpreters and resources, and are responsive to the linguistic, cultural, ethnic, and/or other unique needs of minority groups and

special populations.

At least annually, Mass General Brigham Health Plan reviews data on Mass General Brigham Health Plan members' cultural, ethnic, racial and linguistic needs to define quality initiatives, inform interventions and assess availability of practitioners within defined geographical areas to meet the needs and preferences of our membership.

### Availability and Access Standard for Behavioral Health Services

To ensure up-to-date referral information, providers are required to notify Optum of any changes or limitations in appointment access up to and including when a clinic or a member of the professional staff:

- No longer accepts new patients
- Is available during limited hours or only in certain settings
- Has any other restrictions on treating members
- Is temporarily or permanently unable to meet Optum standards for appointment access

Availability and access standards are defined as follows:

Provider	Access Ratio to	Availability by Geographic Standards
Primary Care	1:200	Two primary care providers within 15 miles or 30 minutes travel time from member's residence
OB/GYN Specialists	1:500	One provider within 15 miles or 30 minutes travel time from member's residence
High Volume Specialists	1:1500	One provider within 15 miles or 30 minutes travel time from member's residence
Acute Care Facilities	N/A	One facility within 20 miles or 40 minutes travel time from member's residence
Rehabilitation Facility	N/A	One facility within 30 miles or 60 minutes travel time from member's residence
Urgent Care Services	N/A	One facility within 15 miles or 30 minutes travel time from member's residence

Mass General Brigham Health Plan reserves the right to either expand or limit its provider networks according to Mass General Brigham Health Plan's business objectives. In determining network expansion needs, Mass General Brigham Health Plan evaluates these availability and access standards along with other criteria.



Mass General Brigham Health Plan and Optum are also required to monitor accessibility of behavioral health appointments based on the following standards:

Type of care	Appointment must be offered:
Emergency Services	Immediately, 24 hours per day, seven days per week
ESP Services	Immediately, 24 hours per day, seven days per week
Urgent Care	Within 48 hours
Routine/Non-urgent Services	Within 14 calendar days

*Notification of access limitations may be made by contacting Optum at 844-451-3518. To help provide timely appointments, providers with unexpected same-day or same-week openings are also encouraged to call the Network/Provider Relations line, stating name, phone number, practice/ organization, specific site location, days, and times available, and whether openings are with psychologists, pharmacologists, or therapists.*

### Cultural Competency

Mass General Brigham Health Plan has a diverse membership in terms of linguistic abilities and cultural and ethnic backgrounds. To promote access to providers who can communicate with the member in a linguistically appropriate and culturally sensitive manner, Mass General Brigham Health Plan uses several strategies to capture robust and detailed linguistic, ethnic, and cultural data on our members, including the use of health needs assessment tools and querying members upon contact with Mass General Brigham Health Plan Member Service. Mass General Brigham Health Plan captures linguistic capabilities of providers as part of the credentialing process for individual clinicians.

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 providers’ self-report of languages spoken serves as the measure of their linguistic ability and a proxy for cultural and ethnic backgrounds.

Mass General Brigham Health Plan also employs US Census Data on prevalent non-English languages spoken in Massachusetts and identifies those languages spoken by 10,000 or more individuals, five years and older, within each Massachusetts county.

For more information, please see the “Access and Availability Requirements” section of this manual.

### Wait Time Access Standards

Mass General Brigham Health Plan providers must ensure the availability of prompt provider consultation, including arrangements to assure coverage for members after hours. Mass General Brigham Health Plan also requires the hours of operation offered for all members to be the same regardless of their coverage.

In addition to after-hours access standards, patients should be seen within a reasonable time after their arrival. A reasonable time is defined as within 30 minutes of the appointment time.

Patient calls regarding active clinical problems and received during routine office hours should be returned within the hour when clinically appropriate, or on a same day basis otherwise. Telephone calls regarding routine administrative requests should be returned within two business days.

Mass General Brigham Health Plan is also required to monitor and report on member access to specific primary care and specialty services. This is done with an access and availability survey administered by Mass General Brigham Health Plan Provider Relations Department.

The survey seeks responses as to the availability or wait time access for services such as:

- Emergency care
- Urgent care
- Routine symptomatic care
- Routine non-symptomatic care
- After-hours care
- DSS custody initial exam
- DSS custody comprehensive exam

\*Please see the “Quality Management Programs” section of this manual which provides the standards applicable to each of the above services.

## Fraud, Waste, and Abuse

### Fraud Prevention

Mass General Brigham Health Plan expects providers to comply with all federal and state regulations that prohibit fraudulent behavior, including but not limited to:

- Recording clear and accurate documentation of all services rendered in a timely manner as close as possible to the date of service
- Not signing blank certification forms that are used by suppliers to justify payment for home oxygen, wheelchairs, and other medical equipment
- Being suspicious of any vendor offering discounts, free services, or cash in exchange for referrals
- Refusing to certify the need for medical supplies for patients not seen and/or examined
- Specifying the diagnosis when ordering a particular service (e.g., lab test)
- Knowing and adhering to the practice’s billing policies and procedures
- Verifying the identity of patients since insurance cards can be borrowed, stolen and fabricated
- Carefully scrutinizing requests for controlled substances, particularly with new patients.

### Reporting Health Care Fraud

Providers who suspect health care fraud should report any suspicions to their organization’s Compliance Office or Executive Director.

Suspicious or concerns involving a Mass General Brigham Health Plan member or provider can be reported to Mass General Brigham Health Plan’s Quality and Compliance Office in writing or by email. These concerns can also be reported anonymously to the Mass General Brigham Health Plan Compliance Hotline 24 hours a day, seven days a week. The Hotline is operated by an independent company and is *not* staffed by Mass General Brigham Health Plan employees.

Fraudulent acts or suspicions may be reported as follows:

Mail: Mass General Brigham Health Plan  
Quality and Compliance  
399 Revolution Drive  
Suite 810  
Somerville, MA 02145

Phone: Mass General Brigham Health Plan  
Quality and Compliance Office  
800-433-5556 (then dial 0 to  
have your call directed)  
Mass General Brigham Health Plan  
Compliance Hotline (anonymous)  
844-556-2925

### False Claims Act

In complying with our obligations under the Deficit Reduction Act of 2005, Mass General Brigham Health Plan provides detailed information to our employees, contractors and agents regarding the False Claims Act and comparable state anti-fraud statutes, including whistleblower protections. To that end, Mass General Brigham Health Plan has developed and continues to refine our policies and procedures regarding fraud and abuse detection,

prevention and reporting including but not limited to the following documents:

- Code of Ethics
- Compliance Hotline Policy
- Non-Retaliation for Reporting of Compliance Violations
- Fraud Reporting and Whistleblower Protections Policy

### **Waste Identification, Reimbursement Validation and Recoveries**

Mass General Brigham Health Plan's Payment Integrity department is responsible for identifying waste and for validating all claims reimbursements. The department is responsible for identifying and recovering claim overpayments, which may be the result of billing errors, payment errors, unbundling, duplicates, retroactive contract reviews, or other claims payment anomalies. The department performs several operational activities to ensure the accuracy of providers' billing submissions, and of claims payments. The Payment Integrity department also utilizes internal and external resources to prevent incorrect payment of claims and will initiate recovery if and when overpaid claims are identified.

Mass General Brigham Health Plan has established an overpayment identification and reimbursement validation audit process to verify the accuracy of charges and payments appearing on Provider (facility, physician and ancillary Provider) claims and to ensure that all charges and payments are consistent with Mass General Brigham Health Plan's Provider Agreements, Mass General Brigham Health Plan's policies and procedures, and applicable nationally recognized medical, claims administration and claims reimbursement policies.

Mass General Brigham Health Plan's policies, which include but not limited to medical policies; claims administration rules; and payment guidelines; apply to all reimbursement

and claims matters. In any matter where Mass General Brigham Health Plan does not maintain an applicable policy, Mass General Brigham Health Plan adopts and follows industry standards and policies relating to procedural coding, medical claims administration, and medical claims reimbursement which are recognized by governmental payers, such as the Centers for Medicare and Medicaid Services (CMS) as well as national health insurance carrier organizations, and the American Medical Association (AMA).

Mass General Brigham Health Plan may conduct reimbursement validation audits on claims that Mass General Brigham Health Plan has paid during the current fiscal year or has paid during the two (2) prior fiscal years. Mass General Brigham Health Plan may also initiate reimbursement validation audits up to six (6) years after a claim payment to investigate whether a Provider has engaged in billing practices that may constitute fraud or abuse.

Provider reimbursement validation audits can take place in two (2) audit venues: on-site and/or off-site audits. Mass General Brigham Health Plan determines the venue, or combination of venues that its Audit Specialists shall employ in an audit.

### **General Claims Audits**

General post payment claims audits are conducted to identify the accuracy of charges and the consistency of claims reimbursement with Mass General Brigham Health Plan's policies, Provider Agreements, Payment Guidelines, and applicable nationally recognized medical claims reimbursement and administration policies, including but not limited to: CPT, MassHealth, and CMS guidelines. Audits topics can include, but are not limited to:

- Overpayments due to incorrect setup or update of contract/fee schedules in the system
- Overpayments due to claims paid based

upon conflicting authorizations or duplicate payments

- Overpayments resulting from incorrect revenue/procedure codes
- Provider Billing for services at a higher level than provided
- Provider Billing for services not documented and not provided
- Incorrect coding, including unbundling component service codes, modifier usage, units of service, duplicate payments
- Historical claim audits to include the global surgical period for codes submitted on the current claim
- Medical necessity based on Mass General Brigham Health Plan, MassHealth, and/or CMS guidelines as applicable to the member benefit plan

When an overpayment event is identified, Mass General Brigham Health Plan Payment Integrity will begin its overpayment recovery process by sending written notification to the provider containing instructions for the process (“Notification of Audit”). In the event the provider does not agree with the identified overpayment amount, the provider should follow the process described in the “Provider Audit Appeals” section of the Provider Manual. If providers do not agree with Payment Integrity’s findings, providers should follow the appeal process outlined within the overpayment notification or findings letter to ensure their appeal rights are preserved and appropriately addressed.

Providers who remain unsatisfied upon resolution of the appeal should refer to the instructions outlined within the dispute determination letter.

If Mass General Brigham Health Plan does not hear from the provider within 30 days from either the initial written overpayment notification or the dispute determination notification, the final overpayment amount will be offset from future claims payments. In cases

where recovery through offsetting will take longer than six months, Mass General Brigham Health Plan reserves the right to seek additional legal recourse such as referral to a collection service.

### On-Site Audit

In the on-site audit, a Mass General Brigham Health Plan Audit Specialist or designated party conducts the audit of designated medical records at the Provider’s site. For on-site audits, Mass General Brigham Health Plan requests that the Provider make a suitable work area for the Audit Specialist to perform the audit activities while on-site during the duration of the audit.

Mass General Brigham Health Plan requires that a Provider schedule an audit at a mutually convenient time for Mass General Brigham Health Plan’s Audit Specialist, medical records department, and the patient account representative. The Provider and Mass General Brigham Health Plan agree that cancellation of a scheduled audit requires written notification no less than fifteen (15) business days prior to the scheduled audit, and should be sent to Mass General Brigham Health Plan’s Manager of Provider Audit and the designated facility representative.

The inspection and copying of medical records are conducted in compliance with the Provider’s standard policies that govern such processes and that are applied uniformly to all payers. Along with the medical records, the Provider must make available the pharmacy profile and corresponding fee book. The fee book must include all updated versions in electronic format suitable for use on a personal computer (Excel or other program), unless the Provider makes other arrangements with the Mass General Brigham Health Plan Manager of Provider Audit. All designated records must be produced within twenty-one (21) days of the request by Mass General Brigham Health Plan. Unless the parties agree otherwise, the Provider must schedule the audit to occur no

later than thirty (30) business days from the request.

At the conclusion of the audit, and if the Provider agrees with the findings, the Audit Specialist provides the Provider a dated copy of the signed, finalized Discrepancy Report. If the Provider does not agree with the audit findings at the time of the exit interview, the Provider has thirty (30) business days to submit additional supporting documentation.

Mass General Brigham Health Plan's Claims department retracts all audit discrepancies thirty (30) days after the signed, finalized Discrepancy Report. If the Provider fails to provide additional supporting documentation and/or does not respond within thirty (30) days, Mass General Brigham Health Plan's Claims department retracts all audit discrepancies.

### **Off-Site Audit**

The second reimbursement validation audit venue is the off-site audit in which the Mass General Brigham Health Plan Audit Specialist or designated party requests specific medical record information from the Provider be sent to Mass General Brigham Health Plan for review.

Pursuant to Mass General Brigham Health Plan's Provider agreements, Mass General Brigham Health Plan has the right to inspect, review and make copies of records related to an audit. All requests to inspect, review and make copies of medical records are submitted to the Provider in writing. Mass General Brigham Health Plan specifies whether the Provider must make the original medical records or copies of the requested records available for inspection.

### **Provider Appeals**

If a Provider disagrees with Mass General Brigham Health Plan's audit findings, the Provider may appeal the audit findings by submitting a request for an appeal to the Mass General Brigham Health Plan Provider Appeals

department or designated party. Please refer to Section 10, "Provider Audit Appeals" for more information.

In accordance with the Mass General Brigham Health Plan agreement in effect with the Provider, Members cannot be billed for audit discrepancies.

Mass General Brigham Health Plan strictly adheres to state and federal requirements regarding confidentiality of patient medical records. A separate patient authorization is provided when required by law. In accordance with the Mass General Brigham Health Plan agreement in effect, patients are not billed for audit discrepancies.

### **Fraud, Abuse, and the Special Investigations Unit**

Mass General Brigham Health Plan receives state and federal funding for payment of services provided to our members. In accepting claims payment from Mass General Brigham Health Plan, health care providers are receiving state and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered fraud or abuse against the Medicaid program. As a provider, you are responsible for knowing and abiding by all applicable state and federal regulations.

Mass General Brigham Health Plan is dedicated to eradicating fraud and abuse from its programs and cooperates in fraud and abuse investigations conducted by state and/or federal agencies, including: the Attorney General's Office; the Federal Bureau of Investigation; the Drug Enforcement Administration; the Health and Human Services Office of Inspector General; as well as local authorities. As part of Mass General Brigham Health Plan's responsibilities, the Payment Integrity department is responsible for identifying and recovering claim overpayments



resulting from a variety of issues. The department performs several operational activities to detect and prevent fraudulent, abusive, or wasteful activities.

Examples of fraudulent/abusive activities include, but are not limited to:

- Billing for services not rendered or not medically necessary
- Submitting false information to obtain authorizations to furnish services or items to Medicaid recipients
- Prescribing items or referring services which are not medically necessary
- Misrepresenting services rendered
- Submitting a claim for provider services on behalf of an individual who is unlicensed, or who has been excluded from participation in the Medicare and Medicaid programs
- Retaining Medicaid funds that were improperly paid
- Billing Medicaid recipients for covered services

Mass General Brigham Health Plan, through its Special Investigations Unit, investigates all reports of fraud and/or abuse committed by members and providers. Credible allegations of fraud or abuse will be reported to Mass General Brigham Health Plan's partners within the government. Mass General Brigham Health Plan may also take any number of actions to resolve fraud or abuse allegations, including but not limited to medical record audits; instituting prepayment review of a provider's claims; stopping payment on a provider's claims; provider education; and/or demanding recovery for discovered overpayments. Moreover, depending on the severity of the fraud/abuse finding, Mass General Brigham Health Plan reserves the right to impose sanctions, including and up to terminating the provider from Mass General Brigham Health Plan's network. Mass General Brigham Health Plan seeks recovery of all excess payments discovered as a result of its fraud and abuse

operational efforts.

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## Preservation of Records and Data

In accordance with the provider agreement, network providers and Mass General Brigham Health Plan shall each preserve all books, records and data that are required to be maintained under the provisions of the agreement for a period of seven years or longer, as required by law from the date of final payment under the agreement for any specific contract year.

During the term of this agreement, access to these items shall be provided at the designated facility or Mass General Brigham Health Plan offices in Massachusetts at reasonable times. The facility and Mass General Brigham Health Plan shall retain such documents that are pertinent to adjudicatory proceedings, audits, or other actions, including appeals, commenced during seven years or longer as required by law after any specific contract year, until such proceedings have reached final disposition or until resolution of all issues if such disposition or resolution occurs beyond the end of the seven-year period.

If any litigation, claim, negotiation, audit, or other action involving the records is initiated before the expiration of the applicable retention period, all records shall be retained until completion of the action and resolution of all issues that arise from it or until the end of the retention period, whichever is later. Furthermore, any such records shall be maintained upon any allegation of fraud or abuse or upon request by Mass General Brigham Health Plan or any state or federal government agency, for potential use in a specific purpose or investigation or as otherwise required by law. These records shall be maintained for a period of time determined by the requesting entity until completion of the action and resolution of all issues that arise from it or until the end of the retention period,

whichever is later.

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## Code of Ethics

Concerns regarding Mass General Brigham Health Plan’s adherence to our Code of Ethics should be reported to our Quality and Compliance Office as directed above.

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## Provider Marketing Activities

Provider site marketing is defined as any activity occurring at, or originating from, a provider site wherein Mass General Brigham Health Plan staff, designees, or contracted providers, including physicians and office staff, personally present Mass General Brigham Health Plan marketing materials or other marketing materials produced by the provider site to members that the Executive Office of Health and Human Services (EOHHS) can reasonably determine influence the member to enroll in Mass General Brigham Health Plan’s MassHealth plan or to disenroll from Mass General Brigham Health Plan’s MassHealth plan into another MassHealth plan. This shall include direct mail campaigns sent by the provider site to its patients who are members.

Provider site marketing (including cold calls) is prohibited except for posting EOHHS approved written materials and promotional marketing materials at network provider sites throughout Mass General Brigham Health Plan’s service area. Participating providers may display Mass General Brigham Health Plan marketing materials if appropriate notice is conspicuously posted for all other plans with which the provider has a contract.

Providers are encouraged to communicate with their patients about managed care options and to advise them in determining what plan best meets the health needs of the patient and his or her family. Such advice, whether presented

verbally or in writing, must be individually based in consideration of treatment needs and not merely a promotion of one plan over another. Providers who wish to let their patients know of their affiliation with one or more managed care organizations (such as Mass General Brigham Health Plan) must list each plan with which they hold contracts. If marketing material is included with such communication, and specifically in the case of MassHealth members, the material, together with the intended communication, must be pre-approved by MassHealth before distribution. However, such information must not be used to influence enrollment in conjunction with private insurance. If a provider is no longer affiliated with Mass General Brigham Health Plan, but remains affiliated with other participant MCOs, the provider may notify his or her patients of the new status and the impact of such changes on the patient.

Mass General Brigham Health Plan representatives are required to wear proper identification (Mass General Brigham Health Plan photo ID badge) during all outreach and Mass General Brigham Health Plan business related activities, perform these activities only at Mass General Brigham Health Plan approved sites and regions, sign in as a representative of Mass General Brigham Health Plan and provide their own photocopying and/or other equipment.

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## “Hold Harmless” Provision

Providers contractually agree that in no event, including, but not limited to, non-payment by Mass General Brigham Health Plan, Mass General Brigham Health Plan’s insolvency, or breach of the Provider Agreement, should a provider or any of its medical personnel bill, charge, collect a deposit from, or have any recourse against any Mass General Brigham Health Plan member or person, other than Mass General Brigham Health Plan, acting on their behalf for services provided. The provider

must not solicit or require from any member or in any other way payment of any additional fee as a condition for receiving care. Providers must look solely to Mass General Brigham Health Plan for payment with respect to covered services rendered to all Mass General Brigham Health Plan members.

This provision does not prohibit collection of supplemental charges or copayments on Mass General Brigham Health Plan's behalf made in accordance with the terms of the applicable Subscriber Group Agreement between Mass General Brigham Health Plan and the member.

If you have questions about this contract provision, please contact your Mass General Brigham Health Plan Provider Relations Manager.

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## Provider Notification and Training

The Provider Relations department works in partnership with provider offices to build and maintain positive working relationships and respond to the needs of both providers and members.

Mass General Brigham Health Plan believes in keeping providers informed and so uses direct mail, newsletters, and other vehicles for communicating policy or procedural changes and/or pertinent, updates and information. The provider network's implementation and adherence to communicated procedural changes is monitored with internal reports, provider site visits, reported member grievances, and other resources.

Providers receive a minimum of 30 days advanced notice on any changes that may affect how they do business with Mass General Brigham Health Plan. Where a policy or procedure change results in modification in payments or covered services or otherwise substantially impacts network providers, notification will be made at least 60 days prior

to the effective date unless mandated sooner by state or federal agencies.

Mass General Brigham Health Plan *Provider News* is our monthly e-newsletter for notifying our network of important changes and updates, including revisions to the Mass General Brigham Health Plan Provider Payment Guidelines and the *Provider Manual*. Providers are strongly encouraged to sign up to receive Mass General Brigham Health Plan's updates.

Provider Relations Managers incorporate provider notifications into their agenda for provider visits to reiterate Mass General Brigham Health Plan provider notifications and to address any need for clarification.

Mass General Brigham Health Plan also hosts periodic forums for network providers, focusing on administrative and clinical topics, as well as policy and procedural changes. These forums may be offered in person or with a "webinar" option.

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## Role of the Mass General Brigham Health Plan Provider Network Account Executive

Every contracted provider is assigned a dedicated Provider Network Account Executive early in the contracting process, often before the provider sees his/ her first Mass General Brigham Health Plan patient. The Provider Network Account Executive serves as the primary liaison between Mass General Brigham Health Plan's and our provider network. Provider Network Account Executives work in partnership with Mass General Brigham Health Plan's Contracting Department and other staff in administering contractual provisions of the Provider Agreement and/or to ensure contract compliance. Provider Network Account Executives meet regularly with designated staff within their provider territories to:

- Coordinate and conduct on-site training



- and educational programs
- Respond to inquiries related to policies, procedures, and operational issues
- Facilitate problem resolution
- Manage the flow of information to and from provider offices
- Ensure contract compliance
- Monitor performance pattern

## Section 4

# Provider Portal

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## Section 4

### Provider Portal

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#### Overview

The Mass General Brigham Health Plan Provider Portal puts a variety of self-service tools at your fingertips:

- Submit prior authorization and referral requests.
- View authorization and referral requests.
- Submit claims and claims correspondence.
- View claims status.
- Submit appeals.
- Manage your practice information.
- View patient rosters and reports.
- View member eligibility and benefits.

You can register for the portal any time on or after your effective date. To register, go to [Provider.MGBHP.org](https://Provider.MGBHP.org), click the Account Registration tab, and follow the instructions provided.



## Section 5

# Quality Management Program

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## Section 5

# Quality Management Program

### Overview

Mass General Brigham Health Plan is committed to improving the quality and safety of care and services to its members. This commitment is demonstrated through the maintenance of a comprehensive Quality Management Program. The program's goals support the mission and objectives of Mass General Brigham Health Plan, relevant state and federal regulations, Mass General Brigham Health Plan's contract with MassHealth, accrediting agency standards (such as the National Committee on Quality Assurance [NCQA]), and the Massachusetts Division of Insurance's licensure requirements.

The intent of Mass General Brigham Health Plan's Quality Management Program is to improve the quality and safety of clinical care and services provided to members and providers. It is based on the fundamentals of quality management: plan, monitor, improve, and evaluate, and the "Plan-Do-Study-Act" cycle approach to continuous performance improvement.

Mass General Brigham Health Plan's Quality Management Program ensures a comprehensive, systematic, coordinated, integrated, and formal process for continuous assessing, monitoring, evaluating, and improving the quality of clinical care and quality of services provided to members (use of the term "monitoring" shall refer to the monitoring, evaluation, and quality improvement cycle).

Quality monitoring and improvement activities are oriented around routine reporting, management, and analysis of complaints and grievances; specific quality improvement projects; peer review; and the implementation and evaluation of the quality improvement plan.

Quality management and improvement activities are aimed at creating highly integrated collaborative partnerships, both internally and externally, in order to ensure excellence in care and service—as well as to establish and share best practices.

The Advisory Commission on Consumer Protection and Quality in the Health Care Industry recommends that all health care organizations should make it their explicit purpose to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States. In *Crossing the Quality Chasm: A New Health System for the 21 Century* (Committee on Quality Health Care in America, Institute in America, Institute of Medicine, 2001), the Institute of Medicine called upon all health care organizations to pursue six major aims and that, specifically, health care should possess the following qualities:

- **Safety**—Avoiding injuries to patients from the care that is intended to help them.
  - **Effectiveness**—Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).
- **Patient-centeredness**—Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timeliness**—Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficiency**—Avoiding waste, in particular waste of equipment, supplies, ideas, and energy.
- **Equity**—Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Mass General Brigham Health Plan is committed to achieving each of these quality aims, and our Quality Management Program provides the specifications for that effort.

### Scope

The scope of Mass General Brigham Health Plan's Quality Management Program, which speaks to each of the major goals, is designed to continuously monitor, evaluate, and improve the clinical care and service provided to its enrolled members. The Quality Management Program is also designed to support and reflect the plan's commitment to continuous performance improvement in all aspects of care and services provided to its members.

The program is continuous, broad based and collaborative, involving all departments, programs and staff. The components of the program are implemented by the actions of the leadership, directors, clinicians, and support staff that design, measure, assess and improve their work processes. Other sources of guidance include input from patients, external benchmarks, and aggregate data.

The review and evaluation of these components are coordinated by the Quality Assurance and Performance Improvement Department in order to demonstrate that the process is cross functional, multi-disciplinary, integrated and effective in demonstrating improvements in the quality of clinical care and services provided. The quality management program includes quality planning, measurement, and improvement functions. Each area of improvement focuses on the measurement and assurance of effective patient centered care.

All quality management and improvement activities can be viewed as a process, and processes link together to form a system. The linkage of the processes enables the focus of quality improvement to be on the processes in the organization and not on the individual departments or people. As such, the

organization measures and improves the performance of important processes in all organizational functions. Those processes that have the greatest impact on outcomes and customer satisfaction are given the highest priority. Quality Management retains responsibility and oversight for any quality management function that falls within the scope of the program and delegated to another entity.

Mass General Brigham Health Plan's Quality Management Program maintains a strong linkage with the Care Management Program, fostering ongoing and enhanced quality improvement collaborations and interactions, including:

- Identifying opportunities to improve care and service and develop quality improvement interventions
- Translating quality into measurable terms and using data to drive improvements
- Identifying and addressing instances of substandard care including patient safety, member complaints and sanctioned providers
- Promoting a collaborative approach to performance improvement that uses the concepts and tools of Continuous Quality and Performance Improvement
- Measuring and evaluating the effectiveness of planned interventions in improving care and service
- Tracking the implementation and outcomes of quality improvement interventions
- Measuring and evaluating the effectiveness and impact of the enhancement of comprehensive health management programs in the areas of health promotion, asthma, diabetes, depression and high-risk pregnancy on the well-being and quality of life of our members

Mass General Brigham Health Plan's care



management programs strive to:

- Support the relationship between practitioners and their patients with a plan of care
- Emphasize prevention of exacerbations and complications using evidence-based guidelines
- Promote patient empowerment strategies such as motivational coaching and self-management, and continuous evaluation of the clinical, social, and economic outcomes with the aim of improving overall health
- Maintain a multi-disciplinary, continuum-based approach to health care management that focuses on populations at risk for selected conditions

Mass General Brigham Health Plan's Quality Management Program encompasses the entire organization and includes the following components:

- Evaluation of population-based systems of care that address the needs of vulnerable patients
- Access improvements, including provider availability and cultural competence
- Promotion of compliance with current preventive health recommendations
- Evaluation of care coordination activities
- Development and approval of clinical guidelines and standards
- Assessment of member perceptions of health care and service quality
- Member complaints and appeals
- Provider complaints and appeals
- Credentialing of physicians and other providers
- Evaluation of provider performance
- Medical record review
- Policies supporting members' rights, responsibilities, and confidentiality
- Assessment of new technology
- Development of a data collection system

to evaluate outcomes of care, services, and processes

- Risk management activities
- Structure and Quality Management Program oversight

### Mass General Brigham Health Plan Board of Directors

The Mass General Brigham Health Plan Board of Directors is responsible for Mass General Brigham Health Plan's Quality Improvement Program. The Board delegates oversight responsibility for quality of care and services to the Quality Program Committee, which is chaired by the Senior Medical Director of Quality, and the Director of Quality Assurance & Performance Improvement. This committee reports to the Mass General Brigham Health Plan Executive Committee.

### Quality Improvement Committee (QIC)

This committee develops, implements, and monitors the Quality Improvement (QI) program and functions by ensuring that Mass General Brigham Health Plan performance improvement activities meet the needs of its members to support population health, and external regulatory requirements.

QIC members include decision makers who represent stakeholders within the Quality Department as well as representatives from other departments including Clinical Operations, Customer Service, Pharmacy Operations, Marketing and Behavioral Health. Each member is responsible for contributing subject matter expertise to ensure a balanced discussion of Quality Improvement programs and improvement initiatives at Mass General Brigham Health Plan.

### Quality Program Committee (QPC)

This committee is responsible for the development, implementation, and oversight of Mass General Brigham Health Plan's

Quality Improvement program, including oversight of other organizational committees involved in Quality Improvement initiatives.

QPC members include decision makers who represent stakeholders within the Quality Department as well as representatives from other departments including Clinical Operations, Pharmacy Operations, Commercial Sales, Regulatory Affairs/Compliance, the Medicaid Office, and Behavioral Health. Each member is responsible for contributing subject matter expertise to ensure a balanced discussion of Quality Improvement programs and improvement initiatives at Mass General Brigham Health Plan. In addition to internal participants, QPC includes members from external organizations including Optum and participating network providers.

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## Clinical Practice Guidelines

Mass General Brigham Health Plan participates in local and statewide forums to establish uniform guidelines that all state purchasers, payers and providers endorse.

Mass General Brigham Health Plan adopts regional and national clinical practice guidelines from recognized sources that are:

- Significant to our membership (prevalence of disease in our population)
- Based on sound scientific evidence or expert consensus
- Developed with practicing clinicians (local or national) in the applicable specialty
- Addressing documented variation in important care processes and outcomes

Annually, Mass General Brigham Health Plan establishes external benchmarks for important quality measures addressed by clinical practice guidelines and compares its performance relative to these benchmarks. Mass General Brigham Health Plan also uses Clinical Practice Guidelines for its Disease Management

Programs. Mass General Brigham Health Plan selects at least two important aspects of care from the clinical practice guidelines that relate to its Disease Management Programs for quality performance measurement and improvement activities.

Clinical Practice Guidelines are reviewed by Mass General Brigham Health Plan's clinical leadership at least every two years and/or as regional and national guidelines change.

Updates to the guidelines are posted on Mass General Brigham Health Plan's website, and written notification of update guidelines are provided in Mass General Brigham Health Plan's e- newsletter following Internet posting.

For a list of clinical practice guidelines currently endorsed by Mass General Brigham Health Plan, please visit [MGBHP.org/providers/ resources](https://mgbhp.org/providers/resources) under Practice Guidelines. If you do not have access to the Internet, please contact Provider Services at [HealthPlanProvidersService@mgb.org](mailto:HealthPlanProvidersService@mgb.org) to request a copy.

## Health Care Access Standards

As part of its ongoing quality of care efforts, and to meet regulatory and contractual requirement, Mass General Brigham Health Plan monitors and reports on member access to primary care and specialty services. This is done by the following methods:

- Office-based access and availability surveys administered by Mass General Brigham Health Plan Provider Relations Managers to provider office staff
- Member satisfaction surveys
- Site-based surveys
- Consumer Assessment of Health Care Providers and Systems (CAHPS) surveys
- Geographic and numerical assessment:
  - Mileage from member's residence to provider location
  - Ratio of provider to members

The survey seeks responses to verify a provider's compliance with the availability or wait time access for the following services:

- Emergency services (including all necessary care coordination with home health, case management, behavioral health or other providers involved in the care of member) must be provided immediately and be available 24 hours a day, seven days a week
- Primary care
  - Urgent*—within 48 hours of the member's request
    - *Non-urgent, symptomatic*—within 10 calendar days of the request
    - *Non-symptomatic*—within 45 calendar days of the request, unless an appointment is required sooner in order to ensure the provision of screenings in accordance with the MassHealth Early and Periodic Screening, Diagnosis, and Treatment, Preventive Pediatric Healthcare Screening, and Diagnosis Periodicity Schedules.
- Specialty care
  - *Urgent*—within 48 hours of request
  - *Non-urgent, symptomatic*—within 30 calendar days of request
  - *Non-symptomatic*—within 60 calendar days of the request
- Behavioral health
  - Emergency and ESP services (including all necessary care coordination with home health, case management, mental health, or other providers involved in the care of member) must be provided immediately and be available 24 hours a day, seven days a week.
  - For services described in an inpatient of 24-hour diversionary services discharge plan:

- *Non-24-hour diversionary services*— within two calendar days of discharge
- *Medication management*— within 14 calendar days of discharge
- *Other outpatient services*— within seven calendar days of discharge
- *Intensive care coordination services*— within the time frame directed by the Executive Office of Health and Human Services.
- *Urgent*—within 48 hours of request
- *All other behavioral health care*—within 14 calendar days
- Children newly placed in the Department of Children and Family (DCF) custody—for enrollees newly placed in the care or custody of DCF—providers must make best efforts to provide a DCF Health Care Screening within seven calendar days of receiving a request, and provide an initial Comprehensive Medical Examination within 30 calendar days of receiving a request unless otherwise mandated by the MassHealth Early and Periodic Screening, Diagnosis and Treatment and Preventive Pediatric Healthcare Screening and Diagnosis Periodicity Schedules. Providers must make best efforts to communicate with the child's assigned DSS caseworker(s) and when appropriate, inform them of rendered Mass General Brigham Health Plan covered services that support the child's needs.

### Waiting Room Wait Time

In addition to these access standards, patients should be seen within a reasonable time after timely arrival. A reasonable time is defined as within 30 minutes from the appointment time.

## Patient Safety Site Visits

Mass General Brigham Health Plan reserves the right to conduct a site visit when an identified quality of care issue arises or when member complaints about the provider or practice site reach a specified threshold. Site visits are conducted when three or more member complaints/grievances are received or when Mass General Brigham Health Plan becomes aware of quality of care concerns deemed serious based on a severity rating and/or review by the Mass General Brigham Health Plan Credentialing Committee.

Such complaints include but are not limited to:

- Reported cases of a patient's concern when the time spent with the clinician is perceived as inadequate to have fully addressed the purpose for the specific visit
- Failure of clinicians to adhere to patient safety measures (e.g., washing of hands, wearing of protective gloves, etc.)
- Sharp containers located within a child's reach
- Inappropriate disposal of hazardous waste
- Changes in procedures or policies post passing of the initial site visit (e.g., medical records no longer adequately secured)

A site visit is scheduled within 60 days of the registered concern, and providers may be asked for a corrective action plan with continuing follow-up site visits until all deficiencies have been addressed.

## Medical Records and Documentation Standards

As part of the contracting and quality oversight processes, Mass General Brigham Health Plan conducts a pre- contracting site visit and medical records review of all primary care office provider offices (including those staffed by

nurse practitioners practicing in an expanded role as PCPs), in addition to high volume behavioral health provider practices. When applicable, a facility review is also conducted for newly contracted facilities prior to enrollment with Mass General Brigham Health Plan.

Site visits are performed by the Provider Relations staff or outside consultants and provide a mechanism for practitioner education and facilitation of continuous improvement in the provision of patient care and service. Site visits for potentially high-volume behavioral health practitioners are conducted by Mass General Brigham Health Plan's delegate, Optum, a fully accredited NCQA managed behavioral health care organization.

Practice sites are assessed against the following standards:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining rooms
- Appointment availability.

At a minimum, the medical record keeping practices of each site are assessed against the following standards:

- Secure/confidential filing and storing system
- Legible file markers
- Records easily located

When a practice site passes Mass General Brigham Health Plan's threshold, the provider moves forward in the contracting process.

If a practice site fails to achieve a score of 80 percent on all three components of the office site visit (including the overall score) the practice is notified of the score, the need for a corrective action plan, and that the site will be re-evaluated within six months. At the time the practice site achieves at least 80 percent on all components of the review, Mass General

Brigham Health Plan moves forward with the contracting process. When full compliance is not achieved during a corrective visit following the initial site visit, an additional visit is scheduled within 30 days. If full compliance is not achieved during this visit, it may result in a decision by Mass General Brigham Health Plan to terminate the practice and affiliated practitioners.

Site visit outcomes apply to all clinicians practicing within the same office site. Provider practices are notified in writing of their score.

Mass General Brigham Health Plan reserves the right to conduct a site visit for other provider types when an identified quality of care issue arises or when member complaints about the provider or practice site reach a specified threshold. Site visits are conducted when three or more member complaints/grievances are received or when Mass General Brigham Health Plan becomes aware of quality of care concerns deemed serious based on a severity rating and/or review by the Mass General Brigham Health Plan Credentialing Committee.

Such complaints include but are not limited to:

- Reported cases of a patient's concern when the time spent with the clinician is perceived as inadequate to have fully addressed the purpose for the specific visit
- Failure of clinicians to adhere to patient safety measures (e.g., washing of hands, wearing of protective gloves, etc.)
- Failure of the practice to ensure a patient's safety and confidentiality (e.g., exam rooms not adequately locked, etc.).
- Sharp containers located within a child's reach
- Inappropriate disposal of hazardous waste
- Changes in procedures or policies post passing of the initial site visit (e.g., medical records no longer adequately

secured)

A site visit is scheduled within 60 days of the registered concern, and providers may be asked for a corrective action plan with continuing follow-up site visits until all deficiencies have been addressed

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## Medical Records Review and Documentation Standards

To streamline utilization and quality review, medical records must adhere to nationally accepted standards for paper and systematic documentation pertaining to the appropriateness, course and result of treatments/services and corresponding outcomes. As part of ongoing monitoring of network practitioners, Mass General Brigham Health Plan may conduct a review of medical records in a random sample of the network of PCPs. If a medical review is conducted, results are analyzed, and providers are notified of their results.

Documentation of the provision of effective patient care should contain all relevant information regarding the patient's diagnoses and overall health status, up to and including:

- Patient's primary language spoken
- Encounter date
- Clinical information/assessments
- Treatment/services provided
- Treatment plans
- Treatment goals and outcomes
- Contacts with the patient's family, guardians, and/or significant others

Medical records are examined for evidence of compliance with each of the following essential medical record standards:

- Name, DOB, MR#, PCP identified on record
- History and physicals recorded on record
- Allergies and adverse reactions

documented

- Problem list is present and updated
- Medication list is present and updated
- Visit notes contain clinical findings and evaluation
- Preventive services and risk screenings are recorded
- Lab, radiology, and hospital reports are filed
- Advanced directives are discussed with patients 18 years and older
- Behavioral health screening completed at well child visit

In the event that a medical record audit is conducted, the Mass General Brigham Health Plan reviewer must be given full access to randomly selected medical charts or direct access to an EMR system.

Compliance for each element requires that the element be present and easily found. Therefore, when an element is present but perhaps misfiled the record may fail if the reviewer needs more than 5–10 seconds to locate it.

Some elements require that documentation only be present and correctly filed.

The following elements also must be updated regularly. This is verified by checking recent office visit notes:

- Allergies and adverse reactions, or their absence, documented
- Problem list is present and updated
- Medication list is present and updated
- Preventive services and risk screenings are recorded

If allergies, medical conditions, medications, or screenings are present in a recent office visit note but not documented on the corresponding forms, the record will fail compliance.

In cases where only requested portions of the chart are available to the reviewer, the audit will be considered incomplete. Mass General

Brigham Health Plan reserves the right to schedule a follow-up visit to complete the audit.

### Medical Records Documentation Guidelines

In addition to the items referenced above, Mass General Brigham Health Plan reserves the right to audit member charts for compliance with all elements of medical records documentation requirements. The following guidelines are provided to assist network providers with ensuring and maintaining compliance with appropriate medical records documentation.

#### *Advance Directives*

All members 18 years of age and older are notified in writing of their right to execute advance directives. Members are provided information about their rights to:

Make decisions concerning medical care

- Accept or refuse medical or surgical treatment
- Formulate advance directives (e.g., living wills, durable powers of attorney for health care, or health care proxy designations)

Participating PCPs are encouraged to discuss advance directives with adult patients and are required to document results of the discussion in the medical record. Mass General Brigham Health Plan audits practitioners' medical records for documentation of education and information about Advance Directives.

Mass General Brigham Health Plan refers members and providers to the Massachusetts Medical Society's website, [MassMed.org](https://www.massmed.org) to the "Patients," "Patient Education Materials," and "Health Care Proxy Information and Forms" sections to obtain information and forms.

#### *Personal/Biographical Data*

Must include, at a minimum and if applicable, full name, date of birth, sex, marital status,



race, primary language, address, telephone number (home, mobile, work), employer name, insurance name, insurance ID number, and any disabilities, such as visually and/or hearing impaired, uses a wheelchair, and other information.

### ***Two Unique Identifiers***

Must be found on each and every page of the medical record. Examples of identifiers are patient name, medical record number, Mass General Brigham Health Plan ID number, and date of birth.

### ***Medical Record Entries***

All medical record entries, whether related to a visit or for other purposes, must be dated and author-identified (signed). Author identification signature may be handwritten stamped, unique electronic identifier or initials. Professional designation (credentials) should accompany the signature.

### ***Legibility***

The medical record must be legible enough for someone other than the author to understand the content of each entry.

### ***Allergies/Adverse Reactions***

Medication allergies and adverse reactions, or lack thereof, must be noted in a prominent location in the chart. Other allergies significant to the member's health status should be documented as well. If the patient has no known allergies and/or history of adverse reaction, the record should reflect this.

### ***Alcohol, Tobacco, and Drugs***

Documentation of an assessment for alcohol, tobacco and illicit drug use must be present for all members aged 12 and older, including seniors. Members aged 12–21 must, at a minimum, be assessed at each well child-care visit.

### ***Patient Medical History***

A comprehensive medical history including serious illnesses, accidents, surgeries/procedures and relevant family and social history. An appropriate entry with regards to immunization records should be noted in the chart. For children and adolescents, past medical history relates to prenatal care, birth, surgeries, and childhood illnesses.

### ***Problem List***

Significant illnesses and medical conditions (acute, chronic, active, resolved, physical, and mental), surgeries and relevant family and social history must be documented on the problem list. Short-term illnesses (e.g., flu) and "rule out" conditions may be excluded. This form must be updated at the time a new significant problem is identified and confirmed.

### ***Medication List***

A medication list must be present in the record that includes, at a minimum, the name of the prescription medication, dosage, frequency, and the date prescribed. Short-term, illness-specific medications (e.g., antibiotics) need not be included on this list but should be documented in the notes of any visits that occur for the duration of the medication therapy. When a medication is discontinued, this should be noted on the medication list with the date that the medication was discontinued. In the absence of a structured medication list, all medications must be relisted in each visit note.

### ***Visit Note***

All visit note entries must contain the following elements, except where not applicable based on the nature of the visit: date of visit, purpose of visit, pertinent history, physical exam, diagnosis, or clinical impression including under/over utilization of specialty services or pharmaceuticals, description of treatment provided including any medical goods or



supplies dispensed or prescribed, plan of care and author identification. Author identification signature may be handwritten, stamped, a unique electronic identifier or initials. Professional designation (credentials) should accompany the signature. If the service is performed by someone other than the provider claiming payment for the service, the identity, by name and title, of the person who performed the service must be documented.

Some visits may not require all of the elements of a visit note. Examples of such visits include, PPD planting/reading, blood pressure check, flu shot, and medication counseling.

Standards for each clinical element of the visit, with examples, are as follows:

- Purpose of visit—Chief complaint; consists of the patient’s reason for the visit. May quote the patient directly (e.g., “I have an itchy rash on my arm,” or “in for a blood pressure check”).
- Pertinent history—History of the condition identifying subjective and objective information pertinent to the reason the patient presents (e.g., “Pt. complains of a stuffy nose and dry cough for three days. Cough is worse at night. Has been taking OTC cough medicine 6 hours with no relief. No fever or sore throat. . .”).
- Physical exam—Objective and subjective information, whether positive or negative, pertinent to the chief complaint (e.g., “Chest clear to auscultation. Normal breath sounds”).
- Diagnosis/clinical impression—Assessment must be consistent with findings from history and physical (e.g., “otitis media,” “well-controlled hypertension,” “well child”).
- Plan of care—Plans for treatment of condition and/or follow-up care must be consistent with the diagnosis. Plans

should include instructions to member as appropriate, and notation of when member is expected to return for next visit. (e.g., “amoxicillin t.i.d. x 10 days,” “Hct, Pb, dental referral. RTC 1 yr. or prn.”). Notes and/or encounter forms should reflect follow-up care, calls, or visits, when indicated, including the specific time of return recorded as weeks, months or as needed.

- Laboratory/radiology/other—Results/reports of laboratory tests, x-rays and other studies ordered must be filed in the medical record initialed by the ordering practitioner signifying review. The review and signature cannot be done by someone other than the ordering practitioner. When the information is available electronically, there must be evidence of review by the ordering practitioner. If a test or study ordered at the primary care site is performed at another location, these results must also be filed in the primary care site’s medical record. Abnormal reports must be accompanied by a documented follow-up plan.
- Consultation referrals—Referrals to consultants must be appropriate and clearly documented. Clinical documentation must be present in the chart, which supports the decision to refer to a consultant. Documentation of the referral should include the name, location, and specialty of the consultant, the reason for the referral, the date of the referral, and whenever possible, the date of the scheduled appointment.
- Consultation reports—For each referral, there must be a corresponding report in the chart for the consultant, as well as documented acknowledgement of the report by the provider. Results/reports of all consultations must be initialed by the ordering practitioner signifying review. The review and signature cannot be done

by someone other than the ordering practitioner. If the consultant's findings are abnormal, there must be documentation in the chart of the follow-up plan. There must be no evidence of inappropriate risk to a patient as a result of diagnostic or therapeutic procedures from consultations or the provider's procedures.

- **Unresolved problems**—Any problems identified at a visit that are not resolved during that visit must be addressed and documented in subsequent visits.
- **Preventive Screenings**—Evidence that preventive screenings and services were offered in accordance with the early periodic screening diagnosis and treatment (EPSDT) periodicity schedule for children and adolescents or for individuals over the age of 21, in accordance with the provider's own guidelines, is present.
- **Advance Directives**—Evidence that the provider attempted to discuss advance directives with all adult patients is in the patient's medical record.

### **Additional Pediatric Documentation Standards**

The medical records of all Mass General Brigham Health Plan members under age 21 must reflect periodic health maintenance visits as defined by the [Massachusetts Quality Health Partners \(MHQP\) Pediatric Preventive Health Guidelines](#) in effect at the time of the visit. Some health maintenance standards below apply to pediatric members of all ages while others apply only to certain ages or are required once over a specified time frame.

Mass General Brigham Health Plan documentation requirements include, but are not limited to, the following (the ages at which each standard applies will be noted below the definition of each standard and will be followed

by the documentation expectation):

#### ***Initial/Interval Medical History***

For children and adolescents, past medical history relates to prenatal care, birth, surgeries, and childhood illnesses. The initial medical history must contain information about past illnesses, accidents and surgeries, family medical history, growth and development history, assessment of immunization status, assessment of medications and herbal remedies, psychosocial history and documentation of the use of cigarette, alcohol, and/or other substances.

The interval history must contain a review of systems and an assessment of the member's physical and emotional history since the last visit.

#### ***Comprehensive Physical Exam***

Documentation of a complete, unclothed physical exam, including measurement of height and weight, must be present. Head circumference should be measured until age two and documentation of blood pressure should begin by age three.

#### ***Developmental Assessment***

The member's current level of functioning must be assessed as concisely and objectively as possible in all the following areas.

Documentation such as "development on target" or "development WNL" is acceptable.

#### ***Physical***

Gross motor, fine motor, and sexual development

#### ***Cognitive***

Self-help and self-care skills and ability to reason and solve problems

#### ***Language***

Expression, comprehension, and articulation

### ***Psychosocial***

Social integration, peer relationships, psychological problems, risk-taking behavior, school performance and family issues. Ask about daycare arrangements for infants, toddlers, and preschoolers. Follow-up should be documented, as appropriate, for developmental delays or problems.

### ***Sensory Screening Hearing***

- *Infancy*—The results of a formal newborn hearing screening, administered prior to a newborn's discharge from the birthing center or hospital should be documented in the chart. A gross hearing screening (e.g., "turns to sound," "hearing OK") must be documented for all members under age three. Newborns should be assessed before discharge or at least by 1 month of age. A subjective assessment should be conducted at all other routine check-ups.
- *1–17 (Early childhood–adolescence)*—Conduct objective hearing screening at ages 4, 5, 6, 8, 10, 12, 15, and 17. A subjective assessment should be conducted at all other routine check-ups.

If testing is performed elsewhere (e.g., school), it does not need to be repeated by the provider, but findings, including the date of testing, must be documented in the medical record. Follow-up should be documented, as appropriate, for abnormal findings.

### ***Vision***

- *0–1 (Infancy)*—A gross vision screening (e.g., "follows to midline," "vision OK") must be documented for all members under three. Newborns should be assessed using corneal light reflex and red reflex before discharge or at least by 2 weeks of age. Evaluation of fixation preference, alignment and eye

disease should be conducted by age six months.

- *1–17 (Early Childhood–Adolescence)*—Visual acuity testing should be performed at ages 3, 4, 5, 6, 8, 10, 12, 15, and 17 years.
- *Screen for strabismus between ages 3 and 5*—A child must be screened at entry to kindergarten if not screened during the prior year per Massachusetts Preschool Vision Screening Protocol.

### ***Dental Assessment/Referral***

Documentation of an assessment of dental care must be present in the chart. For members under age three, a discussion of fluoride and bottle caries must be present and for members aged three and older, teeth must be checked for obvious dental problems and an assessment must be documented as to whether the member is receiving regular dental care. Referral to a dentist must be provided to those members with abnormal findings.

### ***Health Education/Anticipatory Guidance***

Age-appropriate assessment, discussion and education relating to physical, developmental, psychosocial, safety and other issues must be documented at each well child-care visit.

### ***Immunization Assessment/Administration***

Updated documentation of assessment of immunization status, and administration of immunizations according to most current Department of Public Health (DPH) guidelines, must be present in the chart on an immunization flow sheet. For immunizations administered, the documentation must include, at a minimum, the name of the immunization, the initials of the person who administered the vaccine, and the date administered. It is recommended that the lot number also be documented. For immunization records received from prior providers, including the

hepatitis B #1 received in the hospital at birth, review by the provider must be explicitly documented. “Immunizations up-to-date” is not adequate documentation to indicate review. For hepatitis B immunizations received at birth, the name of the hospital and the date administered must also be documented.

### Exposure to Lead Risk Assessment

#### *0–10 (Infancy–Mid-Childhood)*

There must be documented evidence that the provider assessed the member for exposure to lead according to the following schedule:

- Initial screening between 9–12 months of age
- Annually at 2 and 3 years of age
- At age 4 if the child lives in a city/town with high risk for childhood lead poisoning
- At entry to kindergarten if not screened before

Documentation that the member is either “high” or “low” risk is acceptable. For members documented as “high risk,” results of a blood lead test must be present in the chart.

### Tuberculin Test

#### *0–21 (Infancy–Young Adult)*

Tuberculin skin testing for all patients at high risk. Risk factors include having spent time with someone with known or suspected TB; coming from a country where TB is very common; having HIV infection; having injected illicit drugs; living in the U.S. where TB is more common (e.g., shelters, migrant farm camps, prisons); or spending time with others with these risk factors. Documentation of a reading of the results by a clinician must be present and dated 48–72 hours after testing. Determine the need for repeat skin testing by the likelihood of continued exposure to infectious TB.

### Early and Periodic Screening and Diagnostic Testing (EPSDT)

Primary care providers (PCPs) caring for Mass General Brigham Health Plan MassHealth members under age 21 must offer to conduct periodic and medically necessary inter-periodic screens as defined by Appendix W of MassHealth’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) Periodicity Schedules.

### Other Testing

There should be documentation for other screening tests, such as sickle cell, cholesterol, urinalysis/ culture and for sexually transmitted diseases, as appropriate to the member’s risk and the provider’s judgment. At a minimum, the date and results of the test must be documented.

In accordance with Mass General Brigham Health Plan’s Member Rights and Responsibilities, members have the right to ask for and receive a copy of their medical record and request that it be changed or corrected.

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### Serious Reportable Events/ Occurrences

A serious reportable event (SRE) is an event that occurs on the premises of a provider’s site that results in an adverse patient outcome, is identifiable and measurable, has been identified to be in a class of events that are usually or reasonably preventable, and is of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the provider.

Potential SREs or quality of care (QOC) occurrences may be identified by members, providers, or Mass General Brigham Health Plan staff and may come into Mass General Brigham Health Plan through Mass General Brigham

Health Plan Customer Service or any other department. The duty to report a SRE is the responsibility of the individual facility or provider. The facility or provider must document their findings and provide a copy of the report to both DPH and the Mass General Brigham Health Plan Director of Quality Management and Improvement within the required time frame.

Issues of concern may also be found through claims data or when medical record audits are performed by Mass General Brigham Health Plan. Claims data are reviewed on a quarterly basis to identify possible SREs. Any problems

identified include both acts of commission and omission, deficiencies in the clinical quality of care, inappropriate behavior during the utilization management process, and any instances of provider impairment documented to be a result of substance abuse or behavioral health issues. All contracted providers must participate in and comply with programs implemented by the Commonwealth of Massachusetts through its agencies, such as, but not limited to the Executive Office of Health and Human Services (EOHHS), to identify, report, analyze, and prevent SREs, and to notify Mass General Brigham Health Plan of any SRE.

Mass General Brigham Health Plan promptly reviews and responds within 30 days to actual or potential QOC occurrences. The provider will have within seven days to report SREs. Mass General Brigham Health Plan uses the National Quality Forum's (NQF) definition of SREs and the NQF's current listing of "never events."

Mass General Brigham Health Plan does not reimburse services associated with SREs that are determined to be preventable after a root cause analysis (RCA) has been completed. To administer this policy, Mass General Brigham Health Plan recognizes but is not limited to the SREs identified by the National Quality Forum, Healthy Mass, and the CMS Medicare Hospital

Acquired Conditions and Present on Admission indicator reporting.

This policy applies to all hospitals and sites covered by their hospital license, ambulatory surgery centers, and providers performing the billable procedure(s) during which an "event" occurred.

Mass General Brigham Health Plan will reimburse eligible providers who accept transferred patients previously injured by an SRE at another institution (facility) or under the care of another provider.

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## Clinical Performance Improvement Initiative (CPII)

As a participating Group Insurance Commission (GIC) plan, Mass General Brigham Health Plan tiers providers at the group level for PCPs and individually for select physician specialties.

In an effort to promote quality improvement and cost efficiency in the delivery of health care, in 2003 the Massachusetts GIC established the Clinical Performance Improvement Initiative (CPII).

CPII involves aggregation of a consolidated multi-plan claims database of over 150 million claim lines submitted by GIC participating carriers to be analyzed by the GIC consultants Resolution Health Inc. and Mercer/Vips. Subsequently, GIC participating plans use the findings provided by these GIC consultants to construct quality of care and efficiency profiles and in developing "tiered" networks.

Mass General Brigham Health Plan continues to work collaboratively with the GIC, its participating carriers and their consultants on the CPI Initiative. The original methodology has been updated by GIC as a result of feedback from members, providers, and other key stakeholders to make it easier to understand,

include more quality data measures, and produce greater consistency across the plans.

Mass General Brigham Health Plan's tiered network applies only to GIC enrollees. Tier assignments affect only copayment amounts and have no impact on current contract terms and/or reimbursement rates.

A tier designation is not an endorsement or recommendation by Mass General Brigham Health Plan and does not suggest high quality or substandard care for an individual patient by any given practice or provider. In addition to such quality designations, other factors such as a provider's medical training, hospital affiliation, malpractice history, appointment access and interpersonal skills should also be considered by a member when selecting a provider.

## Section 6

# Clinical Programs

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## Section 6

### Clinical Programs

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#### Care Management Programs

Mass General Brigham Health Plan Care Management and Disease Management programs serve members across physical, behavioral and psychosocial conditions. Our Care Management programs are designed to provide comprehensive, multi-disciplinary, and fully integrated care management services that complement and support the care delivered by providers as they help their patients make effective use of available health care resources.

Our holistic and culturally sensitive model is intended to support member adherence to provider's recommended treatment and facilitate self-management. Program participants are identified through our member health needs assessment, medical and pharmacy utilization resource data, or clinician, provider and self-referrals.

In addition to obtaining and sustaining the most appropriate, accessible, and cost-effective health care for Mass General Brigham Health Plan members, our care managers:

- Collaborate with practitioners, members, families, providers, social service agencies, and community organizations in developing and executing care management plans for members with complex health care needs
- Support and reinforce members in their efforts to adhere to treatment interventions recommended by their providers through motivational coaching
- Advocate for members to obtain the most appropriate health care services available, through education, referral, and negotiation
- Educate members, families, and health care providers regarding benefits, availability of services, community resources, entitlement programs, and

health care alternatives

- Educate members and families regarding health risks, preventative health measures, treatment plans, and medications
- Identify and facilitate access to social service agencies, community organizations, patient support groups, and other adjunct services
- Participate, as needed, in case conferences, family meetings, and informational sessions
- Work with members on their unique discharge planning needs throughout the continuum of care, and specialized equipment needs to maximize their independence in the community
- Provide in home care management to our neediest members with highly complex, unstable, or chronic high-end medical, behavioral health and psycho- social conditions

For more information or to refer a member to Care Management, contact Mass General Brigham Health Plan Clinical Services department at 855-444-4647, or send an email\* to [HealthPlanCareManagement@mgb.org](mailto:HealthPlanCareManagement@mgb.org).

\*Please do not send Protected Health Information (PHI) through unsecured email.

#### Care Partnership Program

In addition to Mass General Brigham Health Plan's traditional care and disease management programs, Mass General Brigham Health Plan offers a specialized program, called Care Partnership. Through multiple referral sources and the use of predictive modeling software, Mass General Brigham Health Plan is able to reach out to members whose complex medical conditions or challenges with effective self-management require more intensive support in order to prevent more serious complications and disease progression.

Because these members typically lack a well-coordinated care plan, have multiple comorbidities, and may face a multitude of psychosocial challenges, our program employs a comprehensive approach focused on medical, social, and behavioral health care management services. Our Care Managers partner with members, their families, their PCPs, and other health care personnel to develop patient centered goals, promote effective self-management, assist in the coordination of care, and facilitate supportive relationships. Care Managers use motivational and coaching techniques in their care planning and interventions to both improve health status and to avoid hospitalizations.

### **Social Care Management**

We recognize that often the primary barrier to effective medical care for our members is not medical in nature. Some of the most pressing concerns for many members are income, housing, food, utilities, clothing, and finding transportation.

Mass General Brigham Health Plan has social care managers with extensive experience in the field of social and human services. Social Care Managers help members identify and procure community-based services. They conduct health needs assessments and collaborate with other care managers to help minimize barriers so that members can meet their medical, behavioral, and psychosocial goals.

### **Smoking Cessation**

The smoking cessation program at Mass General Brigham Health Plan is designed to provide members with information about methods to quit and to help members decide on the method that is most appropriate for them. The Mass General Brigham Health Plan Tobacco Treatment Specialist helps members develop behavior change strategies for dealing with cravings and facilitate access to prescription and over-the-counter cessation

medications (both covered under Mass General Brigham Health Plan's pharmacy program). Mass General Brigham Health Plan members who obtain a prescription for over-the-counter nicotine replacement therapy (such as the patch, gum, or inhaler) pay only the pharmacy copayment. Only members with pharmacy coverage qualify for nicotine replacement therapy.

Individuals may be identified for the program through a health needs assessment, self-referral, and referral by a care manager or a provider.

For more information about Mass General Brigham Health Plan's Smoking Cessation program, please contact Mass General Brigham Health Plan's Provider Service Center (8:00 AM to 6:00 PM Monday through Friday) at 855-444-4647 or send an email to the Smoking Cessation counselor at [HealthPlanQuitSmoking@mgb.org](mailto:HealthPlanQuitSmoking@mgb.org).

### **Maternal and Child Health**

Mass General Brigham Health Plan is strongly committed to making these services available to women with medical or psychosocial conditions that render them vulnerable to pre-term or low birth-weight delivery. Members are referred to the program from a variety of sources including clinician and member self-referral.

Mass General Brigham Health Plan's Maternal-Child Health care managers (MCH) work closely with providers to maximize access to the efficacy of prenatal care. If enrolled in the Maternal-Child Health program, the MCH care manager can ensure a member's comprehensive access to such services as behavioral health or substance abuse services, direct referral to Mass General Brigham Health Plan's smoking cessation counselor, and full coverage of breast pumps and postpartum home visits.

The Pediatric Care Management program addresses the health care needs of children and

infants with serious illness and unique health care needs including medical, behavioral, developmental, psychosocial concerns and conditions and complications arising from the newborn period. The role of the Pediatric Care Manager is to educate, coordinate and facilitate care, emphasizing collaboration with the provider, the member's parents or guardians, other health care providers, social service agencies, and community organizations in developing and executing a care management plan for the member.

Many of the cases involve children with special health care needs, enabling us to link families with special resources and programs available for this population. Mass General Brigham Health Plan is committed to working with providers for children with special health care needs. We promote the American Academy of Pediatrics "medical home" model of care to develop supportive and collaborative partnerships with our providers to improve the care and quality of life for these members.

### **Text4baby**

"Text4baby" is a free app that sends health-related text messages to expectant mothers and mothers of infants.

Each year in the U.S. more than 500,000 babies are born prematurely, and an estimated 28,000 children die before their first birthday. In response to this national public health crisis, the National Healthy Mothers, Healthy Babies (HMHB) Coalition launched text4baby to help new mothers care for their health and give their babies the best possible start in life.

Women who sign up for the service by texting BABY to 511411 (or BEBE in Spanish) receive free SMS text messages each week, timed to their due date or baby's date of birth. These messages focus on a variety of topics critical to maternal and child health, including birth defects prevention, immunization, nutrition, seasonal flu, mental health, oral health, and

safe sleep. Text4baby messages also connect women to prenatal and infant care services and other resources.

### **Outreach Partners**

The National HMHB Coalition is working with a broad range of partners to encourage the women they reach to take advantage of this free service. Outreach partners include state and local health departments, community health centers, WIC programs, health plans, retail partners, community organizations, major medical associations, and non-profit organizations.

Text4baby is made possible through a broad, public-private partnership that includes government, corporations, academic institutions, professional associations, tribal agencies and non-profit organizations. Founding partners are HMHB, Voxiva, CTIA–The Wireless Foundation, and WPP. U.S. government partners include the White House Office of Science and Technology Policy and the Department of Health and Human Services. The mobile health platform is provided by Voxiva and free messaging services are generously provided by participating wireless service providers. Implementation partners include BabyCenter, Danya International, Syniverse, Keynote Systems, and The George Washington University.

Promoting prenatal and post-partum health is one of Mass General Brigham Health Plan's major health and quality initiatives, and a priority in our efforts to address health disparities in our State. Our partnership with text4baby is a natural extension of our work in these areas.

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## **Disease Management Programs**

### **Diabetes Disease Management**

Mass General Brigham Health Plan's Diabetes Disease Management Program strives to help Mass General Brigham Health Plan members

take control of their diabetes through member and provider- oriented outreach strategies and interventions. The program rests on the assumption that, for most patients, diabetes is a controllable illness and that much of diabetes morbidity is preventable.

Using the *American Diabetes Association Clinical Practice Recommendations* as a framework, the goal of Mass General Brigham Health Plan’s comprehensive Diabetes Disease Management Program is to promote optimal member/provider management to help minimize disease-related complications. The multi-pronged approach attempts to improve member’s self-management skills while increasing member knowledge of the disease process. The varied components on the Diabetes Disease Management Program are all geared to assisting the primary care provider (PCP) to more effectively manage their Mass General Brigham Health Plan patients with diabetes in a more proactive fashion. The aim of Mass General Brigham Health Plan’s diabetes program is early detection and optimal member/provider management and control.

Mass General Brigham Health Plan’s Diabetes Disease Program is intended to provide outreach to members at varying levels of intensity on a stratification of clinical data to help members more effectively manage their diabetes, reduce the risk for short- and long-term complications, enhance member understanding of diabetes and good self-management practice and improve their self-assessed “quality of life.” In addition, the diabetes program delivers cultural, competent education meeting the member’s individual needs.

Members are identified for the program through multiple sources including inpatient; outpatient; ER and pharmacy utilization claims data; direct referrals from health care providers; member self-referral; and other sources of referral. Participation is voluntary and at no cost. Members may opt out of the

program any time.

### **Member Resources**

Members identified as being higher risk receive outreach phone calls from a Diabetes Care Manager, who conducts assessments and develops individualized care plans based on the needs of members, including:

- Disease-specific education on the importance of glucose monitoring, the connection with dental health, medication adherence, timely preventative screenings, disease signs and complications, weight management, dietary needs, and the importance of communicating with their providers
- Referral to Mass General Brigham Health Plan’s tobacco treatment specialist for quitting smoking and our on-site behavioral health care managers for managing depression
- Collaboration with the member/family, PCP, and other health care providers to implement a care management plan
- Reimbursement for outpatient diabetes educators and registered dietitians

### **Provider Resources**

#### **REPORTING MEMBER UTILIZATION**

Mass General Brigham Health Plan provides practice site quarterly specific reports derived from health plan claims data to support providers in managing a patient’s outcome. These reports are available through [Provider.MGBHP.org](https://Provider.MGBHP.org) and include:

- *Diabetes Member Utilization Report*—Member-level information over a 12-month period that includes:
  - Number of diabetic related hospitalizations
  - Number of diabetic related visits to the ER
  - Receipt of HbA1c test

- Receipt of LDL test
- Receipt of retinal screening examination
- Presence of a cardiovascular comorbidity
- Last dispensed ACE/ARB
- Last dispensed statin
- **Diabetes Screening Rates**—A graphic report showing the screening rates of recommended tests for diabetes for your site compared to a benchmark rate of Mass General Brigham Health Plan overall for a specific reporting time period, including:
  - Two or more HbA1c tests
  - Four or more HbA1c tests
  - LDL-C screening
  - Retinal eye exam
- **Diabetes Screening Rate Trend**—A graphic report showing the screening rates for recommended tests for diabetes for your site compared to benchmark rate of Mass General Brigham Health Plan overall. This report presents the same results as the Diabetes Screening Rates Report for up to 12 months
- Clinical Practice Guidelines
- American Diabetes Association Clinical Practice Recommendations

In addition to the reports available on [Provider.MGBHP.org](https://Provider.MGBHP.org), Mass General Brigham Health Plan mails to primary care practice sites Diabetes Gap Reports, a member specific utilization report that identifies which recommended screening(s) their patient may have missed based on claims information and other relevant information related to cardiovascular comorbidity.

### Outcome Measurements and Effectiveness

Some of the key measures that Mass General Brigham Health Plan looks at to assess the program include:

- HEDIS measure: Comprehensive Diabetes Care; Central to the program is improving screening rates (HgbA1C, retinal eye exams, lipid screening, micro-albuminuria) for at-risk members in an effort to improve health outcomes.
- Member satisfaction with diabetes educational tools
- Member satisfaction with Care Management intervention

### Asthma Disease Management

Mass General Brigham Health Plan has a multifaceted Asthma Disease Management program that focuses on improving our adult and child members' understanding of what controlled asthma means, understand their medications, proper way to use an inhaler, environmental triggers, and managing exacerbations. Our program provides outreach to members at varying levels of intensity based on a stratification of medical and pharmacy claims data and assists the provider with information to proactively manage the Mass General Brigham Health Plan patient with asthma.

Members targeted for enrollment in the asthma disease management program include those who are at high risk for ineffective management of their asthma disease process as manifested by frequent utilization of the emergency room for asthma related problems, asthma related inpatient admissions, and high recent and chronic use of symptom-relief and crisis asthma medications.

Built on the NHLBI Asthma Management Guidelines, our program reinforces the provider's treatment plan.

Members are identified for the program through multiple sources, including inpatient, outpatient, emergency room services, and pharmacy claims data, direct referrals from health care providers, member self-referral and other sources of referral. Participation is

voluntary and at no cost. Members may opt out of the program at any time.

### **Member Resources**

Members identified as being at the highest risk may receive additional educational material mailings to help them manage their asthma. An Asthma Care Manager conducts an assessment to evaluate asthma control, employing the asthma control test, and provides a personalized care plan that includes the following interventions to minimize exacerbations and reduce impairment:

- Education about the disease process, necessary lifestyle changes
- Provides resources and strategies to eliminate and avoid factors that may exacerbate asthma
- Makes referrals to support groups, community resources, the Mass General Brigham Health Plan smoking cessation counselor and other health and social agencies
- Makes provision for covered benefits such as smoking cessation, allergy treatments

### **Provider Resources**

#### **REPORTING MEMBER UTILIZATION**

Mass General Brigham Health Plan provides primary care sites with quarterly specific reports derived from health plan claims data to support providers in managing a patient's outcome. These reports are available through [Provider.MGBHP.org](https://Provider.MGBHP.org) and include:

- **Quarterly Site based Asthma Registry:** These reports are issued quarterly and provide a risk stratified summary of relevant asthma related utilization for each member identified with asthma at the practice site during the prior 12 months of the member's Mass General Brigham Health Plan enrollment. The following variables are included in these reports:
  - Summary of asthma related

hospitalization and readmissions

- Summary of asthma-related emergency room visits
  - Summary of specialist visits
  - Summary of pulmonary function tests
  - Dispensed medications
  - Number of inhaled and oral steroid prescriptions
  - Number of combined inhaler prescriptions
  - Number of leukotriene modifier prescriptions
  - Number of inhaled steroid/long-acting beta agonist prescriptions
  - Number of systemic steroid prescriptions
- **Asthma Care Quality Measure Trend Report:** This report provides a site level profile of the quarterly Asthma Disease Management Program measures. A primary care site can compare how it is doing against the Mass General Brigham Health Plan benchmark among primary care sites with 75 or more Mass General Brigham Health Plan members in the asthma population for any quarter during the past 12 quarters. A site may also look for trends in asthma care at their site that show improvement or identify areas where an action may be taken to improve care and utilization.
  - **A primary care site bi-weekly Asthma Trigger Reports:** These reports identify individual members with evidence of current problematic asthma control as evidenced by high use of bronchodilators or systemic steroids or asthma related emergency department use. The following variables are included in these reports:
    - An asthma related ER visit in the past 2 weeks OR a paid claim for an asthma ER visit in the past 6 weeks;
    - A systemic steroid dispensing



in the past 2 weeks AND have received at least 3 systemic steroids in the past 4 months and at least 1 beta agonist dispensing in the past 4 months;

- A beta-agonist dispensing in the past 2 weeks AND have received at least 3 beta-agonists in the past 4 months;
- Have seen a specialist with the diagnosis of asthma

### Chronic Obstructive Pulmonary Disease

Mass General Brigham Health Plan's Chronic Obstructive Pulmonary Disease (COPD) Program offers personalized health support to participants affected with COPD.

Our goal is to empower participants to make smarter life choices that help slow inevitable disease progression and allow them to maximize their functional independence. It strives to improve the participant's quality of life while reducing hospitalizations and emergency room visits, resulting in lower COPD-related healthcare costs.

Our program provides outreach to members at varying levels of intensity based on a stratification of medical and pharmacy claims data and assists the provider with information to proactively manage the Mass General Brigham Health Plan patient with COPD.

Members targeted for enrollment in the COPD disease management program include those who are at high risk for ineffective management based on progressive or severe COPD, emergency room visits and inpatient admissions for COPD exacerbations.

Members are identified for the program through multiple sources including outpatient, emergency, hospital setting, pharmacy claims data, direct referrals from health care

providers, member self-referral, and other sources of referral. Participation is voluntary and at no cost. Members may opt out of the program at any time.

The program also encourages participants to stay connected to their provider's plan of care.

### Cardiovascular Disease

Mass General Brigham Health Plan's Coronary Artery Disease (CAD) and Congestive Heart Failure (CHF) Programs offer personalized health support to participants affected by CAD and CHF.

Our programs encouraging participants to collaborate with their physician and prevent disease progression disability, as well as the development of other chronic conditions.

Our programs empower participants to improve their health status and increase compliance with their provider's treatment regimen.

Our programs provide outreach to members at varying levels of intensity based on a stratification of medical and pharmacy claims data and assists the provider with information to proactively manage the Mass General Brigham Health Plan patient.

Members targeted for enrollment in the CAD and CHF disease management programs include those who are at high risk for ineffective management of their disease process as manifested by frequent utilization of the emergency room and inpatient admissions for related problems.

Members are identified for the program through multiple sources, including inpatient, outpatient, emergency room services, pharmacy claims data, direct referrals from health care providers, member self-referral, and other sources of referral. Participation is voluntary and at no cost. Members may opt out of the program at any time.



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## Other Programs

### Proactive Well-Childcare

Mass General Brigham Health Plan provides a comprehensive program to deliver proactive well childcare services by establishing expectations regarding the importance and content of well-childcare; and by communicating these to enrollees and providers. Mass General Brigham Health Plan endorses the Massachusetts Health Quality Partners' (MHQP) Pediatric Preventive Care Guidelines. Clinical programs are designed to support and collaborate with primary care practices and school based programs. The objectives of proactive well-childcare are:

- To provide comprehensive and continuous health care designed to prevent illness and disability
- To foster early detection and prompt treatment of health problems before they become chronic or cause irreversible damage
- To create an awareness of the availability and value of preventive health care services

Information regarding the MHQP guidelines for pediatric preventive care is available to all pediatric providers. These guidelines are accessible on the [2022 Pediatric Preventive Care Guidelines](#) page and include comprehensive clinical instruction on health maintenance visits, routine lab work, sensory screening, infectious disease screening, cancer screening, and general counseling and guidance. Health maintenance visits include the following:

- History and physical exam
- Developmental assessment
- Nutritional assessment
- Dental assessment and referral
- Head circumference (until 24 months)
- Immunization assessment
- Behavioral health screening

For detailed information on documentation standards for these services, please refer to the “Quality Management Programs” section of this manual.

### School-based Health Center Program

Mass General Brigham Health Plan contracts with school-based health centers (SBHCs) to facilitate better access to quality health care for children and adolescents.

Contracted SBHCs provide HMO covered services to school-aged Mass General Brigham Health Plan members within the school setting. During the school year, students can easily access the services that each center provides.

#### ***Covered Services***

To facilitate access to primary care and urgent care services for students at SBHCs, Mass General Brigham Health Plan will reimburse for those services delivered provided all other claim processing rules are met.

Examples of covered services include:

- Comprehensive physical examinations
- Immunizations
- Treatment of minor illness or minor injuries
- Pregnancy testing
- Sexually transmitted disease testing and treatment
- HIV/AIDS testing and counseling

SBHCs do not make direct referrals to specialists. Rather, the SBHC must refer the member back to the PCP except for emergencies.

#### ***Coordination of Care Form***

The child or adolescent's PCP is notified of services rendered at the school-based health center through the use of the Coordination of

Care correspondence form. The Coordination of Care form helps to establish a link between health care providers whose ultimate goal is to ensure timely access and proper follow-up to care delivered at SBHCs.

## Organ Transplants

For members requiring transplant services, Mass General Brigham Health Plan has partnered with OptumHealth Care Solutions for the use of its comprehensive transplant network.

Optum has established relationships with medical centers that have demonstrated expertise in various transplant services. Use of transplant services through the Optum network is available to all members. When services within Optum's network are not available to meet a member's needs, consideration for the best placement possible will be given outside of Optum's contracted network.

The member's appropriate specialty provider or the PCP in cooperation with the member's specialty provider may initiate authorization requests for all transplant-related services with Mass General Brigham Health Plan. All pertinent medical information must be submitted to Mass General Brigham Health Plan in writing to obtain authorization for transplant services. Transplants are coordinated through Mass General Brigham Health Plan's Clinical Services Department prior to providing any services, including evaluation. The medical criteria established by Mass General Brigham Health Plan will be applied and each potential transplant must be deemed medically necessary, not experimental in nature, and appropriate for the medical condition for which the transplant is proposed.

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## Nurse Advice Line

Mass General Brigham Health Plan offers its members a toll free 24/7 Nurse Advice Line. Patients can speak directly with a registered

nurse at any time of the day, seven days a week. Members may also listen to automated information on a wide range of health-related topics, ranging from aging and women's health to nutrition and surgery. The Nurse Advice Line doesn't take the place of a primary care visit. It is intended to help our members decide if they should make an appointment with their PCP or go to the emergency room. The nurse also provides helpful suggestions for how your patients might care for themselves at home.

Your patients may access Mass General Brigham Health Plan's Nurse Advice Line at:

- Commercial: 1-800-462-5449

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## Online Clinical Reports

Mass General Brigham Health Plan provides its primary care network with a wealth of clinical resources to help in effectively managing patient care. This provision of timely, actionable site and patient-level data allows PCPs to download electronic versions of various reports and manipulate the data based on the specific needs of their practice.

Access to the data is entirely at the discretion of the provider office. To protect the confidentiality of our members and due to the sensitive contents of these reports, providers are strongly encouraged to grant role-based access only, and review user permissions regularly.

### Available Reports

- *Asthma Site Summary Report*—Key Measurements for a primary care site for asthma care quality measures compared to the best achievable performance results for the most recent quarter
- *Asthma Care Quality Measure Trend*—Graphs displaying the same results as the Asthma Site
- *Summary Report* for the last 12 quarters
- *Asthma Member Utilization Report*—

- Asthma related utilization of Mass General Brigham Health Plan members assigned to the primary care site
- *Diabetes Screening Rates*—A graphical report showing the screening rates of recommended tests for diabetes for the primary care site compared to a benchmark rate of Mass General Brigham Health Plan overall
  - *Diabetes Screening Rates Trend*—A graphical report showing the screening rates for the recommended tests for diabetes for the primary care site compared to a benchmark rate of Mass General Brigham Health Plan overall for the past 12 quarters
  - *Diabetes Member Utilization Report*—A detailed report of utilization by Mass General Brigham Health Plan members enrolled at the primary care site
  - *ER Site Summary Report*—Summary of ER visits not resulting in an inpatient admission for members assigned to the primary care site
  - *ER Site Summary Trend Report*—Graphs of measures of ER visits not resulting in an inpatient admission for Mass General Brigham Health Plan benchmark and for the primary care site
  - *Mammography*—A report of female members between the ages of 40 and 74 who have not had a mammogram in the past year
  - *Member ER Visit Summary Report*—Summary of ER utilization for members assigned to the primary care site
  - *Member ER Visit Detail Report*—A list of each ER visit during the reporting period, by member assigned to the primary care site
  - *Seven-month Infants with Fewer Than Three Well Visits*—A report of infants assigned the PCP who are seven months old as of the month end and who have had less than three well child visits between birth to six months of age
  - *Have You Seen/Screened Me? Screening Rates*—A graphical report comparing the rate of pediatric well child visits and the rate of MassHealth pediatric behavioral health screens to the Mass General Brigham Health Plan benchmark
  - *Have You Seen Me? Report*—Detailed report listing members between the ages of 1–18 who did not have a well-child visit in the past year
  - *Have You Immunized Me? Report*—Detailed report listing members between the ages of 18 and 24 months of age during the past quarter

Provider offices can also access other administrative reports and conduct many transactions on a self- service basis without assistance from Mass General Brigham Health Plan staff.

For a detailed list of [Provider.MGBHP.org](https://Provider.MGBHP.org) reports and available transactions, please visit the Member and Provider Management sections of this manual.

To enroll in the provider portal, please visit [Provider.MGBHP.org](https://Provider.MGBHP.org) to follow the easy registration instructions—or consult with your site’s appointed User Administrator.

Providers needing additional assistance can email [HealthPlanPRWeb@mgb.org](mailto:HealthPlanPRWeb@mgb.org).

## Section 7

# Utilization Management

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## Section 7

# Utilization Management

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### Overview

This section defines Mass General Brigham Health Plan's policies and procedures regarding authorization requests and highlights guidelines associated with prior authorizations and notifications.

Mass General Brigham Health Plan's Utilization Management (UM) program is designed to ensure the provision of the highest quality of health care to our members while at the same time promoting appropriate, efficient, and cost-effective resource utilization. As such, Mass General Brigham Health Plan's UM program focuses on:

- Evaluating requests for services by determining the medical necessity, appropriateness, and effectiveness of the requested services
- Promoting continuity of patient care through the facilitation and coordination of patient services to ensure a smooth transition for members across the continuum of health care
- Analyzing utilization statistics to identify trends and opportunities for improvement
- Reviewing, revising, and developing medical coverage policies to ensure that utilization management criteria are objective and based on medical evidence, and that Mass General Brigham Health Plan members have appropriate access to new and emerging efficacious technologies

Referrals, prior authorization, notification, concurrent review, retrospective review, and discharge planning are all elements of Mass General Brigham Health Plan's utilization management program.

Mass General Brigham Health Plan recognizes that underutilization of medically appropriate services has the potential to adversely affect our members' health and wellness. For this reason, Mass General Brigham Health Plan promotes appropriate utilization of services. Mass General Brigham Health Plan's utilization management decisions are based on appropriateness of care and service and the existence of coverage. Mass General Brigham Health Plan does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, nor does Mass General Brigham Health Plan provide financial incentives to UM decision makers to encourage decisions that result in underutilization.

The treating provider, in conjunction with the member or designee, is responsible for making all clinical decisions regarding the care and treatment of the member. Mass General Brigham Health Plan's Clinical Department is responsible for making all utilization decisions in accordance with the member's plan of covered benefits and established medical necessity criteria.

Mass General Brigham Health Plan network providers are contractually prohibited from holding any Mass General Brigham Health Plan member financially liable for any service administratively denied by Mass General Brigham Health Plan for the failure of the provider to obtain the required prior authorization or notification for the service, or for services denied because the provider failed to submit supporting clinical documentation with their request.

Mass General Brigham Health Plan periodically reviews the services for which prior authorization is required as practice patterns in the network warrant. Providers are notified of changes via the monthly eNewsletter, Mass General Brigham Health Plan's website, and/or written communications.

## Requesting and Obtaining an Authorization or Referral

To determine prior authorization, referral and notification requirements for general services, see the Prior Authorization, Notification, and Referral Guidelines on [Provider.MGBHP.org](https://Provider.MGBHP.org).

Most Surgical Day Care (SDC) services do not require authorization. A consolidated list of SDC procedures requiring authorization can be found in the Surgical Day Fact Sheet on [Provider.MGBHP.org](https://Provider.MGBHP.org).

Not all DME and orthotics require authorization. See the Prior Authorization List for DME, Medical Supplies, Oxygen Related Equipment, Orthotics, Prosthetics, and Hearing Aids on [Provider.MGBHP.org](https://Provider.MGBHP.org).

## Submission through Provider.MassGeneralBrighamHealthPlan.org

All in-network referrals, authorizations and notifications must be submitted through the Mass General Brigham Health Plan online authorization tool, accessed through the provider portal, [Provider.MGBHP.org](https://Provider.MGBHP.org).

Clinical documentation to support authorization requests can also be submitted through [the Provider portal](https://Provider.MGBHP.org). To expedite decision making, complete clinical information supporting medical necessity should be uploaded with the request on [Provider.MGBHP.org](https://Provider.MGBHP.org).

Authorization or referral requests to a non-Mass General Brigham Health Plan network provider cannot be submitted through [Provider.MGBHP.org](https://Provider.MGBHP.org) and require fax or mail submission.

Authorization requests that cannot be submitted online may be faxed to 617-586-1700.

## Valid Prior Authorization Requests

A valid prior authorization request is defined as one where:

- The request is initiated by the primary care provider (PCP), treating specialist, or the treating provider
- The provider is part of the Mass General Brigham Health Plan network
- The member is actively enrolled with Mass General Brigham Health Plan at the time of the service
- The appropriate authorization template is completed for those service requests that require submission through [Provider.MGBHP.org](https://Provider.MGBHP.org)
- The appropriate authorization form is completed for service requests that are still faxed or mailed
- A physician prescription is included with a request for enteral formulas, infusion therapy, and DME
- Clinical documentation to support medical necessity is included

## Confirmation of Requested Authorizations

Network providers obtain confirmation of received authorization requests and UM decision-making from our online Provider portal, [Provider.MGBHP.org](https://Provider.MGBHP.org), including the authorization identification number, authorization decision, number of days/visits, and the duration approved or denied.

Authorization reports specific to a member, individual authorization, or an aggregate of all requests made by the servicing provider are available through [Provider.MGBHP.org](https://Provider.MGBHP.org).

Only those requests made by the requesting servicing provider may be viewed by the requesting servicing provider.

Existence of an authorization identification number does not ensure that a request has been approved. All requests are assigned an



authorization identification number for tracking purposes independent of the approval status. It is imperative that providers validate the status of a specific authorization request.

The Mass General Brigham Health Plan *Service Authorization Report* informs the provider that a request was either:

- Approved (A) based on medical necessity, benefit coverage, and member eligibility
- Closed (C) due to a change in level of care (i.e., an observation stay that escalates to an inpatient admission) or administrative error
- Denied (D) based on medical necessity or administrative guidelines
- Pended (P) awaiting clinical review or more information
- Medreview (M) awaiting clinical review or more information

All authorization decisions resulting in an adverse determination are also communicated to the requesting provider by phone and in writing.

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## Utilization Management Methods

### Referrals

Mass General Brigham Health Plan promotes a health care delivery model that supports PCP coordination and oversight of care. Mass General Brigham Health Plan recognizes that its members are best served when there is coordination between specialty and primary care clinicians.

To ensure reimbursement, care provided by a Specialist requires a referral from the Mass General Brigham Health Plan Primary Care Physician (PCP). The Mass General Brigham Health Plan PCP is the only provider authorized to make referrals to Specialists within Mass General Brigham Health Plan's network. The PCP should notify Mass General Brigham Health Plan of the referral before the initial

recommended specialty visit and no later than 90 days after the initial specialty visit. Without the required referrals, payment is subject to denial.

Specialty referrals are allowed when all the following occur:

- The PCP determines such referrals are appropriate
- The specialist participates in the Mass General Brigham Health Plan network
- The specialist agrees to a treatment plan for the Member
- The specialist provides the PCP with all necessary clinical and administrative information on a regular basis
- The services provided are consistent with the terms of the Mass General Brigham Health Plan subscriber agreement

Some services such as family planning, gynecologist, or obstetrician for routine, preventive, or urgent care, behavioral health services, and emergency services do *not* require a referral.

PCPs are required to enter referral request information as follows:

- For Mass General Brigham Health Plan network specialists, referrals should be submitted through [Provider.MGBHP.org](https://Provider.MGBHP.org)
- For out-of-network Specialists, referrals are submitted by fax or mail **and are subject to prior authorization**
- Referrals are *not* required for the following:
  - Emergency services
  - A gynecologist or obstetrician for routine, preventive, or urgent care
  - Family planning services provided by a Mass General Brigham Health Plan



- provider or clinic
- Outpatient and diversionary BH services
- Routine vision
- PPO members

### Prior Authorization (Prospective Review)

Prior authorization allows for the efficient use of covered health care services and helps to ensure that members receive the most appropriate level of care in the most appropriate setting.

Mass General Brigham Health Plan identifies certain services as requiring prior medical necessity review and approval subsequent to meeting established criteria. Prior authorization processes support care management involvement by connecting the utilization management Care Manager with the provider and member prior to the delivery of services. Certain requested services, procedures, or admissions require prior authorization. Prior authorizations are based on medical necessity and are not a guarantee of payment. Requests for services requiring prior authorization must be submitted prior to delivery of service. Failure to obtain the required prior authorization can result in a denial of payment to the provider.

For elective services, such as admissions and surgical day, Mass General Brigham Health Plan requires at a minimum, submission five business days prior to the admission. Authorization determinations for elective services can take up to 14 calendar days to ensure adequate time for review and processing .

Prior authorization is not required for:

- Emergency room care
- Observation

Prior authorization is required for

\*Emergent acute inpatient admissions

\* Authorization for emergency admissions must include supporting clinical documentation at the time of authorization submission. Mass General Brigham Health Plan will make a medical necessity determination based on clinical information submitted.

Requests for prior authorization services are forwarded to a utilization management registered nurse for review. The utilization management Care Manager will determine whether the requested service meets established review criteria guidelines. The utilization management registered nurse or designated support staff will contact the servicing provider or PCP whenever there is a question regarding the requested type of service or setting. Additional clinical information may be required in order to make a medical necessity decision.

Prior authorization approvals are made by Mass General Brigham Health Plan utilization management registered nurses based on medical necessity criteria. Prior authorization denials (adverse determination) for medical necessity are made only by a Mass General Brigham Health Plan Medical Director or a designated physician reviewer, based upon medical necessity criteria, the specific needs of the individual patient, and the availability of local resources.

### ***Durable Medical Equipment (DME)***

DME purchases and rentals must be requested by the member's PCP, Mass General Brigham Health Plan treating provider, or an approved vendor.

Some DME items are not subject to authorization requirements. For a list of

services that require prior authorization, please review the Mass General Brigham Health Plan DME Prior Authorization list on [Provider.MGBHP.org](https://Provider.MGBHP.org). This list also includes medical supplies, oxygen related equipment, orthotics, and prosthetics that require prior authorization.

DME prior authorization requests are submitted through [Provider.MGBHP.org](https://Provider.MGBHP.org). The physician's prescription and supportive documentation for the requested DME must be attached to the electronic request. A valid authorization request, supportive documentation, and a physician's prescription are required before a requested service can be approved.

Providers need to submit requests including supporting information and a prescription directly to the participating vendor. Mass General Brigham Health Plan staff works directly with the vendors to ensure efficient and timely filling of requests.

### Enteral Products

Authorization requests for enteral products are submitted through Mass General Brigham Health Plan's online authorization tool, accessed at [Provider.MGBHP.org](https://Provider.MGBHP.org). A valid authorization request and completed Medical Necessity Review Form for Enteral Nutrition Products (Special Formula) indicating the specific product and quantity are required before a determination can be made to approve a requested service.

### Prior Authorization Requests Submitted Directly to a Delegated Entity

#### eviCore Healthcare

The following elective outpatient services require prior authorization through eviCore Healthcare:

- Selected Molecular & Genetic Testing

The medical services that may be reviewed

include inpatient services, select inpatient and outpatient surgical procedures and select imaging and ancillary services.

When these services are rendered as part of a hospital emergency room, observation stay, surgical care or inpatient stay, they are not subject to prior authorization requirements.

Submit requests directly to eviCore by:

- Accessing online services at [EviCore.com](https://EviCore.com)  
After a quick and easy one-time registration, you can initiate a request, check status, review guidelines, and more.
- Calling eviCore toll-free,  
8:00 AM to 9:00 PM ET at 888-693-3211

Once approved, the authorization number can be found on [Provider.MGBHP.org](https://Provider.MGBHP.org). eviCore approves by the specific facility performing the study and by the specific CPT code(s). It is the responsibility of the rendering/performing facility to confirm that they are the approved facility for rendering the service and the specific study authorized by CPT code. Any change in the authorized study or provider requires a new authorization. Failure to obtain authorization or submit supporting documentation to establish medical necessity could result in an administrative denial of services to the provider.

### Sleep Studies and Therapy Management

CareCentrix (CCX) provides sleep study and therapy management services for all Mass General Brigham Health Plan product lines. Testing may be approved in the patient's home, using a Home Sleep Test (HST) or in an in-network sleep lab using a polysomnogram.

Submit requests directly to SMS by:

- Visiting the SMS website  
[SleepManagementSolutions.com](https://SleepManagementSolutions.com) and accessing the secure Sleep Portal to submit the request

- Phoning SMS/CCX Monday-Friday, 8:00 AM to 5:00 PM ET, at 886-827-5861

For information on billable codes, access Mass General Brigham Health Plan's Provider Payment Guideline for Sleep Studies and Therapy Management.

### **Behavioral Health Services**

Optum manages the delivery of behavioral health services for Mass General Brigham Health Plan members.

See the Behavioral Health Provider Manual and access their web site on [Provider.MGBHP.org](https://Provider.MGBHP.org).

### **Concurrent Review**

Concurrent review is required for subsequent days of care or visits or services beyond the initial authorization or required notification. Concurrent review must be conducted via [Provider.MGBHP.org](https://Provider.MGBHP.org) where indicated. For services that cannot be conducted via [Provider.MGBHP.org](https://Provider.MGBHP.org), you may fax, or mail.

Most requests for concurrent services are submitted through [Provider.MGBHP.org](https://Provider.MGBHP.org). Follow the *Provider Portal User Guide* for continued stay authorizations. Those service requests that are not accepted through the Provider Portal must be faxed or mailed to Mass General Brigham Health Plan. See "Submission through Fax or Mail" explained earlier in this section for details. All concurrent requests must be supported by clinical documentation to determine medical necessity. Failure to obtain authorization or submit supporting documentation to establish medical necessity could result in an administrative denial of services to the provider.

Concurrent review includes utilization management, discharge planning, and quality of care activities that take place during an inpatient stay, an ongoing outpatient course of

treatment or ongoing home care course of treatment (for example, acute hospital, skilled nursing facilities, skilled home care, and continuous DME supplies/equipment).

The concurrent review process also includes:

- Collecting relevant clinical information by chart review, assignment of certified days and estimated length of stay, application of professionally developed medical necessity criteria, assignment of level of care, and benefit review. These criteria are not absolute and are used in conjunction with an assessment of the needs of the member and the availability of local health care resources
- Obtaining a request from the appropriate facility staff, practitioners, or providers for authorization of services
- Reviewing relevant clinical information to support the medical necessity
- Determining benefit coverage for authorization of service
- Communication with the health care team involved in the member's care, the member, and/or his or her representative and the provider
- Notifying facility staff, practitioners, and providers of coverage determinations in the appropriate manner and time frame
- Identifying discharge planning needs and facilitating timely discharge planning
- Identifying and referring potential quality of care concerns, Never Events/Serious Reportable Events, and Hospital Acquired Conditions for additional review
- Identifying members for referral to Mass General Brigham Health Plan's Care Management specialty programs

All existing services will be continued without liability to the member until the member has been notified of an adverse determination. However, denial of payment to the facility and/or attending physician may be made when days of care or visits do not support medically necessary care.

## Retrospective Review

As part of Mass General Brigham Health Plan's UM program in assessing overutilization and underutilization of services, focused retrospective review activity may be performed as cost drivers, HEDIS scores, changes in medical and pharmacy utilization trends, provider profiling and financial audits suggest.

Retrospective review is also performed as part of the utilization management process after services have been completed. Post service reviews should be submitted within 30 days of discharge.

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## UM Time Frame for Decision-Making and Notification

Authorizations are made as expeditiously as possible, but no later than within the designated time frames.

**Commercial and Qualified Health Plans**

<b>UM Subset</b>	<b>Decision Time Frame</b>	<b>Verbal Notification Provider</b>	<b>Written Approval Notification Provider and Member</b>	<b>Written Denial Notification</b>
Pre-service/Initial Determination <i>Non-urgent</i>	Within two business days of obtaining all necessary information. Decision and notification must occur no later than 14 calendar days after receipt of the request, independent of receipt of necessary information	Approval and Denial: Within 24 hours of decision, but must not exceed the overall decision time frame of 14 calendar days after receipt of the request	Within two business days following verbal notification	Within one business day following verbal notification, but no later than 14 calendar days after receipt of the request
Pre-service/Initial Determination <i>Urgent care</i>	Up to 72 hours/three calendar days of receipt of the request	Approval and Denial: Within 24 hours of decision, but must not exceed the overall decision time frame of 72 hours/three calendar days from receipt of the request	Within two business days following verbal notification	Within one business day of verbal notification or three calendar days of verbal notification (always using the lesser time frame)
Concurrent Review <i>Urgent</i>  Inpatient stays are always considered Urgent/Expedited	Within 24 hours/one calendar day of receipt of the request	Approval and Denial: Within 24 hours/one calendar day of receipt of the request	Within one business day following verbal notification	Within one business day of verbal notification or three calendar days of verbal notification (always using the lesser time frame)

UM Subset	Decision Time Frame	Verbal Notification Provider	Written Approval Notification Provider and Member	Written Denial Notification
Concurrent <i>Non-urgent</i>	Within 1 business day of obtaining all necessary information. Decision and notification must occur no later than 14 calendar days after receipt of the request, independent of receipt of necessary information.	<b>Approval:</b> Within one business day of decision. Must not exceed the overall decision time frame of 14 calendar days.  <b>Denial:</b> Within 24 hours of decision. Must not exceed the overall decision time frame of 14 calendar days.	Within one business day following verbal notification	Within one business day following verbal notification or three calendar days following verbal notification (always using the lesser time frame)
Retrospective <i>Review</i>	Within 30 calendar days of receipt of the request.	N/A	Within 14 calendar days after receipt of the request	Within 14 calendar days after receipt of the request
Reconsideration of Adverse Determination (Initial and concurrent medical necessity review determinations)	Within one business day of receipt of request for reconsideration	Within one business day of receipt of request for reconsideration	According to type of request as described above	According to type of request as described above

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## Notification

Notification to Mass General Brigham Health Plan of provided services assists utilization management registered nurse in identifying those members who might benefit from care management intervention. Notification also allows Mass General Brigham Health Plan to monitor utilization statistics and to initiate improvements to Mass General Brigham Health Plan's service network in conjunction with primary care sites. Mass General Brigham Health Plan collaborates with its contracted provider community and appreciates the coordination of communication between provider and Mass General Brigham Health Plan.

Depending on the service type, notification is either "requested" or "required." "Required" notification is a condition for payment. Please refer to the Prior Authorization and Notification Grid for further clarification and the most current information on services subject to prior authorization or notification requirements.

### Requested Notification

*Requested* notification is not a condition for payment. Claims will adjudicate as long as all other claims processing rules have been met, the provider rendering the service is in the Mass General Brigham Health Plan network and the member has active eligibility.

Emergency care providers should contact a member's primary care provider to coordinate care once the member is screened and stabilized.

### Required Notification

"*Required* notification" applies to select services in which a notification in the system is required for payment.

Please refer to the Prior Authorization and Notification Grid for further clarification and the most current information on services subject to prior authorization or notification requirements.

Mass General Brigham Health Plan network providers are contractually prohibited from holding any Mass General Brigham Health Plan member financially liable for any service denied by Mass General Brigham Health Plan for the failure of the provider to provide timely notification of provided services.

Most notifications for network providers are submitted through [Provider.MGBHP.org](https://Provider.MGBHP.org). Information that normally would accompany a prior authorization request should be submitted at the time of the notification.

An example of a service that requires notification is:

Skilled home care evaluations, providers are required to notify Mass General Brigham Health Plan of skilled evaluations to ensure proper payment.



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## Contracted Provider Network

Contracted providers have agreed to provide covered services to Mass General Brigham Health Plan members. Contracted providers are not employees, agents or representatives of Mass General Brigham Health Plan.

Mass General Brigham Health Plan Provider Directory is available by visiting our website at [Provider.MGBHP.org](https://Provider.MGBHP.org). Provider Service Professionals are also available to help PCP offices locate a contracted provider.

### Information about Mass General Brigham Health Plan Providers

More information about a Massachusetts licensed provider's education, hospital affiliations, board certification status, etc. is available from the Board of Registration in Medicine at [MassMedBoard.org](https://MassMedBoard.org).

The following websites also provide useful information in selecting quality health care providers:

- Leapfrog: [LeapFrogGroup.org](https://LeapFrogGroup.org) (For information on the quality of a hospital)
- Massachusetts Health Quality Partners: [mhqp.org](https://mhqp.org) (For learning how different medical groups treat the same type of illness)
- Joint Commission for the Accreditation of Healthcare Organizations:
- [Qualitycheck.org](https://Qualitycheck.org) (For comparing quality of care at many hospitals, home care agencies, laboratories, nursing homes, and behavioral health programs)

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## Out-of-Network Authorization Request Exceptions

PCPs should always refer members to in-network providers. Should the PCP refer a member to a non- contracted provider, the PCP

must obtain an approved prior authorization from Mass General Brigham Health Plan to confirm coverage. Members should be advised to speak with Mass General Brigham Health Plan regarding their options prior to seeking out-of-network care.

Authorization is required for all non-emergent out-of- network service requests.

Mass General Brigham Health Plan's contracted Provider Directory is available at [Provider.MGBHP.org](https://Provider.MGBHP.org).

Mass General Brigham Health Plan works with members, and providers to provide continuity of care and to ensure uninterrupted access to medically necessary covered services, whether current members or newly enrolled.

In most cases, a pre-existing relationship with a non- contracted provider is not reason alone to justify the need for an out-of-network provider. There are some circumstances when Mass General Brigham Health Plan will provide coverage for services to be rendered by an out-of-network provider as listed below.

Authorization requests for out-of-network specialists are submitted by fax or mail and are subject to medical necessity review.

### Conditions for Accessing Out-of- Network Providers

- A member chooses to continue with his or her PCP for up to 30 days after the provider's termination
- A member undergoing active treatment for a chronic or acute medical condition chooses to continue with the provider for up to 90 days after provider's termination
- A member in her second or third trimester of pregnancy chooses to continue with her provider for treatment through the first post-partum visit
- A member is receiving care directly related to a terminal illness may continue

treatment with the provider treating the terminal illness through the time of death

#### ***Transition of Care for Newly Enrolled Members***

- The provider is giving the insured an ongoing course of treatment or is the insured's primary care practitioner for up to 30 days
- A member in her second or third trimester of pregnancy chooses to continue with her provider for treatment through the first post-partum visit
- A member receiving care directly related to a terminal illness may continue treatment with the provider treating the terminal illness through the time of death

#### ***Other Coverage Conditions***

- A participating in-network provider is unavailable because of distance and travel
- To minimize disruption of care when delays in accessing a participating in-network provider for medically necessary covered services, other than those attributed to the member, would result in interrupted access to medically necessary services
- In the absence of a participating in-network provider with the qualifications and expertise matching the health care needs of the member for medically necessary covered services. Provisions are made to authorize an out-of-network provider for as long as Mass General Brigham Health Plan is unable to provide the medically necessary covered services in-network
- When the member's PCP determines that the member needs a service and would be subjected to unnecessary risk if the member received those services separately and not all related services are available in-network

#### **All Members**

- Mass General Brigham Health Plan will assist the member, as needed, in choosing an in-network provider that is located within the shortest travel time from the member's residence, considering the availability of public transportation. Mass General Brigham Health Plan does its best to ensure that, if a member accesses an out-of-network provider, the provider will be clinically appropriate and qualified to provide the services by checking the physician's profile with the Massachusetts Board of Registration in Medicine
- Mass General Brigham Health Plan requires out-of-network providers to coordinate with Mass General Brigham Health Plan's Contracting department for payment of services so that any cost to the member is not greater than the cost would be if provided by an in-network provider. Mass General Brigham Health Plan informs the out-of-network provider of his or her obligations under state and federal law to communicate with the member in his or her primary language, either directly or through a skilled medical interpreter
- If the provider is the only available provider in the network, to the extent possible, Mass General Brigham Health Plan shall ensure that such provider does not, because of moral or religious objections, decline covered services to the member
- All non-emergent, out-of-network services are subject to prior authorization
- All behavioral health requests for out-of-network providers are reviewed by Mass General Brigham Health Plan's behavioral health delegate, Optum, an NCQA-accredited managed behavioral health care organization

A letter of agreement is required for each unique authorization including agreed upon terms for rendering services.

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## Discharge Planning

Discharge planning occurs through the entire continuum of care for members engaged in medical as well as behavioral health treatments since members are discharged from home care and outpatient service, as well as inpatient stays more commonly associated with discharge planning.

Discharge planning for Mass General Brigham Health Plan members is initiated as expeditiously as possible on admission to the inpatient facility, and with the initiation of home and outpatient services, and is addressed throughout the continuum of care to facilitate timely and appropriate discharge and post-discharge services.

Utilization management registered nurses ensure that treating providers have up-to-date benefit information, understand the member's benefit plan, possible barriers with authorizing transition services, and know how to access covered services.

Utilization management registered nurses assist with transition of care when requested by the facility for in-network services and out-of-network authorizations when the network of providers cannot meet the member's after care needs. In addition to assisting the provider with traditional authorization/benefit information, the utilization management registered nurse collaborates and coordinates services with the provider and works with other appropriate members of the health care team, including but not limited to, Mass General Brigham Health Plan care-management programs, behavioral health care management programs, community and agency resources, and the member's designee on their unique discharge planning needs in order to coordinate services and facilitate a smooth transfer of the patient to the appropriate level of care and/or into clinical care management programs that will continue

to support the member's recovery.

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## Care Management

Mass General Brigham Health Plan believes that care management services are best provided by those clinicians closest to the member. As such, the Mass General Brigham Health Plan Care Management Programs are designed to supplement those care management services that are available at the primary care site or the treating facility. The care management process is directed at coordinating care and creating appropriate cost-effective alternatives for catastrophic, chronically ill, acutely ill, or injured members on a case-by-case basis to facilitate the achievement of realistic care management goals.

For more information, please refer to the "Clinical Programs" section of this manual. To refer a member to one of Mass General Brigham Health Plan's Care Management Programs, call 855-444-4647.

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## Medical Necessity Decision-Making

Mass General Brigham Health Plan recognizes that underutilization of medically appropriate services has the potential to adversely affect our members' health and wellness. For this reason, Mass General Brigham Health Plan promotes appropriate utilization of services. Mass General Brigham Health Plan's utilization management (UM) decisions are based only on appropriateness of care and service and existence of coverage. Mass General Brigham Health Plan does not arbitrarily deny or reduce the amount, duration, or scope of a covered service solely because of the diagnosis, type of illness, or condition of the Member or make authorization determinations solely on diagnosis, type of illness or the condition of the Member.

All medical necessity decisions are made only

after careful consideration of the applicable written medical criteria, interpreted considering the individual needs of the member and the unique characteristics of the situation.

Mass General Brigham Health Plan does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, nor does Mass General Brigham Health Plan provide financial incentives to UM decision-makers to encourage decisions that result in underutilization.

In all instances of medical necessity denials, it is Mass General Brigham Health Plan's policy to provide the treating/referring practitioner with an opportunity to discuss a potential denial decision with the appropriate practitioner.

### **Collection of Clinical Information for UM Decision-making**

The Mass General Brigham Health Plan Clinical Operations staff requests only that clinical information which is relevant and necessary for decision-making. Mass General Brigham Health Plan uses relevant clinical information and consults with appropriate health care providers when making a medical necessity decision.

When the provided clinical information does not support an authorization for medical necessity coverage, the utilization management registered nurse and/or physician reviewer outreaches to the treating provider for case discussion. A decision will be made based on the available information if the treating provider does not respond within the time frame specified.

All clinical information is collected in accordance with applicable federal and state regulations regarding the confidentiality of medical information.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Mass

General Brigham Health Plan is entitled to request and receive protected health information for purposes of treatment, payment, and health care operations without the authorization of the member.

### **Clinical Criteria**

Mass General Brigham Health Plan internally develops and uses medical necessity guidelines and criteria to review medical appropriateness of targeted services based on its member population and service utilization. Utilization management criteria and procedures for their application are reviewed at least annually and guidelines and criteria are updated when appropriate.

Mass General Brigham Health Plan uses McKesson's InterQual criteria tools or the Mass General Brigham Health Plan Medical Necessity Guidelines on [Provider.MGBHP.org](https://www.massgeneralbrigham.org/provider/MGBHP.org) to make decisions for authorization or requested services or treatment.

Medical necessity guidelines and criteria are based on sound clinical evidence of safety and efficacy, and developed and amended using various professional and government agencies and local health care delivery plans. These include, but are not limited to:

- Centers for Medicare and Medicaid Services
- Commonwealth of Massachusetts Division of Medical Assistance
- National therapy associations
- The Massachusetts Department of Public Health
- The Massachusetts Health Quality Partnership
- The Centers for Disease Control
- Professionally recognized Clinical Practice Guidelines
- Mass General Brigham Health Plan reinsurer
- Formal literature review using Hayes Inc., an independent health technology assessment organization providing

assessment of the safety and efficacy of technologies

- Cochrane Peer reviewed journals, Epsco, [UpToDate.com](https://www.uptodate.com), and Ovid
- Regional and national managed care organizations
- The Massachusetts Division of Insurance, Managed Care Consumer Protection and Accreditation of Carriers
- Expert review by board-certified practicing specialists.

The utilization management registered nurse and/or physician reviewer evaluates all relevant information before making a determination of medical necessity. Clinical guidelines and criteria are used to facilitate fair and consistent medical necessity decisions. At a minimum, the utilization management registered nurse considers the following factors when applying criteria to a given member: age, comorbidities, complications, progress of treatment, psychosocial situation, and home and family environment, when applicable.

Medical necessity criteria are applied in context with individual member's unique circumstances and the capacity of the local provider delivery system. When criteria do not appropriately address the individual member's needs or unique circumstances, the utilization management registered nurse and/or physician reviewer may override the criteria for an approval of services.

Providers can obtain a copy of internally developed criteria used for a specific determination of medical necessity by accessing [Provider.MGBHP.org](https://Provider.MGBHP.org). Proprietary criteria are made available to providers and members on request and only to the extent it is relevant to the treatment or service.

### **Division of Insurance Definition of Medical Necessity**

Medically Necessary health care services are

those that are consistent with generally accepted principles of professional medical practice as determined by whether:

- (a) The service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual,
- (b) Is known to be effective, based on scientific evidence, professional standards, and expert opinion, in improving health outcomes, or
- (c) For services and interventions not in widespread use, is based on scientific evidence

### **Information Request**

#### **PROVIDER SERVICE**

Phone: 855-444 4647

Monday to Friday, 8:00 AM to 6:00 PM

#### **MEMBER SERVICE**

Phone: 800-462-5449

TTY 711

Monday to Friday, 8:00 AM to 6:00 PM

Thursday, 8:00 AM to 8:00 PM

For after-hour requests and utilization management issues, these lines are available 24 hours a day, seven days a week. All requests and messages will be retrieved on the next business day. Language assistance is available to all members.

### **Medical Necessity Denials**

A medical necessity denial is a decision made by Mass General Brigham Health Plan to deny, terminate, modify, or suspend a requested health care benefit based on failure to meet medical necessity, appropriateness of health care setting, or criteria for level of care or effectiveness of care.

Only a Mass General Brigham Health Plan physician reviewer or physician designee may make medical necessity determinations for denial of service. Appropriate Mass General

Brigham Health Plan network specialists and external review specialists are used for complex specialty reviews and to review new procedures or technology. Reconsideration (clinical peer review) may be requested for services that are denied prospectively or concurrently based on medical necessity.

Reconsideration is an informal process offered to providers. It is not an appeal nor is it a precondition for filing a formal appeal. A physician reviewer conducts the reconsideration within one business day of the request.

Written notifications of medical necessity denials contain the following information:

- The specific information upon which the denial was made,
- The member's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical necessity review criteria,
- Specification of any alternative treatment option that is available through Mass General Brigham Health Plan or the community, if any,
- A summary of the applicable medical necessity review criteria and applicable clinical practice guidelines,
- How the provider may contact a physician reviewer to discuss the denial,
- A description of Mass General Brigham Health Plan's formal appeals process, the mechanism for instituting the appeals process, and the procedures for obtaining an external review of the decision.

### Administrative Denials

Administrative denials for authorization of requested services or payment for services rendered may be made when:

Member issued

- A service is explicitly excluded as a

covered benefit under the member's benefit plan,

- The requested benefit has been exhausted.

Mass General Brigham Health Plan network providers are contractually prohibited from holding any Mass General Brigham Health Plan member financially liable for any service administratively denied by Mass General Brigham Health Plan for failure of the provider to adhere to established utilization processes.

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## Delegation of Utilization Management

Mass General Brigham Health Plan delegates some utilization management activities to external entities and provides oversight of those entities. UM delegation arrangements are made in accordance with the requirements of the National Committee on Quality Assurance (NCQA), the Massachusetts Division of Insurance, the Executive Office of Health and Human Services (EOHHS), and other regulatory requirements. Mass General Brigham Health Plan has entered delegated arrangements with:

- Optum for the utilization and care management of behavioral health services on behalf of Mass General Brigham Health Plan members. Optum is a fully NCQA accredited Managed Behavioral Health Organization.
- Optum Rx has been delegated certain utilization management functions for a



select group of pharmaceuticals. Mass General Brigham Health Plan's Pharmacy and Therapeutics Committee approves all pharmaceuticals to be included in Optum Rx's prior authorization process. The responsibility for making denials based on medical necessity remains with Mass General Brigham Health Plan.

- eviCore has been delegated certain utilization management functions for elective, non-emergent outpatient high tech radiology services (including MRI, MRA, CT, and PET imaging studies), selected cardiac imaging and diagnostic services, selected molecular and genetic testing, and radiation therapy.
- [CareCentrix](#) has been delegated sleep diagnostic and therapy management services.
- Medical Review Institute of America—Mass General Brigham Health Plan partnered with Medical Review Institute of America (MRIoA) to supplement the prior authorization review process. MRIoA

is an external review organization that is staffed with board-certified physicians with a wide variety of specialties. In the rare instance when Mass General Brigham Health Plan physician reviewers are unavailable, MRIoA will provide support for the UM reviews. In these instances, MRIoA representatives may reach out to the requesting provider to obtain additional clinical information or conduct a physician-to-physician review.

Mass General Brigham Health Plan maintains close communications with its delegated partners to ensure seamless operations and

positive member and provider experiences.

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## Technology Assessment

Mass General Brigham Health Plan reviews and evaluates new and emerging technologies, including diagnostics, surgical procedures, medical therapies, equipment, and pharmaceuticals to determine their safety and effectiveness. In its evaluation efforts, Mass General Brigham Health Plan uses numerous sources of information including, but not limited to, the Hayes Medical Technology Directory, the Cochrane Library, peer reviewed scientific literature, policy statements from professional medical organizations, national consensus guidelines, FDA reviews, and internal and external expert consultants. Additionally, Mass General Brigham Health Plan may analyze market trends and legal and ethical issues in its evaluations as appropriate.

Medical Directors are responsible for making medical necessity decisions on urgent requests for new technologies that have not been evaluated and approved by Mass General Brigham Health Plan. The Clinical Policy and Quality Committee is responsible for approving new and emerging technologies based upon recommendations submitted by the Technology Assessment Team.

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## Online Clinical Reports on [Provider.MassGeneralBrighamHealthPlan.org](#)

Mass General Brigham Health Plan provides its primary care network with a wealth of clinical resources to help effectively manage their patients via Provider portal, [Provider.MGBHP.org](#). This provision of timely, actionable site- and patient-level data allows PCPs to download electronic versions of a variety of reports and analyze the data based on the specific needs of their practice.



Available reports include both quality and utilization information. This includes both quality measures and utilization for members with asthma and diabetes as well as ER utilization. For a detailed list of [Provider.MGBHP.org](#) reports and available transactions, please visit the Member and Provider Management sections of this manual.

Access to the data is entirely at the discretion of the Provider office. To protect the confidentiality of our members and due to the sensitive contents of these reports, providers are strongly encouraged to grant role-based access only and review user permissions regularly.

## Section 8

# Billing Guidelines

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## Section 8

### Billing Guidelines

#### Billing, Reimbursement, and Claims Submission

##### Submitting a Claim

Mass General Brigham Health Plan is committed to processing clean claims within at least 45 days of receipt. The claim receipt's Julian date is embedded in the Mass General Brigham Health Plan claim number as shown on the Explanation of Payment (EOP).

A clean claim is defined as one that includes at least the following information:

- Full member name
- Member's date of birth
- Full Mass General Brigham Health Plan member identification number
- Date of service
- Valid diagnosis code(s)
- Valid procedure code(s)
- Valid place of service code(s)
- Charge information and units
- National provider identifier (NPI) group number
- National provider identifier (NPI) rendering provider number, when applicable
- Vendor name and address
- Provider's federal tax identification number

##### Claim Submission Guidelines

When using a billing agent or clearinghouse, providers are responsible for meeting all Mass General Brigham Health Plan claim submission requirements.

Mass General Brigham Health Plan requires the submission of all paper and electronic claims within 90 days of the date of service unless otherwise contractually agreed.

Mass General Brigham Health Plan will not accept handwritten claims, or handwritten corrected claims.

Mass General Brigham Health Plan will only accept claims for services that you, your organization or your staff perform. Pass-through billing is not permitted and may not be billed to our members.

Mass General Brigham Health Plan's claim submission guidelines are as follows:

Claim Type	Submission Format
Professional Charges	CMS-1500
Durable Medical Equipment (DME)	CMS-1500
DME Supplies, Home Infusion Services, etc.	CMS-1500
Institutional/Facility Charges	UB-04

##### EDI (Electronic) Claims

Claims submitted electronically are subject to the claim edits established by Mass General Brigham Health Plan. Mass General Brigham Health Plan's payer ID number is 04293. Companion Guides are available to assist providers interested in electronic claim submissions.

##### Paper Claims

Paper claims must be submitted on the proper forms, within the aforementioned time frames or per specific contract arrangements. Claim forms other than those noted above cannot be accepted. Mass General Brigham Health Plan's front edits apply to both EDI and paper claim submissions.

##### NEW CLAIMS ONLY

Mail: Mass General Brigham Health Plan  
P. O. Box 323  
Glen Burnie, MD 21060

This address is for submission of brand-new paper claims only. To avoid processing delays, please do not send claims adjustment requests or any other correspondence to this address.

#### CLAIM ADJUSTMENT REQUESTS

Mail: Mass General Brigham Health Plan  
Attn: Correspondence Department  
399 Revolution Drive, Suite 810  
Somerville, MA 02145

#### CLAIMS APPEAL REQUESTS

Mail: Mass General Brigham Health Plan  
Attn: Appeals Department  
399 Revolution Drive, Suite 810  
Somerville, MA 02145

### Corrected Claims

Mass General Brigham Health Plan accepts both electronic and paper corrected claims, in accordance with guidelines of the National Uniform Claim Committee (NUCC) and HIPAA EDI standards. Corrected claims must be submitted with the most recent version of the claim to be adjusted. For example: a corrected claim to the original claim (00000E00000) should include the original claim number. A second corrected claim request should include the latest version (00000E00000A1).

#### *Electronic Submissions*

To submit a corrected facility or professional claim electronically:

- Enter the frequency code (third digit of the bill type for institutional claims; separate code for professional claims) in Loop 2300, CLM05-3 as either “7” (corrected claim) or “8” (void or cancel a prior claim)
- Enter the original claim number in Loop 2300, REF segment with an F8 qualifier. For example, for claim # 12234E01234, enter REF\*F8\*12234E01234

Provider payment disputes that require additional documentation must be submitted on paper, using the Request for Review Form.

#### *Late Charge Billing*

Mass General Brigham Health Plan accepts corrected claims to report services rendered in addition to the services described on an original claim. Mass General Brigham Health Plan will not accept separate claims containing only late charges.

Mass General Brigham Health Plan will not accept Late Charge claims from institutional (facility) providers, including, but not limited to hospitals; ambulatory surgery centers; skilled nursing facilities (SNF); hospice; home infusion agencies; or home health agencies.

### Claim Adjustments/Requests for Review

Request for a review and possible adjustment of a previously processed claim (not otherwise classified as an appeal) should be submitted to the Claim Adjustment Requests mailbox within 90 days of the EOP date on which the original claim was processed. All such requests should be submitted by completing a Request for Review Form and including any supporting documentation, with the exception of electronically submitted corrected claims.

#### *Filing Limit Adjustments*

To be considered for review, requests for review and adjustment for a claim received over the filing limit must be submitted within 90 days of the EOP date on which the claim originally denied. Disputes received beyond 90 days will not be considered.

If the initial claim submission is after the timely filing limit and the circumstances for the late submission are beyond the provider’s control, the provider may submit a request for review by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing limit and any supporting documentation. Documented proof of timely

submission must be submitted with any request for review and payment of a claim previously denied due to the filing limit. A completed Request for Review Form must also be sent with the request.

For paper claim submissions, the following are considered acceptable proof of timely submission:

- A copy of the computerized printout of the Patient Account Ledger indicating the claim was billed to Mass General Brigham Health Plan, with the submission date circled in black or blue ink
- Copy of Explanation of Benefits (EOB) from the primary insurer that shows timely submission (90 days) from the date carrier processed the claim
- Proof of follow-up with the member for lack of insurance information, such as proof that the member or another carrier had been billed, if the Member did not identify him/herself as a Mass General Brigham Health Plan member at the time of service.

For EDI claim submissions, the following are considered acceptable proof of timely submission:

- For claims submitted through a clearinghouse: A copy of the transmission report and rejection report showing the claim did not reject at the clearinghouse, and the claim was accepted for processing by Mass General Brigham Health Plan within the time limit
- For claims submitted directly to Mass General Brigham Health Plan: The corresponding report showing the claim did not reject at Mass General Brigham Health Plan and was accepted for processing by Mass General Brigham Health Plan within the time limit
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim

A copy of the Patient Account Ledger is not acceptable documentation for EDI claims except when the member did not identify him/herself as a Mass General Brigham Health Plan member at the time of service.

The following are not considered to be valid proof of timely submission:

- Copy of original claim form
- Copy of transmission report without matching rejection/error reports (EDI)
- A Mass General Brigham Health Plan rejection report or a report from the provider's clearinghouse without patient detail
- A computerized printout of the Patient Account ledger stating "billed carrier"
- A computerized printout of the Patient Account ledger stating another carrier was billed in error, where Mass General Brigham Health Plan is the primary carrier via NEHEN
- Hand-written Patient Account Ledger
- Verbal requests

### Behavioral Health Services Claims

Mass General Brigham Health Plan's Behavioral Health benefit is administered through Mass General Brigham Health Plan delegated partner Optum. Claims, appeals, and adjustment requests for behavioral health specific services must be submitted to Optum directly.

### Billing for Professional Services, Durable Medical Equipment, and Supplies

Professional charges, as well as DME and supplies must be billed on a CMS-1500 claim form and include all pertinent and/or required information. Missing, incomplete, or invalid information can result in claim denials.

In addition, the group and the rendering clinician's NPI numbers are required on most professional claim submissions. Claims submitted without a valid number are subject

to rejection by Mass General Brigham Health Plan.

### **Billing for Inpatient and Outpatient Facility Services**

Institutional charges must be billed on a UB-04 claim form and include all pertinent and/or required information. Where appropriate, valid ICD-10, revenue (REV), CPT-4 and/or HCPCS, and standard three-digit type of bill codes are required on institutional claims.

Mass General Brigham Health Plan requires the facility's NPI on all institutional claim submissions. Claims submitted without valid numbers are subject to rejection by Mass General Brigham Health Plan.

### **Room Charges**

Mass General Brigham Health Plan covers only the semi-private room rate unless a private room is pre-authorized. When not pre-authorized, the semi-private room rate will be applied to all private room charges during claim adjudication.

### **Itemization**

Itemization of inpatient charges is required upon request with each day of service separately reported. Please refer to Mass General Brigham Health Plan's UB-04 Claim Form Completion Guidelines for more information on required fields.

### **Coordination of Benefits (COB) Guidelines**

Coordination of Benefits (COB) is the process to determine how medical, dental, and other health care services will be paid when a person is covered under more than one insurer. Providers are required to notify Mass General Brigham Health Plan when other coverage is identified.

Providers are responsible for verifying eligibility at the point of service, which includes possible

Medicare coverage. This is particularly important given Medicare's 12-month filing limit and the significant reductions to allowed exceptions. Please note that an EOP from another insurer no longer qualifies as one of the exceptions.

The order of benefit determination is the term used for establishing the primary versus secondary insurer or carrier. The primary carrier must pay its portion of the claim first before billing the secondary carrier for review and potential payment of the balance up to its benefit or policy limits.

When a member enrolls with Mass General Brigham Health Plan through an employer plan, Mass General Brigham Health Plan will coordinate benefits as applicable to determine primary or secondary coverage. All payments for covered Mass General Brigham Health Plan services rendered are considered as payment in full.

Services and charges must be billed on an appropriate claim form and submitted to Mass General Brigham Health Plan within 90 days of receipt of the Explanation of Payment (EOP) or remittance advice from the primary insurance carrier.

### **Third-Party Liability Claims**

When a Mass General Brigham Health Plan member is involved in an automobile accident, providers should notify Mass General Brigham Health Plan directly by calling the Third-Party Liability Department at 617-772-5729 and making the proper notation on submitted claims. A Mass General Brigham Health Plan representative can assist with the process of determining which carrier should be billed for services.

When Mass General Brigham Health Plan is the secondary carrier, all claims must be submitted with a copy of the primary carrier's EOP, remittance advice, or denial letter.

## Workers Compensation (WC) Claims

When a Mass General Brigham Health Plan member is injured on the job, the employer's workers compensation carrier should be billed directly for the services. Only upon denial from the workers compensation carrier will Mass General Brigham Health Plan consider additional claims.

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## Reconciling Mass General Brigham Health Plan Explanation of Payment (EOP)

Each EOP claim line reflects the specific service codes billed to Mass General Brigham Health Plan. Denied claim lines will have corresponding "Remarks" explaining the reason for the denial.

A claim line can be denied for many reasons, including but not limited to:

- The payment submitted is included in the allowance for another service/procedure
- The service code submitted is not within the Mass General Brigham Health Plan contract
- The member was not effective for some or all dates of service (i.e., Mass General Brigham Health Plan was billed for five days but the member was effective for only three of those days)
- The time limit for filing the claim has expired
- A required authorization is required and not on file

Providers with questions or concerns on the disposition of a denied claim should first validate that all reasons for the claim denial have been considered before re-submitting to Mass General Brigham Health Plan.

Providers are strongly encouraged to reconcile the EOP timely or at least within 90 days of

receipt. Requests for adjustments or corrections received beyond the 90-day adjustment request filing limit cannot be considered for reprocessing.

To assist in reconciling, Mass General Brigham Health Plan offers instant access to PDF versions of current and historical EOP copies on our secure Provider portal. To enroll, please visit and simply follow the easy registration instructions or consult with your site's appointed user administrator.

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## Provider Reimbursement

Reimbursement for services rendered must be treated as payment in full. With the exception of an applicable copayment, coinsurance or deductible, providers may not seek or accept payment from a Mass General Brigham Health Plan member for any covered service rendered.

Providers should look solely to Mass General Brigham Health Plan for payment with respect to Mass General Brigham Health Plan covered services rendered. Furthermore, a provider may not maintain any action at law or in equity against any member to collect any sums that are owed to the provider by Mass General Brigham Health Plan for any reason, up to and including Mass General Brigham Health Plan's failure to pay, insolvency, or otherwise breach of the terms and conditions of the Mass General Brigham Health Plan Provider Agreement.

In the event that a non-medically necessary or non-Mass General Brigham Health Plan covered service is provided in place of a Mass General Brigham Health Plan-covered service, the provider may not seek reimbursement from the member unless documentation is provided indicating the provider explained the liability of payment for the non-medically necessary or non-Mass General Brigham Health Plan covered service to the member prior to services being rendered. Documentation must indicate that



the member both understood and agreed to accept liability for payment at the time of service.

### **Serious Reportable Events/Occurrences**

A serious reportable event (SRE) is an event that occurs on the premises of a provider's site that results in an adverse patient outcome, is identifiable and measurable, has been identified to be in a class of events that are usually or reasonably preventable, and is of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the provider.

Potential SREs or quality of care (QOC) occurrences may be identified by members, providers, or Mass General Brigham Health Plan staff and may come into Mass General Brigham Health Plan through Mass General Brigham Health Plan Customer Service, or any other department. The duty to report an SRE is the responsibility of the individual facility or provider. The facility or provider must document their findings; and provide a copy of the report to both DPH and to the Mass General Brigham Health Plan Director of Quality Management and Improvement within the required time frame. Issues of concern may also be found through claims data or when medical record audits are performed by Mass General Brigham Health Plan. Claims data are reviewed on a quarterly basis to identify possible SREs. Any problems identified include both acts of commission and omission, deficiencies in the clinical quality of care, inappropriate behavior during the utilization management process, and any instances of provider impairment documented to be a result of substance abuse or behavioral health issues. All contracted providers must participate in and comply with programs implemented by the Commonwealth of Massachusetts through its agencies to identify, report, analyze and prevent SREs, and to notify Mass General Brigham Health Plan of any SRE.

Mass General Brigham Health Plan reviews and promptly responds within 30 days to actual or potential QOC occurrences. The provider will have within seven days to report SREs. Mass General Brigham Health Plan uses the National Quality Forum's (NQF) definition of SREs (referred to as "never events") and the NQF's current listing of "never events."

Mass General Brigham Health Plan does not reimburse services associated with SREs, "never events," and/or provider preventable conditions.

To administer this policy, Mass General Brigham Health Plan recognizes, but is not limited to, the SREs identified by the National Quality Forum, HealthyMass, and the CMS Medicare Hospital Acquired Conditions and Present on Admission indicator reporting.

This policy applies to all hospitals and sites covered by their hospital license, ambulatory surgery centers, and providers performing the billable procedure(s) during which an "event" occurred.

Mass General Brigham Health Plan will reimburse eligible providers who accept transferred patients previously injured by an SRE at another institution (facility) or under the care of another provider.

Prov Name Patient Account#	Member Number / Name		Prov NPI#		Prov NHP# Claim Number		DRG	
1 12/16/2016 12/16/2016 0250	1	\$0.37	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	DENIED
2 12/16/2016 12/16/2016 73590 0320	1	\$240.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	DENIED
3 12/16/2016 12/16/2016 99284 0450	1	\$1,321.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	DENIED
<b>Totals:</b>		<b>\$1,561.37</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>
<b>Remarks:</b> Claim denied as patient cannot be identified as our insured.								

*On this example of an EOP section above, all claim lines were denied, with corresponding explanations below.*

## Audits

Mass General Brigham Health Plan's audit process ensures accuracy of charges and consistency with plan policies, provider agreements, and applicable nationally recognized medical claims reimbursement and administration policies. Mass General Brigham Health Plan auditing specialists, possessing thorough knowledge of medical procedures, terminology, and procedural coding, will perform the audits, review findings, and respond to provider questions or concerns.

Audits may be conducted on claims paid during the current year or two prior Mass General Brigham Health Plan fiscal (calendar) years, and up to six years, when investigating possible cases of fraud or abuse. Mass General Brigham Health Plan policies, including but not limited to medical policies, claims administration policies, and provider payment guidelines, will apply to all reimbursement and claims matters. In any matter where Mass General Brigham Health Plan does not maintain a specific policy or guideline, Mass General Brigham Health Plan adopts and follows the national standards and policies relating to procedural coding, medical claims administration, and reimbursement, which are recognized by government payers such as the Centers for Medicare and Medicaid Services (CMS), national health insurance carrier organizations, local coverage determinations, and the American Medical Association (AMA).

Pursuant to the Mass General Brigham Health Plan Provider Agreement, Mass General

Brigham Health Plan has the right to inspect, review and make copies of medical records. All requests for medical record review are made in writing. The inspection of medical records is conducted in compliance with the provider's standard policies governing such processes and that are applied uniformly to all payers.

Provider notification includes the audit parameters and corresponding medical records. The number of selected medical records is determined based on generally accepted statistical sampling methodology, rules, and techniques recognized in the field of statistical probability. Should additional areas of questions be identified, Mass General Brigham Health Plan reserves the right, at its election, to expand the scope of any audit, and perform extrapolation of audit results to the defined audit population. If extrapolation methodology is selected, the process shall be performed in accordance with generally accepted sampling principles as outlined above. Mass General Brigham Health Plan strictly adheres to state and federal requirements regarding confidentiality of patient medical records. A separate consent form will be provided when required by law.

When an initial review of a provider's medical records is required, Mass General Brigham Health Plan's provider audit process includes written 30 days' prior notification. For on-site audits, the provider must arrange a suitable work area, and make available to the auditor the medical records, including, but not limited to pharmacy profile and corresponding fee book when applicable. The fee book should be

an electronic file, such as Excel or similar program, unless another format has been agreed upon.

When additional records or documentation are necessary to complete the audit, the auditor will submit a written request for information to the provider's representative identifying the necessary documents to complete the audit, specifying a reasonable time period within which the provider will supply the requested documents.

Unless otherwise contractually agreed upon, Mass General Brigham Health Plan does not reimburse for audit-related administrative fees incurred by a provider.

### General Claims Audits

General post-payment claims audits are conducted to identify the accuracy of charges and the consistency of claims reimbursement with Mass General Brigham Health Plan's policies, Provider Agreements, Payment Guidelines, and applicable nationally recognized medical claims reimbursement and administration policies, including, but not limited to CPT and CMS guidelines. Audits include, but are not limited to:

- Billing for services at a higher level than provided
- Billing for services not documented and not provided
- Incorrect coding, including unbundling component service codes, modifier usage, units of service, duplicate payments
- Historical claim audits to include the global surgical period for codes submitted on the current claim
- Medical necessity based on Mass General Brigham Health Plan and/or CMS guidelines as applicable to the member benefit plan

For claim overpayments greater than \$500, the provider is notified in writing from Mass General Brigham Health Plan 30, or more, days

prior to the retraction of any monies—identifying claim discrepancies totaling over \$500 per vendor that have been identified by Mass General Brigham Health Plan's post-payment audit resulting in claim adjustments. All adjustments are processed against future payments. Unless otherwise instructed, providers should not issue a refund to Mass General Brigham Health Plan for overpayments identified by Mass General Brigham Health Plan however, this does not alter the Provider's obligation under federal or state law to report and return any overpayments).

If the provider disagrees with the adjustments, a letter of appeal or a completed Mass General Brigham Health Plan Provider Audit Appeal Form may be submitted to Mass General Brigham Health Plan's Appeals department within 90 days of receipt (or 30 days, if requesting an extension), along with comprehensive documentation to support the dispute of relevant charges. Mass General Brigham Health Plan will review the appeal and, when appropriate, consult with Mass General Brigham Health Plan clinicians or subject matter experts in the areas under consideration. To the extent that the provider fails to submit evidence of why the adjustment is being disputed, the provider will be notified of Mass General Brigham Health Plan's inability to thoroughly review the appeal request. The provider can resubmit (provided this occurs within the 90-day EOP window) and the appeal's receipt date will be consistent with the date Mass General Brigham Health Plan received the additional documentation.

Mass General Brigham Health Plan will review the appeal and, when appropriate, consult with clinicians or subject matter experts in the areas under consideration. The appeal determination will be final and if the determination is favorable to the provider, the claims in question will be adjusted accordingly within 10-calendar days of the final determination notification.

## External Hospital Audits

Audits are conducted at a mutually convenient time and cancellations by either party require written 15 days advance notice. In the event that an audit is cancelled, the audit must be rescheduled within 45 days of the originally scheduled date. Mass General Brigham Health Plan's audits involving inpatient and outpatient claims also include an exit interview to review and discuss the findings.

Documented unbilled services are charges for documented services that were detailed and billed for on the original audited claim but not billed to the full extent of the actual services provided. These charges will be considered for payment only when an accounting of the services is presented at the time of the on-site audit review for verification and acceptance during the on-site audit review. In addition, the charges must be submitted on a Mass General Brigham Health Plan accepted claim form.

The accepted charges will be adjusted (netted out) against the unsupported charges at the conclusion of the audit.

If there is a question of medical necessity or level of care, the hospital designee will coordinate dissemination and review of the findings with hospital staff and present a rebuttal position prior to the exit interview or within the 30-day appeal period.

At the conclusion of the audit, if the hospital designee agrees with the findings, the auditor will provide a dated copy of the signed and final Discrepancy Report.

Adjustments will be made 30 calendar days after the date indicated on the Discrepancy Report and will reflect accordingly in subsequent Mass General Brigham Health Plan EOPs. Alternative arrangements for payment to Mass General Brigham Health Plan must be made in writing and signed by all parties.

## Physician and Ancillary Audits

Physician and ancillary provider audits may consist of both off-site and on-site audits, with the audit of designated medical records conducted at either Mass General Brigham Health Plan or the vendor's office, when applicable. The determination of an off-site and/or on-site audit will be made by Mass General Brigham Health Plan.

Adjustments will be made 30 calendar days after the date indicated on the Discrepancy Report and will reflect accordingly in subsequent Mass General Brigham Health Plan EOPs. Alternative arrangements for payment to Mass General Brigham Health Plan must be made in writing and signed by all parties.

### ***Hold Harmless Provision***

Providers contractually agree that in no event, including but not limited to, non-payment by Mass General Brigham Health Plan, Mass General Brigham Health Plan's insolvency, or breach of the Provider Agreement, should a provider or any of its medical personnel bill, charge, collect a deposit from, or have any recourse against any Mass General Brigham Health Plan member or person, other than Mass General Brigham Health Plan, acting on their behalf for services provided. The provider must not solicit or require from any member, or in any other way, payment of any additional fee as a condition for receiving care.

Providers must look solely to Mass General Brigham Health Plan for payment with respect to covered services rendered to all Mass General Brigham Health Plan members.

This provision does not prohibit collection of supplemental charges or copayments on Mass General Brigham Health Plan's behalf made in accordance with the terms of the applicable Subscriber Group Agreement between Mass General Brigham Health Plan and the member.

## Payment Guidelines

Mass General Brigham Health Plan payment guidelines are designed to help with claim submissions by promoting accurate coding and by clarifying coverage. Mass General Brigham Health Plan’s payment guidelines are found at [Provider.MGBHP.org](https://Provider.MGBHP.org).

Updates to Payment Guidelines are announced through our monthly newsletter.

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## Aetna Signature Administrators (Aetna HealthSCOPE)

### Medical Claims

Submit medical claims to Aetna HealthSCOPE:

Provider Service 800-603-9647

Payer ID 45321

Paper Claims NHB Claims  
PO Box 323  
Glen Burnie, MD 21090

### Behavioral Health Claims

Submit behavioral health claims to Optum:

Provider Service 844-451-3520

Payer ID 87726

Paper Claims PO Box 30757  
Salt Lake City, UT  
84130-0757

## Section 9

# Pharmacy

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## Section 9 Pharmacy

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### Optum Rx

Mass General Brigham Health Plan has partnered with Optum Rx for pharmacy benefit management services. Optum Rx provides members with access to a comprehensive retail pharmacy network, as well as administers a variety of services including pharmacy claims processing, mail order, and specialty and formulary management.

### Formulary Drug Lookup Tool

Mass General Brigham Health Plan's drug lookup tool is designed to provide information about Mass General Brigham Health Plan drug coverage. It provides a searchable formulary by information such as drug name, member cost share, and prior authorization limitations.

Mass General Brigham Health Plan encourages providers to use the Formulary Drug Lookup Tool to become familiar with Mass General Brigham Health Plan's drugs selection. Our formulary is regularly reviewed, evaluated, and revised by the Mass General Brigham Health Plan Pharmacy and Therapeutics Committee. This committee is comprised of representatives from various practices and specialties.

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### E-prescribing

E-prescribing is the transmission (using electronic media) of a prescription or prescription-related information, between a prescriber, dispenser, pharmacy benefit manager, or health plan either directly or through an intermediary, including an e-prescribing network such as Surescripts.

Mass General Brigham Health Plan understands and embraces the value that e-prescribing brings to the effective care of its members and

continues its commitment, along with its contracted pharmacy benefits management partner, Optum Rx, in bringing these capabilities to the provider community. Specifically, Mass General Brigham Health Plan provides member eligibility and coverage status, medication history, and formulary information to physicians who use e-prescribing tools.

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## Pharmacy Coverage

### Over-the-Counter Benefit

Mass General Brigham Health Plan covers many over-the-counter products, including smoking deterrents. To ensure safe and appropriate use, covered over-the-counter items do require a prescription and must be obtained from a participating pharmacy. Mass General Brigham Health Plan's pharmacy network includes most Massachusetts pharmacies (refer to Optum Rx's Pharmacy Directory for a complete listing of participating pharmacies). Visit [Provider.MGBHP.org](https://Provider.MGBHP.org) for a listing of some of the covered over-the-counter medications available to Mass General Brigham Health Plan members.

Certain products are covered even for Mass General Brigham Health Plan members without pharmacy coverage:

- Diabetic supplies (lancets, test strips, glucose monitors, alcohol pads)

### Generic Interchange Policy

Mass General Brigham Health Plan has a mandatory generic substitution policy. The generic equivalent must be dispensed when available. Multi-source brand name drugs are not covered when a clinically equivalent lower cost generic is available. Brand name medications may be covered only when a generic is not available.



## Exception Requests

There may be cases where a medication, a quantity of medication, or a brand name medication is not normally covered by Mass General Brigham Health Plan, but the prescribing physician feels that it is medically necessary for the patient. In these instances, the physician can submit a fax form to Optum Rx, available on [Provider.MGBHP.org](https://Provider.MGBHP.org).

Mass General Brigham Health Plan's medication prior authorization and step-therapy criteria can be found within the Pharmacy section of our website.

Exception requests are reviewed by Optum Rx. Because we are committed to providing our members with prompt access to care, decisions regarding override requests are generally communicated within 24 hours to two business days from the time complete medical documentation is received.

## Quantity Limitations

Quantity limitations have been implemented on certain medications to ensure the safe and appropriate use of the medications. Quantity limitations are approved by Mass General Brigham Health Plan's Pharmacy and Therapeutics Committee. See the Formulary Drug Lookup Tool to determine if a medication has a quantity limitation.

## Prior Authorization Drug Policy

To ensure appropriate utilization, Mass General Brigham Health Plan delegates to Optum Rx prior authorization of some drugs. Prescribers can request clinical reviews by calling the Prior Authorization department at Optum Rx. Optum Rx staff will ask several questions to determine if the patient meets the established clinical criteria for the drug. After the clinical review, if the medication is approved for the patient, the Prior Authorization department at Optum Rx will process the authorization

and the pharmacy will be systematically notified of the decision and can then dispense the prescription. Please refer to the Formulary Drug Lookup Tool for medications requiring prior authorization. The clinical criteria for prior authorizations are reviewed annually by our Pharmacy and Therapeutics Committee and are available in the Pharmacy section of our website.

The "Appeals" section of this manual describes the process to appeal any decision made by Mass General Brigham Health Plan to deny, terminate, modify, or suspend a requested health care benefit based on failure to meet medical necessity, appropriateness of health care setting, or criteria for level of care or effectiveness of care.

## Step-Therapy Programs

Step therapy programs require use of specific, lower cost, therapeutically equivalent medications within a therapeutic class before higher cost alternatives are approved. Prescriptions for "first-line" medication(s) are covered; prescriptions for "second-line" medications process automatically if the member has previously received a first-line medication(s) in the past 6–12 months of Mass General Brigham Health Plan enrollment. The look-back period depends on the particular program; physicians may submit an override request to prescribe a second-line medication prior to using a first-line medication or if the member has previously failed a first-line medication outside of the drug look-back period. The request can be submitted by calling the Prior Authorization (PA) department at Optum Rx, or by faxing a request form. Step therapy programs are approved by Mass General Brigham Health Plan's Pharmacy and Therapeutics Committee.

## Specialty Medications Programs

Certain injectables or specialty medications (such as oral oncology) are covered only when obtained from any Mass General Brigham

Health Plan contracted specialty pharmacy including Optum Rx Specialty Pharmacy. The Mass General Brigham Health Plan Specialty Medications Program offers a less costly method for purchasing expensive injectable drugs. Providers may still choose to administer the medications providing oversight to patients' health status.

Under the program, medication and supplies will be shipped out and labeled specifically for each patient and delivered to the provider's office within 24–48 hours after ordering. Providers will then bill Mass General Brigham Health Plan only for the administration of the injectable drug. In addition, for those injectable medications that are self-administered or for patients with transportation restrictions, the specialty pharmacy can ship injectable medications and necessary administration supplies, if applicable, directly to the members' homes.

Please visit [Provider.MGBHP.org](https://Provider.MGBHP.org) for copies of the specialty pharmacy prior authorization fax forms, the list of specialty drugs, and medications supplied.

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## Maintenance 90 Program

Mass General Brigham Health Plan members are automatically enrolled in our Maintenance 90-day program for ongoing prescription refills. Members who have filled a non-specialty maintenance medication (such as drugs used for asthma, hypertension, high cholesterol, or arthritis) at least twice in the past four months will need to fill a 90-day supply on their next fill. The copayment for a 90-day supply is reduced for most medications.

Please provide your patients with a 90-day script when appropriate.

If you feel it is medically necessary for your patient to remain on a 30-day supply, please call Mass General Brigham Health Plan Provider

Service at 855-444-4647 to request an opt-out for your patient. Please indicate the medication(s) that should be opted-out, the proposed time frame for exclusion, and the reason for the 30-day supply.

A member can request to stay with 30-day refills by calling Optum Rx at the phone number on the back of their Mass General Brigham Health Plan ID card.

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## Mail-Order Program

Certain non-specialty maintenance medications (such as drugs used for asthma, hypertension, high cholesterol, and arthritis) are available through Optum Rx's mail service. This service allows Mass General Brigham Health Plan members to order a 90-day supply of certain prescription medicines at a reduced cost.

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## Access 90 Program

Access90 provides Mass General Brigham Health Plan members with a 90-day supply of certain maintenance medications when purchased through participating pharmacies. This program allows Mass General Brigham Health Plan members to obtain a 90-day supply of certain medicines at a reduced cost.

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## More Information

Updates to the Mass General Brigham Health Plan formulary are communicated through the provider newsletter.

Optum Rx Contact Information:  
Non-Specialty Drug Requests  
Main Phone: 844-294-0395

Commercial  
Phone: 800-294-5979  
Fax: 888-836-0730

## Section 10

# Appeals and Grievances

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## Section 10

# Appeals and Grievances

### Provider Grievances and Administrative Appeals

Complaints regarding reimbursement, a specific claim rejection, or any other provider issue should be reported to Mass General Brigham Health Plan Provider Service.

- A grievance (or complaint) is a statement of dissatisfaction with Mass General Brigham Health Plan's actions or services.
- An appeal is a request for Mass General Brigham Health Plan to reconsider an adverse action or denied claim submitted with documentation supporting the request for reconsideration.

#### Requesting an Administrative Appeal

As described in the Billing Guidelines Section of the Provider Manual, providers can request a review and possible adjustment of a previously processed claim within 90 days of the Explanation of Payment (EOP) date on which the original claim was processed. If the provider is not satisfied with the outcome of the request, an appeal can be submitted to Mass General Brigham Health Plan's Appeals and Grievances Department.

An appeal is a request for reconsideration of a claim denial by Mass General Brigham Health Plan. Appeal requests must be submitted in writing within one of the following timeframes:

- 90 days of receipt of the Mass General Brigham Health Plan Explanation of Payment (EOP)
- 90 days of receipt of the EOP from another insurance, when applicable
- 90 days of the date of the claims adjustment letter

The appeal must include additional, relevant information and documentation to support the

request. Requests received beyond the 90-day appeal requests filing limit will not be considered.

When submitting a provider appeal, please use the [Request for Claim Review Form](#).

Appeals may be submitted as follows:

Mail: Mass General Brigham Health Plan  
Appeals and Grievances Dept  
399 Revolution Drive, Suite 810  
Somerville, MA 02145  
Fax: 617-526-1980

#### Administrative Appeal Process

Mass General Brigham Health Plan has established a comprehensive process to resolve provider grievances and appeals:

- Appeals are reviewed by Mass General Brigham Health Plan's Provider Appeals department. Appeal reviews are completed within 60 calendar days from the date of Mass General Brigham Health Plan's receipt of the appeal request and all supporting documentation.
- If the appeal request is approved, the claim is adjusted, and the provider is notified via Mass General Brigham Health Plan's EOP (Providers should allow an additional two weeks for the appealed claim to be reprocessed and reflected in a future EOP).
- When the appeal request is denied, the Provider is notified of the reason, in writing, and when applicable, provided with instructions for filing an external appeal.
- If additional information is needed to review the appeal, the Provider is notified in writing and allowed an additional 60 days from the date of Mass General Brigham Health Plan's response letter to submit the required information.

Providers who are notified in writing by Mass General Brigham Health Plan of the administrative denial of an authorization

request due to the absence of supporting documentation to establish medical necessity should proceed as follows:

- If the service has not yet taken place, do not submit an appeal. Instead, create a new request through [Provider. MGBHP.org](https://www.mgbhp.org) with the supporting documentation.
- If the service has already taken place and the claim has denied, submit an appeal request with the supporting documentation.

### Appealing a Behavioral Health Service Denial

Optum is Mass General Brigham Health Plan's Behavioral Health Partner, and will delegate all Behavioral Health (BH) related matters, including grievances/complaints and appeals. All BH related grievances/complaints and appeals must be submitted to Optum directly.

For more information, please refer to the Behavioral Health provider manual or contact Optum.

## Provider Audit Appeals

### General Claims Audit Appeal Requests

For claims audited and adjusted post-payment, if the provider disagrees with the reason for the adjustments, a letter of appeal or a completed Mass General Brigham Health Plan Provider Audit Appeal Form may be submitted to Mass General Brigham Health Plan's Appeals Department within 90 days of the EOP.

The request must be accompanied by comprehensive documentation to support the dispute of relevant charges. To the extent that the provider fails to submit evidence of why the adjustment is being disputed, the provider will be notified of Mass General Brigham Health Plan's inability to thoroughly review the request. The provider can resubmit the appeal within the 90 day EOP window. The appeal's receipt date will be consistent with the date

Mass General Brigham Health Plan received the additional documentation.

Mass General Brigham Health Plan will review the appeal and, when appropriate, consult with Mass General Brigham Health Plan clinicians or subject matter experts in the areas under consideration. The appeal request will be processed within 60 calendar days from Mass General Brigham Health Plan's receipt of all required documentation.

The appeal determination will be final. If the appeal request is approved, Mass General Brigham Health Plan will adjust the claims in question within 10 calendar days of the provider's notification of the final determination.

## Member Inquiries, Complaints, and Grievances

Mass General Brigham Health Plan is committed to ensuring the satisfaction of our members and the timely resolution of all inquiries and reports of dissatisfaction by a member (or his/her authorized representative) about any action or inaction by Mass General Brigham Health Plan or a health care provider. Mass General Brigham Health Plan provides processes for members that allow for the adequate and timely resolution of inquiries and grievances/complaints.

### Inquiries

An inquiry is any oral or written question made by, or on behalf of, a member to Mass General Brigham Health Plan or its designees that is not the subject of an adverse determination or adverse action, and that does not express dissatisfaction about Mass General Brigham Health Plan or its operations, processes, services, benefits, or providers.

Upon receipt of an inquiry, Mass General Brigham Health Plan's Customer Service

Representative will document the matter and, to the extent possible, attempt to resolve it at the time of the inquiry.

### Complaints and Grievances

While grievances are typically reported by members, Mass General Brigham Health Plan will investigate all reported incidents when there are member care and other concerns. Possible subjects for grievances include, but are not limited to:

- **Quality of Care**—A member’s perception of poor provision of clinical care and/or treatment by medical staff
- **Access**—A member reports of an inability to access needed care in accordance with wait-time standards or in a manner that met the member’s perceived needs
  - Access is defined as the extent to which a member can obtain services (telephone access and scheduling an appointment) at the time they are needed. It can also include wait time to be seen once the member arrives for a visit or geographic access to a network provider
- **Service/Administration**—A member asserts that there was a problem with interpersonal relationships, such as rudeness on the part of a provider or Mass General Brigham Health Plan staff person and/or deficiencies in what would generally be considered good customer or patient service
- **Billing and Financial**—A member’s dispute of responsibility for rendered services, cost sharing amounts, or other financial obligations
- **Provider’s Facility**—A member asserts the provider’s facility was inadequate, including, but not limited to cleanliness of waiting room, restrooms, and overall physical access to the premises
- **Privacy Violation**—A member reports that his or her protected health information (PHI) was released, misdirected, or violated by Mass General Brigham Health

Plan or a provider

- **Member Rights**—A member reports that his or her member rights were violated by Mass General Brigham Health Plan or a provider. This can include a member’s allegation that Mass General Brigham Health Plan is not providing behavioral health services in the same way that physical health services are provided, as required by Mental Health Parity Laws

Grievances are researched and resolved as expeditiously as warranted, but no later than 30 calendar days from the verbal or written notice of the grievance.

Members may designate a representative to act on their behalf, and such representative is granted all the rights of a member with respect to the grievance process, unless limited in writing by the member, law, or judicial order.

The member must complete and return a signed and dated Designation of Appeal or Grievance Representative Form prior to the deadline for resolving the grievance. If the signed form is not returned, communication can only take place with the member.

Mass General Brigham Health Plan ensures that any parties involved in the resolution of inquiries, grievances, and any subsequent corrective actions, have the necessary knowledge, skills, training, credentials, and authority to make and implement sound decisions. and that they have not been involved in any previous level of review or decision-making. Members or their representatives are provided with a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing.

A member may file a complaint or grievance by telephone, fax, letter, or in person. For grievances received via Customer Service, Mass General Brigham Health Plan Customer Service Professionals assist members with reasonable assistance, including but not limited to, interpreter services, toll-free numbers

(including TTY/TTD access), explaining the grievance or appeal process, and assisting with the completion of any forms. All grievances are logged and when conveyed verbally to a Customer Service Professional, the process includes a reduction of the oral grievance to writing.

Received grievances are referred to the Appeals and Grievances Coordinator who will send the member or member's representative an acknowledgment letter within one business day. The letter instructs the member, or member's, representative to sign and return a copy of the letter to Mass General Brigham Health Plan prior to the deadline for resolving the grievance. However, the investigation of a member's grievance is not postponed pending return the signed letter. The member or authorized representative's signature simply acknowledges that Mass General Brigham Health Plan has captured the details of the grievance correctly.

A Mass General Brigham Health Plan health care professional with the appropriate clinical expertise in treating the medical condition, performing the procedure or providing treatment that is the subject of a grievance, will make an initial assessment as to the clinical urgency of the situation and establish a resolution time frame accordingly if the grievance involves:

- The denial of a member or member's representative's request that an internal appeal be expedited
- Any clinical issue

The Mass General Brigham Health Plan Appeal Committee will resolve a grievance if the subject of the grievance involves:

- The denial of payment for services received because of failure to follow prior authorization/referral procedures
- The denial of a member or member representative's request for an internal appeal because the request was not made

in a timely fashion

- The denial of coverage for non-covered services
- The denial of coverage for services with benefit limitations
- Reduction in Mass General Brigham Health Plan Provider payment due to copayments, deductibles, or coinsurance

When the subject matter involves the act or omission on the part of a Mass General Brigham Health Plan employee, resolution is made by the employee's department, unless circumstances warrant as determined by the Appeals and Grievance Manager, that resolution should be made external to the employee's department.

For grievances involving non-clinically related actions or omissions of a provider, the Grievance Coordinator requests assistance from the provider to investigate the grievance. Network providers' adherence to the grievance process is monitored regularly to identify training and other interventions.

For grievances/complaints concerning a provider, the nature of the complaint determines whether the matter is addressed directly with the clinician or with the site administrator. In either case, the provider is contacted to discuss the matter and asked for a written response stating the facts, including supporting documentation when appropriate. To allow timely completion of the review of all relevant information within the specified time frame, a response from the provider is expected within five business days unless otherwise agreed upon. The response must address all identified concerns and include corrective actions for each when applicable.

Upon receipt of the provider's response and review of all relevant information, a written response is sent to the member containing the substance of the complaint, as well as findings and actions taken in response, taking into consideration the confidentiality rights of all parties. At a minimum, the resolution will



acknowledge receipt of the grievance and that it has been investigated. If the grievance resolution results in an adverse action, the response letter will advise the member of his or her right to appeal the decision.

### **Behavioral Health Inquiries and Grievances**

Management of all behavioral health–related inquiries and grievances is delegated to Mass General Brigham Health Plan’s Behavioral Health Partner, Optum.

For more information, please see the Behavioral Health Provider Manual or contact Optum.

### **Dental Services Inquiries and Grievances**

Mass General Brigham Health Plan delegates the grievance process for routine dental services for certain Commercial/QHP members to Delta Dental.

Please verify the member’s dental coverage with Mass General Brigham Health Plan Customer Service Department.

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## **Member Clinical Appeals**

### **Expedited Clinical Appeals**

Mass General Brigham Health Plan will provide an expedited appeal process if it is believed that the member’s health, life, or ability to regain maximum function may be put at risk by waiting 30 calendar days for a standard appeal decision. Mass General Brigham Health Plan will grant a request for an expedited appeal unless the request is not related to the member’s health condition.

Members have the right to apply for an expedited external review at the same time a request for internal expedited review is requested (see “Commercial Expedited External Review” section on how to submit an external review).

Mass General Brigham Health Plan will continue to authorize disputed services during the formal appeal process if those services had initially been authorized by Mass General Brigham Health Plan, unless the member indicates that s/he does not want to continue receiving services.

Mass General Brigham Health Plan will provide an expedited appeal process under certain circumstances:

- When an appeal is submitted by or on behalf of a member who is an inpatient in a hospital, a resolution will be provided prior to the member’s discharge from the hospital.
- When the treating provider certifies that the requested service or equipment is medically necessary and there is a substantial and immediate risk of serious harm should the service or equipment not be provided pending the outcome of the normal appeal process, resolution will be made within 48 hours.
- When an expedited appeal is submitted by or on behalf of a member with a terminal illness, resolution will be provided within 72 hours and a written response within five business days from the receipt of the appeal.
- If the appeal for a member with a terminal illness is upheld, the member or representative may request a conference with a Mass General Brigham Health Plan medical director. The conference should be scheduled within 10 calendar days of the notification of the determination, or within 5 calendar days if the treating provider has consulted with Mass General Brigham Health Plan’s Chief Medical Officer or Medical Director and it has been determined that the conference should be at an earlier date. Decisions on expedited appeals will be made within 72 hours of receipt.

### Expedited External Review

Members, or their representatives, can file an expedited external appeal at the same time they file an internal expedited appeal or if they are dissatisfied with the expedited internal appeal decision. A request must be made to the Department of Health (DPH) Office of Patient Protection (OPP) within four months after the expedited internal appeal decision, but within two days if they wish to receive continuing services without liability.

An application fee of \$25.00, payable to the OPP, must accompany the request. The application fee may be waived if the OPP determines that payment of the fee would result in an extreme financial hardship for the member.

Members or their representative should also submit a copy of Mass General Brigham Health Plan's final adverse determination letter along with the request. OPP will complete the expedited appeal within 72 hours of receipt.

### Standard Clinical Appeals

A treating provider may file a clinical appeal on behalf of a member for any decision made by Mass General Brigham Health Plan to deny, terminate, modify, or suspend a requested health care benefit based on failure to meet medical necessity, appropriateness of health care setting, or criteria for level of care or effectiveness of care.

An appeal must be filed within 180 calendar days of Mass General Brigham Health Plan's decision to deny, terminate, modify, or suspend a requested health care service.

In order to file an appeal on behalf of a member, or if an individual other than the member or legal guardian requests the appeal, Mass General Brigham Health Plan must be provided with written authorization from the member designating the provider as the appeal representative.

The Designation of Appeal Representative Form should be used for this purpose. The member must complete and return a signed and dated copy of this form prior to the deadline for resolving the appeal. Failure to return the signed form means communication can only take place with the member. The appeal process will not be held up pending receipt of the form.

When filing an appeal on behalf of a member, the provider must identify the specific requested benefit that Mass General Brigham Health Plan denied, terminated, modified, or suspended, the original date of Mass General Brigham Health Plan's decision, and the reason(s) the decision should be overturned. The Provider may request a peer-to-peer discussion with the Mass General Brigham Health Plan medical director involved in the Internal Appeal regarding these matters.

Appeals may be filed by telephone, mail, fax, or in person. Mass General Brigham Health Plan will send a written acknowledgment of the appeal on behalf of a member, along with a detailed notice of the appeal process, within one business day of receiving the request.

An appeal will be conducted by a health care professional that 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, and who was not involved in the original Adverse Action.

When an appeal is submitted by or on behalf of a member with a terminal illness, resolution will be provided within five business days of the request. For a standard Internal Appeal resolution, Mass General Brigham Health Plan Health Partners will complete the appeal and contact the provider within 30 calendar days with the outcome of the review.

The time frame for a standard appeal may be extended for up to 15 additional calendar days

due to circumstances beyond Mass General Brigham Health Plan's control, and providing that the member or representative agrees to the extension.

The Appeal and Grievance Coordinator will make reasonable efforts to provide oral notice to the member/member representative within one business day of the decision being made with a written notice to follow within 30 days of receipt of the appeal.

Mass General Brigham Health Plan will continue to authorize disputed services during the formal appeal process if those services had initially been authorized by Mass General Brigham Health Plan. Continued authorization will not, however, be granted for services that were terminated pursuant to the expiration of a defined benefit limit.

Providers, if acting in the capacity of an authorized representative, may request that Mass General Brigham Health Plan reconsider an appeal decision if the provider has or will soon have additional clinical information that was not available at the time the decision was made.

Upon a reconsideration request, Mass General Brigham Health Plan will agree in writing to a new time period for review. To initiate reconsideration, contact the Appeal Coordinator.

Appeals may be filed by telephone, mail, fax, or in person. Mass General Brigham Health Plan will send a written acknowledgment of the appeal on behalf of a member, along with a detailed notice of the appeal process within one business day of receiving the request.

An appeal will be conducted by a health care professional that 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, and who was not involved in the original

Adverse Action.

When an appeal is submitted by or on behalf of a member with a terminal illness, resolution will be provided within five business days of the request.

For a standard Internal Appeal resolution, Mass General Brigham Health Plan will complete the appeal and contact the provider within 30 calendar days with the outcome of the review.

The time frame for a standard appeal may be extended for up to 15 additional calendar days due to circumstances beyond Mass General Brigham Health Plan's control and providing that the member or representative agree to the extension.

The Appeals and Grievances Coordinator will make reasonable efforts to provide oral notice to the member/member representative within one business day of the decision being made with a written notice to follow within 30 days of receipt of the appeal.

Mass General Brigham Health Plan will continue to authorize disputed services during the formal appeal process if those services had initially been authorized by Mass General Brigham Health Plan. Continued authorization will not, however, be granted for services that were terminated pursuant to the expiration of a defined benefit limit.

Providers, if acting in the capacity of an authorized representative, may request that Mass General Brigham Health Plan reconsider an appeal decision if the provider has or will soon have additional clinical information that was not available at the time the decision was made.

Upon a reconsideration request, Mass General Brigham Health Plan will agree in writing to a new time period for review. To initiate reconsideration, contact the Appeal Coordinator.

**Contact Information**

Mass General Brigham Health Plan  
 Appeals and Grievances Department  
 399 Revolution Drive, Suite 810  
 Somerville, MA 02145  
 Phone: 855-444-4647  
 Fax: 617-526-1980

**Standard External Reviews**

As part of every written appeal decision that upholds an original decision to deny, terminate, modify, or suspend a requested health care benefit, a member or authorized representative is informed in detail of additional appeal options and the procedures for accessing those options.

Members (or their authorized representatives) have the option of requesting an external appeal with the Office of Patient Protection (OPP) if they are not satisfied with the final outcome of Mass General Brigham Health Plan's appeal process.

In order to activate the external review process with the Office of Patient Protection you will be asked to:

- Complete and submit the Request for Independent External Review of a Health Insurance Grievance form (enclosed with the Notice of Decision from Mass General Brigham Health Plan) to the Office of Patient Protection within four months of receiving Mass General Brigham Health Plan's written decision on your appeal
- Submit a \$25 fee to the Office of Patient Protection along with your request. The Office of Patient Protection may waive the fee in circumstances of financial hardship
- Submit a copy of Mass General Brigham Health Plan's final adverse determination letter to the Office of Patient Protection along with your request

OPP will complete the appeal within 45 days of receipt of the appeal.

**Contact Information**

Mass General Brigham Health Plan  
 Appeals and Grievance Department  
 399 Revolution Drive, Suite 810  
 Somerville, MA 02145  
 Phone: 855-444-4647  
 Fax: 617-526-1980

**To initiate an external review, contact:**

Office of Patient Protection (OPP)  
 Health Policy Commission  
 50 Milk Street, 8th Floor  
 Boston, MA 02109  
 Phone: 800-436-7757  
 Fax: 617-624-5046

**Access to Appeal File by Member or Member Representative**

Members or their representative have the right to receive a copy of all documentation used in the processing of their appeal, free of charge.

Limitations may be imposed, only if, in the judgment of a licensed health care professional, the access requested is likely to endanger the life or physical safety of the individual or another person.

The member (or an authorized representative) must submit their request in writing to Mass General Brigham Health Plan and it will be processed by the Appeal and Grievance Coordinator, in consultation as necessary with the Compliance Office.

Requests for access to appeal files will be processed as quickly as possible, taking into consideration the member's condition, the subject of the appeal, and the time frames for further appeals.

**Continuation of Ongoing Services During Appeal**

If the internal appeal filed concerns the denial, modification, or termination of a Mass General Brigham Health Plan covered service that the member is receiving at the time of the adverse action, the member has the right to continue

his or her benefits through the conclusion of the appeals process. Continued authorization will not, however, be granted for services that were terminated pursuant to the expiration of a defined benefit limit.

If the internal appeal filed concerns the denial, modification, or termination of a non-covered service that the member is receiving, and Mass General Brigham Health Plan does not reverse the adverse action, the member may be liable for payment of the service.

### ***Notification of Decision***

If Mass General Brigham Health Plan does not act upon an appeal within the required timeframe, or an otherwise agreed upon extension, the appeal will be decided in the member's favor. Any extension deemed necessary to complete review of an appeal must be authorized by mutual written agreement between the member (or an authorized representative) and Mass General Brigham Health Plan.

### ***Reconsideration of Appeal Decision***

Providers, if acting in the capacity of an authorized representative, may request that Mass General Brigham Health Plan reconsider an appeal decision if the provider has, or will soon have, additional clinical information that was not available at the time the decision was made. Upon a reconsideration request, Mass General Brigham Health Plan will agree in writing to a new time period for review. To initiate reconsideration, contact the individual identified in the decision letter upon receipt.

### **Consumer Protection from Collections and Credit Reporting During Appeals**

Effective 7/1/15, Massachusetts Law requires health care providers (and their agents) to abstain from reporting a member's medical debt to a consumer credit reporting agency or sending members to collection agencies or debt collectors while an internal or external appeal is on-going. This consumer protection also

extends for 30 days following the resolution of the internal or external appeal.

### **Behavioral Health Appeals**

Management for all behavioral health related appeals is delegated to Mass General Brigham Health Plan's Behavioral Health Partner, Optum.

For more information, please see the Behavioral Health Provider Manual or contact Optum.

### **Dental Services Appeals**

Mass General Brigham Health Plan delegates the internal grievance/appeal process for routine dental services for some Commercial/QHP members to Delta Dental.

Please verify the member's dental coverage with Mass General Brigham Health Plan's Customer Service Department.

# Appendix A

## Contact Information

*Please do not send protected health information (PHI) through unsecured email.*

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### Mass General Brigham Health Plan

#### ADDRESS

Mass General Brigham Health Plan  
399 Revolution Drive, Suite 810  
Somerville, MA 02145  
WEB: [MGBHP.org](https://MGBHP.org)

#### Appeals and Grievances

MAIL  
  
Appeals and Grievances Dept  
399 Revolution Drive Suite 810  
Somerville, MA 02145  
FAX: 617-526-1980

#### Authorizations and Clinical

WEB:  
  
FAX: 617-586-1700

#### Claims (New Paper Claims Only)

HMO: P.O. Box 853908  
Richardson, TX 75085-3908  
  
PPO: P.O. Box 852099  
Richardson, TX 75085-2099

#### Claims Adjustments, Appeals, and Correspondence

ADDRESS: Mass General Brigham Health Plan  
399 Revolution Drive, Suite 810  
Somerville, MA 02145  
  
FAX: 617-526-1902  
  
*COB Only*  
FAX: 617-526-1918

### **Compliance Hotline**

To report fraud, abuse, or other compliance problems:

PHONE: 844-556-2925

### **Provider Portal Support**

EMAIL: [HealthPlanPRWeb@mgb.org](mailto:HealthPlanPRWeb@mgb.org)

### **Provider Enrollment & Credentialing**

EMAIL: [HealthPlanPEC@mgb.org](mailto:HealthPlanPEC@mgb.org)

FAX: 617-526-1982

### **Provider Service**

PHONE: 855-444-4647

Monday through Friday 8:00 AM to 6:00 PM

EMAIL: [HealthPlanProvidersService@mgb.org](mailto:HealthPlanProvidersService@mgb.org)

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## **Aetna Signature Administrators (Aetna HealthSCOPE)**

### **Provider Service**

PHONE: 800-603-9647

### **Medical Claims (HealthSCOPE)**

PAYER ID: 45321

#### **PAPER CLAIMS**

NHB Claims

PO Box 323

Glen Burnie, MD 21090

### **Behavioral Health Claims (Optum)**

PHONE: 844-451-3520

PAYER ID: 87726

#### **PAPER CLAIMS**

PO Box 30757

Salt Lake City, UT 84130-0757



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## Delegated Partners

*Please do not send protected health information (PHI) through email.*

### Behavioral Health

*Optum*

PHONE

Commercial: 844-451-3518

PHS Plans: 844-451-3520

### Dental

*Delta Dental*

PHONE: 800-872-0500

WEB: [DeltaDentalMa.com](https://DeltaDentalMa.com)

### High-Tech Radiology (MRI, PET, CT), Selected Cardiac Imaging & Diagnostic Services, Selected Molecular & Genetic Testing, Radiation Therapy

*eviCore Healthcare*

PHONE: 888-693-3211

FAX: 888-693-3210

WEB: [evicore.com](https://evicore.com)

### Pharmacy

*Optum Rx*

PHS PLANS: 800-364-6331

#### NON-SPECIALTY DRUG PRIOR AUTHORIZATION

MAIN PHONE: 844-294-0395

COMMERCIAL PHONE: 800-294-5979

FAX: 888-836-0730

#### QUALIFIED HEALTH PLAN

PHONE: 855-582-2022

FAX: 855-245-2134

#### SPECIALTY DRUG PRIOR AUTHORIZATION

PHONE: 866-814-5506

FAX: 866-249-6155

### Sleep Studies

*Sleep Management Solutions, Inc.*

PHONE: 866-827-5861

FAX: 866-626-9338

WEB: [sleepmanagementsolutions.com](https://sleepmanagementsolutions.com)

## Appendix B

### Glossary

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#### **Access**

The extent to which a patient can obtain services (telephone access and scheduling an appointment) at the time they are needed.

#### **Access90 Program**

Access90 provides Mass General Brigham Health Plan members with a 90-day supply of certain maintenance medications when purchased through participating pharmacies.

#### **Administratively Necessary Day**

A day of acute inpatient hospitalization on which a member's care needs to be provided in a setting other than an acute inpatient hospital, and on which a member is clinically ready for discharge but for whom an appropriate setting is not available.

#### **Advance Directives**

Advance directives are documents signed by a competent person giving direction to health care providers about treatment choices in certain circumstances. There are two types of advance directives: (1) A durable power of attorney for health care ("durable power") allows you to name a "patient advocate" to act for you and carry out your wishes. (2) A living will allow you to state your wishes in writing, but does not name a patient advocate.

#### **Adverse Determination**

A determination by Mass General Brigham Health Plan or its designees, based upon 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.

#### **Ancillary Services**

Additional services related to care, such as laboratory work, x-ray, and anesthesia.

#### **Appeal**

A formal request by a member or provider for reconsideration of a decision, either clinical or administrative with documentation supporting the request for reconsideration.

#### **Authorization**

The review and approval by clinicians of certain services for determination of whether the services are medically appropriate and can reasonably be expected to improve the member's condition or prevent future regression.

**Authorization Number**

A number issued to a provider signifying receipt of a request for services requiring prior authorization. All requests are assigned an authorization identification number for tracking purposes independent of the approval status.

**Availability**

The extent to which an organization geographically distributes practitioners of the appropriate type and number to meet the needs of its membership.

**Business Days**

See “Working Days.”

**Care Management**

A collaborative process of assessment, planning, facilitating, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes\*.

\*From Standards of Practice for Case Management, copyright by Case Management Society of America.

**CDS**

Controlled dangerous substance.

**Clean Claim**

A claim that can be processed without obtaining more information from the provider of the service.

**Clinical Reviewer**

A health care professional who has the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of an adverse action or clinically related grievance and who was not involved in the matter being appealed or grieved.

**Co-morbid Disorders**

The simultaneous manifestation of a physical disorder and a behavioral health disorder, or two different physical disorders.

**Continuing Services**

Mass General Brigham Health Plan covered services that were previously authorized by Mass General Brigham Health Plan and are the subjects of an internal appeal involving a decision by Mass General Brigham Health Plan to terminate, suspend or reduce the previous authorization and which are provided by Mass General Brigham Health Plan, pending the resolution of the internal.

**Coordination of Benefits (COB)**

A process by which it is determined how medical, dental, or other care services will be paid when a

person is covered under more than one health plan.

**Covered Services**

Those medically necessary hospital, medical and other health care services to which a member is entitled under the terms of his or her Mass General Brigham Health Plan Subscriber Group Agreement.

**Credentialing**

A process to ensure that contracted providers meet a minimum level of quality as established by the health plan.

**Cultural Competence**

A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

“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 people.

“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 Culturally and Linguistically Appropriate Services in Health Care.

**DEA**

Drug Enforcement Administration.

**Durable Medical Equipment (DME)**

Equipment which can stand repeated use, is primarily used to serve a medical purpose, generally not useful to a person in the absence of illness or injury, and it’s appropriate for use in the home.

**Early Intervention (EI) Services**

A comprehensive program for children three years of age and younger whose developmental patterns are atypical or at serious risk of becoming atypical through biological or environmental components. Early intervention services are family-centered and community-based in order to facilitate developmental progress.

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)**

Delivery of health care services to members under age 21.

**Emergency Medical Condition**

A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- 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,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

## **Emergency Services**

Covered inpatient and outpatient services that are furnished to a member by a provider that is qualified to furnish such services under Title XIX of the Social Security Act that are needed to evaluate or stabilize a member's emergency medical condition.

## **E-prescribing**

The transmission, using electronic media, of a prescription or prescription-related information, between a prescriber, dispenser, pharmacy benefit manager, or health plan, either directly or through an intermediary, including an e-prescribing network.

## **EPSDT (Early Periodic Screening, Diagnosis, and Treatment) Periodicity Schedule**

Screening procedures arranged according to the intervals or age levels at which each procedure is to be provided.

## **Ethnicity**

Identity with or membership in a particular racial, national, or cultural group and observance of that group's customs, beliefs, and language.

## **GIC (Group Insurance Commission)**

An employer group that provides and administers health insurance and other benefits to the Commonwealth's employees and retirees, and their dependents and survivors.

## **Grievance**

Any expression of dissatisfaction by a member or member's representative about any action or inaction by Mass General Brigham Health Plan. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee of Mass General Brigham Health Plan, or failure to respect the member's rights.

## **HealthCare Administrative Solutions, Inc. (HCAS)**

A non-profit entity founded in 2007 with collaboration from several Massachusetts health plans to streamline the credentialing and re-credentialing processes.

## **Health Care Agent**

A health care agent is a person a member has chosen in advance to make health care decisions in the event the member becomes unable to do so.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

Federal legislation enacted to improve the continuity of health insurance coverage in group and individual markets, combat waste, fraud, and abuse in health insurance and health care delivery, simplify the administration of health insurance and protect the confidentiality and security of individually identifiable health information.

**Health Maintenance Organization (HMO)**

An entity that provides, offers, or arranges for coverage of health services which emphasize preventive care and consists of a network of physicians and other providers who deliver those services to plan members.

**Healthcare Effectiveness Data and Information Set (HEDIS)**

A set of standardized performance measures designed to provider purchasers and consumers with the information they need to reliably compare the performance of managed care organizations.

**Health Risk Assessment (HRA)**

A tool that identifies and quantifies a member's physical and behavioral health status, and morbidity and mortality risk derived from the collection and review of demographic, physical and behavioral health, and lifestyle information. This tool should identify the communication method used by deaf, hard-of-hearing and deaf /blind members, and the need for ASL Interpreters or Communication Access Real Time Translation (CART) services.

**Inquiry**

Any oral or written question by a member to Mass General Brigham Health Plan regarding any aspect of Mass General Brigham Health Plan's operations that does not express dissatisfaction about Mass General Brigham Health Plan or its operations, processes, services, benefits, or providers.

**Joint Commission on the Accreditation of Health Organizations (JCAHO)**

A standards-setting and accrediting body in health care which evaluates and accredits approximately 17,000 US health care organizations and programs.

**Living Will**

A legal document that a person uses to make known his or her wishes regarding life prolonging medical treatments. It can also be referred to as an advance directive, health care directive, or a physician's directive.

**Managed Care**

A system of health care delivery that is provided and coordinated by a primary care provider. The goal is a system that delivers value by giving people access to quality, cost-effective health care.

**Managed Care Organization (MCO)**

Any entity that provides, or arranges for the provision of, covered services under a capitated payment

arrangement, that is licensed and accredited by the Massachusetts Division of Insurance as a health maintenance organization, or is organized primarily for the purpose of providing health care services, makes the services it provides to its members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other members within the area served by the entity.

### **Mass General Brigham Health Plan Care Manager**

A Mass General Brigham Health Plan-employed health care professional that communicates and collaborates with the member and the member's health care team in the delivery of coordinated and appropriate quality health care services under Mass General Brigham Health Plan's care management programs, applying standard protocols, policies, and procedures.

### **Mass General Brigham Health Plan Nurse Partner**

A Mass General Brigham Health Plan-employed registered nurse who is assigned to a high-volume inpatient facility to work collaboratively with primary care providers and Mass General Brigham Health Plan Nurse Case Managers to arrange for effective discharge planning for Mass General Brigham Health Plan members.

### **Member**

A person by whom or on whose behalf periodic payment has been made to and accepted by Mass General Brigham Health Plan and who is thereby entitled to receive covered services, and who has chosen or been assigned a specific physician as his or her primary care provider.

### **Member Representative**

Any individual that has been authorized by the member in writing to act on the member's behalf.

### **Members with Special Health Care Needs**

Includes (1) adults with complex/chronic medical conditions requiring specialized health care services, including persons with physical, mental/substance use, and/or developmental disabilities, such as persons with cognitive, intellectual, mobility, psychiatric, and/or sensory disabilities described below, and including such persons who are homeless; and (2) children/adolescents who have, or are 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 what is required by children generally.

- **Cognitive Disability** – a condition that leads to disturbances in brain functions, such as memory, orientation, awareness, perception, reasoning, and judgement. Many conditions can cause cognitive disabilities, including but not limited to Alzheimer's disease, bipolar disorder, Parkinson's disease, traumatic injury, stroke, depression, alcoholism, and chronic fatigue syndrome.
- **Intellectual Disability** – is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior that affect many everyday social and practical skills.
- **Mobility Disability** – an impairment or condition that limits or makes difficult the major life activity of moving a person's body or a portion of his or her body. "Mobility disability" includes, but is not limited to, orthopedic and neuro-motor disabilities and any other impairment or condition that limits an individual's ability to walk, maneuver around objects, ascend or descend steps or slopes, and/or operate controls. An individual with a mobility disability may use a wheelchair or other assistive device for mobility or may be semi-ambulatory.



- **Psychiatric Disability** – a mental disorder that is a health condition characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Examples include, but are not limited to, depression, bipolar disorder, anxiety disorder, schizophrenia, and addiction.
- **Sensory disability** – any condition that substantially affects hearing, speech, or vision.

**Minor**

A child who is under the age of 18, considered the age of majority in Massachusetts.

**National Committee on Quality Assurance (NCQA)**

An entity that evaluates and accredits over half of the nation's health maintenance organizations on key clinical and administrative processes, preventive care measures, and member satisfaction.

**National Practitioner Data Bank (NPDB)**

An alert system intended to facilitate a comprehensive review of health care practitioners' professional credentials.

**Non-Symptomatic Care**

A member encounter with a provider that is not associated with any presenting medical signs. Examples include well-child visits and annual adult physical examinations.

**Non-Urgent Symptomatic Care**

A member encounter with a provider that is associated with presenting medical signs and symptoms, but that does not require urgent or immediate medical attention.

**Notification**

The process by which Mass General Brigham Health Plan is informed of the delivery of specific services. Notification is a requirement for reimbursement of specific services under Mass General Brigham Health Plan's Utilization Management program.

**Optum Health**

The behavioral health organization contracted by Mass General Brigham Health Plan to work in collaboration with the Mass General Brigham Health Plan Behavioral Health Department to administer Mass General Brigham Health Plan's Behavioral Health Program.

**Organ Donation Card**

A card which indicates a person's willingness to "help someone to live after death." The card functions like a personal consent form for organ donation and indicates to both the relatives and medical personnel on his or her willingness to donate organs for transplantation. The presence of the card does not imply that aggressive life-saving measures will not be performed in case of emergency. It is taken into account only after the diagnosis of brain death has been made.

**Participating Provider**

Those participating provider groups, primary care providers, specialists, hospitals, or other providers who have entered into an agreement with Mass General Brigham Health Plan to provide covered services to members.

**Patient Care Assessment Committee (PCAC)**

Committee responsible for development and implementation of the Board approved quality work plan that articulates specific improvement goals, activities and outcomes in areas of clinical and service quality, utilization management, credentialing and peer review; provides direction for all quality improvement activities, including those that have been delegated.

The PCAC is also responsible for providing oversight and advisory input on policies, or recommending changes in policies and procedures, that impact clinical and service quality, including evaluating and approving new medical technologies. Additionally, the PCAC is accountable for peer review activities and credentialing of practitioners and for providing guidance for clinician profiling activities.

**Patient Protection and Affordable Care Act (PPACA)**

Also known as the federal health care reform bill, signed into law in 2010. This legislation makes sweeping changes to the U.S. health care system, to be implemented over the next several years.

**Participating Provider Group (PPG)**

An individual, organized partnership, professional corporation or other legal association or entity which practices the specialties of general internal medicine, general pediatrics, or family practice, having a contract with Mass General Brigham Health Plan to provide, arrange for, and coordinate the provision of covered services to its members, including the services of primary care providers.

**Primary Care**

The provision of coordinated, comprehensive medical services, on both a first contact and a continuous basis, to a member. The provision of primary care incorporates an initial medical history intake, medical diagnosis and treatment, communication of information about illness prevention, health maintenance, and referral services.

**Primary Care Provider (PCP)**

An individual practitioner and those working at his or her direction, selected by or assigned to a member to provide and coordinate the provision of covered services to meet the member's health care needs and to initiate and coordinate specialty services when required.

**Prior Authorization**

The process of requesting services, including home health care, durable medical equipment, outpatient therapies, certain emergency services, and hospital admissions or other services which require clinical review by Mass General Brigham Health Plan.

**Provider**

A health care professional licensed by the Commonwealth of Massachusetts, including but not limited to physicians, mid-level clinicians, hospitals, durable medical equipment, home health care, home infusion therapy, and laboratory.

**Provider Performance Incentive**

A financial incentive program or reward between Mass General Brigham Health Plan and its network provider(s) (Provider Performance Incentives) that is tied to either the contractor or network providers achieving a clearly defined goal that was previously agreed to by relevant parties.

**Qualified Health Plan (QHP)**

A health plan certified by the State Based Exchange (SBE) operated by the Massachusetts Commonwealth Health Insurance Connector Authority (“The Connector”).

**Quality Improvement**

A continuous process that identifies problems in health care delivery, tests solutions to those problems and constantly monitors the solutions for improvement.

**Race**

A group of persons related by common descent or heredity.

**Rural Area**

A geographic area where the population density is less than 1,000 persons per square mile.

**School-Based Programs**

Health care programs funded by the Department of Public Health and located at schools to facilitate better access to quality health care for children and adolescents.

**Subscriber Group**

A group of potential or actual members for which Mass General Brigham Health Plan has agreed with a payer through a Subscriber Group Agreement to provide a defined set of covered services for a specified premium, and who are eligible to receive services as Mass General Brigham Health Plan members.

**Suburban Area**

A geographic area where the population density is between 1,000 and 3,000 persons per square mile.

**Urban Area**

A geographic area where the population density is greater than 3,000 persons per square mile.

**Urgent Care**

Acute but not life or limb-threatening symptoms that are sufficiently bothersome, or of recent onset

(e.g., acute abdominal pain, fever>100F, dyspnea, serious orthopedic injuries, vomiting, and persistent diarrhea).

**Working Days**

Sometimes defined as business days, this term is used to define the number of working days in a statement. Note that Mass General Brigham Health Plan holidays affect the working/business days count.