Mass General Brigham
ACO Provider Manual

Section 1: Member information

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Section 1: Member information

Mass General Brigham ACO

Mass General Brigham Health Plan and Mass General Brigham ACO offer care and coverage through MassHealth, and Mass General Brigham Health Plan.

As both provider and insurer, Mass General Brigham ACO and Mass General Brigham Health Plan work together in providing integrated medical and behavioral health care.

As an ACO program member, Mass General Brigham ACO members must select a Mass General Brigham Health Plan Primary Care Provider (PCP).

Mass General Brigham ACO member benefits vary based on their plan design. A member may be enrolled in any of the following MassHealth plans:

- Standard
- CommonHealth
- Family Assistance
- CarePlus

Mass General Brigham ACO members may be eligible for any service covered directly by MassHealth, such as routine dental care. Please refer to the Member Handbook and the Covered Services list for more information.

Member Enrollment

The Mass General Brigham Health Plan's Provider Portal is designed to offer network providers around the clock access to enrollment and eligibility information via timely updates and helpful reports. Member enrollment and eligibility changes are provided daily to PCPs through the provider portal to enhance patient care, facilitate PCP outreach efforts and enable updates to their own practice management systems.

Primary Care Assignments

Mass General Brigham ACO members must select a primary care site and a Primary Care Provider (PCP) who participates in the Mass General Brigham ACO network.

PCPs should make best efforts to reach out to newly assigned members to provide an overview of their practice, assess any medical needs and, when applicable, schedule an initial appointment.

Enrollment Activities

Mass General Brigham ACO members who do not select a PCP upon enrollment are allowed a grace period to make a selection and otherwise, are assigned to an ACO participating PCP using criteria such as location, gender and other family member's PCPs. Members can change PCPs at any time by logging into their Member Portal account or contacting Customer Service.

When applicable, primary care network providers can also process updates to a Mass General Brigham ACO member's PCP assignment within the same practice, including satellite locations, through the Mass General Brigham Health Plan's provider portal.

The Provider Portal provides important enrollment transaction updates for Primary Care offices, including retroactive enrollment changes. Available reports include:

- *A Provider Roster* report listing all currently enrolled clinicians
- *A Member Roster* report listing all actively enrolled Mass General Brigham ACO members assigned to the site
- *Transaction* reports listing the latest enrollment transactions including:
  - Patients no longer enrolled with Mass General Brigham ACO
  - Patients who have elected to get their primary care elsewhere
  - New Mass General Brigham ACO members who have chosen the practice as their primary care site

  - Existing Mass General Brigham ACO members who have transferred from another Mass General Brigham Health Plan primary care site
  - PCP updates processed by Mass General Brigham Health Plan at the member's request.
- When applicable, the portal's *Redetermination* reports also provide advanced information to primary care practices on Mass General Brigham ACO members whose MassHealth eligibility is being redetermined.
- To ensure proper reimbursement, providers are strongly encouraged to review available enrollment activity data regularly and notify Mass General Brigham Health Plan's Provider Service (855-444-4647) of any discrepancies.

Mass General Brigham 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 contacted as follows:

Providers

Phone: 855-444-4647

Mon.–Fri., 8:00 am – 5:00 pm
Closed 12:00 pm-12:45 pm

Members

Phone: 800-462-5449 (TTY:711)

Email:

HealthPlanCustomerServiceMembers@mgb.org

Mon.–Fri. 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.

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

Member Onboarding

Once enrolled, Mass General Brigham ACO members have access to a variety of materials detailing benefit and other important information via the member portal and public website. Available materials include the MassHealth Covered Services List and Member Handbook plus corresponding amendments. In addition, the member portal provides medical and pharmacy claims history, status on submitted approval requests and other member information on file with Mass General Brigham Health Plan.

Mass General Brigham ACO members are provided with a Mass identification card and Welcome Guide containing information about how to use their plan.

Member Eligibility and Identification

All members receive a Mass General Brigham ACO member identification card that must be presented in addition to the MassHealth card when accessing services.

A Mass General Brigham ACO member ID card itself does not guarantee that an individual is currently enrolled with Mass General Brigham Health Plan, however providers are responsible for verifying eligibility at each visit and when applicable, daily via the provider portal. This includes but is not limited to while a patient is hospitalized. Eligibility information is also available on the New England Healthcare Exchange Network (NEHEN).

Mass General Brigham Health Plan will only reimburse for covered services rendered to a patient eligible on the date of service and when all prior-authorization and payment requirements are met. Except in emergencies, patient eligibility should be determined prior to rendering services.

The provider portal is designed to offer providers around the clock access to member information and other administrative functions.

Member ID Cards

Mass General Brigham ACO Identification (ID) Cards The Mass General Brigham ACO member ID card provides important information for members and providers as shown below: Product reference | Mass General Brigham Health Plan

Patient Relations

Member Rights and Responsibilities

Mass General Brigham ACO 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, providers must treat Mass General Brigham ACO members with fairness, honesty, and respect, including refraining from any biases based on race, color, national origin, age, disability, sex, religion, sexual orientation, gender identity, gender expression, ancestry, marital status, veteran status, occupation, claims experience, duration of coverage, pre- existing condition, expected health status, or ability to pay for services.

Member Rights Mass General Brigham ACO members have the right to:

- Receive information about Mass General Brigham Health Plan, our services, our providers and practitioners, their covered benefits, and their 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 their treatment options, regardless of cost or benefit coverage, with their provider in a way which is understood by them. Members may be responsible for payment of services not included in the Covered Services list for your coverage type.
- Be included in all decisions about their healthcare, including the right to refuse treatment and the right to receive a second opinion on a medical procedure at no cost to them.
    - Access emergency care 24 hours a day, seven days a week.
    - Change their PCP.
    - Access an easy process to voice their concerns and expect follow-up by Mass General Brigham Health Plan.
    - File a grievance or appeal if they have had an unsatisfactory experience with Mass General Brigham Health Plan or with any of our contracted providers, or if they disagree with certain decisions made by Mass General Brigham Health Plan.
    - Make recommendations regarding Mass General Brigham Health Plan' "Member Rights and Responsibilities."
    - Create and apply an advanced directive, such as a will or a healthcare proxy, if they are 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 their rights without negatively affecting the way Mass General Brigham Health Plan and/or their provider treats them.
    - Ask for and receive a copy of their 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 they are eligible for.

Mass General Brigham ACO members have the responsibility to:

- Choose a primary care provider (PCP), the provider responsible for managing their care.
- Call their PCP when they need healthcare.

- Tell any healthcare provider that they are a Mass General Brigham ACO member.
- Give complete and accurate health information that Mass General Brigham Health Plan or their provider needs to provide care.

- Understand the role of their PCP in providing their care and arranging other healthcare services that they may need.
- To the degree it is possible, understand their health problems and take part in making decisions about their healthcare and in developing treatment goals with their provider.
- Follow the plans and instructions agreed to by them and their provider.
- Understand their benefits and know what is covered and what is not covered.
- Call their PCP within 48 hours of any emergency or out-of-network treatment. If they experience 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.

Assistance with Interpretation and Communication

When applicable, Mass General Brigham Health Plan contracted practices must provide interpreter services free of charge to limited English proficiency (LEP) members, including but not limited to over the phone communication. 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 take into account 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.

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.

The following resources are available to assist providers in meeting this obligation:

- The US Department of Health and Human Services Office of Minority Health's publication, "A Patient-Centered Guide to
- Implementing Language Access Services in Healthcare Organizations," can be found at: www.minorityhealth.hhs.gov. This website also includes information on interpreter services, regulations, and requirements.
- Additional information on Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency," and its applicability to healthcare providers can be found at www.lep.gov.

Privacy Rights

Mass General Brigham Health Plan believes strongly in safeguarding the personal and health information of our members and expects all providers to fully comply with 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 patient, HIPAA allows for the exchange of information needed for treatment, payment, and healthcare operations. Examples that are applicable to the relationship between Mass General Brigham Health Plan and 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.

- *Healthcare 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

Mass General Brigham ACO 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 needs to consent to the release of information concerning that medical treatment, even to the parent(s).

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

Providers with questions or concerns about Mass General Brigham Health Plan's privacy practices can call the Compliance Hotline at 1-844-556-2925.

Accessing Emergency Services

Mass General Brigham ACO members are covered for emergency care, even when traveling outside the service area throughout the United States and its territories. Coverage includes use of an ambulance and post-stabilization care services related to an emergency. Members can go to any emergency room; the hospital does not have to be part of the Mass General Brigham Health Plan provider network.

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 othersIf 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 Community Behavioral Health Center (CBHC) 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 care. If applicable, the PCP will arrange follow-up care. Members experiencing a behavioral health emergency should be instructed to contact their behavioral health provider if they have one.

Members are covered for emergency care 24 hours a day and seven days a week, even when traveling or outside the service area.

Community Behavioral Health Centers (CBHCs) 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.

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, CBHC, or a community-based location, such as the PCP's office.

PCPs should consider contacting a local CBHC for Mass General Brigham Health Plan Mass General Brigham ACO 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

CBHCs are available 24/7 and should respond within 60 minutes of being contacted. Additional information about CBHCs is available from the Mass.gov website at: Community Behavioral Health Centers | Mass.gov

For a listing of CBHCs in all areas of the state, patients can refer to the Provider Directory.

Optum Partnership

Mass General Brigham Health Plan partners with Optum BH in managing the delivery of behavioral health services for all Mass General Brigham ACO members.

The following behavioral health areas of responsibility are delegated to Optum BH:

- Utilization management/care management.
- Claims processing and claims payment.
- Provider contracting and credentialing.
- Provider relations and network management.
- Quality management and improvement.
- Service authorization.

Advance Directives

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

When applicable, providers should discuss with patients their wishes for an advance directive as part of office visits. The discussion should be documented in the patient's medical record and updated regularly, including whether the patient chooses to execute an advance directive. If a patient establishes a written advance directive, it is advised that a provider maintain a copy of this in the patient's medical record. Additional information on advance directives is available at www.caringinfo.org.

Communicating with Patients

Effective patient-provider communication is vital to good health outcomes and patient satisfaction. Low literacy rates can sometimes compromise a patient's understanding, despite the clinician's efforts. Many patients struggle with understanding; patients with limited health literacy are more likely to be hospitalized or more frequently use emergency services. Limited English proficiency and/or a patient's medical and emotional health can also affect communication between patients and medical practice staff.

Patients should be educated on the first visit as to what to expect from providers and their office staff. Information such as missed appointments and other 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 acceptable and what is not acceptable behavior for effective patient-provider interactions. Provider office staff should also receive adequate training for dealing with patients up to and including:

- Respecting 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 creating rapport with the patient, asking for his or her goals 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.

When communicating with limited English proficiency 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 the patients' 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. When 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 plan to effectively manage them. It is sometimes possible to predict patients who may become easily agitated, irrational, or violent, depending on their medical condition.

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 directly address their patient's underlying feelings, making eye contact always, and address the patient in a respectful manner using their preferred title and name.

Terminating a Patient from Your Practice

Mass General Brigham Health Plan recognizes the critical importance of a positive relationship between patients and their caring providers and is committed to working with members and providers in developing and maintaining strong therapeutic relationships. However, we recognize that at times the relationship may be jeopardized by the actions of a member and that 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. 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. Termination from a provider's 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.

Mass General Brigham Health Plan is committed to collaborating closely with the provider and the member, including but 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.

At a minimum, 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 to dismiss the patient. 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, Mass General Brigham Health Plan may request Additional 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 the issues cannot be addressed to the satisfaction of both parties and that the only alternative is terminating the member as a patient, the decision should not be

communicated to the member until after jointly coordinating 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.

To avoid delays in the review of submitted requests, please do not submit these to MassHealth directly. MassHealth will not process practice-level disenrollment requests submitted to them directly.

Notification to Member

The provider is responsible for communicating, in writing, to the member and 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 previous 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
- 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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Section 2: Covered services

Overview

Covered Services

Mass General Brigham ACO members have benefit coverage as outlined by their plan:

MassHealth Standard and CommonHealth, Family Assistance, and CarePlus. For a complete list of ACO covered services

It is important for providers to confirm a (covered by Mass General Brigham Health Plan) member's eligibility and coverage upon arrival for an appointment as coverage for certain services varies by plan.

Some benefits have limits, and it is important to note each plan's definition of "benefit period" and non-ACO covered services (covered by MassHealth directly), please refer to the Covered Services booklet. The Covered Services booklet provides a table-formatted summary of benefit coverage for each plan.

- Benefits with a contract or benefit period limit apply a calendar year: January 1 through December 31
- Some benefits have a rolling period (for example, a routine eye exam may be covered once every 12 months or 24 months based on the patient's age). This would require that the next appointment be booked 12 months/24 months and 1 day after the current appointment.

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 patient's Mass General Brigham ACO Mass primary care provider (PCP) or Mass General Brigham ACO network provider*
- Referred by the PCP when required (most specialty care outside the Mass General Brigham Health Plan network requires a referral
- Prior authorized when required
- Medically necessary
- Covered health care services
- Provided to eligible patients enrolled in Mass General Brigham ACO

*Exceptions: Mass General Brigham ACO members can access family planning services from any MassHealth Provider. Mass General Brigham ACO members can access emergency services as note in Section 1, "Accessing Emergency Services"

Covered Services

Mass General Brigham ACO members have benefit coverage as outlined by their plan: MassHealth Standard and CommonHealth, Family Assistance, and CarePlus.

It is important to note Mass General Brigham ACO members have coverage for services through MassHealth that are not covered by Mass General Brigham Health Plan. For example, adult day services for the disabled may be covered through MassHealth but are not covered by Mass General Brigham Health Plan. Members may confuse their "Fee for Service Medicaid "or MassHealth coverage with their Mass General Brigham ACO Mass coverage. Mass General Brigham Health Plan's Customer Service team is available to further clarify coverage for members. Mass General Brigham ACO members have some variation in coverage based on their plan; the following is a high-level outline of excluded services.

Long Term Care

Mass General Brigham Health Plan's Long-Term Care (LTC) coverage for MassHealth members allows 100 LTC days a contract year/benefit period. LTC coverage depends on the member's MassHealth benefit plan as follows:

- MassHealth Standard, CommonHealth, Family

Assistance, and CarePlus: Mass General Brigham Health Plan covers up to 100 days of a combination of Nursing Facility, Chronic Disease and Rehabilitation Hospital services In a Contract Year (January 1 – December 31st).

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- Depending on the facility type, a Status Change for Members in a Nursing Facility or Chronic Disease and Rehabilitation Inpatient Hospital form (commonly referred to as the SC1 Form) and a MassHealth Payment of Nursing Facility Services form (commonly referred to as the Screening Form) may be required from the facility.

- Copies of the required forms must be provided to Mass General Brigham Health Plan immediately upon request. For Nursing Facility admissions (which require the additional Screening form) the requested copy must be received by Mass General Brigham Health Plan no later than by the 100th day. Noncompliance will result in payments being withheld and released only upon confirmation from the MassHealth Enrollment Center (MEC) that the form has been correctly completed and accepted in their system.

Non-covered laboratory services include:

- Test performed for experimental or Clinical Investigational purposes or that are themselves experimental or clinically investigational
- Tests only for the purpose of civic, criminal,
- administrative, or social service agency investigation, proceedings, or monitoring activities
- Test for residential monitoring purposes
- Tests performed to establish paternity
- Tests performed by an independent clinical laboratory for services that the laboratory is not certified by Centers for Medicare & Medicaid Services (CMS) to perform
- Services provided by a provider not in the Mass General Brigham ACO network unless prior authorized

Overview of Excluded *Medical Services for MassHealth Plans*

	Care Plus Plan	**CommonHealth and Standard Plans**	**Family Assistance Plan**
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services (members under age 21)	Excluded	Included	Excluded, however Preventive Pediatric Healthcare Screenings and Diagnostic [PPHSD] Services are covered.
Early Intensive Behavioral Intervention (EIBI)	Excluded	Included	Included
Early Intervention	Excluded	Included	Included
Fluoride Varnish	Excluded	Included	Included
Non-Emergent Transportation Out of State (outside a 50-mile radius of the MA border	Included	Included	Excluded

- Except as otherwise noted or determined Medically Necessary by EOHHS, the reasons, or mammoplasty following mastectomy or as required by law following services are not covered under MassHealth and as such are not covered by Mass General Brigham Health Plan
- Assisted reproduction including but not limited to in-vitro fertilization and gamete intra-fallopian tube (GIFT) procedures
- Cosmetic surgery, except as determined to be medically necessary for correction or repair of damage following an injury or illness, for other medically necessary reasons, or mammoplasty following mastectomy or as required by law

Experimental treatment

- Non-covered laboratory services as specified in 130 CMR 401.411
- Out-of-country care (outside USA and territories) including emergency care
- Personal comfort items including, but not limited to, air conditioners, radios, telephones, and televisions

Services and supplies not directed by Mass General Brigham ACO Provider

These services do not need to be directed by a Mass General Brigham Health Plan provider:

- Emergency services
- Family planning services provided by a MassHealth provider

Clinical Trials

Mass General Brigham Health Plan does cover care provided as part of a Qualified Clinical Trial for the treatment of cancer or other life- threatening medical condition to the extent the care would be covered if not provided as part of a Qualified Clinical Trial. Coverage is provided when services are provided by a Mass General Brigham Health Plan network provider or with prior authorization for a provider outside the Mass General Brigham ACO network. Covered costs exclude: the investigational item, device, or service; items and services solely for data collection and analysis; or for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. Costs and limitations imposed are not greater than costs or limitations when the services are provided outside of an approved clinical trial.

The PCP (or treating provider in consultation with the PCP) must obtain prior authorization for a member's participation in a Qualified Clinical Trial or the member must provide medical and scientific information that demonstrates the member meets the conditions for participation in the qualified clinical trial. The prior authorization process must be followed. Qualified clinical trials meet the following:

The clinical trial is intended to treat cancer or other life-threatening medical conditions in a patient who has been so diagnosed.

The clinical trial has been peer reviewed and is approved by one of the following:

- United States National Institutes of Health (NIH)
- Center for Disease Control and Prevention
- Agency for Health Care Research and Quality Centers for Medicare and Medicaid Services
- The Department of Defense, Veterans Affairs, or the Department of Energy
- A qualified non-governmental research entity identified in NIH guidelines for grants, is a study or trial under the United States Food and Drug Administration approved investigational new drug application, or it is a drug trial that is exempt from investigational new drug application requirements
- The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise. With respect to Phase I clinical trials, the facility shall be an academic medical center or an affiliated facility, and the clinicians

- conducting the trial shall have staff privileges at said academic medical center
- The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial
- The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards
- The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial
- The clinical trial does not unjustifiably duplicate existing studies

The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

Dental Care

Mass General Brigham Health Plan has limited dental benefits for its patients as outlined below.

EMERGENCY DENTAL CARE
Mass General Brigham Health Plan covers emergency dental services only when there is a traumatic injury to sound, natural, and permanent teeth caused by a source external to the mouth and the emergency dental services are provided in a hospital emergency room or operating room within 72 hours following the injury.

FLUORIDE VARNISH
Mass General Brigham ACO providers offering fluoride varnish application are entitled to reimbursement. Fluoride varnish is usually deemed medically necessary beginning on or around six months of age (first tooth eruption) and may be medically necessary for members up to adulthood (up to age 21).

Fluoride varnish is applied during a well-child visit to prevent early childhood dental caries in children at moderate to high risk as determined by the Caries Assessment Tool (CAT). More information on this tool is available from the American Academy of Pediatrics website at www.aap.org. Fluoride varnish is recommended no more frequently than every 180 days from the first tooth eruption (usually at six months) to the third birthday. It is expected that this procedure will occur during a pediatric preventive care visit and will be delivered along with anticipatory guidance for oral health and/or dental referral when necessary. While this benefit is primarily intended for children up to age three, reimbursement is allowed for children up to adulthood (see above).

To be eligible for fluoride varnish reimbursement, all the following criteria must be met:

- 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 21.
- 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 Plans' Customer Service team for help finding a certified provider.

Oral Surgery

Coverage for Mass General Brigham Health Plan Mass General Brigham ACO members is limited to medically necessary oral surgery, including the extraction of wisdom teeth, performed in a Surgical Day Care (SDC) or as an inpatient because of an underlying medical condition. The coverage applies to the procedure, facility, and all professional fees.

Other Dental Care

For Mass General Brigham ACO members under age 21, and under special circumstances for adults, routine dental care may be covered by MassHealth. For more information on covered services, please refer to MassHealth Covered Services List.

Orthodontics (braces) for teeth and dentures are not covered by Mass General Brigham Health ACO for members but may be covered by MassHealth. Full and partial dentures, and repairs to said dentures, are covered for adults age 21 and over by MassHealth.

Vision

Mass General Brigham ACO Mass members have coverage for a comprehensive eye exam; however, the frequency of the eye exam may vary according to the patient's age; please check the plan materials.

All Mass General Brigham ACO members have coverage for medically necessary ophthalmological care, including vision training, under the specialty care coverage.

All Mass General Brigham ACO members have coverage for lenses that are medically necessary to treat medical conditions such as keratoconus or after cataract surgery. Other than this limited coverage, eyewear (eyeglasses and contact lenses) is not covered. Scleral lenses (bandage lenses) are covered when medically necessary; prior authorization is required.

Mass General Brigham ACO members have coverage for routine vision exams:

- Once per 12-month period for patients under the age of 21
- Once per 24-month period for patients age 21 and older
- For all patients, when medically necessary
- Eyeglasses are covered through MassHealth for MassHealth CarePlus, CommonHealth/Standard, and Family Assistance members.

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Section 3: Provider Management

Joining the Mass General Brigham Health Plan Network

Providers can join the Mass General Brigham Health Plan ACO network by submitting the request in writing to the Mass General Brigham Health Plan Network Growth team.

Participation in the Mass General Brigham ACO 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 on a date determined by Mass General Brigham Health Plan, and the provider will be notified accordingly. Mass General Brigham Health Plan will not reimburse any services rendered 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.

To initiate these changes, please send an email* to HealthPlanPEC@mgb.org.

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

Board Certification Requirement

Board certification for PCPs and specialty physicians is required to ensure that the percentage of board-certified PCPs and specialty physicians participating in the Mass General Brigham Health Plan network, 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 in order to participate in the network.

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 period 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 the Mass General Brigham Health Plan ACO 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 who is contracted with the Mass General Brigham Health Plan ACO network to provide and coordinate comprehensive healthcare 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 patients 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 patients. For optimal coordination of care, Mass General Brigham Health Plan Mass General Brigham ACO PCPs should only refer to specialists within the Mass General Brigham Health Plan ACO network whenever possible.

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

Role of the Specialty Provider

A specialty provider is responsible for the provision of covered specialty care services working in collaboration with the members' PCP.

Specialty providers should 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.

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 meets 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 in order 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 in order to be participants in Mass General Brigham Health Plan Mass General Brigham ACO 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' behavioral health benefits manager, Optum BH.

The Credentialing Committee

The Credentialing Committee is Mass General Brigham Health Plan' peer review body with responsibility for oversight of the credentialing and recredentialing functions. The committee meets monthly, or as needed, 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' 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' provider networks:

- Approved
- 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, type of procedure, or patient served. Mass General Brigham Health Plan' credentialing policies do not discriminate against particular clinicians who service "high-risk" populations or who specialize in conditions or procedures requiring costly treatment.

Practitioner rights in the credentialing and recredentialing 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

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' 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.

An appeal process is available for practitioners who are not offered network participation after re-credentialing only. Notification of their right to appeal a credentialing decision and a description of the appeal process is included in Mass General Brigham Health Plan' 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' 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-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 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

- 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 period or until conditions for full participation are met
- Termination from the 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 can 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 (EOHHS), applicable state licensing boards, the NPDB, and other applicable entities of any reportable incidents. Updates to Mass General Brigham Health Plan' 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' 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' Appeals Panel to review the appeal. The Appeals Panel consists of: Mass General Brigham Health Plan' Vice President of Provider Network Management, Mass General Brigham Health Plan' Chief Medical Officer and the Directors 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' 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' 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 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' eligibility as an NPDB reporting entity

Upon receipt, Mass General Brigham Health Plan will review the applicable reason(s) and make a determination 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' 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 the Mass General Brigham Health Plan provider network and, where applicable, be listed in Mass General Brigham Health Plan' provider directory, 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/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:
Mass General Brigham Health Plan
Credentialing Department
399 Revolution Drive, Suite 810
Somerville, MA 02145

Fax: 617-526-1982

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

Mass General Brigham Health Plan' 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, including with the Drug Enforcement Administration (as applicable), and carry malpractice insurance coverage of $1,000,000 per occurrence and
- $3,000,000 aggregate
- Determine if an applicant has any pending Medicare or Medicaid sanctions
- 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' Credentialing staff checks state licensing boards' disciplinary action lists for license restrictions/sanctions and the Office of the Inspector

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 NPDB 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 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 MDs, 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.

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' 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 requires completion of request in the Mass General Brigham Health Plan' Provider Enrollment Portal or an HCAS Enrollment Form, 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.

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 an Mass General Brigham Health Plan contracted group, must submit a request through Mass General Brigham Health Plan' 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 clinicians enrolled in Mass General Brigham Health Plan, including original effective dates of the affiliation via the Provider Roster reports available from theMass General Brigham Health Plan Provider Portal
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' Credentialing Committee.

For questions on a clinician's enrollment status, please check the provider portal or contact Mass General Brigham Health Plan Provider Service at **855-444- 4647**.

MassHealth Provider Enrollment Requirement

Federal regulations set forth at 42 CFR § 438.602 require that all Mass General Brigham Health Plan network providers enter into a MassHealth Non-Billing MCE Network-only Provider Contract or another MassHealth provider contract. This contract should be completed within 30 days of receiving the notice.

Visit the following website to complete the contract process: https://www.mass.gov/forms/submit

Note: Contracts are to be submitted to MassHealth directly per the instructions. This specific provider contract does not require Mass General Brigham Health Plan network provider to render services to MassHealth fee-for service members.

Mass General Brigham Health Plan will then forward you the MassHealth PIDSL number and effective date that MassHealth assigns to you.

If you do not enter into a MassHealth Non-Billing MCE Network-only Provider Contract or another MassHealth provider contract, Mass General Brigham Health Plan may be required to terminate you from our ACO (provider network).

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 within the Mass General Brigham Health Plan Provider Portal. The Provider Enrollment Portal gives you easy access to submit requests such as the following:

- Enroll a new provider in 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 sending 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. 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 the Mass General Brigham Health Plan Provider Portal, on the standardized provider information change form, or using a similar document on the provider's stationery that includes at a minimum:

- The provider's name
- 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' 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. The provider must adhere to Mass General Brigham Health Plan' 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' knowledge will be automatically denied. Disputes in these cases can be addressed through Mass General Brigham Health Plan' 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' 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 Network Account Executive 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 the Mass General Brigham Health Plan Provider Portal, 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.massgeneralbrighamhealthplan.org and attesting to obtaining the member's consent.

Behavioral Health Care Integration

Mass General Brigham Health Plan and its designated behavioral health contractor, Optum BH, are committed to fully integrating Mass General Brigham ACO patients' medical and behavioral health care. 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 BH to develop specific programs and provider procedures that standardize communication and linkage between Mass General Brigham ACO members' primary care and behavioral health providers. Linkage between all providers (primary care, mental health, and substance use 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 authorizations for appropriate services, and maintaining continuity of care.

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 ACO members, we require network providers to:

- Accept Mass General Brigham ACO members as patients to the extent other health plan members are accepted.
- Make Mass General Brigham ACO patients aware of all available care options, including clinical care management. Treat Mass General Brigham ACO patients 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' behalf and supporting appropriate medical record information exchange at a provider and/or patient'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 Mass General Brigham ACO patients of advanced directive concurrent with appropriate medical records documentation.
- Coordinate transfers from one behavioral health provider to another. The transferring provider must obtain a release of information from the member and send a case summary, including the reason for the transition to the new provider
- 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.
- Respect and support Mass General Brigham Health Plan Members Rights and Responsibilities.
- Of equal importance, Mass General Brigham ACO 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's adherence to credentialing decisions as defined herein.

Access and Availability Requirements

Mass General Brigham Health Plan' Provider Network Management staff regularly evaluates access and availability and the comprehensiveness of Mass General Brigham Health Plan' 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 ACO patients' 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.

Mass General Brigham Health Plan is strongly committed to ensuring member satisfaction and the timely resolution of reported concerns regarding availability and access standards defined as follows:

Provider	Access Ratio to Members	Availability by Geographic Standards *
Primary Care	1:750	Two primary care providers (PCPs) within 15 miles or 30 minutes travel time from member's residence (except Oaks Bluff and Nantucket which are within 40 miles or 40 minutes from a 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 20 miles or 40 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' business objectives. In determining network expansion needs, Mass General Brigham Health Plan evaluates these availability and access standards along with other criteria.

Cultural Competency

Mass General Brigham Health Plan has a diverse patient population in terms of linguistic abilities and cultural and ethnic backgrounds. To promote access to clinicians who have the ability to communicate with the member in a linguistically appropriate and culturally sensitive manner, Mass General Brigham Health Plan uses a number of 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.

Wait Time Access Standards

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

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 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 required to monitor and report on member access to specific primary care and specialty services. This is done via an access and availability survey administered by Mass General Brigham Health Plan Provider Network Management 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
- Department of Social Service (DSS) custody initial exam

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.

Suspicions or concerns involving a Mass General Brigham Health Plan member or clinician can be reported to Mass General Brigham Health Plan's 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 Legal, Regulatory and Compliance Department
399 Revolution Drive
Suite 810
Boston, MA 02210

Phone:

Mass General Brigham Health Plan
Legal, Regulatory & Compliance Department
800-433-5556 (then dial 0 to have your call directed)

Mass General Brigham Health Plan
Compliance Hotline (anonymous)
844-556-2925

Website

Submit a report through our Compliance website using this link:
EthicsPoint - Mass General Brigham Health Plan

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 antifraud 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' 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 Provider Agreements, Mass General Brigham Health Plan' policies and procedures, and applicable nationally recognized medical, claims administration, and claims reimbursement policies. Mass General Brigham Health Plan' 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 & Medicaid Services (CMS), 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' 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. Audit 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, and/or 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' 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' 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 with 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' 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' 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' 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' 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' 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 our partners within the government. Mass General Brigham Health Plan may also take any number of actions to resolve fraud or abuse allegations, including 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' network. As stated above, Mass General Brigham Health Plan seeks recovery of all excess payments discovered as a result of its fraud and abuse operational efforts.

When an overpayment event is identified, Mass General Brigham Health Plan 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 Mass General Brigham Health Plan does not hear from the provider in 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.

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 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 and at least as long as 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.

Code of Ethics

Concerns regarding Mass General Brigham Health Plan' adherence to our Code of Ethics should be reported to Mass General Brigham Health Plan's 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.

Provider Marketing Activities

Any activities occurring at or originating from a provider site whereby Mass General Brigham Health Plan staff or designees, including physicians and office staff, personally present Mass General Brigham Plan marketing materials or other marketing materials to members that can reasonably be determined to influence the patient to enroll in Mass General Brigham Plan MassHealth plan or to disenroll from Mass General Brigham Plan are prohibited. This includes direct mail campaigns sent by the provider site to its patients who are members. The exception is posting of written materials that have been pre-approved by EOHHS at provider sites and posting written promotional marketing materials at network provider sites throughout the Mass General Health Plan service area.

"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 patient 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 Network Account Executive.

Provider Notification and Training

Mass General Brigham Health Plans' Provider Network Management 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 uses direct mail, newsletters, and other vehicles for communicating policy, 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' advance 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 Administrative Newsletter" 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' updates by visiting:

https://massgeneralbrighamhealthplan.org/providers/education

Provider Network Account Executives incorporate provider notifications into their agenda for provider visits to reiterate Mass General Brigham Health Plans' 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.

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

The Provider Network Account Executive serves as the primary liaison between Mass General Brigham Health Plan and our provider network. Provider Network Account Executives work in partnership with Mass General Brigham Health Plans' 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 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 patterns

Section 4: Provider portal

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Section 4: Provider portal

Overview

Mass General Brigham Health Plan providers and third-party billers are required to register and actively use provider.massgeneralbrighamhealthplan.org. Mass General Brigham Health Plan's secure provider portal. Through the provider portal, users have access to a variety of transactions in a self-service capacity. The Provider Portal allows providers access to patient information under the context of the provider site to which the user is associated. Mass General Brigham Health Plan Provider Portal supports access to multiple provider sites with a single account (if required).

Mass General Brigham Health Plan strives to protect the privacy of each member's Protected Health Information (PHI) and other personally identifiable information. User actions are audited regularly. Your access to the Provider Portal is subject to the approval of the designated user administrator of the provider site you are associated with, as well as Mass General Brigham Health Plan.

User access to their provider site information must be renewed every 180 days. Accounts inactive for 30 days or more are subject to automatic terminations.

The provider portal is your primary point of contact when you need to conduct the following transactions with Mass General Brigham Health Plan. Only inquiries that cannot be addressed via the provider portal should be directed to Mass General Brigham Health Plan Provider Service at HealthPlanProviderService@mgb.org.

Using the Provider Portal

Member Eligibility

The provider portal is designed to give contracted providers around the clock access to member information. Eligibility information is updated immediately after any changes to ensure the most up-to-date information is displayed.

Providers are responsible for verifying member eligibility daily through the provider portal prior to rendering services.

Claims Status

The provider portal is your primary point of contact when you need to check claim status with Mass General Brigham Health Plan. A user can verify the status of a submitted claim while in process and/or finalized by Mass General Brigham Health Plan. Only limited claim status can be obtained by calling Mass General Brigham Health Plan Provider Service or by emailing them directly at HealthPlanProviderService@mgb.org.

Explanation of Payments (EOPs)

Providers have instant access to current and historical copies of Mass General Brigham Health Plan EOPs as downloadable PDFs Providers can access EOPs by claim number from the ECHO Provider Payments Portal at providerspayment.com. To search for an EOP by date range and to see a detailed explanation of payment for each transaction, log into providerpayments.com or create a new account using your TIN and an ECHO® draft number and payment amount.

Virtual Credit Card (VCC), Electronic Funds Transfer and Electronic Remittance Advice

Providers are required to register for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA/835). Providers who are not registered to receive payments electronically will be automatically enrolled in the Virtual Credit Card payment option. If you are enrolled in this payment method, each explanation of payment (EOP) will contain a virtual credit card with a number unique to that payment transaction and an instruction page for processing. To sign up for EFT payments, Providers will need to enroll through the ECHO Provider EFT/ERA Enrollment Once registration is complete, providers will no longer receive paper checks. Providers can now access their ERA (835 files) from their designated clearinghouse or by enrolling through the ECHO Provider EFT/ERA Enrollment.

Referrals and Authorizations

Referrals and prior authorizations are submitted through the provider portal. Clinical documentation should be uploaded to support an authorization request. As a Mass General Brigham ACO member, referrals are not required for in-network providers.

The provider portal provides real-time access to authorization and referral status requests. Providers should refer to the provider portal Mass General Brigham Health Plan Provider Portal for status inquiries. A report is available to verify the existence of any required prior authorization and/or referral for patients referred to the provider's office by another provider.

PCP Panel Status and Changes within Your Practice Site

Through the provider portal, Mass General Brigham Health Plan provides updated PCP assignment information daily to PCP offices. Discrepancies in a patient's PCP information can be systematically corrected by the PCP office through Mass General Brigham Health Plan Provider Portal or initiated by the patient by calling Mass General Brigham Health Plan Member Service.

The primary way to notify Mass General Brigham Health Plan of enrollment changes is through the provider portal. Requests that can be submitted through the provider portal include:

- Enroll a new clinician into your group
- Terminate an existing clinician from your group
- Open and close your panels
- Provider demographic changes

Through the provider portal, you can also view real time status information on your enrollment request as well as receive email notification when your request has been completed.

Reports

The Enrollment Reports function is divided into four sections:

- Member Roster Report—Allows you to download a complete listing of patients by provider.
- Redetermination Report —This report will display all members for the currently selected site with recent Medicaid and Connector redetermination dates.
- Site Provider Roster Report—Displays a current listing of enrolled practitioners for your site. Providers are required to regularly review this report and notify Mass General Brigham Health Plan of any changes to their roster.

Clinical Reports

Providers can access site-based member utilization data on ER utilization, immunization rates, and other disease management (e.g., asthma, diabetes).

Site Documents

Providers have access to securely retrieve sensitive reports and other data requested of Mass General Brigham Health Plan.

User Administrator Functions

All sites must have at least one designated User Administrator to manage user accounts and permissions for your practice. The User Administrator has access to view all Provider Portal users registered for the site and change permissions as needed. Request for new access to your site must be approved by your User Administrator.

To enroll, please visit provider.massgeneralbrighamhealthplan.org and follow the easy registration instructions or consult with your site's appointed User Administrator.

For detailed step-by-step instructions on the provider portal functionality please refer to the provider portal user guide.

Providers needing more help can email* Healthplanprweb@mgb.org

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

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 patients. 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' 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 the Quality Management Program is to improve the quality and safety of clinical care and services provided to patients and clinicians. 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.

The 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, 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 healthcare Industry recommends that all healthcare organizations 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 healthcare organizations to pursue six major aims and that, specifically, healthcare 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 refrain 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 the Quality Management Program provides the specifications for that effort. Clinicians are expected to collaborate with Mass General Brigham Health Plan in all quality management efforts including, but not limited to, compliance with Leapfrog Safety Measures for reducing hospital injuries and managing serious errors. More information on these safety standards is available at: Leapfrog Hospital Survey | Leapfrog

Scope

The scope of the 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 patients. The Quality Management Program is also designed to support and reflect Mass General Brigham Health 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 Department 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 is delegated to another entity.

The 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.
- The 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 multidisciplinary, continuum-based approach to health care management that focuses on populations at risk for selected conditions.

The 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 healthcare 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

MassHealth ACO Quality Measures

ACOs are accountable for providing high- value, cross-continuum care, across a range of measures that improves member experience, quality, and outcomes.
MassHealth will regularly evaluate measures and determine whether measures should be added, modified, or removed.

MassHealth's ACO quality measures cover a host of domains including but not limited to Prevention and primary care. Chronic disease management. Substance use disorder and Member experience surveys.

Mass General Brigham Health Plan Board of Directors

The Mass General Brigham Health Plan Board of Directors is responsible for the Quality Improvement Program. The Board delegates oversight responsibility for quality of care and services to the Quality Program Committee. This committee reports directly to the Board.
Day-to-day oversight of the Quality Improvement Program is the responsibility of the Chief Medical Officer and Quality leadership.

Quality Program Committee (QPC)

This committee is responsible for the development, implementation, and oversight of the 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. In addition to internal participants, QPC includes members from external organizations including Optum BH and participating network providers.

Quality Improvement Committee (QIC)

This committee develops, implements, and monitors the Quality Improvement (QI) program and functions by ensuring that 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.

Performance Reporting and Improvement

Provider Profiling System

Mass General Brigham Health Plan shall establish and maintain a profiling system for all providers rendering care for Mass General Brigham Health Plan for the purpose of obtaining and providing detailed information which includes, but is not limited to:

- Patient satisfaction
- Outcomes
- Access and utilization data for a provider

The provider agrees to cooperate and participate in such systems in a manner that is conducive to quality improvement activities.

Reporting

Upon request, primary care sites are provided with reports outlining their performance in areas including but not limited to:

- Emergency room utilization
- Preventive Care
- Chronic Disease
- Patient satisfaction*
- Cost and utilization

*Annually, Mass General Brigham Health Plan conducts a survey of patients' satisfaction with their primary care site. The survey focuses on patients' satisfaction with access to routine and urgent care, the effectiveness of communication with the practice staff, and the perceived level of courtesy and respect demonstrated by reception staff. Practice specific results are subsequently shared with practice sites.

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:

- Significance 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
- Address 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' 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' website,

For a list of clinical practice guidelines currently endorsed by Mass General Brigham Health Plan, please visit Provider resources | Mass General Brigham Health Plan If you do not have access to the Internet, please contact Provider Service at

Healthplanproviderservice@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.

- 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 members) 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 and 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 CBHC services (including all necessary care coordination with home health, case management, mental health or other providers involved in the care of members) must be provided immediately and be available 24 hours a day, seven days a week.
- For services described in an inpatient or 24-hour diversionary services discharge plan:
  - *Non–24-hour diversionary services*—with- in 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*—with- in the time frame directed by the Executive Office of Health and Human Services.
- *Urgent*—within 48 hours of request
- *All other behavioral healthcare*—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.

For more details, call Mass General Brigham Health Plan Provider Service at 855- 444-4647.

Office Site Audits

- Mass General Brigham Health Plan reserves the right to conduct a site visit for providers whom grievances have been filed against.

Except in the instance of a Quality-of-Care Site Visit (see below), a CMS or state review may be substituted for a Mass General Brigham Health Plan site visit. If Mass General Brigham Health Plan is using a state review in lieu of a conducted site visit Mass General Brigham Health Plan must verify that the review was completed within the time limits and meets Mass General Brigham Health Plan's site visit standard. In this instance, organizational provider applicants must provide a copy of the CMS or state review report performed within the previous 36 months (about 3 years) and a copy of the organization's QI (Quality Improvement Plan and Credentialing Process. 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. During the site visit, specific established standards are applied which are reviewed and approved by Mass General Brigham Health Plan' Provider Network Management. Site visits for potentially high-volume behavioral health practitioners are conducted by Mass General Brigham Health Plan' delegate, Optum BH, a fully accredited NCQA managed behavioral healthcare organization.

- Practice sites are assessed against the following standards:
- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining rooms
- Appointment availability.

Quality-of-Care Site Visits are conducted when three (3) or more member complaints/grievances are received, or when the Senior Director, Quality receives and external or internal complaint about a quality-of-care concern that is deemed serious based on a severity rating and/or review by the Credentialing Committee, a site visit will be conducted by the Senior Director, Quality, or his/her delegate.

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 30 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 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 conducts an annual review of medical records in a random sample of the network of PCPs and inpatient hospital sites. These medical record audit 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

In monitoring adherence to medical records documentation standards, Mass General Brigham Health Plan staff conduct medical record audits at randomly selected primary care sites to review a sample of medical records.

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
- Medications 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

The Mass General Brigham Health Plan reviewer must be given full access to the randomly selected medical charts or direct access to an EMR system. Compliance for each element requires that the element be present and easily found. The percentage of compliance is calculated based on the number of elements passed divided by the total number of elements.

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
- Medications list is present and updated
- Preventive services and risk screenings are recorded

When recording compliance, the Mass General Brigham Health Plan reviewers use the Documentation Standards Review tool. Upon completion of the audit, Quality Management staff analyze the results and develop site- specific reports. These reports are then delivered to the previously identified "key contacts" at each PCP or inpatient hospital site.

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 with 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 also 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, 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.

Drugs, Alcohol and Tobacco

Documentation of an assessment for alcohol, tobacco and illicit drug use must be present for all members age 12 and older, including seniors. Members age 12−21 must, at a minimum, be assessed at each well childcare 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 when a new significant problem is identified and confirmed.

Immunizations

An immunization record (for children) is up to date and (for adult) an appropriate history has been made in the medical record.

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 recorded in each visit note.

Under- or Over Utilization

There is appropriate notation for under- or over-utilization of specialty services or pharmaceuticals.

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 q 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—Working diagnosis/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 members 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—Laboratory and other studies are ordered, as appropriate. 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.

- Consultation, laboratory, and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review (review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
- Unresolved problems—Any problems identified at a visit that is 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, including the administration of behavioral health screenings, 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 cigarettes, 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 members' 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, and 10. 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, and 15 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 age 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.

The documentation should include the following:

Standard: 0-1 Age Range:

- Counsel against bottle-propping when feeding infants and babies.
- Counsel against bottles to bed.
- Assess oral health at each visit and need for fluoride supplementation at 6 months based upon availability in water supply and dietary source of fluoride.
- Encourage brushing with a soft toothbrush/cloth and water at age 6 months.
- Encourage weaning from bottle and drinking from a cup by the first birthday.
- Apply fluoride varnish to primary teeth of all infants and children every 6 months if not applied at dental home and every 3 months if at high risk for caries.

Standard 1-21 Age Range:

- Apply fluoride varnish to primary teeth for all children aged 1-5 every 6 months if not applied at dental home and every 3 months if at high risk for caries.

- Assess oral health at each visit and need for fluoride supplementation up to age 14 based on availability in water supply and dietary source of fluoride.
- Counsel on good dental hygiene habits, including brushing twice daily.
- Counsel on the establishment of a dental home beginning at 12 months or after eruption of first tooth.
- Counsel on use of mouth guards when playing sports.

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 childcare 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 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 quite 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. For more information, please see the Behavioral Health Provider Manual.

Other Testing

There should be documentation for other screening tests 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.

Additional Inpatient Hospital Documentation Standards

- Member identification
- Admission date

- Dates of application for and authorization of Mass Health benefits, if applicable
- Emergency admission justification, if applicable
- Dates of operating room use, if applicable
- Dates of initial and continued stay review
- Physician Name
- Plan of care
- Reason and plan for continued stay

In accordance with Mass General Brigham Health Plan 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.

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 Clinical Review Specialist Patient Safety Nurse 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 monthly 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 thirty days to submit the required DPH SRE reports to the Plan 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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Section 6: Clinical programs and utilization management

Mass General Brigham Health Plan Care Management Program

Mass General Brigham Health Plan is dedicated to providing well- managed patient-centered care to Mass General Brigham ACO members. For optimal coordinated care, Mass General Brigham ACO members should always be referred within the Mass General Brigham ACO network.

The Mass General Brigham Health Plan Care management program primarily serves members identified as high-risk and rising risk. Interventions are tailored to meet members where they are with increased services being made available to those with complex, costly, and/or chronic needs.

The care management program combines local, in-person care management at the points of care and in the community with remote, health-plan-based, telephonic Care Management. As appropriate, services may be delivered in the members' home.

With this well-coordinated and patient-centered model, the care management program promotes high-quality and efficient care delivery. The program is intended to help reduce avoidable readmission and ED utilization, while improving member health outcomes and satisfaction.

Mass General Brigham Health Plan Care Teams

Integrated and multidisciplinary care teams are available to members across all Mass General Brigham ACO practices. These collaborative teams will include cross-organizational clinical staff and primarily serve those that are identified as high risk or rising risk patients. With this collaborative model, this program expects to:

- Deliver stronger care coordination
- Improve communication with patient and within the care team
- Improve patient outcomes
- Reduce duplicative spending and services
- Develop and strengthen community physician relations
- Improve quality of care
- Improve patient satisfaction and engagement
- Ensure that the patient has access to the right care at the right time

Mass General Brigham Health Plan Care Management Services

High-risk and rising-risk patients enrolled in Mass General Brigham Health Plan's Care Management Program are eligible to receive the following services as appropriate based on individual patient needs and goals:

- Comprehensive Assessments (if Care Needs
- Screening indicates the member has a
- Special Health Care Need)
- Development of patient-centered Care Plans
- Referrals to specialty and disease management programs as appropriate
- Referrals to LTSS and BH CPs as needed and appropriate
- Home visits
- Face-to-face and/or telephonic Care Management
- Care Management focused on improving health outcomes, reducing inappropriate utilization of resources, and ensuring communication and collaboration across the care continuum.
- Assistance when appropriate with improving Social Determinants of Health (SDOH) as they relate to and affect the members' health status
- Disease management
- Wellness programs
- Transitions of care management
- Medication reconciliation and medication education

Mass General Brigham Health Plan Utilization Management

The Utilization Management (UM) program is designed to ensure the provision of the highest quality of health care to Mass General Brigham ACO members while at the same time promoting appropriate, efficient, and cost-effective resource utilization. As such, the 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 ACO patients have appropriate access to new and emerging efficacious technologies.

Referrals, prior authorization, notification, concurrent review, retrospective review, and discharge planning are all elements of the utilization management program.

As underutilization of medically appropriate services has the potential to adversely affect patients' health and wellness, Mass General Brigham Health Plan promotes appropriate utilization of services. 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 clinicians are responsible for making all utilization decisions in accordance with the patient'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 ACO 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 eNewsletter, the provider portal, and/or written communications.

Requesting and Obtaining an Authorization or Referral

Referrals for MGB ACO members are not required for in-network providers. Prior authorization and notification requirements for general services are available on Providers | Mass General Brigham Health Plan.

Most Surgical Day Care (SDC) services do not require authorization. A consolidated list of SDC procedures requiring authorization can be found on Providers | Mass General Brigham Health Plan.

Not all DME and orthotics require authorization. See the Prior Authorization Exemptions for DME, Orthotic and Prosthetics list on Providers | Mass General Brigham Health Plan.

Submission through the Provider Portal

Required referrals, authorizations and notifications must be submitted through Mass General Brigham Health Plan online authorization tool, accessed through the provider portal, Mass General Brigham Health Plan Provider Portal Clinical documentation to support authorization requests can also be submitted via the provider portal. To expedite

decision making, complete clinical information supporting medical necessity should be uploaded with the request on the Mass General Brigham Health Plan Provider Portal . Authorization or referral requests to a non- Mass General Brigham Health Plan network provider cannot be submitted through the provider portal and requires fax submission:

Fax Number: 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 patient is actively enrolled with Mass General Brigham Health Plan 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 the Mass General Brigham Health Plan Provider Portal.
- 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

Mass General Brigham Health Plan providers obtain confirmation of received authorization requests and UM decision-making from the Mass General Brigham Health Plan Provider Portal 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 the provider portal.

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 *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, or
- 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.

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. Referrals are not required to specialists within the Mass General Brigham Health Plan ACO network.

To ensure reimbursement, care provided by a non-Mass General Brigham Health Plan ACO network specialist may require a referral from the PCP. The Mass General Brigham Health Plan PCP is the only provider authorized to make referrals to specialists. The PCP should submit 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.

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.

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 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 that requests be submitted a minimum of five (5) business before the scheduled admission. Authorization determinations for elective services can take up to 14 calendar days to ensure adequate time for review and processing (See “UM Time Frame for Decision-making and Notification”). Prior authorization is not required for:

- Emergency room care
- Observation

Requests for prior authorization services are forwarded to a Utilization Management Care Manager for review. The Utilization Management Care Manager will determine whether the requested service meets established review criteria guidelines. The Utilization Management Care Manager 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 Care Managers based on medical necessity criteria. Prior authorization denials (adverse determination) for medical necessity are made only by the Deputy Chief Medical Officer, a Mass General Brigham Health Plan Medical Director, or a designated physician reviewer, based upon medical necessity criteria, the specific needs of the individual member and the availability of local resources.

Durable Medical Equipment (DME)

DME purchases and rentals must be requested by the patient’s PCP, 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 DME Prior Authorization list on the provider portal. This list also includes medical supplies, oxygen-related equipment, orthotics and prosthetics that require prior authorization.

DME prior authorization requests are submitted through Mass General Brigham Health Plan Provider Portal. 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 Providers | Mass General Brigham Health Plan. A valid authorization request and completed Combined MassHealth Managed Care Organization (MCO) Medical Necessity

Review Form for Enteral Nutrition Products (special formula) form 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 www.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 AM to 9 PM **ET** at: **888-693-3211**

Once approved, an authorization number is faxed to the ordering/referring practitioner and the rendering/performing provider. 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

Mass General Brigham Health Plan partners with CareCentrix, Inc. (CCX) to provide sleep study and therapy management services. 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 CareCentrix by:

- Visiting the CareCentrix website https://www.carecentrixportal.com and accessing the secure Sleep Portal to submit the request.
- Phoning CareCentrix, Monday through Friday, 8AM to 5:00 PM, EST, 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. Criteria for medical necessity decision making is available on the Mass General Brigham Health Plan Provider Portal.

Behavioral Health Services

Mass General Brigham Health Plan partners with Optum BH to manage the delivery of behavioral health services for all Mass General Brigham ACO patients. For more information, contact Optum BH at 844-451- 3519.

Concurrent Review

Concurrent review is required for subsequent days of care or visits or services beyond the initial authorization. Concurrent review must be conducted via the Mass General Brigham Health Plan Provider Portal where indicated. For services that cannot be conducted via the Provider Portal, you may fax or mail. Most requests for concurrent services are submitted through the provider portal. Follow the provider portal User Guide for revising authorizations. Those service requests that are not accepted through the provider portal must be faxed or mailed to Mass General Brigham Health Plan. 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.

In the event that the Utilization Management Care Manager is unable to perform concurrent review, cases may be reviewed retrospectively. A copy of the medical record will be requested in accordance with applicable confidentiality requirements.

UM Time Frame for Decision- Making and Notification

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

MassHealth members will receive written notification of prior authorization and concurrent authorization approvals.

UM Time Frame for Decision-Making and Notification

UM Subset	Decision Time Frame	Verbal Notification Provider	Written/Electronic Provider Approval Notification	Written Denial Notification
Pre-service/Initial Determination *Non-urgent Standard*	Within 14 *calendar* days after receipt of the request the member or authorized representative may request an extension for up to 14 additional *calendar* days	**Denial** Within 14 *calendar* days after receipt of the request	Electronic notification is available on the next *business* day after the decision determination and within 14 *calendar* days after receipt of the request	Within 14 *calendar* days after receipt of the request
Pre-service/Initial Determination *Urgent/Expedited*	Up to 72 hours/three *calendar* days of receipt of the request the member or authorized representative may request an extension for up to 14 additional *calendar* days	**Denial** Within 72 hours/three *calendar* day of receipt of request	Electronic notification is available on the next business day after the decision determination and within three business days after receipt of the request	Within 72 hours/three calendar days of verbal notification and not to exceed three business days from receipt of receipt of the request
Concurrent Review *Urgent/Expedited* Inpatient stays are always considered Urgent/Expedited	Within 24 hours/one *calendar* day of receipt of the request. The member or authorized representative may request an extension for up to 14 additional calendar days	**Denial** Within 24 hours/one *calendar* day of receipt of request **Approval** Within 24 hours/1 *calendar* day of receipt of request	Electronic notification is available on the next business after the decision determination and within three business days after receipt of the request	Within 72 hours/three *calendar* days of verbal notification and not to exceed 3 business days from receipt of request exceed three business days from receipt of request Service is continued Service is continued without liability to member until notification

Continues on next page

UM Subset	Decision Time Frame	Verbal Notification Provider	Written/Electronic Provider Approval Notification	Written Denial Notification
Concurrent *Non-urgent/ Standard*	Within 14 *calendar* days after receipt of the request. The member or authorized representative may request an extension for up to 14 additional *calendar* days	**Denial** Within 14 *calendar* days after receipt of the request **Approval** Within 14 *calendar* days of receipt of the request	Electronic notification is available on the next *business* day after the decision determination and within 14 *calendar* days after receipt of the request	Within 1 business day following verbal notification, but no later than 14 calendar days after receipt of the request
Reconsideration of Adverse Determination (Initial and concurrent medical necessity review determination)	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
For termination, suspension, or reduction of a previous authorization	N/A	N/A	N/A	At least 10 *calendar* days prior to date of action

Notification of Birth Process (NOB)

- Babies will no longer be automatically assigned to their mother's plan. Plan assignments for newborns are now prospective. MassHealth no longer assigns plans retroactively to date of birth. There are two new fields on the NOB so the family can select the baby's PCP and plan when the NOB is completed in the hospital
- Hospitals will be required to notify MassHealth within 10 days of a baby's birth whenever possible. However, you will no longer be required to notify Mass General Brigham Health Plan.
- The family can also enroll the newborn in a health plan by visiting MassHealthchoices.com or calling MassHealth customer service at 800-841-2900, Monday-Friday 8 am – 5 pm.
- Babies will be enrolled in MassHealth fee-for service until MassHealth receives the NOB and assigns a plan. If the family does not enroll the newborn in a plan either on the NOB or within 14 days of NOB submission, MassHealth will automatically assign the newborn into a managed care plan.

To determine eligibility and plan Information hospitals should check the MassHealth electronic verification system daily.

For further details please refer to the MassHealth All Provider Bulletin 305 Policies and Procedures for Newborn Members Dec 2020
Changes for Sick Newborns

For sick newborns, submit authorizations under the baby's ID once the baby is enrolled in Mass General Brigham Health Plan. When eligibility has been established, you must submit a prior approval request to Mass General Brigham Health Plan within 24 hours. Notification of the admission should be submitted by the hospital.

Out-of-Network Requests

Mass General Brigham Health Plan PCPs should always refer members within the Mass General Brigham Health Plan MGBACO network. Should the PCP refer a member outside the Mass General Brigham Health Plan network, the PCP must obtain the applicable referral and prior authorizations to confirm coverage.

Authorization is required for all non-emergent out-of-network service requests except for early intervention services, and family planning services provided to Mass General Brigham ACO members. Mass General Brigham ACO members may obtain family planning services at any MassHealth family service planning provider, even if the provider is out of the Mass General Brigham Health Plan network.

Mass General Brigham Health Plan providers can be found in the Provider Directory.

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

In most cases, a pre-existing relationship with an out-of-network provider is not reason alone to justify the need for an out-of-network provider.

Requests for services by an out-of-network provider are submitted electronically via a web portal Mass General Brigham Health Plan Provider Portal and are subject to medical necessity review.

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 ACO 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 Care Managers 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. Discharge planning transcends the care setting, and therefore, all Utilization Management Care Managers are required to be proficient in all operations that encompass discharge planning, including a full understanding of community resources available to the member.

Utilization Management Care Managers arrange for in-network services and out-of- network authorizations when the network of providers cannot meet the members after-care needs. In addition to assisting the provider with traditional authorization/benefit information, the Utilization Management Care Manager collaborates and coordinates services with the provider and works with other appropriate members of the health care team, including but limited to, Mass General Brigham Health Plan care management programs, behavioral health care management programs, community and agency resources and the patient'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 patient's recovery.

Discharge Planning to Support Members Experiencing or at Risk of Homelessness

MassHealth has established specific discharge planning requirements for Acute Inpatient Hospitals, Freestanding Psychiatric Hospitals and Accountable Partnership Plans. These requirements were put in place to create more effective discharge planning efforts in order to decrease the number of people who are discharged from healthcare facilities directly to homeless shelters.

For additional information on MassHealth requirements can be found at MassHealth Managed Care Entity Bulletin 64 July 2021

As required, please notify us to initiate a member's discharge planning process at: massbhcca@optum.com (behavioral health), or masshealthcm@allwayshealth.org (medical) Please provide the following member information in your email: patient's full name, date of birth, referring facility name, facility discharge specialist name, phone number and email.

Medical Necessity Decision-Making

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 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 patient or make authorization determinations solely on diagnosis, type of illness or the condition of the patient.

All medical necessity decisions are made only after careful consideration of the applicable written medical criteria, interpreted in light of 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 care manager 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 patient.

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 Change Healthcare's InterQual criteria tools or the Mass General Brigham Health Plan Medical Necessity Guidelines on massgeneralbrighamhealthplan.org to

make decisions for authorization or requested services or treatment.

Guidelines and criteria internally developed are reviewed at least annually and criteria are updated, when appropriate, by Mass General Brigham Health Plan clinicians under the direction of the Deputy Chief Medical Officer and Medical Directors. Development and review of non-unified guidelines/criteria under Mass General Brigham Health Plan's Pharmacy Program occur through Mass General Brigham Health Plan's Pharmacy and Therapeutics Committee. Development of unified guidelines/criteria is completed by MassHealth, and an additional review is completed by Mass General Brigham Health Plan's Pharmacy and Therapeutics Committee. Development, review, and application of medical necessity guideline/criteria for behavioral health services is governed by the policies and procedures under Optum Rx, a fully National Committee for Quality Assurance (NCQA) accredited managed behavioral health organization, Mass General Brigham Health Plans' behavioral health delegate, and accepted by, Mass General Brigham Health Plans' Medical Policy Committee (MPC). Development, review and application of medical necessity guidelines/criteria for genetic and molecular pathology testing is governed by the policies and procedures under, eviCore healthcare, an NCQA certified utilization management organization, a utilization management delegate and accepted by Mass General Brigham Health Plans' MPC Development, review and application of medical necessity guidelines/criteria for sleep studies are governed by the policies and procedures under CareCentrix a utilization management delegate.

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.

The Utilization Management Care Manager 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 Care Manager considers the following factors when applying criteria to a given member: age, co-morbidities, complications, progress of treatment, psychosocial situation, home, and family environment, when applicable. Medical necessity criteria are applied in context with individual members' 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 Care Manager 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 massgeneralbrighamhealthplan.org. Proprietary criteria are made available to providers and members on request and only to the extent it is relevant to the particular treatment or service.

MassHealth's Definition of Medical Necessity

Medically necessary services for Mass General Brigham ACO members are those health care services:

Reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity.

For which there is no comparable medical service or site of service available or suitable for the member requesting the service that is more conservative or less costly of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality.

Information Request

PROVIDER SERVICE
Phone 855-444-4647
Mon.-Fri. 8:00 a.m.-5:00 p.m. Closed
12:00pm – 12:45pm.
ACO MEMBER SERVICE Phone
800-462-5449 TTY 711
Email: HealthPlanCustomerService- Members@mgb.org
Mon.-Fri. 8:00 a.m.-6:00 p.m.
Thursday, 8:00 a.m.-8:00 p.m.

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 (adverse determination) is a decision made 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. Clinical peer review may be requested for services that are denied prospectively or concurrently on the basis of medical necessity. Clinical peer review 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 Clinical peer review 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 members' 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 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 the 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 ACO patient financially liable for any service administratively denied by Mass General Brigham Health Plan for failure of the provider to adhere to established utilization processes.

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.

- Optum BH for the utilization and care management of behavioral health services on behalf of Mass

General Brigham Health Plan patients. Optum BH is a fully NCQA accredited Managed Behavioral Health Organization.

- Optum Rx has been delegated utilization management functions for pharmaceuticals reviewed by Mass General Brigham Health Plan's Pharmacy and Therapeutics Committee. Coverage of unified pharmaceuticals is decided by MassHealth, and coverage of non-unified pharmaceuticals is decided by Mass General Brigham Health Plan.
- eviCore Healthcare has been delegated the following elective outpatient services requiring prior authorization through eviCore Healthcare: Selected Molecular & Genetic Testing
- 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.
- CareCentrix, Inc (CCX) has been delegated sleep diagnostic and therapy management services.
- Medical Review Institute of America (MRIoA) has been delegated 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.

Nurse Advice Line

Mass General Brigham ACO members have access to 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 does not 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 the Mass General Brigham ACO Nurse Advice Line at 1-833-372-5644

Online Clinical Reports on the Provider Portal

Clinical reports to help effectively manage patients are available via the provider portal. 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.

Access to the data is entirely at the discretion of the provider's 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 7: Billing guidelines

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Section 7: Billing guidelines

Chapter 2 Billing, Reimbursement, and Claims Submission

Submitting a Claim

Mass General Brigham Health Plan processes claims for Mass General Brigham ACO members in accordance with MassHealth regulations, contractual requirements, and applicable state and federal law. Claims processing timelines apply once a claim meets the definition of a clean claim.

Definition of a Clean Claim (MGB ACO)

A clean claim is complete, accurate, submitted in accordance with MassHealth and Mass General Brigham Health Plan requirements, and can be adjudicated without additional documentation, manual intervention, or MassHealth dependency.

Required Elements of a Clean Claim

- 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
- NPI rendering provider number, when applicable
- Provider name and address
- Provider's federal tax identification number

Claims that Do Not Qualify as Clean Claims

Claims requiring prior authorization, MassHealth eligibility confirmation, COB/TPL review, documentation, or manual pricing do not quality as clean claims.

Pended Claims and Provider Responsibility

Claims requiring additional information may be pended or denied. Turnaround-time requirements begin only once a claim meets the clean claim definition.

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' payer ID number is 04293. Companion Guides are available to assist providers interested in electronic claim submissions.

For questions regarding electronic claims submissions, please contact Mass General Brigham Health Plan Provider Service at 855-444-4647.

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-end 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. Address all other correspondence as shown below.

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 the 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 claims (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 along with 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 though 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 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 patient did not identify him/herself as a Mass General Brigham Health Plan patient 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 the New England Healthcare Exchange Network

- Hand-written Patient Account Ledger
- Verbal requests

Behavioral Health Services Claims

Mass General Brigham Health Plan's benefit is administered through Optum BH. Claims, appeals, and adjustment requests for behavioral health specific services must be submitted to Optum BH 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 semiprivate room rate unless a private room is preauthorized. 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

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. The COB team can be reached at 617-772-5729 (prompt #1). Providers should use a TPL Indicator Form for reporting other insurance information discovered during patient encounters for all Mass General Brigham Health Plan members. These forms are available to providers by calling Provider Service.

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 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.

When a patient enrolls with Mass General Brigham ACO Mass General Brigham Health Plan is *always* the payer of last resort. All payments for covered Mass General Brigham ACO 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 ACO Mass member is involved in an automobile accident or a slip and fall accident or has suffered an injury as a result of another party's negligence, providers should notify Mass General Brigham Health Plan directly by calling the Third-Party Liability Department at 617-772-5729 (prompt #2) 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. Mass General Brigham Health Plan

Mass General Brigham Health Plan reserves the right to subrogate and succeed to any right of recovery for any services provided to a member injured in a third-party accident.

Workers Compensation (WC) Claims

When a Mass General Brigham ACO 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.

Chapter 3 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, Mass General Brigham Health Plan Provider Portal. To enroll in the provider portal, simply follow the easy registration instructions, or consult with your site's appointed user administrator.

Chapter 4 Provider Reimbursement

Reimbursement for services rendered must be treated as payment in full. Providers may not seek or accept payment from a Mass General Brigham Health Plan patient for any covered service rendered. In addition, providers may not have any claim against or seek payment from MassHealth for any Mass General Brigham Health Plan covered service rendered to a Mass General Brigham Health Plan patient. 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 or MassHealth 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' 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 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 nonmedically 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 clearly identifiable and measurable, 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 be received by Mass General Brigham Health Plan through 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 the MA Department of Public Health (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, 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.

The provider will have seven (7) days from the date the event took place to report SREs using the required SRE form via fax to (617) 526-1916. Mass General Brigham Health Plan reviews and promptly responds within thirty (30) days to actual or potential QOC occurrences. 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, the CMS Hospital Acquired Conditions Reduction Programs (HAC) and Present on Admission (POA) indicators.

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 a "never 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	$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	$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	$0.00 DENIED
Totals:			$1,561.37	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Remarks: 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.

Billing for Missed Appointments

Mass General Brigham Health Plan considers a missed appointment as factored into the overhead cost of providing services and not a distinct reimbursable service. In recognition of this, provider fee schedules are designed to cover this cost, keeping the member from incurring additional costs.

Mass General Brigham Health Plan expects that the practice and its providers will cooperate and participate with Mass General Brigham Health Plan in programs focused on improving member appointment attendance.

Providers must not:

- Bill members for missed appointments.
- Refuse to provide services to members due to missed appointments.
- Refuse to provide services to members because the member has an outstanding balance owed to the practice from a time prior to the patient becoming a Mass General Brigham Health Plan member.

Audits

Mass General Brigham Health Plan' 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 (LCDs), 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' 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 (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, MassHealth, 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, and 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' 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' 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' 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 15 days advance written 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' 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 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 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 Plans' 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' 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' payment guidelines are found at Provider payment guidelines | Mass General Brigham Health Plan.

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Section 8: Pharmacy

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, and specialty and formulary management.

Formulary Drug Lookup Tool

The MassHealth Drug List, maintained by MassHealth, is available to clinicians to provide information about drug coverage. It provides a searchable formulary with information such as drug name, drug class, prior authorization, and other limitations. Please check the Mass General Brigham Health Plan Specialty Drug List for any specialty limitations.

Mass General Brigham Health Plan encourages providers to use the MassHealth Drug List and Mass General Brigham Health Plan's Specialty Drug List to become familiar with the drug selection. Our formulary is unified with the MassHealth Drug List and is regularly reviewed and evaluated by the Mass General Brigham Health Plan Pharmacy and Therapeutics Committee. This committee is comprised of representatives from various practices and specialties.

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 ACO 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 ACO provides patient eligibility/coverage status, medication history, and formulary information to physicians who use e-prescribing tools.

Generic Interchange Policy

Mass General Brigham Health Plan has a mandatory generic substitution policy some exceptions may apply. The generic equivalent must be dispensed when available. Multisource 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 OptumRx, available on Providers | Mass General Brigham Health Plan.

The medication prior authorization and step therapy criteria can be found on Providers | Mass General Brigham Health Plan.

Exception requests are reviewed by Optum Rx. Because we are committed to providing our patients with prompt access to care, decisions regarding override requests are generally communicated within 24 hours 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. See the MassHealth Drug List to determine if a medication has a quantity limitation.

Prior Authorization Drug Policy

To ensure appropriate utilization, Mass General Brigham Health Plan delegates to OptumRx prior authorization of some drugs. Prescribers can request

clinical reviews by calling the Prior Authorization (PA) department at MG 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 MassHealth Drug List 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.

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 ACO enrollment. The look-back period depends upon the particular program. Physicians may submit an exception 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 reviewed 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's contracted specialty pharmacy including Optum Rx Specialty Pharmacy.

The 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. 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 patient's homes.

Please visit Providers | Mass General Brigham Health Plan for copies of the specialty pharmacy prior authorization fax forms, the list of specialty drugs, and medications supplied.

Mandatory 90 Program

The Mandatory 90 program requires a 90-day supply to ensure the member always has the most important medications on hand.

If the member is starting a new medicine, they will be allowed to get a 30-day prescription first to make sure the medicine is right for them. If they are staying on the medicine, then they will be required to get a 90- day supply.

Members will be automatically enrolled in this program to get 90-day refills of ongoing prescriptions after a 30-day. If you feel that your patient should not be part of this program for one or more of their medications, you should call Mass General Brigham Health Plan Customer service to request that your patient not be in the program.

Allowable 90 Program

Allowable 90 provides Mass General Brigham Health Plan members with a 90-day supply of certain maintenance medications when purchased through participating pharmacies.

Medicare Part D

Certain Mass General Brigham ACO patients with Medicare coverage and enrolled in MassHealth have their prescriptions drug benefit covered by Medicare. Mass General Brigham ACO patients received ID cards for their Medicare prescription drug coverage.

Mass General Brigham Medicare Health Plans offer prescription drug coverage, and some plans provide coverage for select Medicare excluded drugs. Examples include certain over-the-counter drugs and vitamins. For more information, please call Mass General Brigham Health Plan Customer Service.

To find out more about Medicare's prescription drug coverage:

- Contact Medicare at 800-633-4227.
- Visit the Medicare website at www.medicare.gov.
- Go to www.cms.gov.

More Information

Updates to the formulary are communicated through the provider newsletters and the provider portal.

Optum Rx Contact Information:

Pharmacy Benefit Requests Phone:
800-711-4555
Fax: 844-403-1029

Prime Therapeutics
Phone:
Fax:

Mass General Brigham HealthPlan MassHealth
Phone: 877-433-7643
Fax: 866-255-7569

Section 9: Appeals and Grievances

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Section 9: Appeals and Grievances

Provider Grievances and Administrative Appeals

Mass General Brigham Health Plan has a comprehensive process for resolving appeals and grievances.

An appeal is a request that Mass General Brigham Health Plan or Optum review an adverse action or denied claim, having provided documentation supporting the request for reconsideration. Appeal requests must be submitted in writing.

A grievance is any expression of dissatisfaction about any action or inaction by Mass General Brigham Health Plan other than an Adverse Action. 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. Grievances should be reported to Mass General Brigham Health Plan' Provider Service.

Requesting an Administrative Appeal

As described in the Billing Guidelines section or as contractually agreed, 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 decision, an appeal can be submitted to Mass General Brigham Health Plan' Provider Appeals Department.

Appeal requests must be submitted in writing within one of the following timeframes:

- 90 days from receipt of the EOP
- 90 days from receipt of EOP from other insurance
- 90 days from the date of the claim's adjustment letter

The appeal must include additional relevant information and documentation to support the request. Requests received beyond the 90-day appeal request filing limit will not be considered.

When submitting a provider appeal, please use the Request for Claim Review Form.

Appeals may be sent to:
Mail: Mass General Brigham Health Plan
Appeals & Grievances Dept.
399 Revolution Drive, Suite 810
Somerville, MA 02145

Fax: 617-526-1902

Administrative Appeals Process

Mass General Brigham Health Plan' administrative appeals option applies only for services already rendered.

Administrative denial letters issued by Mass General Brigham Health Plan' Clinical Department informing the provider that Mass General Brigham Health Plan received insufficient documentation to make a medical necessity decision require the submission of a new approval request through the Mass General Brigham Health Plan Provider Portal. Providers should not appeal these denials. Instead, submit the additional information requested through the Provider Portal.

For denials on services already rendered, the Mass General Brigham Health Plan administrative appeals process includes one appeal level:

- A Level I appeal is the initial request to Mass General Brigham Health Plan for reconsideration of a denied claim. Level I appeal submissions are reviewed and completed within 60 calendar days from the date Mass General Brigham Health Plan receives the request with all supporting documentation. If additional information is needed to finalize the appeal request, the provider will be notified in writing. The requested documentation must be submitted within 60 days from the date of Mass General Brigham Health Plan' Level I appeal letter.
- If approved, Mass General Brigham Health Plan will adjust the claim. The provider will be notified of the outcome via the Mass General Brigham

Health Plan Explanation of Payment which should reflect the reprocessed claim(s) within two weeks once reprocessed.

- If denied, the provider will be notified in writing of the decision and rationale.

Appealing a Behavioral Health Service Denial

Provider appeals and grievances for behavioral health services are handled by Optum BH, Mass General Brigham Health Plan's Behavioral Health Partner. All behavioral health appeals should be submitted directly to Optum BH.

For more information, please refer to the Behavioral Health Provider Manual or contact Optum BH at 844- 451-3519.

Post-Payment Claim Adjustments

Mass General Brigham Health Plan regularly reviews claims post payment and adjusts as needed. Depending on the total dollars adjusted, Mass General Brigham Health Plan proactively notifies the provider of the scheduled adjustments. Providers who disagree with these adjustments can submit a letter of appeal to Mass General Brigham Health Plan' Appeals department within 90 days of the Explanation of Payment (EOP) along with comprehensive documentation to support the dispute of relevant charges.

Appeals are reviewed within 60 calendar days from Mass General Brigham Health Plan' receipt of all required documentation. When appropriate, Mass General Brigham Health Plan will consult with clinicians or subject matter experts in the areas under consideration before finalizing the appeal request.

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 days of the EOP. The appeal's receipt date will be consistent with the date Mass General Brigham Health Plan received the additional documentation.

The appeal determination will be final. If the appeal request is overturned, Mass General Brigham Health Plan will adjust the claims in question within 10 calendar days of the final determination notification. Providers are notified of the claim's reprocessing via the EOP.

Complaints, Grievances and Inquiries

Inquiries

Mass General Brigham Health Plan is also committed to responding to all member inquiries in a timely manner.

An inquiry is any oral or written question made to Mass General Brigham Health Plan Customer Service regarding an aspect of Mass General Brigham Health Plan' operations that does not express dissatisfaction about Mass General Brigham Health Plan.

Upon receipt of an inquiry, Mass General Brigham Health Plan Customer Service Representative will document the matter and, to the extent possible, attempt to resolve it at the time of the inquiry.

Complaints/Grievances

Mass General Brigham Health Plan is committed to ensuring member satisfaction and to the timely resolution of reports of dissatisfaction by a member (or the member's representative on file) about any action or inaction by Mass General Brigham Health Plan or a health care provider. Mass General Brigham Health Plan has processes in place for adequate and timely resolution of member complaints/grievances as well as general inquiries.

Mass General Brigham Health Plan thoroughly investigates all reported expressions of dissatisfaction with Mass General Brigham Health Plan and/or a provider. Possible subjects of grievances include, but are not limited to:

- *Quality of Care*— Concerns with the quality of the care and/or treatment provided by medical staff.
- *Provider Access*— Reports of barriers to needed care in accordance with wait-time access 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 upon arrival, and geographic distance to a network provider.
- *Service/Administration*— Reports of poor member experiences, including rudeness by Mass General Brigham Health Plan and/or provider staff.
- *Billing and Financial*— A dispute of financial responsibility for rendered services and/or rendered as billed.
- *Provider's Facility*— Reports that a provider's facility is deemed inadequate, including but not limited to cleanliness of waiting room, restrooms, and overall physical access to the premises.
- *Privacy Violation*— Member reports that a provider and/or Mass General Brigham Health Plan violated or compromised protected health information (PHI).
- *Member Rights*— Reports of violation of a member's rights by a provider and/or Mass General Brigham Health Plan, including but not limited to Mental Health Parity Laws violations.

When a member designates an authorized representative to act on their behalf, 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 will only take place with the member.

Mass General Brigham Health Plan ensures that any parties involved in the resolution of grievances and any subsequent corrective actions have the necessary skills, training, and subject matter expertise 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 reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing.

A member may file a complaint or grievance by fax, mail, or by contacting Customer Service to be assisted with interpreter services, TTY support, explaining the grievance or appeal process and conducting an intake to submit the grievance or appeal on their behalf.

A 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 request that an internal appeal be expedited
- Any clinical issue
- The Mass General Brigham Health Plan Appeals Committee will resolve a grievance when the subject of the grievance involves:
- The denial of payment for services received because of failure to follow prior authorization procedures
- The denial of a request for an internal appeal because the request was not in a timely fashion

- The denial of non-covered services
- The denial of coverage for services with benefit limitations

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, when appropriate.

For grievances involving non-clinically related actions or omissions of a provider, assistance from the provider is requested in investigating the grievance.

Network provider's adherence to the grievance process is monitored regularly to identify training and other interventions.

For grievances specific to a provider, the nature of the grievance will determine whether the matter is addressed directly with the clinician or with the site's administrator. In either case, the provider is contacted to discuss the matter and obtain a written response addressing all identified concerns, corrective actions taken and supporting documentation when applicable. 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 and review 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.

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. 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 for all behavioral health–related inquiries and grievances is delegated to Mass General Brigham Health Plan's Behavioral Health Partner, Optum BH.

For more information, please see the Behavioral Health Provider Manual or contact Optum BH directly.

Expedited Clinical Appeals

Level I Expedited Appeal (Level II = n/a)

A member, member representative, or provider may request an expedited internal appeal when the member's life, health, or ability to attain, maintain, or regain maximum function would be seriously jeopardized by waiting 30 calendar days for a standard appeal resolution. Punitive action will not be taken against a provider who requests an expedited appeal on behalf of a member. Provider expedited appeal requests will not be granted unless Mass General Brigham Health Plan determines that the provider's request is unrelated to the member's health condition.

An expedited appeal must be filed within 60 calendar days of Mass General Brigham Health Plan' decision to deny, terminate, modify, or suspend a requested health care service.

All expedited requests by a member or Provider on behalf of a member are clinically reviewed to determine if the expedited criteria is met. If expedited criteria is met, a decision will be rendered within the expedited timeframe. If expedited criteria is not met, the request is not granted, and the Provider (if the appeal submitter) is orally informed of the decision. The Appeal and Grievance Coordinator makes a reasonable effort to provide the Member and the Member's Appeal Representative, if any, with prompt oral notice of the decision and sends written notification (Denial or Expedited Review) within two (2) calendar days. The Appeal is then processed in accordance with the standard internal Appeal time limits, and the Member/Appeal Representative is informed of his/her right to file a Grievance regarding the decision not to expedite the time frame.

If the appeal involves a decision by Mass General Brigham Health Plan to reduce or stop covering a service that was previously approved, Mass General Brigham Health Plan will continue to authorize the disputed services during the formal appeal process, unless the member indicates that they do not want to continue receiving services, as long as the appeal request is submitted within 10 days of the adverse action.

To file an appeal on behalf of a member, the provider must submit to Mass General Brigham Health Plan a written authorization from the member, designating the provider as their appeal representative. The Mass General Brigham Health Plan Designation of Appeal Representative Form should be used for this purpose. All Expedited Internal Appeals where the Provider is serving as the Member's Appeal Representative are processed even if Mass General Brigham Health Plan has not received the Designation of Authorized Representative form.

The time frame for making expedited internal appeal resolutions may be extended for up to 14 calendar days if Mass General Brigham Health Plan receives a request for an extension or Mass General Brigham Health Plan requests the extension based on the Member's best interest, and there is likelihood that receipt of additional information would lead to approval of the request and the information will be received within fourteen (14) calendar days. For any extension (either initiated by the member/Appeal Representative or Mass General Brigham Health Plan), the appeal and Grievance Coordinator will provide prompt oral notice to an appellant or their appeal representative. Additionally, the Member Appeal Coordinator will send the Member/Appeal Representative a written Notice of Internal Appeal Extension within two (2) calendar days of the decision to extent the appeal. The letter informs the Member/Appeal Representative of the reason for the extension and his/her right to file a Grievance if it was regarding the Mass General Brigham Health Plan decision to extend the time frame for responding to the Appeal.

Expedited External Review

The expedited internal appeal process is limited to one appeal level. Otherwise, the decision may be appealed via the Office of Medicaid Board of Hearings (BOH). The appeal must be submitted within 20 days of an expedited appeal decision. An appeal submitted to the BOH within 21 to 30 days will be treated as a standard appeal.

To continue receiving ongoing services during a BOH expedited appeal, the Appeal must be requested within 10 calendar days of Mass General Brigham Health Plan' initial appeal decision to uphold the decision to deny, terminate, modify, or suspend a requested health care service.

If the BOH determines that the member submitted the request for a BOH appeal in a timely manner, and the appeal involves the reduction, suspension, or terminations of a previously authorized service, Mass General Brigham Health Plan will authorize continuing services until one of the following occurs:

- The member withdraws the BOH appeal; or
- The BOH issues an adverse decision to the member's appeal request.

Level I Standard 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.

A member appeal must be filed within 120 calendar days of Mass General Brigham Health Plan' decision. However, a member can continue receiving ongoing services during an appeal, as long as the appeal is requested within 10 calendar days of Mass General Brigham Health Plan' decision.

In order to consider an appeal filed by a third-party, Mass General Brigham Health Plan must receive written authorization from the member designating the individual as their appeal representative. Providers submitting appeals on behalf of members should use the Mass General Brigham Health Plan Designation of Appeal Representative Form for this purpose. The appeal process will not be held up pending receipt of the form.

The completed, signed, and dated form must be received prior to the deadline for resolving the appeal. Otherwise, all communication will take place with the member only.

When filing an appeal on behalf of a member, the provider must identify the specific benefit that Mass General Brigham Health Plan denied, terminated, modified, or suspended, the original date of Mass General Brigham Health Plan' 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.

For a standard appeal, Mass General Brigham Health Plan will complete the appeal and contact the provider with the outcome of the review within 30 calendar days.

The time frame for a standard appeal may be extended for up to 14 calendar days if the member requests an extension, or if Mass General Brigham Health Plan requests the extension having determined that it will be in the member's best interest and there is reasonable likelihood that receipt of more information within five calendar days would lead to an approval.

Mass General Brigham Health Plan' Appeals and Grievances Department will make reasonable efforts to provide verbal notification of the decision within one business day, with written notification to follow within 30 days of receipt of the appeal.

A clear description of the procedures for requesting a BOH external appeal, including enclosures of Mass General Brigham Health Plan' Appeals Process and Rights for MassHealth members and a Request for a Fair Hearing Form are included with any denial of appeal notice to the member.

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

Appeals and Grievances Department
Mass General Brigham Health Plan
399 Revolution Drive, Suite 820
Somerville, MA 02145

Email: healthplanappealsgievance@mgb.org
Fax: 617-526-1980

Standard Clinical Appeals *(continued)*

Standard External Reviews

Once the Mass General Brigham Health Plan' appeal options have been exhausted, members may file an appeal with the Board of

BOH appeals of a standard internal appeal must be filed within 120 calendar days after the notification of decision on the final internal appeal.

Any services that are subject of a BOH appeal will continue, pending resolution of the appeal, unless the member specifically indicates that they do not want to receive continuing services, and the BOH receives a written request from the member within 10 calendar days from the notification of decision on the final internal appeal. If the BOH upholds an adverse action to deny, limit, or delay services and the member received continuing services while the BOH Appeal was pending, the member may be financially responsible for the cost of any requested services received during this time period.

Members must complete the Request for Fair Hearing form (included with the appeal decision notification) and submit it to the BOH. Mass General Brigham Health Plan can assist Members in completing this form.

Contact Information

Appeals and Grievances Department
Mass General Brigham Health Plan
399 Revolution Drive, Suite 820
Somerville, MA 02145

Phone: 800-462-5449

To initiate an external review, contact:
Board of Hearing (BOH) Office
of Medicaid
100 Hancock Street, 6th Floor Quincy,
MA 02171

Fax: 617-847-1204

Access to Appeal File by Member or Member Representative

Members or their representatives have the right to receive a copy of all documentation used in the processing of their appeal, free of charge. The request must be submitted in writing to Mass General Brigham Health Plan.

Limitations may be imposed, only if, in the judgment of a licensed health care professional, the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.

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 appeal concerns the denial, modification, or termination of covered service that the member is receiving at the time of the adverse action, the member has the right to continue their benefits through the conclusion of the appeals process. There are timeframes for requesting continuation of coverage, as explained in the table above. Continued authorization will not, however, be granted for services that were terminated pursuant to the expiration of a defined benefit limit.

If the appeal 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.

Reconsideration of Appeal Decision

Providers 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 confirm in writing the agreement to a new time period for review. A reconsideration request can be initiated by contacting the individual identified in the Mass General Brigham Health Plan letter.

Consumer Protection from Collections and Credit Reporting During Appeals

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 going on. 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 BH.

For more information, please see the Behavioral Health Provider Manual or contact Optum BH at 844-451-3519.