

Provider Overview: SCO and One Care

January 2026

Agenda

SCO and One Care Plans

Overview of D-SNP Benefit Structure

Network Information

Model of Care Framework and Person-Centered Care Planning

Interdisciplinary Care Team

Provider Portal

Provider Resources

Provider Appeals

Q&A





SCO and One Care Plans

January 2026

Mass General Brigham Health Plan has been selected to offer Dual Eligible Special Needs Plans (D-SNPs)

Senior Care Options (SCO) is a comprehensive managed care program implemented by EOHHS in collaboration with CMS for the purpose of delivering and coordinating all Medicare and Medicaid-covered benefits for eligible Massachusetts individuals managed by a SCO Plan using a person-centered model of care.

One Care is a comprehensive managed care program implemented by EOHHS in collaboration with CMS for the purpose of delivering and coordinating all Medicare and Medicaid-covered benefits for MassHealth Members eligible for both programs. Services are developed and delivered based on an Enrollee's person-centered assessment and care plan.



^{*}Please note that there is no annual enrollment period. Member coverage begins on the first day of each month, and disenrollment is effective on the last day of the month. Members may enroll or disenroll at any time.

2026 Member ID Cards

For a complete overview of all our products please click on the following link:

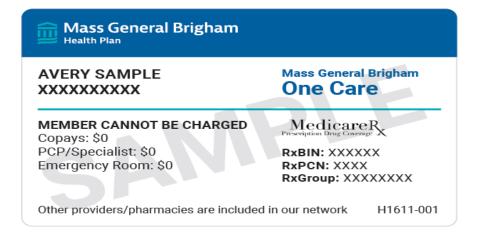
Product reference | Mass General Brigham Health Plan

Card Layout B4: Mass General Brigham SCO

H0777_0020PDT_C

Mass General Brigham Health Plan **Mass General Brigham** AVERY SAMPLE SCO XXXXXXXXX MedicareR, MEMBER CANNOT BE CHARGED Copays: \$0 PCP/Specialist: \$0 RxBIN: XXXXXX Emergency Room: \$0 RxPCN: XXXX RxGroup: XXXXXXXX Other providers/pharmacies are included in our network H0777-001

Card Layout B5: Mass General Brigham One Care



Members

Member Service, Care Coordinator, & Behavioral Health: 888-816-6000 (TTY 711)

24/7 Nurse Advice Line: 833-511-3252

Massachusetts Behavioral Health Helpline: 833-773-2445
For plan information, sign in at Member.MGBHealthPlan.org
In an emergency go to the nearest emergency room or call 911.

Providers

Where to submit claims:

Mass General Brigham Health Plan: 855-444-4647 | Payer ID: 04293

Optum Behavioral Health: 866-262-8067 | Payer ID: 87726 For more information, visit mgbhealthplan.org/claims Pharmacy Help Desk: Optum Rx | 844-368-8732

This card does not guarantee coverage.

ID-B4 (07/25)

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Members

Member Service, Care Coordinator, & Behavioral Health:

888-816-6000 (TTY 711)

24/7 Nurse Advice Line: 833-551-3255

Massachusetts Behavioral Health Helpline: 833-773-2445
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This card does not guarantee coverage.

ID-B5 (07/25)





Overview of D-SNP Benefit Structure

Understanding the unique needs of One Care and SCO Members at an individual level is crucial for providing person-centered care.

Both populations have complex care needs driven by chronic illnesses, behavioral health challenges, functional impairments, HRSN and social isolation needs, requiring a coordinated person-centered care model, and individualized care plan.

One Care

Focuses on recovery, behavioral health, and independent living for younger members with disabilities.

Serves younger adults (21-64) with disabilities and behavioral health needs; dual-eligible for Medicare and MassHealth Standard or CommonHealth; may transition to SCO at 65

Emphasizes behavioral health, developmental disabilities, and social determinants of health (e.g., housing, employment)

Members can choose to be assigned a LTSC (long-term service coordinator). This is a nonclinical coordinator

Integrated care with consumer-directed models, community and peer support, along with behavioral health specialists on the Interdisciplinary Care Team (ICT)

At minimum annual assessments; documents LTSS care decisions and social needs

Tackles social instability (e.g., housing, employment); leverages telehealth and mobile services

Senior Care Options (SCO)

Emphasizes aging in place, chronic condition management, and LTSS coordination for elderly adults.



Serves elderly adults (65+), focusing on age-related needs; dual-eligible for Medicare and MassHealth Standard



Focuses on chronic aging-related conditions (e.g., multiple comorbidities, mobility issues) and long-term services and supports (LTSS) to support independence



Members are assigned a GSSC (geriatric support service coordinator). This is a clinician, and the member is required to have one assigned to them



Chronic condition management with care coordinators/GSSCs, emphasizing formal and informal support to receive home-based care



At minimum bi-annual assessments; documents GSSC assignments and FEW benefit administration, with a focus on preventing institutionalization



Addresses financial challenges (e.g., medications, co-pays) with programs and meal delivery services



Comparing SCO and One Care

Category	SCO (Senior Care Options)	One Care	
Eligibility	Age 65+, Medicare + MassHealth Standard	*Age 21-64, Medicare + MassHealth Standard/CommonHealth	
Medicaid Coverage	Fully integrated: MassHealth + Medicare, Frail Elder Services (FEW)	Fully integrated: MassHealth + Medicare	
Behavioral Health	Integrated within care team and provider network	Integrated within care team and provider network	
LTSS/HCBS services	Covered: PCA, homemaker, adult day health, respite, adult foster care	Covered: PCA, adult foster care, adult day health	
Supplemental benefits and/or expanded benefits through MassHealth	Dental (DentaQuest), Vision (EyeMed), OTC (Convey), Fitness, Transportation (CTS), Home-delivered meals	Dental (DentaQuest), Vision (EyeMed), Transportation (CTS)	
Care coordination	Interdisciplinary Care Team (ICT), includes RN, GSSC, BH (Optum), Community Health Worker (CHW)	Interdisciplinary Care Team (ICT), includes RN, LTSC, BH (Optum), Community Health Worker (CWH)	
Service area (MGB)	Dukes, Nantucket, Bristol, Norfolk, Plymouth, Middlesex, Essex, Suffolk	Dukes, Nantucket, Bristol, Norfolk, Plymouth, Middlesex, Essex, Suffolk	



Medical Product Overview - Medical Cost Sharing

- Members will experience no cost sharing for emergency or urgent care in and/or out of network
- Our plans cover emergency and urgent medical care anywhere in the United States or its territories.
- These benefits do not cover world-wide emergency/urgent care.

	Mass General Brigham SCO (HMO-DSNP)		Mass General Brigham One Care (HMO-DSNP)	
	In-network	Out-of-network	In-network	Out-of-network
Emergency	\$0		\$0	
Urgent Care	\$0		\$0	
Emergency Ambulance	\$0		\$0	
	\$	0	\$	0
Specialty Care				
Primary Care	\$0		\$0	



Understanding Integrated D-SNP Benefits



Combines Medicare (Part A/B/D), Medicaid (MassHealth), Supplemental Benefits (SCO only), and Long-Term Services and Supports



Designed to support medical, behavioral, and social needs



Coordination led by the Interdisciplinary Care Team (ICT) and documented in the Individualized Care Plan (ICP)



We appreciate the diverse needs of the One Care and SCO populations and have designed our programs to meet these needs



- MGBHP has designed its care models, including our care management platform, to reflect our in-depth understanding of the unique needs of the dual-eligible One Care and Senior Care Options (SCO) populations
- Members in each program have complex care needs driven by chronic illnesses, behavioral health challenges, functional impairments, and social needs, requiring a coordinated, person-centered care model





Accessing Benefits: The Care Planning Process



The Initial Comprehensive
Assessment triggers the care
planning process driven by
member identified needs and
goals



Individualized Care Plan (ICP) is developed by the ICT with the member



Documentation within the ICP supports services and authorizations



The Care Coordinator acts as the member's main point of contact and works with the member to update the ICP based on progress/goals



Long-Term Services and Support (LTSS) and Home and Community-Based Services (HCBS) Benefits

LTSS (Long-Term Services and Support): Medical and personal care services that assist individuals with aging, chronic illnesses and or disabilities

Services include: Home care, adult day care, transportation, meal delivery

HCBS (Home Community Based Services): Medicaid optional services that support individuals with disabilities, chronic health conditions and age related needs to live in their homes rather than institutions
 Services include: Personal care, home care, adult day care, transportation (non-medical), meal delivery, respite care



Services include personal care attendants (PCAs), homemaking, adult day health



HCBS waivers support members living at home instead of institutions



Also includes transportation, meals, and respite care



Supplemental & Additional Benefits in SCO and One Care



Dental: cleanings, exams, dentures, fillings, extractions



Vision: annual eye exams, eyeglasses/contact lenses through Eyemed, our vision provider

\$200 allowance for eyeglasses

(lenses and/ or frames) and/or

contact lenses per calendar year.



Hearing: screenings, hearing aids and fittings (covered under MassHealth Standard benefit)



Transportation: nonemergent medical and limited non-medical transportation (2 roundtrips per member per month)



Over-the-Counter (OTC): quarterly allowances for health products (SCO ONLY)



Additional Services:
Personal Care Attendant,
LTSS, Home Modifications
(based on assessed need
and subject to PA)

Note: Some benefits may require prior authorization and are subject to limits.



Prescription Drug Coverage

Medicare Part D coverage for prescription drugs MassHealth
pharmacy
coverage (OTC,
non-Part D meds)

Formularies, prior authorization, step therapy

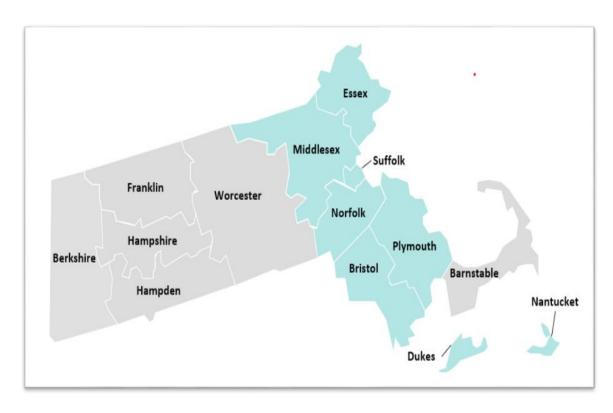
\$0 copay on covered drugs for for dual-eligible members





Network Information

We've got members covered in Massachusetts - Counties



Our plans are offered in select Massachusetts counties:

- Bristol
- Dukes
- Essex
- Middlesex
- Nantucket
- Norfolk
- Plymouth
- Suffolk

To be eligible for SCO, members must:

- Be enrolled in Parts A & B and eligible for Part D
- Be 65 yeas of age or older
- Reside our service area
- Be enrolled in MassHealth Standard
- Not be enrolled in a HCBS Waiver other than Frail Elder Waiver

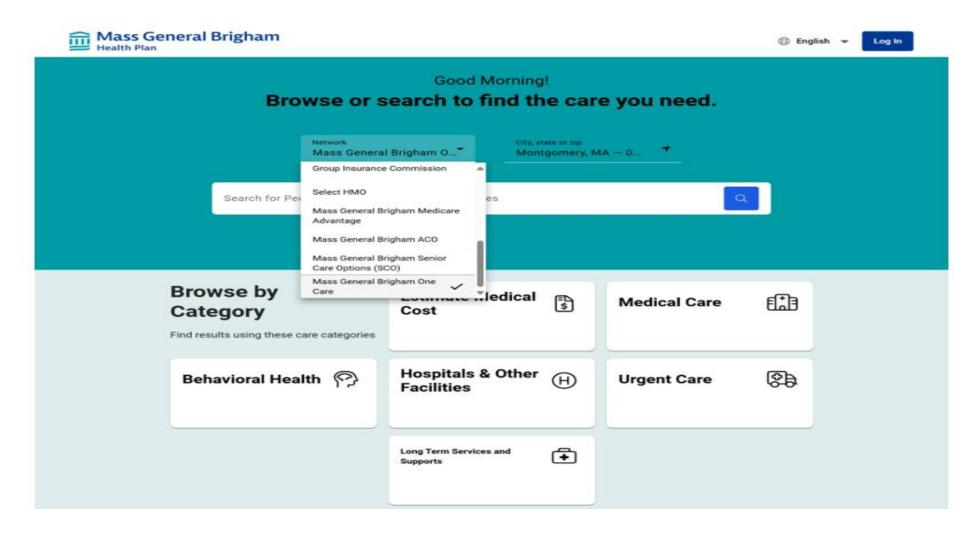
To be eligible for One Care, members must:

- Be enrolled in Parts A & B and eligible for Part D
- Be ages 21-64 (may remain on One Care after turning 65)
- Reside our service area
- Be enrolled in MassHealth Standard or CommonHealth



Provider Directory

SCO and One Care Provider Directory





SCO and One Care Network

This information is still evolving as the network team continues to add additional providers for both SCO and One Care

Please see a snapshot below of facilities included in the SCO and One Care Provider Network:

Skilled Nursing Facilities (SNF) Rest Homes

- Careone
- Cedarbridge/ AKA Marquis
- Lifecare Centers



Hospitals

- MGB Facilities
- Emerson Hospital
- Lawrence General Hospital
- Holy Family
- Boston Medical Center
- Brown University Health
- State Hospitals
 - Shattuck
 - Tewksbury
 - Western MA
- South Shore Health



Aging Service Access Points (ASAPs)

- Ethos
- Greater Lynn Senior Services
- South Shore Elder Services
- Tri-Valley Elder Services
- Senior Care



*Please reference the SCO and One Care Provider Directory for the most up-to-date listing of providers within this network.

SCO/One Care Provider Directory





Model of Care Framework and Person-Centered Care Planning

What is the Model of Care (MOC)?



A CMS and NCQA requiredframework for delivering coordinated, personcentered care



Designed specifically for individuals with complex medical, behavioral and social needs



Guides how MGBHP supports SCO and One Care members



Delivered through the ICT and supported by medical, behavioral health and community-based providers



Person-Centered Care: Putting the Member at the Heart of Every Decision

Focuses on the member's goals, values, and preferences

Encourages shared decision-making between the member, care team, and caregivers

Supports whole-person health: medical, behavioral, and social needs

Promotes independence and quality of life

Drives how MGBHP's SCO and One Care plans deliver integrated care





Americans with Disability Act (ADA)

Mass General Brigham Health Plan's Provider Network is required to ensure that the programs and services are as accessible to an individual with disabilities as they are to an individual without disabilities.

The Provider Network shall:

- Offer timely access to services
- Provide access to Covered Services
- Be responsive to members linguistic, cultural, ethnic or other individual needs

Provider's must comply with all State and federal laws and regulations governing accessibility accommodations, including the ADA.

Providers are required to report/notify the Health Plan of their capabilities including disability access, interpreter services, cultural competency training and any relevant subspecialties

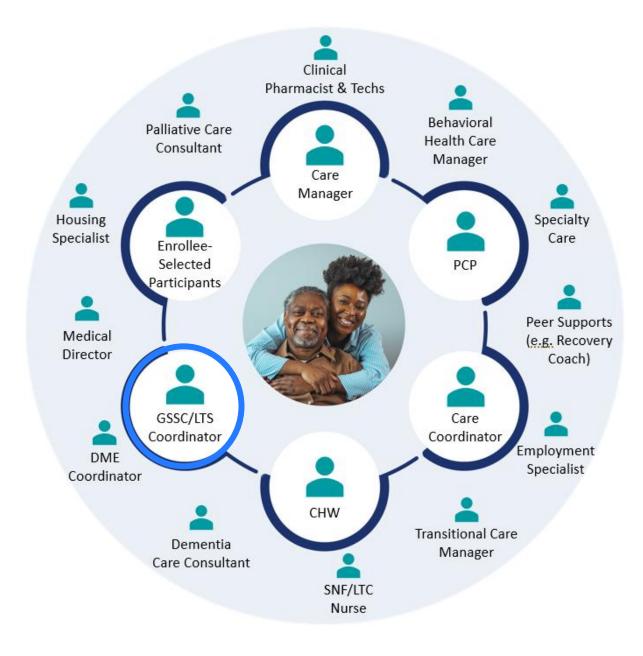




Interdisciplinary Care Team (ICT)

The Care Team

- Integrated Care Team (ICT) composition will reflect the unique needs and priorities of enrollees
- ICT team members will have the skills required to serve individual One Care and SCO enrollees
- Our system's functionality supports the team by allowing work from a single record, ensuring transparency and real-time communication. Access includes the ability to document in all the following areas: care plans, assessments, social determinants of health (SDOH), tasks, and care coordination activities.





Senior Care Options - Interdisciplinary Care Team (ICT)

Core Team Members:

- Primary Care Provider (PCP) Medical lead for care plan
- Geriatric Support Services Coordinator (GSSC) Coordinates LTSS through ASAP agencies.
- Nurse Care Manager Oversees medical management and transitions of care
- Behavioral Health Clinician Addresses mental health and substance use needs
- Member and Caregiver Central to all care planning decisions

Supporting Roles (as needed):

- Pharmacist
- Physical/Occupational Therapist
- Social Worker
- Community Health Worker

Key Purpose:

• Work collaboratively to develop and implement a person-centered Individualized Care Plan (ICP) for SCO members.



One Care - Interdisciplinary Care Team (ICT)

Core team members:

- Primary Care Provider (PCP) Oversees medical treatment and preventive care
- Care Coordinator Central point of contact for the members; coordinates across Medicare & MassHealth benefits
- Long-Term Services & Supports (LTSS) Coordinator- Identifies and manages HCBS supports for members
- Behavioral Health Clinician Integrates mental health and substance use services into care plan.
- Member and Caregiver Set personal goals and guide care planning.

Supporting roles (as needed):

- Specialists (e.g., cardiology, endocrinology)
- Peer Support Specialists
- Pharmacist
- Community-based organization representatives
- Community Health Worker

Key purpose:

• Deliver integrated medical, behavioral health, and LTSS through a unified, person-centered Individualized Care Plan (ICP) that reflects both Medicare and MassHealth requirements.



LTSC & GSSC Roles and Responsibilities

Participate in the ICT

- Participate as a member of the ICT.
- Advocate for the member as part of the ICT.
- Follow up on the concerns and action items raised by the ICT for the member.
- Maintain regular communication with the ICT and alert the ICT of any changes staffing or change in member needs.

Facilitate Key Services

- LTSS Activities (e.g., Home care services, PCA, Adult Foster/Day care)
- Social Determinants of Health (SDOH) Services (e.g., Transportation, Nutrition/Food Services, Financial/Housing Supports)
- Clinical Assessments (e.g., for home care services, SDOH needs assessments)

Monitor Performance

- Report on and monitor key performance indicators across member panel.
- Report on key performance indicators established by the ICT, focusing on measurable outcomes that impact the member's overall well-being in alignment with the care plan.

Ensure a Person- Centered Approach

- Monitor services to ensure the member is getting what is needed.
- Work with the member to decide how and how often you'll communicate.





Provider Appeals

Provider Appeals Process

The One Care and SCO provider appeals process refers to the procedure healthcare providers follow to dispute a denial or payment decision, made on the Member's behalf, by Mass General Brigham Health Plan.

Appeals process

- Appeals are accepted either orally or in writing within
 65 calendar days after receipt of the notice of Adverse Action.
 - Appeals filed later than 65 calendar days from the notice of Adverse Action may be rejected.
- Mass General Brigham Health Plan will send a written acknowledgment of the receipt of the Appeal within one business day.
- Mass General Brigham Health Plan follows all State and Federal Guidelines regarding all appropriate review of Appeals, including timeliness of decision making and decisioning staff and providers.
- Standard Appeals for pre-service and post-service requests will be resolved within 30 calendar days of receipt.





^{*} For further details on the appeals process, please refer to the provider manual

Appeals and Grievance Contact Information

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Contact Information for Appeal and Grievance Submission

By phone:

Provider Service professional at 855-444-4647

Monday-Friday from 8 a.m. to 8 p.m. From October 1-March 31, seven days a week, 8 a.m. to 8 p.m. (TTY: 711)

By email:

MedicareAG@mgb.org

By Mail:

 Mass General Brigham Health Plan Attn: Member Appeals, 399 Revolution Drive. Suite 875 Somerville, MA 02145





Provider Portal

Provider Portal

- The MGBHP provider portal is your one-stop-shop for managing your MGBHP patients.
- Through the portal, you have real-time access to:
 - Verify patient eligibility
 - Verify claims status
 - Submit or check authorizations/referrals
 - Access your explanation of payments (EOPs)
 - Submit a New Claim with or without an invoice
 - Submit a request for claims review
 - View member and provider roster reports
 - Update your practice information
 - And much more!
- If you do not have access to Our Provider Portal, you can register at:

https://provider.massgeneralbrighamhealthplan.org/



Welcome to your Provider Portal

Log in for quick access to tools and resources that support your patients' needs.

Your patients' health is everything to us.



Log in to the Provider Portal

Username Forgot Your Username?

Password Forgot Your Password?

Need an Account?

If you currently have a login for NHPNet, those credentials will work here. There is no need to re-register.

If you meet the appropriate criteria and have read the instructions you may sign up for an account.

Account Registration

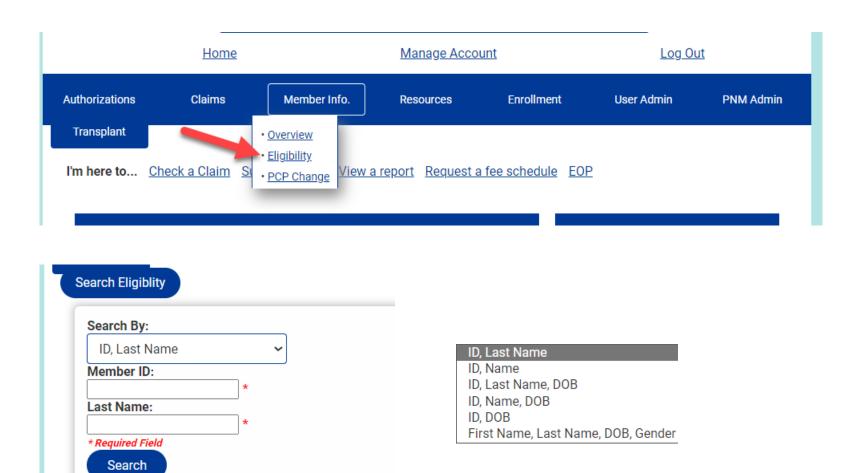




Member Benefits and Eligibility

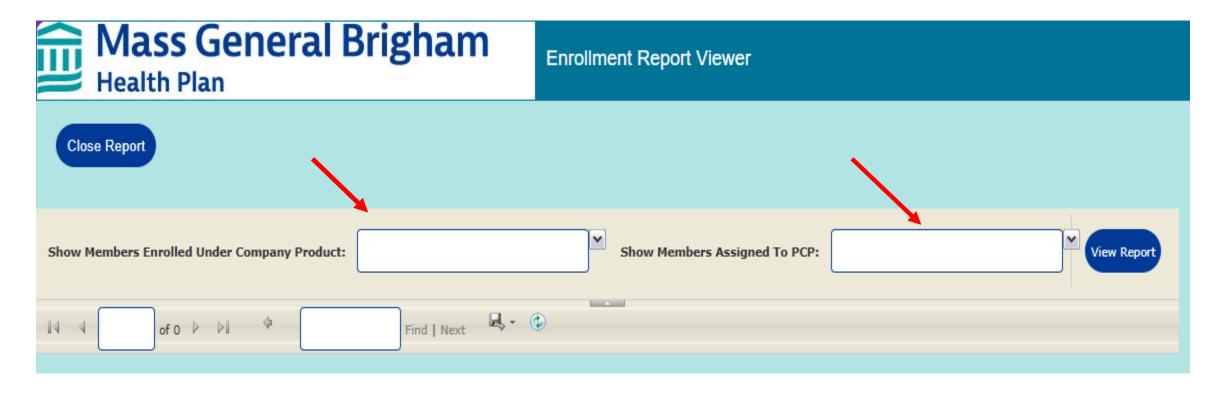
Member Benefits and Eligibility

- Once logged in, from the Home page, choose the Member Info option and select Eligibility
- From there you can use several search options to locate the correct member
- This page will give an overview of member cost sharing and eligibility
- NOTE: the information must match exactly (this includes casing &symbols





Viewing the Member Roster



- Once you are in report select your line of business your interested in viewing.
- You can view members assigned to an individual PCP or view them for ALL PCPs at the site. Depending on provider set up or your access, you may have to generate a roster for each site separately.

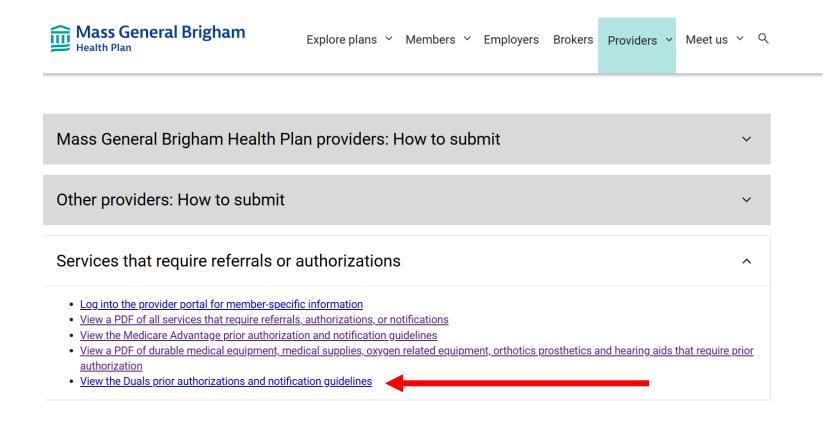




Verifying Prior Authorization Requirements

Prior Authorizations and referral guidelines

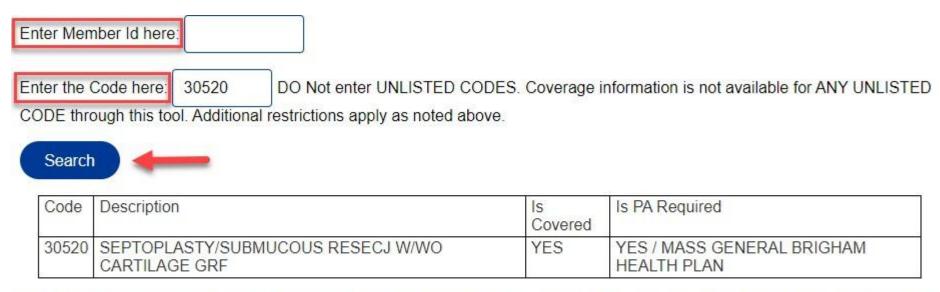
- Authorization guidelines available at: https://massgeneralbrighamhealth
 plan.org/providers/authorization-guidelines
 guidelines
- Or here:
 <u>https://massgeneralbrighamhealth</u>
 plan.org/providers/education
- We will continue to manage our UM for our contracted providers
- Mass General Brigham Health Plan continues to provide care management for our members





Outpatient Code Checker

- This tool allows providers to verify coverage and authorization requirements for most services that require prior authorization.
- You can search by Member ID# and code
- Coverage and prior authorization requirements will display



Confirmation of coverage and prior authorization does not guarantee payment, which is based on member eligibility on the date of service, plan design, specific payment policies, individual provider contract terms and fee schedules. Mass General Brigham Health Plan applies standard industry billing and coding rules to claims.

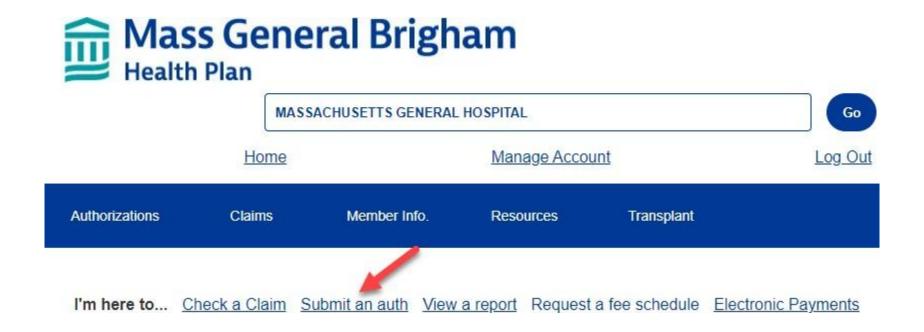




Initiating a Prior Authorization Request

Initiating a Prior Authorization Request

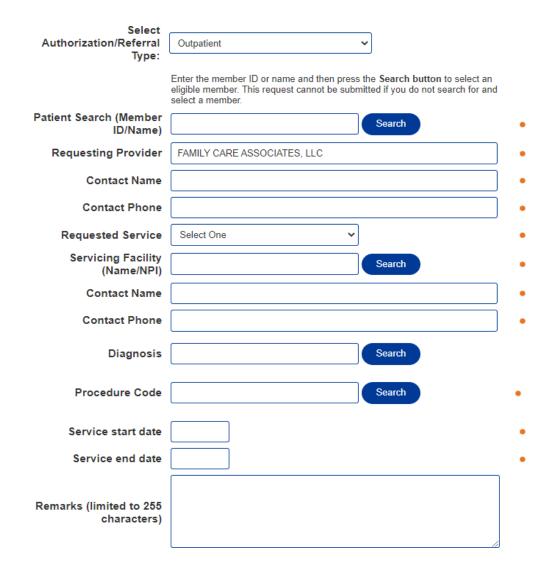
• If a service requires Prior Authorization, providers can click on **Submit an auth** on the Provider Portal homepage to initiate a Prior Authorization request. Prior Authorization requests can also be submitted via fax at 617-586-1645.





Initiating a Prior Authorization Request

- Select the **Authorization/Referral Type** you would like to complete (i.e. Outpatient)
- Enter all required fields. Required fields are denoted with this small sphere (•) next to the field name.
- When you hit **Submit**, the system will verify whether an authorization is required.
 - If no PA is required, then you will be notified.
 Please do not proceed with submission.
 - If PA is required, then InterQual Connect will display for you to conduct a criteria review for certain outpatient Services requiring an authorization. There is an option to Opt-Out of InterQual Connect. For those scenarios, the authorization will pend to the health plan.





Authorization Response

InterQual Connect can be utilized for select outpatient non-LTSS services. LTSS services will not go through InterQual Connect. Those requests will be reviewed directly by the MGBHP UM team.

Response Screen

- Once you complete an Authorization request through InterQual Connect, you will receive a real-time response.
- For all other authorization requests, you can submit/upload your Supporting Clinical Documents by using the **Submit document button**. Authorization requests can also be faxed directly to the MGBHP UM team.
- You can also view documents that have already been attached
- These requests will pend to the MGBHP UM team for review.
- You will be provided a Status of your request once all required information has been submitted and the authorization has been finalized.

Authorizations & Referrals Viewer

This cannot be revised because the status is not MEDREVIEW or APPROVED

Authorizations/Referral Information

Authorization/Referral ID:	22348R00000	Member:	
Member ID:		Member Date Of Birth:	01/01/1954
Product:	MEDICARE ADVANTAGE	Member PCP:	
Referred By:	FAMILY CARE ASSOCIATES, LLC (1417969817)	Referred To:	BRIGHAM AND WOMEN'S HOSPITAL (1790717650)
Inpatient/Outpatient:	Inpatient	Pay To:	BRIGHAM AND WOMEN'S HOSPITAL (1790717650)
Diagnosis Code:	N50.82	Diagnosis Description:	Scrotal pain
Authorization/Referral Status:	PENDING A -General Medicine	Authorization/Referral Date:	12/14/2022
Service Start Date:	12/14/2022	Service End Date:	12/19/2022

Authorization/Referral Service Lines

Line	Status	Code	Code Type	Modifier	Description	Total Units	Used Units
1	PENDING				Inpatient Stay	5	0

Authorization/Referral Supporting Documentation

Description	Document	Size	Uploaded	
Clinicals	UserGuideInpatient_2.7.2022.pdf	896KB	12/14/2022 11:40:AM	Download

Submit Document

Fax Document

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High Level Overview of D-SNP Prior Authorization Process

Prior authorization decisions are based on medical necessity, MassHealth criteria, and the member's care plan.

Submitting a PA request

Provider may submit request for prior authorization through:

- Provider Portal: <u>Mass General Brigham Health</u>
 Plan Provider Portal
- Fax: 617-586-1645

Outreach for information

Providers may be contacted by the UM team for clarifications or missing details in the request. To avoid processing delays, please ensure timely response to inquiries.

Decision & notification

Once a decision is finalized, a letter is sent to the requesting provider and the member. Decisions are also viewable in the Provider Portal.

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Standard decisions are made within 7 calendar days of receipt; expedited decisions within 72 hours

Intake review

Our Utilization Management (UM) team will review requests for completeness and duplication.

Clinical review

After all supporting documentation is received, our UM Care Managers and Medical Directors review the request to determine appropriateness.



Tips for Utilizing InterQual Connect - Medical Network Only

- Have the clinical information (medical chart) available
 - Review the patient's medical chart to assemble documented clinical indications for the requested service (e.g., review history/physical, testing conducted prior to service, treatment plan). If the authorization pends, you will need to upload the clinical information. Any delays in uploading clinical information will result in delayed authorization determinations.
- Answer questions based on the patient's clinical information (medical chart)

 If the appropriate answer isn't available, select "Other clinical information" and add a comment
- Add reviewer comments at the question level to document clinical details
- **Review notes within the criteria**; they serve as a valuable resource in accurately conducting a review by:
 - Explaining criteria rationale
 - Defining medical terminology
 - Detailing new clinical knowledge/evidence

^{*}InterQual is not used for LTSS services





Claims Overview, Submission, and Request for Claim Review

D-SNP Claim Process Overview

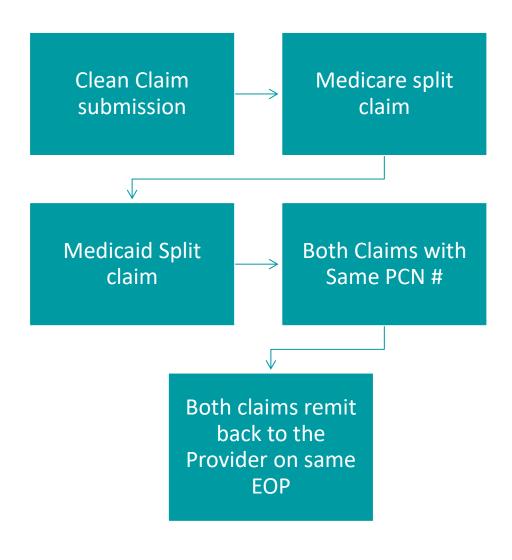
- Mass General Brigham
 Health Plan requires the
 submission of all
 electronic claims within
 90 days of the date of
 service, unless otherwise
 indicated in the Provider
 Agreement.
- When a provider submits a clean claim which includes a completed and accurate UB-04 or CMS 1500 claim form, MGBHP will process the claim within at least 30 days of receipt.
- Requests for adjustments must be submitted no later than
 90 days after the claim's original paid date following the issuance of an (EOP)/Remittance Advice (RA).
- To be considered for a timely filing limit adjustment, requests for review of a claim received over the filing limit must be submitted within 90 days of the Explanation of Payment (EOP) date on which the claim was originally denied. Disputes received beyond 90 days from the original denial date will not be considered.
- Claims that involve coordination of benefits (COB), where MGBHP is the secondary payer, have a timely filing limitation of 90 days from the date of the primary carrier's EOB, but no more than two (2) years after the date of service.
- If a claim is denied for lack of medical records, the requested supporting documentation must be submitted within
 180 days. Providers must submit missing information, such an itemized bill or medical records, with the MGBHP's request letter included, for the claim to be processed.

^{*}Corrected claims must be submitted with reference to the most recent sequential version of the Claim.



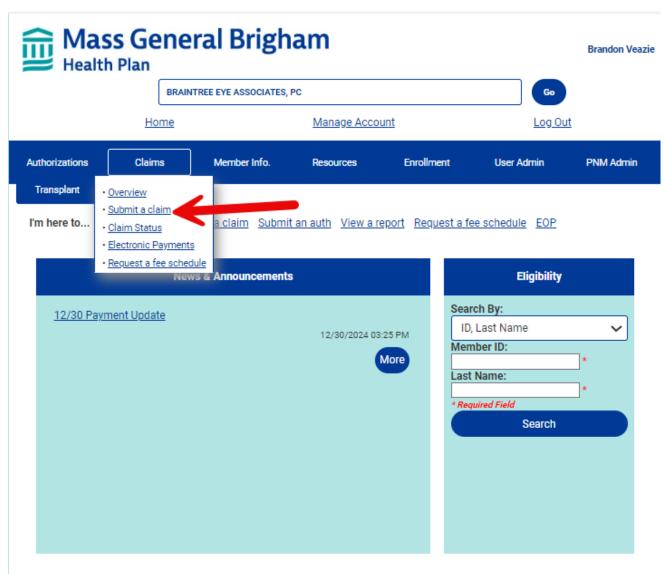
DSNP Claim Submissions

- Upon receipt of a clean claim for DSNP services, MGBHP will split the claim into two separate (2) claims during the adjudication process:
 - One (1) claim for Medicare coverage.
 - One (1) claim for Medicaid coverage
- Medicare will always be the primary payer, with Medicaid as secondary
- Both claims will have the same Patient Control Number (PCN#) and will appear on the same Explanation of Payment (EOP)
- Both claims will be remitted to the provider on the same EOP, however, they may not appear consecutively on the EOP
- Each claim will be paid according to its respective Primary (Medicare) and Secondary (Medicaid) coverage rules
- If claims deny for "Resubmit to appropriate vendor,"
 Providers will need to resubmit the encounter to the appropriate vendor





How to Submit a New Claim



• On the Provider Portal homepage, select **Claims** and then **Submit a Claim**.



Claims Submission Template

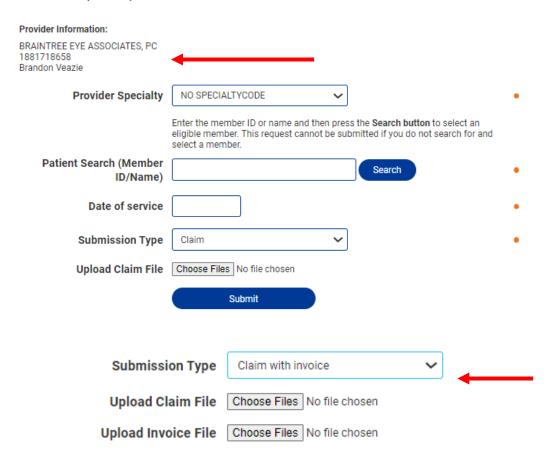
New claim submission

- Verify that the Provider information is accurate for the claim you're submitting.
- Choose a Specialty Code
 - If the specialty for your claim is not available, you may choose No Specialty Code
- Click Search next to the Patient Field. You will get a Pop-Up window that allows you to choose search parameters. Fill them out and click Search again.
 - *<u>it is best to use all capital letters*</u>
- Verify the patient information is correct
- Enter the Date of Service or choose using the calendar
- **Upload** a completed CMS 1500 or UB-04 claim form using the Choose Files button. This will allow you to search for a file on your computer.
 - PDF is the preferred format
 - If your claim requires an invoice choose "Claim with Invoice" from the Submission Type drop down. You may attach the invoice using the second Choose File button
- Click **Submit** and a confirmation screen will appear.

Claim Submission

Important reminders for claim submission

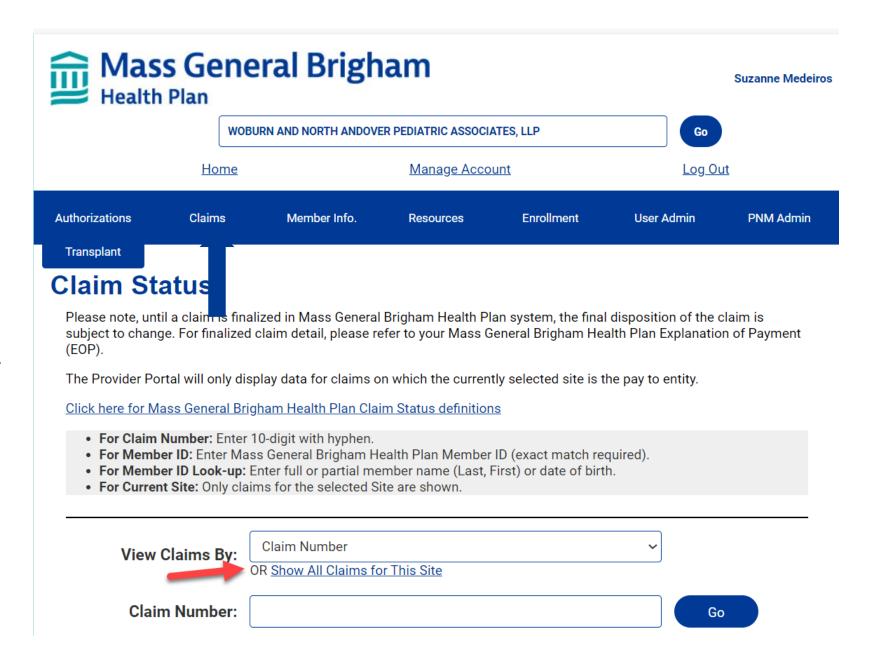
- This page is for submission of Medical claim forms UB 04 and 1500 claims forms only. Medical reimbursements, Pharmacy Forms or Dental Forms will be discarded.
- The only attachments accepted will be for invoices for services and supplies that require an invoice such as DME equipment, supplies such as gauzes tapes, home medical products, buy and bill medications.
- Check all claims for accuracy before submitting All required fields are necessary for reimbursement. In the submitted claim is incomplete you will be notified by mail which will substantially delay your reimbursement.
- . Claims submitted after 5pm EST will be considered received on the following business day.
- Each claim requires a separate submission.





Claims Status

- Providers can check a claim status by choose Claims and then Claims Status from the toolbar.
- Check individual claim status
- Complete list of claims for your site
- Member-specific claims status





Claim Status

- Providers can view a complete claim status on the Claim screen.
- They can verify payment information including payment amount by line, check number & date
- There is also a link to the corresponding EOP

Claim

Claim Information

Claim Number:	23. E	Member ID:	R22		
Member Name:	12	Member Date Of Birth:	/ /1		
Status:	PAID	Submission Date:	10/28/2024		
Servicing Provider:	1%	Servicing Provider NPI:	9		
Total Charges:	\$385.00	Paid Amount:			
Check Date:		Check Number:			
EOP Link:	Download Corresponding Explanation of Payment				
Date Of Service Start:	07/24/2023	Date Of SErvice End::	07/24/2023		
Patient Control Number:		-			
Primary Diagnosis:	I10 - ESSENTIAL PRIMARY HYPERTENSION				
Secondary Diagnosis(es):		101			
Claim Messages:	Erro o riajaourron or aian		ungo		

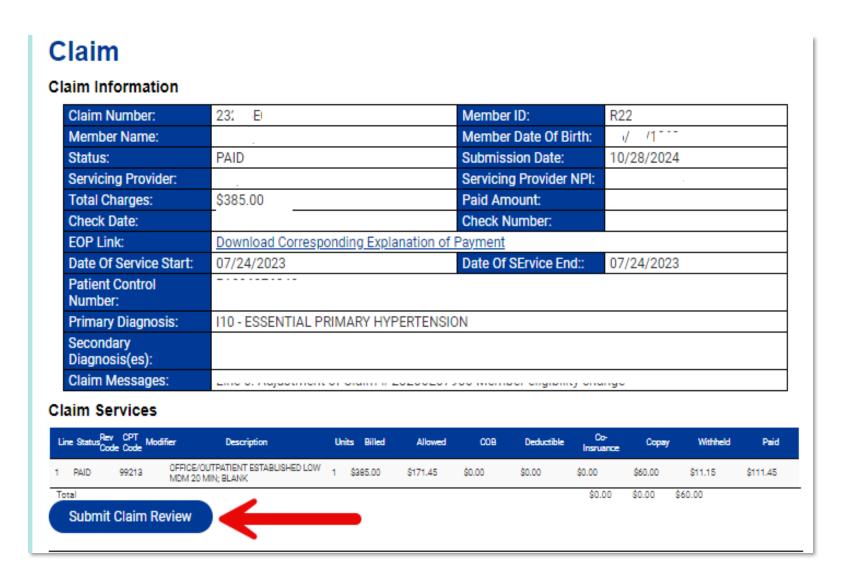
Claim Services

Li	ne Status <mark>Re</mark> Co	v CPT Mod de Code ^{Mod}	ifier Description	Unit	s Billed	Allowed	COB	Deductible	Co- Insruance	Copey	Withheld	Paid
1	PAJD	99213	OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 MIN; BLANK	1	\$385.00	\$171,45	\$0.00	\$0.00	\$0.00	\$60.00	\$11.15	\$111.45



Claim Status Review

- Allows you to pull a Claim Status
- Verify that you have selected:
 - The correct claim
 - Correct member
 - Correct Servicing Provider
- Select the Submit Claim Review option.
 - Reminder: claim reviews must be submitted within timely filing





Claims Information Page

https://massgeneralbrighamhealthplan.org/providers/claims

Highlights:

- Clear guidance for where to send claims
- ID card images to help you identify plans
- Provider Refund/Claims Retraction FAQ
- Request for Claim Review Form



Claims information

Payer ID numbers and addresses for submitting medical and behavioral health claims.



Provider Correspondence Portal

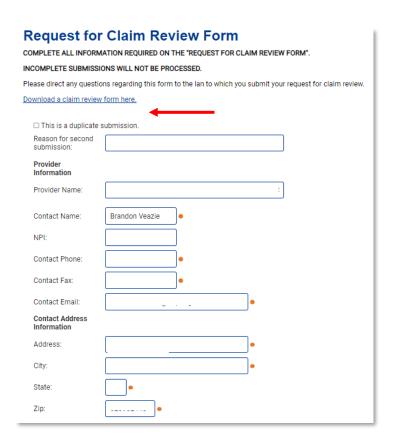
- Enter all required information in the Request for Claim Review
 Form.
- Select appropriate **Review Type** from the dropdown menu. This ensures the upload is triaged to the appropriate area.
- Use the **Choose File** button to upload your attachment.
- Click Submit once you've completed

Important notes:

- A claim review form must be completed and attached to this request. Please add any other supporting documentation for review to the claim review form and upload as one document.
- If previous correspondence has been submitted to Mass General Brigham Health Plan, we ask that you not resubmit via the Correspondence Portal.
- Please indicate if this is a duplicate submission and the reason why.
- Validate your submission was received via Claims Submitted Reviews on the Provider Portal

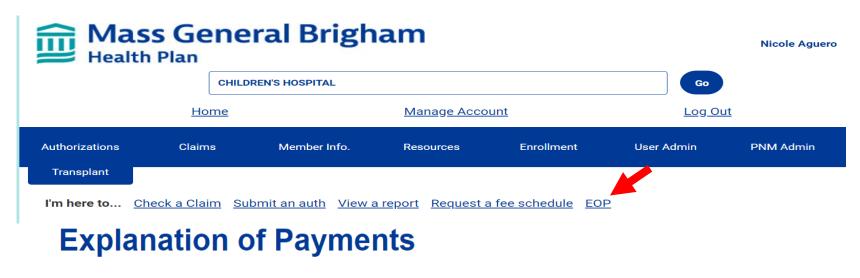
Claim Submitted	Reviews		
Claim Number	Member Id	Member Name	1





Member/Claim Inforr	nation			
Member ID:	R225			
Member Name:				
Date of Service:	7/24/2023			
Claim Number:	23 E			
Denial Code:	•			
Review Type				
Review Type: Contr	act term(s): The provider believes the previously proce 🔻 •			
Comments:				
Upload Document Choose Files No file chosen				
Submit				

Explanation of Payment (EOP)



Search By:	k Date 🗸	•
Check Date:		

Manage E-Payments

- To manage your payments click here
- Visit our e-payment information page for details about your options
- To register for Electronic Remittance Advice (835) or Electronic funds Transfer (EFT) click here
- To review payments issued before 02/09/1980, click here



Paper Claims, Claims/Appeals Submissions

Paper claims, claims/appeals submissions	
Payer ID	04293
New paper claims address	Mass General Brigham Health Plan PO Box #323 Glen Burnie, MD 21060
Claim review submissions	Mass General Brigham Health Plan Attn: Correspondence Department 399 Revolution Drive, Suite 810 Somerville, MA 02145
Claims appeal requests	Mass General Brigham Health Plan Attn: Appeals Department 399 Revolution Drive, Suite 810 Somerville, MA 02145



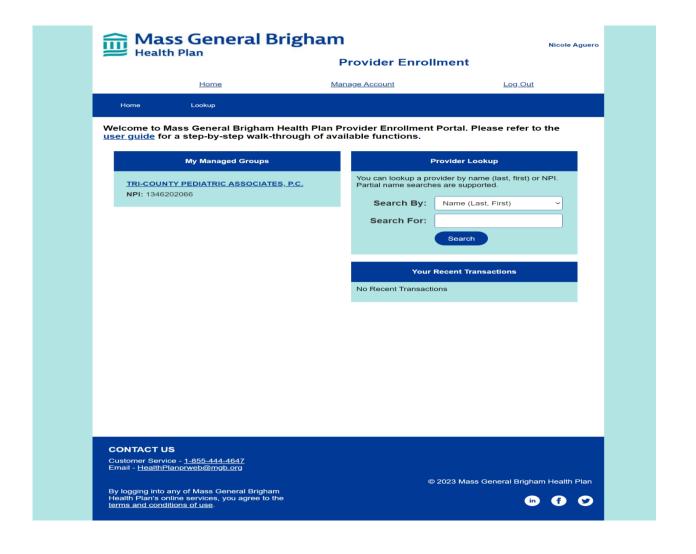


Provider Enrollment/Data Changes

Provider Enrollment Portal changes

The **Provider Enrollment tool** lets you manage updates, changes, and additions to your practice.

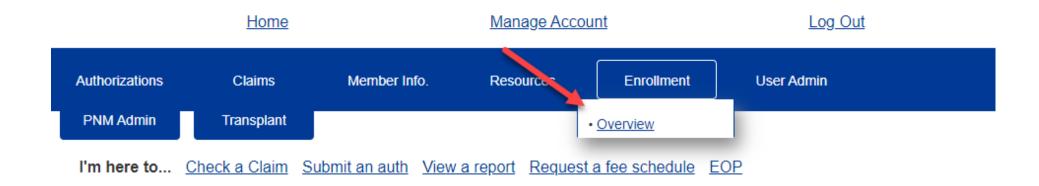
- This page will indicate the sites/locations you have access to make enrollment changes for.
 - Available sites will show in My
 Managed Groups
- This page will show you a timeline of your in-progress submissions.
- The tool allows you to submit requests for provider enrollment, disenrollment, address/phone number changes, and other additional provider data changes.





Accessing Provider Enrollment Portal

On the main page select Enrollment then Overview



<u>Important</u>: If this option is not available you may not have permission to do so. Please speak with your site's User Administrator to have your access updated to include this function.

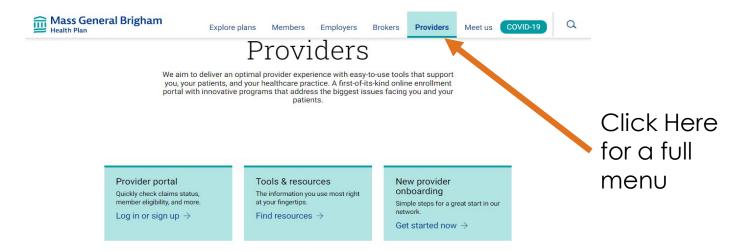


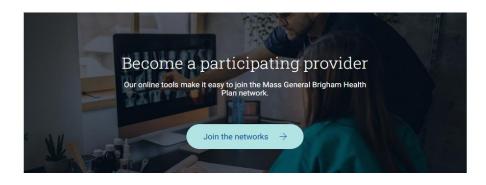


Provider Resources

Mass General Brigham Health Plan Provider page

- https://massgeneralbrighamhealthplan.org/providers
- Our public site has important information and resources for providers, such as:
 - Authorization guidelines
 - Clinical practice guidelines
 - Claims information
 - Medical policies
 - Medical specialty and pharmacy policies
 - Payment policies
 - Care Management Information
 - Provider resources
 - Product reference
 - Provider administrative newsletter

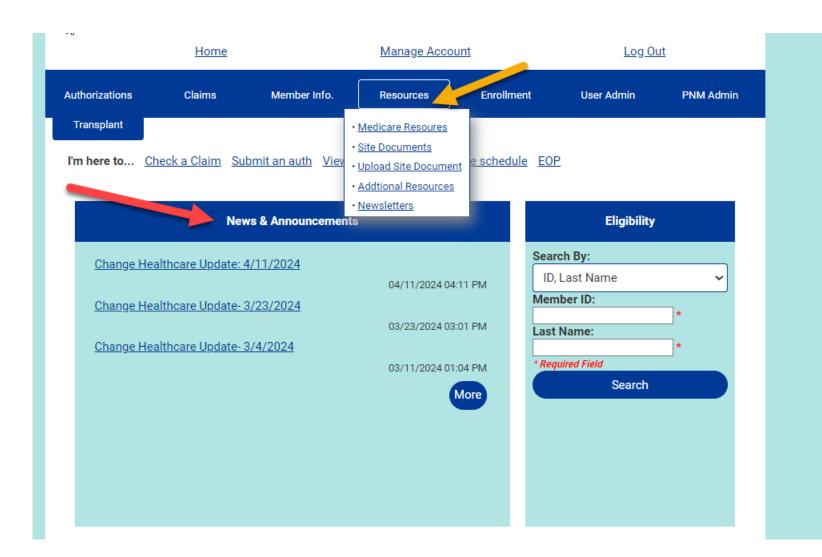






News and Additional Resources

- The News and Announcements section will provide you with recent Provider Communications and updates.
- Under Resources you will find additional tools and informational material.
- The Additional Resources option has several <u>Portal Training Webinars</u> available for review.





Stay Connected

Visit https://massgeneralbrighamhealthplan.org/admin-newsletter to register

Administrative newsletter

(monthly)

Includes important
administrative updates that
make it easier for your practice
to do business with us

Best practice provider blog

(twice per week)

Get the latest in health and health insurance trends, news, and tips



Follow us on X @MGBHealthPlan



Web Resources

Portal:

https://massgeneralbrighamhealthplan.org/

- Member management tools
- Provider enrollment

Public Webpage:

https://massgeneralbrighamhealthplan.org/

General information and resources for providers, members, and employers

Dedicated Provider Resources:

Provider resources | Mass General Brigham Health Plan

SCO & One Care Provider Landing Page:

<u>Dual Eligible Special Needs Plans (D-SNPs) | Mass General Brigham Health Plan</u>



Helpful Provider Resources

SCO and One Care Provider FAQ-Dual Eligible Special Needs Plans (D-SNPs) | Mass General Brigham Health Plan

Provider Manual - SCO One Care Provider Manual

SCO and One Care Provider Directory - SCO and One Care Provider Directory

SCO One and Care Member Landing Page-<u>D-SNP plans</u> | Mass General Brigham Health <u>Plan</u>

Prior Auth Info-Authorization guidelines | Mass General Brigham Health Plan



Mass General Health Plan Provider Resources

Provider Portal: Claims status, eligibility, EOP	Mana Camanal Duighana Haalth Dlan Duaridan Dantal
Claims status, eligibility, Loi	Mass General Brigham Health Plan Provider Portal
Provider Newsletter	Admin Newsletter Archive Mass General Brigham Health Plan
Provider Service Center	Provider Service 855-444-4647 <u>HealthPlanproviderservice@mgb.org</u>
Portal IT support	HealthPlanprweb@mgb.org
Claims Landing Page	Claims information Mass General Brigham Health Plan
Medical policies, payment policies, provider manual, provider directory, drug lookup, forms	Providers Mass General Brigham Health Plan
Provider Resource Center	Provider resources Mass General Brigham Health Plan
Audit denial inquiries	healthplanaudit@mgb.org





