Comprehensive Behavioral Health Provider Training

WellSense
HEALTH PLAN

Introduction

Welcome to the comprehensive behavioral health provider training. Thank you for joining us for this essential training designed to support your success as a valued behavioral health provider within our network.

We are committed to delivering high-quality, person-centered behavioral health services that reflect our mission to improve the health and well-being of our members. This training will equip you with the knowledge and tools necessary to align with our approach to behavioral health insourcing and navigate key processes with confidence.

We appreciate your partnership and look forward to supporting you every step of the way.

WellSense HEALTH PLAN

Agenda

- WellSense and behavioral health insourcing
- Provider portal
- Claim submission methods and timely filing
- WellSense products
- Fraud, waste and abuse
- Provider support
- Taxonomy codes
- Behavioral health and medical referrals

WellSense and behavioral health (BH) insourcing

WellSense HEALTH PLAN

About WellSense

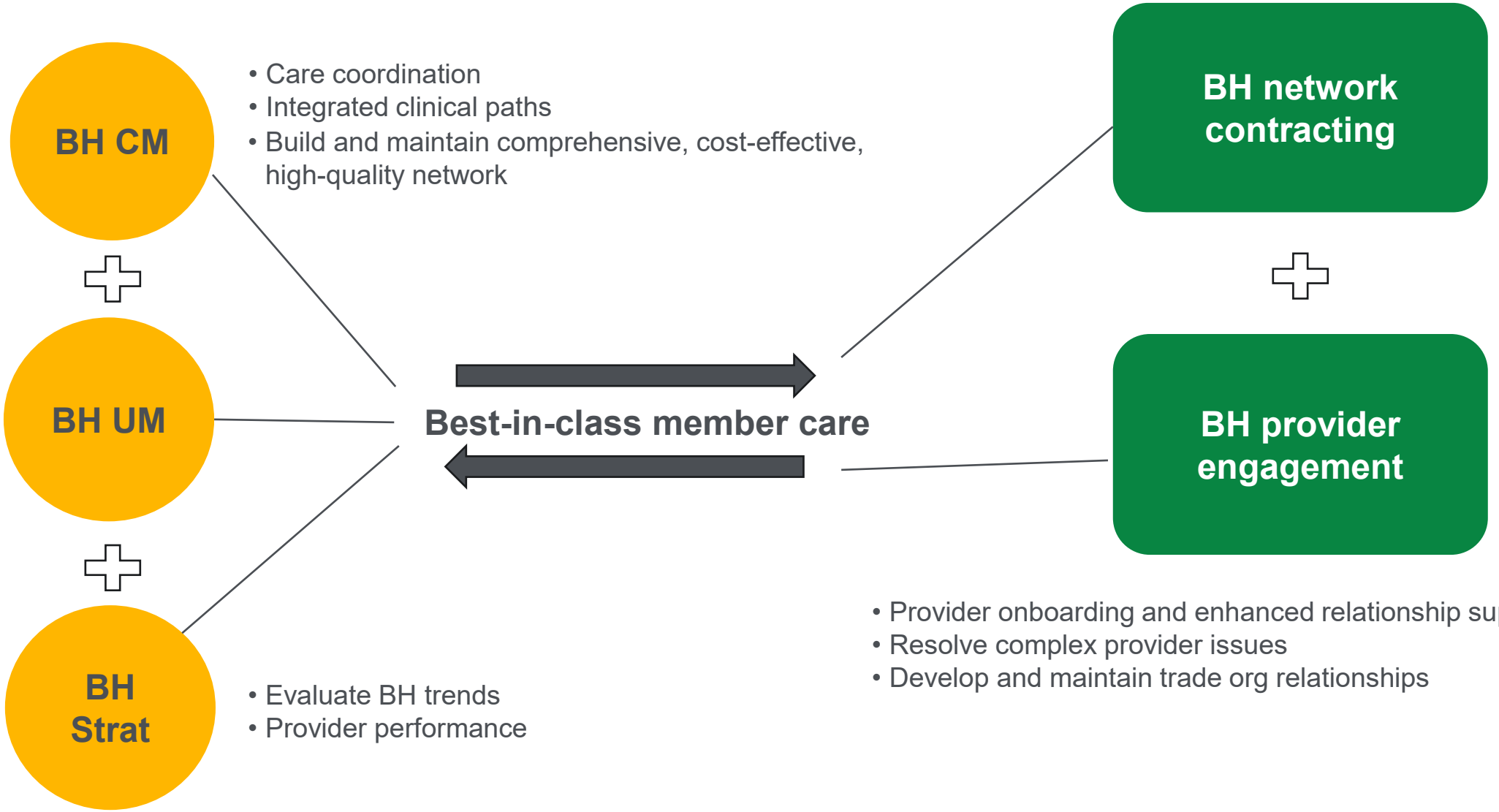
WellSense Health Plan is a nonprofit health insurance company serving more than 770,000 members in Massachusetts and New Hampshire through Medicare, Individual and Family, and Medicaid plans.

Originally founded as Boston Medical Center HealthNet Plan more than 30 years ago, we rebranded in May 2022 to reflect our growth and statewide reach.

Committed to health equity, we strive to provide high-quality healthcare coverage, particularly to underserved populations.

WellSense HEALTH PLAN

WellSense whole-person care



How we support our members

Cost-effective

Providing our members with cost-effective access to a broad range of innovative, person-centered healthcare services to help improve their health and quality of life.

Good stewards

Carefully stewarding the responsibilities entrusted to us by Government Agencies in pursuing the goal of improving the health of their populations.

Partnership

Working in close partnership with Healthcare Providers and community-based organizations to help them improve the efficiency and effectiveness of the care they provide.

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Key dates and provider benefits

Transition dates

We began administering behavioral benefits on:

- **Dec. 1, 2025:** New Hampshire Medicaid products
- **Jan. 1, 2026**: Massachusetts and all other New Hampshire products
- **July 1, 2026:** Continuity of care period ended
- **May 1, 2026:** WellSense requires the HO licensure modifier (BH services performed by a Licensed Clinical Social Worker (LICSW), Licensed Mental Health Counselor (LMHC) or Licensed Marriage and Family Therapist (LMFT) providers are expected to use the correct HO modifier to avoid claim denials.

What to expect

Behavioral health providers in our network will benefit from:

- Direct relationships with the health plan
- Streamlined processes for authorizations, referrals and care coordination

Key benefits

- Integrated, whole-person care coordination
- Direct support for administrative needs
- Access to education tools and valuable resources
- Ongoing support to deliver high-quality care

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Continuity of care

Line of Business	End Date
NH Medicaid	June 30, 2026
All other products in MA and NH	June 30, 2026

COC Policy:_Behavioral_Health_Continuity_of_Care.pdf

- Only active established WellSense members prior to Jan. 1, 2026, are eligible for COC
- On or after July 1, 2026, an out-of-network authorization will be required if you are not contracted, which applies for current and future patients

Provider portal

WellSense HEALTH PLAN

Key functions in the provider portal

Provider portal – facts and registering

Our provider portal, powered by HealthTrio Connect, is a secure online platform designed to help contracted providers manage administrative tasks with greater ease and efficiency.

By registering for the portal, providers can:

- Check member eligibility and benefits in real time
- Confirm coverage, plan type and enrollment details in real time
- Submit and track claims electronically
- See if a claim is pending, paid or denied, and review payment details

For instructions on registering for the portal, visit:
WellSense website training and support page > Training resources > Provider portal

Key functions in the provider portal

Submitting claims

Learn the steps for submitting a claim, how to view the status of a claim, and search for a remittance advice.
Guide (PDF)
Tutorial (Video)

Locating claims remittance advice (RA)
Guide (PDF)

Request for claim review, appeals, corrected claims or credit balance
How to use the Request for Claim Review Form for all EDI claim corrections and claim re-adjudication requests.
Guide (PDF)

Submitting claims

Submit claims to WellSense either electronically (EDI), the preferred and faster method, or by mailing paper claims, which may take longer to process.

Electronic options:

- Online portal (only accepts professional claims)
- Trizetto Payer Solutions
- Clearinghouses like Gateway EDI and NEHEN
- **Payor ID 13337**

Include accurate member ID numbers, service dates, procedure codes and necessary modifiers.

Note: Please contact bhproviders@welllsense.org if you need help with portal access.

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Key functions in the provider portal

Authorizations

The provider portal also allows you to:

- Search existing authorizations by member ID, service type or authorization number
- Confirm if a service requires prior authorization using our Authorization Lookup Tool
- Submit new authorization requests online and track their status.
- UM email box - BHUMAuthInquiry@wellsense.org
    - If after seven business days you have not received an update and would like to inquire on the status of your UM request, please email this box.

Electronic remittance advice (ERA) overview

ERA Authorization form

As a reminder, once your ERA setup is complete, you need to reach out to TriZetto to finalize the setup.

Trizetto provider support:

- physiciansupport@cognizant.com
- TTPSSupport@cognizant.com

If you don’t have a clearinghouse, you can use Trizetto as a source of your 835s.

Claim submission methods and timely filing

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Electronic and paper claims
Claim submission methods

Electronic

You are encouraged to submit claims electronically for faster processing.

- Submit claims electronically directly to us through our online portal or via a third party.
- Register with **Trizetto Payer Solutions** or use a clearinghouse that we accept:
    - Payor ID 13337

Paper claims

Paper claims may be submitted via U.S. mail by filling out the Professional Paper Claim form (CMS-1500) or Institutional Paper Claim form (UB-04/CMS-1450) and sending it to the address below for covered services rendered to our members.

Sending claims via certified mail does not expedite claim processing and may cause additional delays.

MassHealth and QHP
WellSense Health Plan
P.O. Box 55282
Boston, MA 02205-5282

NH Claims
Claims Department
PO Box 55049
Boston, MA 02205-5049

Note: Ensure that claims are submitted with accurate member ID numbers, dates of service, procedure codes and any required modifiers.

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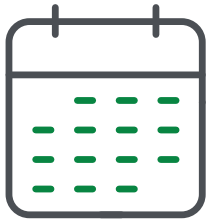
Timely filing

MassHealth ACO/MCO

- **Claims filing limit:** 150 days
- **Appeals filing limit:** 150 calendar days from the original denial date; no later than 300 calendar days from the date of service

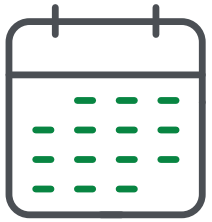


MA Clarity (ACA/QHP)

- **Claims filing limit:** 90 days
- **Appeals filing limit:** 90 calendar days from the original denial date; no later than 180 calendar days from the date of service. The 90 calendar days are from either the date of service, the date of hospital discharge or, in the case of multiple insurers, the date of the primary insurer's explanation of benefits (EOB)

Timely filing

NH Medicaid and NH Medicare Advantage



- **Claims filing limit:** 120 days
- **Appeals filing limit:**
  - **NH Medicaid:** Within 60 days of the original denial date
  - **NH Medicare Advantage:** Within 65 days of the original denial date

NH Clarity

- **Claims filing limit:** 90 days
- **Appeals filing limit:** Within 60 days of the original denial date

How to submit a Massachusetts appeal

Submit Claims | Providers - Massachusetts | WellSense Health Plan

Submit a provider administrative claims appeal

Providers may request that we review a claim that was denied for an administrative reason. We offer one level of internal administrative review to providers. The administrative appeal process is only applicable to claims that have already been processed and denied. An administrative appeal cannot be requested for services rendered to a member who was not eligible on the date(s) of service, or for benefits that are not administered or covered by WellSense. Submit the administrative appeal request within the time frames specified in the Provider Manual.

The following types of provider administrative claim appeals are IN SCOPE for this process:

- Level of compensation/reimbursement
- Timely filing of claims
- Retroactive eligibility
- Lack of prior authorization/Inpatient notification denials
- Non-covered and/or unlisted code denials
- Other Party Liability (OPL)/Third Party Liability (TPL)/Coordination of Benefits (COB)
- Provider audit and Special Investigation Unit (SIU) appeals
- Duplicate claim appeals

All documentation a provider wishes to have considered for a provider administrative appeal must be submitted at the time the appeal is filed. Once a decision has been reached, additional information will not be accepted by WellSense. Providers can submit an Administrative Claim Appeal electronically via our secure provider portal, or via US Mail:

- The preferred method is to submit the Administrative Claim Appeal request through our online portal. See instructions in the Request for Claim Review Section.
- Download and complete the Request for Claim Review Form and submit with all required documents via Mail. Sending requests via certified mail does not expedite processing and may cause additional delay.
  WellSense
  Attn: Provider Administrative Claims Appeals
  P.O. Box 55282
  Boston, MA 02205

**If you require training or assistance with our online portal, please contact your dedicated provider Relations Consultant.*

For more information on appeals, please refer to the Massachusetts provider manual.
Provider Manual | WellSense Health Plan

WellSense HEALTH PLAN

How to submit a New Hampshire appeal

Submit Claims | Providers - New Hampshire | WellSense Health Plan

Submit a provider administrative claims appeal

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  WellSense
  Attn: Provider Administrative Claims Appeals
  P.O. Box 55282
  Boston, MA 02205

**If you require training or assistance with our online portal, please contact your dedicated provider Relations Consultant.*

For more information on appeals, please refer to the New Hampshire Provider Manual.
Provider Manual | WellSense Health Plan

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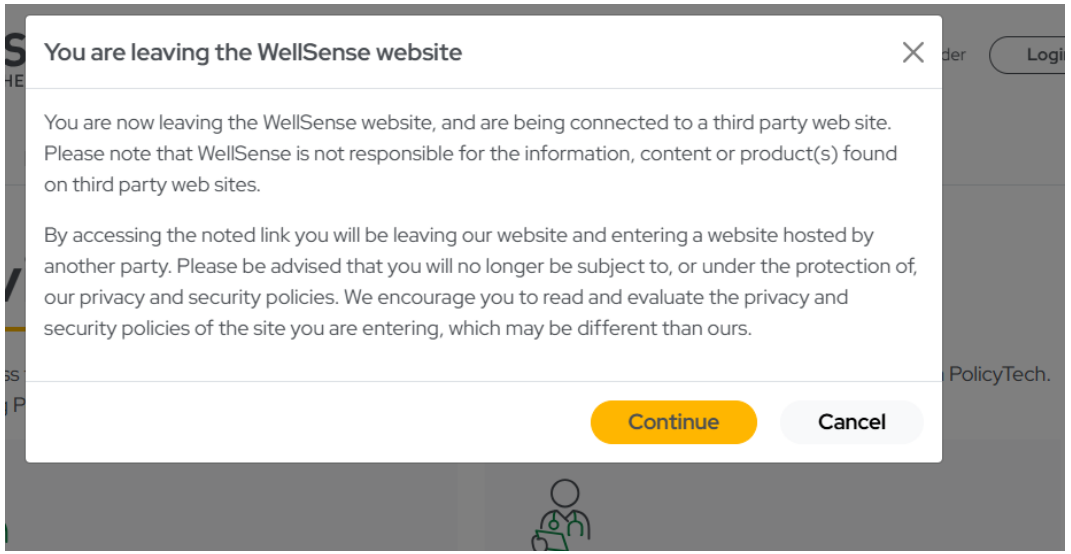
Payment policies

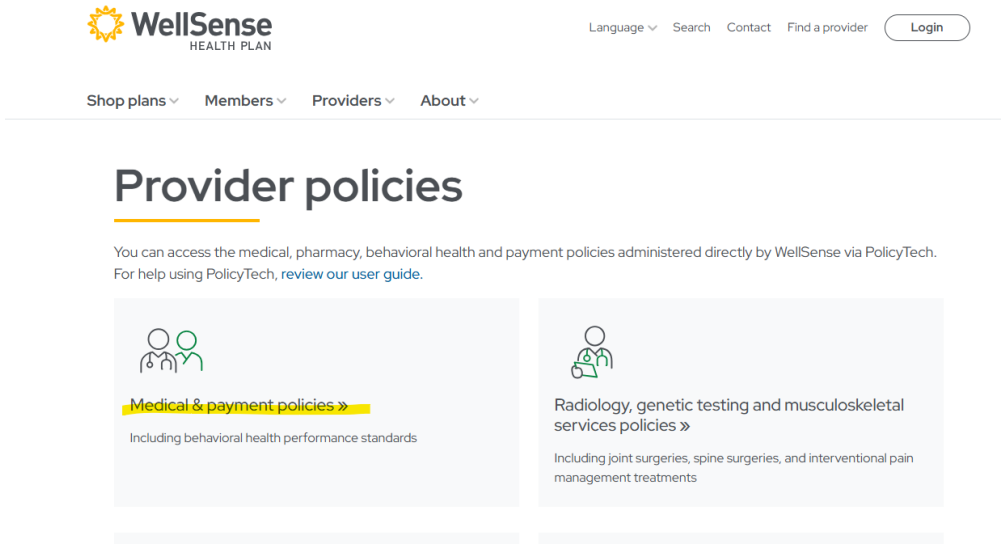
WellSense HEALTH PLAN

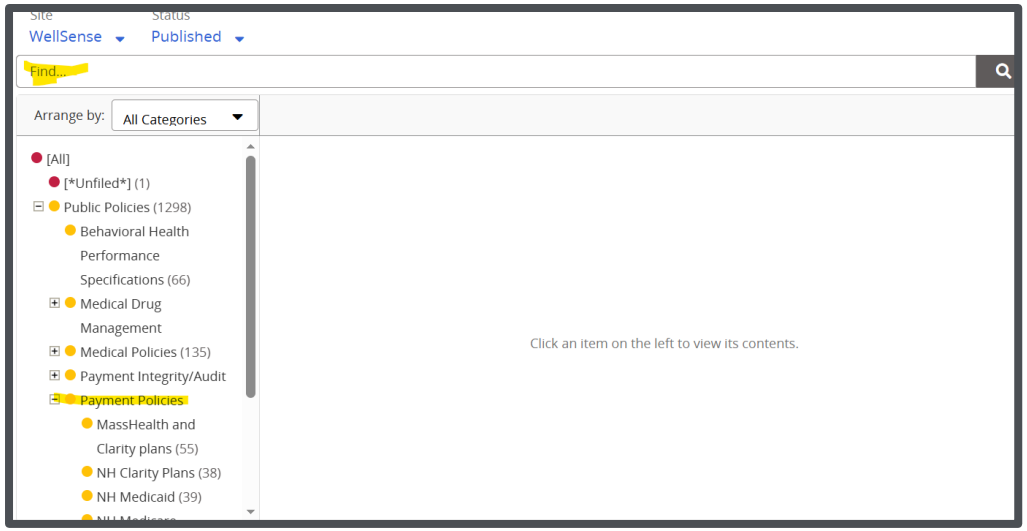
Payment policies

[Policies | Providers | WellSense Health Plan]

Stay informed with our provider policies, offering clear guidelines and protocols to ensure quality and compliance in healthcare services.







WellSense plans

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WellSense plans - Massachusetts

WellSense MassHealth Medicaid ACO plans

- Offer coordinated care through provider partnerships, covering all MassHealth services, including preventive care, prescriptions and mental health services.
- Members also receive extras, including nutrition classes, pregnancy support, car seats, bike helmets, dental kits and fitness reimbursements.

WellSense Massachusetts Clarity plans

- Offer affordable health coverage through the Massachusetts Health Connector.
- Plans include $0 preventive care, prescription drugs, mental health services, telehealth, and no referrals for in-network specialists.
- Members may also access low-cost meal delivery and qualify for $0 monthly premiums.

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WellSense plans - New Hampshire

WellSense New Hampshire Medicaid plans

- Offer comprehensive healthcare coverage, providing access to more than 2,000 providers.
- Benefits include preventive care, prescriptions, and hospital services, as well as extras such as fitness reimbursements, WeightWatchers discounts, and pregnancy support through the Sunny Start program.

WellSense New Hampshire Clarity plans

- Designed to provide individuals and families with affordable, comprehensive health coverage.
- Available to residents of Belknap, Strafford, Merrimack, Hillsborough and Rockingham counties.
- These plans offer a wide range of medical services, including $0 preventive care, behavioral health services, prescription drug coverage and more.
- Members benefit from access to a robust network of healthcare providers and hospitals.

WellSense New Hampshire Medicare Advantage plans

- Offer comprehensive coverage, including hospital, medical and prescription drug benefits, with $0 monthly premiums.
- Members enjoy $0 primary care visits, low copays, dental, vision, hearing benefits, SilverSneakers access and an over-the-counter card.

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Member products and benefits

Massachusetts

- Clarity plans
  Members | Massachusetts Clarity Plans | WellSense Health Plan
- MassHealth Medicaid
  Members I MassHealth | WellSense Health Plan

New Hampshire

- Clarity plans
  Your Benefits | NH Clarity Plans | WellSense Health Plan
- Medicaid
  Members | New Hampshire Medicaid | WellSense Health Plan
- Medicare Advantage
  Members | New Hampshire Medicare Advantage | WellSense Health Plan

WellSense HEALTH PLAN

Fraud, waste and abuse

WellSense HEALTH PLAN

Fraud, waste and abuse

You must report any provider, pharmacy or member who is suspected of committing fraud, waste or abuse. You do not have to give your name to report an incident.

You can report an incident by calling the Compliance Hotline at 888-411-4959.

Or in writing to:
WellSense Health Plan
Compliance Officer
100 City Square
Suite 200
Charlestown, MA 02129.

Once a complaint is received, the Special Investigations Unit (SIU) will conduct a thorough review and proceed with an investigation if appropriate. Please note that we are unable to share the results of any reviews/investigations.

Fraud, waste and abuse definitions

FRAUD: Intentionally making, or attempting to make, a false claim, representation or promise in an effort to receive payment or property to which one is not entitled. It can also be a concealment or omission of a material fact.

WASTE: Poor or inefficient practices occurring without intent to deceive that result in the provision of unnecessary healthcare services and subsequent expenditures.

ABUSE: Any activity that unjustly allows the perpetrator to obtain money or healthcare services to which he or she is not entitled but for which there is not the intent to deceive that is necessary for fraud to have occurred.

Common fraud, waste and abuse schemes/situations to avoid

- Billing for services not rendered
- Billing for a noncovered service as a covered service
- Billing for medically unnecessary services
- Misrepresenting dates of service, locations of service and/or provider of service
- Billing services performed by one professional under another professional's provider ID
- Waiving of deductibles and/or copayments
- Incorrect reporting of diagnoses, modifiers or procedures
- Overutilization of services
- False or unnecessary issuance of prescription drugs
- Up coding services by billing for services at a higher complexity than services actually provided
- Unbundling billing for services included in a panel, global reimbursement or capitation arrangement
- Paying or receiving kickbacks in exchange for referring business
- Charging members out of pocket for covered services
- Cutting and pasting electronic medical records (cloning)
- Double billing for services
- Billing for a provider whose license has lapsed, is no longer in practice, is deceased or is an ineligible provider

Suspected member fraud that should be reported

- Insurance card sharing
- Ineligible members (financial or geographical)
- Identity theft (look for complaints of members claiming they did not have a service with you, or that their ID was stolen; photo ID does not match individual seen in your office)
- Allegations of forged prescriptions
- Doctor shopping
- Theft of prescription pads/paper

Provider support

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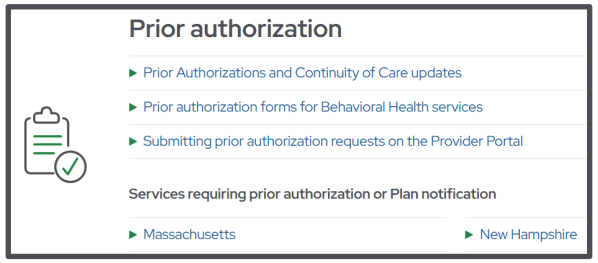
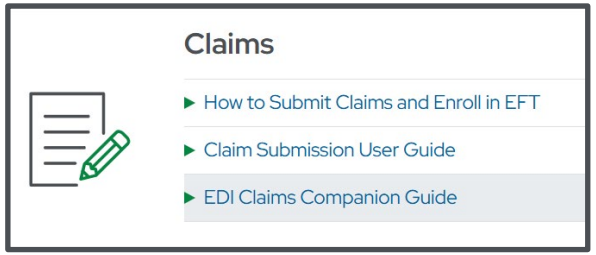
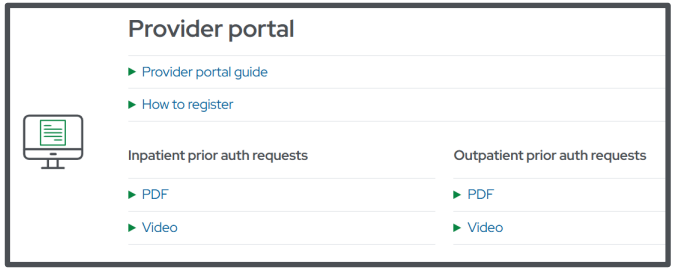
Behavioral health landing page

- A centralized resource for everything behavioral health
- A roadmap guiding you to a successful transition to WellSense







Access the behavioral health landing page at **Behavioral health insourcing | WellSense Health Plan**.

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Provider support

Provider links and key contact information

Resource	Function	Contact information
Behavioral health insourcing landing page	Provides direct access to information specific to behavioral health specific	https://www.wellsense.org/providers/behavioral-health-insourcing
Provider information	Nonpar provider information submission	provider.info@wellsense.org
Provider processing	Changes and onboarding	Provider.behavioralhealth@wellsense.org
Electronic remittance advice (ERA)	Providers electing electronic remittance advice	ERA.requests@wellsense.org
ERA form	Fill out form to get access to ERAs/835s	ERA_Authorization_Form.pdf
Provider Service phone number		**888-566-0008**
MassHealth website	General MassHealth information	Information for MassHealth Providers | Mass.gov

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Provider support

Provider links and key contact information

Resource	Function	Contact information
Standard MassHealth fee schedule	Questions related to the MassHealth fee schedule	https://www.mass.gov/doc/managed-behavioral-health-vendor-appendix-l-minimum-fee-schedule/download
UM email	If after seven business days you have not received an update and would like to inquire on the status of your UM request, please email this box.	BHUMAuthInquiry@wellsense.org

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Provider resources

Use the resources and guides linked below to quickly access contact, partner, claims, appeals and prior authorization information.

WellSense website

wellsense.org:

- Provider manual, including a forms section
- Provider directory
- Provider portal: Check member eligibility, claims status, remittance history, benefit summaries and important reports
- Claim forms and guidelines
- Clinical and reimbursement policies
- Quick reference guides
    - Registration Process Provider Portal Training Guide
    - Overview Member Eligibility Provider Portal Training Guide
    - Prior Authorization Provider Portal Training Guide
    - Submitting Claims Provider Portal Training Guide
- News and updates

Provider relations

Provider Relations is here to train you on utilizing the provider portal to its fullest extent. Reach out if training is needed for office staff or if you need secure access.

Call your Provider Relations Consultant for:

- New provider orientation
- Requests for materials
- General plan questions
- Participation status
- Requests to join the plan
- Re-education
- Provider portal training
- Review of policies and procedures

WellSense HEALTH PLAN

Taxonomy Codes

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HEALTH PLAN

Taxonomy codes

What is a taxonomy code

- A taxonomy code is a standardized 10-character code used in healthcare billing to identify a provider's type, specialty and practice area.
- It tells insurance companies what kind of healthcare provider rendered the service (e.g., family medicine, cardiology, behavioral health or a specific nursing role).
- Taxonomy codes are submitted on claims and enrollment records to help payers process claims accurately and apply the correct payment rules.

How does a provider find their taxonomy code?

- Go to the official NPI Registry at https://npiregistry.cms.hhs.gov/.
- In the search bar, enter your name or NPI number.
- Click search.
- From the results, select your record.
- In your NPI profile, scroll to the Taxonomy section.
- There you will see your primary taxonomy code and any additional taxonomy codes if applicable.

MassHealth taxonomy code requirement

What is the MassHealth taxonomy code requirement?

- MassHealth requires providers to maintain accurate taxonomy codes in their National Provider Identifier (NPI) records to correctly identify their provider type and specialty.
- MassHealth is piloting a new system with two managed care providers in Massachusetts, one of which is WellSense. As part of this pilot program, providers must include the NPI for both billing and rendering/attending providers on all claims submitted to WellSense. Eventually, all managed care providers in Massachusetts will need to comply with this requirement.
- MassHealth now requires that the managed care organizations participating in the pilot, including WellSense, submit encounter data with accurate taxonomy codes for billing, rendering and attending providers. Claims or encounters submitted without required taxonomy codes may be rejected, with limited exceptions, such as pharmacy claims. Because we need to have encounters accepted by MassHealth, we must require providers to submit this information.
- Providers are responsible for selecting and maintaining taxonomy codes in the NPPES system and ensuring consistency across MassHealth enrollment and claim submissions.

New Hampshire Medicaid taxonomy code requirement

What is the NH Medicaid taxonomy code requirement?

- New Hampshire Medicaid requires providers to maintain accurate National Provider Identifier (NPI) information, including taxonomy codes, to support correct provider identification and claims processing.
- During New Hampshire Medicaid enrollment, providers must submit their NPI and associated taxonomy code(s) that reflect their provider type, specialty and scope of practice. New Hampshire Medicaid uses taxonomy codes as part of its enrollment and provider classification process, particularly for specified provider types.
- Providers are responsible for ensuring their taxonomy codes in the NPPES system align with their New Hampshire Medicaid enrollment information and the services they are billing. Providers must also keep enrollment data up to date if their specialty or scope of services change.
- Providers must include the NPI for both billing and rendering/attending providers on all claims submitted to WellSense. Claims or encounters submitted without required taxonomy codes may be rejected.

Using taxonomy as a billing provider when submitting 837P electronic claims

A billing provider taxonomy code is **required** and must be submitted for all claims with dates of service on or after **Sept. 1, 2026.**

- Loop: 2000A
- Segment: PRV
- Data Element: PRV01 = BI; PRV02 = PXC; PRV03 = Taxonomy Code

SEGMENT DETAIL

PRV - BILLING PROVIDER SPECIALTY INFORMATION

X12 Segment Name:	Provider Information
X12 Purpose:	To specify the identifying characteristics of a provider
X12 Syntax:	1. P0203 If either PRV02 or PRV03 is present, then the other is required.
Loop:	2000A — BILLING PROVIDER HIERARCHICAL LEVEL
Segment Repeat:	1
Usage:	SITUATIONAL
Situational Rule:	Required when the payer's adjudication is known to be impacted by the provider taxonomy code. If not required by this implementation guide, do not send.
TR3 Example:	PRV*BI*PXC*207Q00000X~

DIAGRAM

PRV * PRV01 1221 Provider Code M 1 ID 1/3 * PRV02 128 Reference Ident Qual X 1 ID 2/3 * PRV03 127 Reference Ident X 1 AN 1/50 * PRV04 156 State or Prov Code O 1 ID 2/2 * PRV05 C035 Provider Spec. Inf. O 1 * PRV06 1223 Provider Org Code O 1 ID 3/3 ~

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	**Provider Code** Code identifying the type of provider CODE: BI — DEFINITION: Billing	M 1 ID 1/3
REQUIRED	PRV02	128	**Reference Identification Qualifier** Code qualifying the Reference Identification SYNTAX: P0203 CODE: PXC — DEFINITION: Health Care Provider Taxonomy Code CODE SOURCE 682: Health Care Provider Taxonomy	X 1 ID 2/3
REQUIRED	PRV03	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: P0203 IMPLEMENTATION NAME: Provider Taxonomy Code	X 1 AN 1/50

WellSense HEALTH PLAN

Using taxonomy as a rendering provider when submitting 837P electronic claims

A rendering provider taxonomy code is only required if the rendering provider is different than the billing provider.

- Loop: 2310B
- Segment: PRV
- Data Element: PRV01 = PE; PRV02 = PXC; PRV03 = Taxonomy Code

SEGMENT DETAIL

PRV - RENDERING PROVIDER SPECIALTY INFORMATION

X12 Segment Name:	Provider Information
X12 Purpose:	To specify the identifying characteristics of a provider
X12 Syntax:	1. P0203 If either PRV02 or PRV03 is present, then the other is required.
Loop:	2310B — RENDERING PROVIDER NAME
Segment Repeat:	1
Usage:	SITUATIONAL
Situational Rule:	Required when adjudication is known to be impacted by the provider taxonomy code. If not required by this implementation guide, do not send.
TR3 Notes:	1. The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.
TR3 Example:	PRV*PE*PXC*1223G0001X~

DIAGRAM

PRV * PRV01 1221 Provider Code M 1 ID 1/3 * PRV02 128 Reference Ident Qual X 1 ID 2/3 * PRV03 127 Reference Ident X 1 AN 1/50 * PRV04 156 ~~State or Prov Code~~ O 1 ID 2/2 * PRV05 C035 ~~Provider Spec. Inf.~~ O 1 * PRV06 1223 ~~Provider Org Code~~ O 1 ID 3/3 ~

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
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WellSense HEALTH PLAN

Using taxonomy as a billing provider when submitting electronic 8371 institutional claims

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- Segment: PRV
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SEGMENT DETAIL

PRV - BILLING PROVIDER SPECIALTY INFORMATION

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TR3 Example:	PRV*BI*PXC*282NR1301X~

ELEMENT DETAIL

USAGE	REF DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	**Provider Code** Code identifying the type of provider CODE: BI — DEFINITION: Billing	M 1 ID 1/3
REQUIRED	PRV02	128	**Reference Identification Qualifier** Code qualifying the Reference Identification SYNTAX: P0203 CODE: PXC — DEFINITION: Health Care Provider Taxonomy Code CODE SOURCE 682: Health Care Provider Taxonomy	X 1 ID 2/3
REQUIRED	PRV03	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: P0203 IMPLEMENTATION NAME: Provider Taxonomy Code	X 1 AN 1/50

WellSense HEALTH PLAN

Using taxonomy as attending provider when submitting electronic 8371 institutional claims

- Loop: 200A
- Segment: PRV
- Data Element: PRV01 = AT; PRV02 = PXC; PRV03 = Taxonomy Code

3.43"

5.78"

SEGMENT DETAIL

PRV - ATTENDING PROVIDER SPECIALTY INFORMATION

X12 Segment Name:	Provider Information
X12 Purpose:	To specify the identifying characteristics of a provider
X12 Syntax:	1. P0203 If either PRV02 or PRV03 is present, then the other is required.
Loop:	2310A — ATTENDING PROVIDER NAME
Segment Repeat:	1
Usage:	SITUATIONAL
Situational Rule:	Required when adjudication of the destination payer, or any subsequent payer listed on this claim, is known to be impacted by the attending provider taxonomy code. If not required by this implementation guide, do not send.
TR3 Example:	PRV*AT*PXC*208D00000X~

DIAGRAM

PRV * PRV01 1221 Provider Code M 1 ID 1/3 * PRV02 128 Reference Ident Qual X 1 ID 2/3 * PRV03 127 Reference Ident X 1 AN 1/50 * PRV04 156 ~~State or Prov Code~~ O 1 ID 2/2 * PRV05 C035 ~~Provider Spec. Inf.~~ O 1 * PRV06 1223 ~~Provider Org Code~~ O 1 ID 3/3 ~

ELEMENT DETAIL

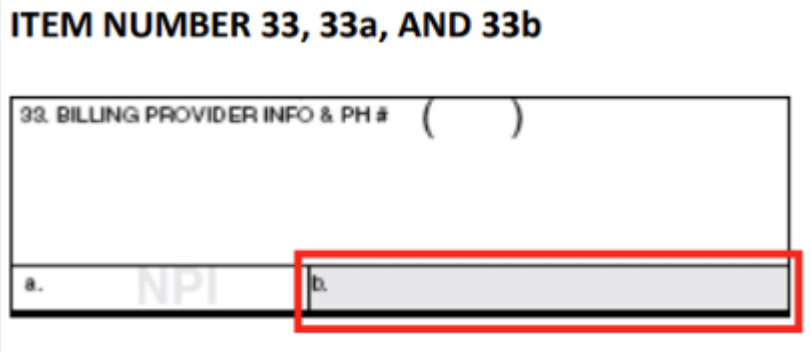
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	**Provider Code** Code identifying the type of provider CODE: AT — DEFINITION: Attending	M 1 ID 1/3
REQUIRED	PRV02	128	**Reference Identification Qualifier** Code qualifying the Reference Identification SYNTAX: P0203 CODE: PXC — DEFINITION: Health Care Provider Taxonomy Code CODE SOURCE 682: Health Care Provider Taxonomy	X 1 ID 2/3
REQUIRED	PRV03	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: P0203 IMPLEMENTATION NAME: Provider Taxonomy Code	X 1 AN 1/50

WellSense HEALTH PLAN

Using taxonomy when submitting CMS-1500 paper claims

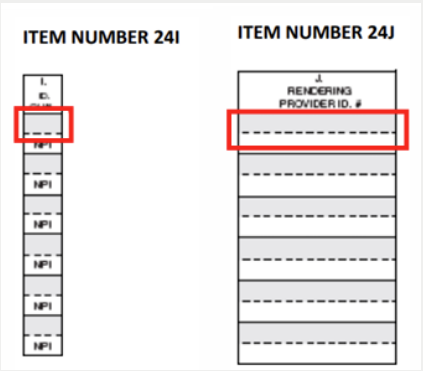
Billing provider

- A billing provider taxonomy code is required for all claims.
- Populate qualifier ZZ, Provider Taxonomy, followed by the taxonomy code in 33b.
- Do not use a space, hyphen or other separator between the qualifier and number.



Rendering provider

- A rendering provider taxonomy code is only required if the rendering provider is different than the billing provider.
- In that case, populate qualifier ZZ, Provider Taxonomy, in the shaded area of 24I.
- Populate the taxonomy code in the shaded area of 24J.
- For providers who use an electronic health record (EHR), you may need to contact your EHR vendor for assistance on how to populate this information correctly in your claim as each system is set up differently.



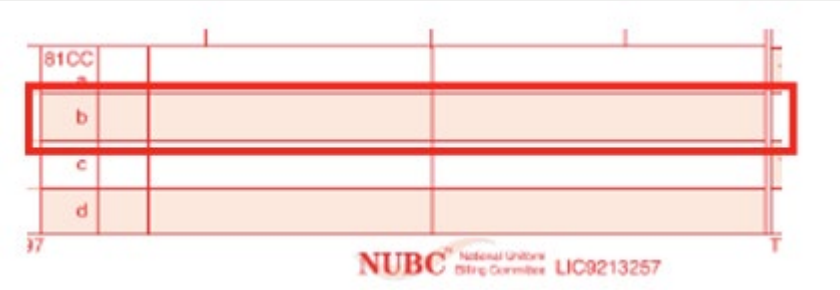
WellSense HEALTH PLAN

Using taxonomy when submitting UB-04 paper institutional claims

Billing provider
A billing provider taxonomy code is **required** for all claims with **dates of service on or after Sept. 1, 2026.**

Form locator 81a: Populate qualifier B3, Provider Taxonomy, in the left column and the taxonomy code in the middle column.

Other provider(s)
Form locator 81b-d: Populate qualifier B3, Provider Taxonomy, in the left column and the taxonomy code in the middle column.



WellSense HEALTH PLAN

Behavioral health and medical referrals

WellSense HEALTH PLAN

Behavioral health referrals - When to refer

Behavioral health referrals are indicated when symptoms exceed the scope of brief primary care management, pose safety risk, impair medical care or significantly disrupt functioning. Early referral and use of statewide centralized access points improve timeliness, equity and outcomes. You should consider referrals to behavioral health specialists when any of the following are present:

- Positive or concerning screening results
- Safety concerns or psychiatric risk
- Symptoms persist despite primary care management
- Co-occurring chronic medical conditions
- Functional impairment or life disruption

Behavioral health referrals – How to refer

- Evaluate member's condition and identify type of care needed. Links to screening tools are provided on the next page.
- Offer a brief overview of additional care opportunities and review relevant services and care options with the member.
- Discuss the information that will be shared as part of referral process and obtain a Release of Information (ROI) from the member.
- Help the member connect with the appropriate behavioral health providers and/or resources.
- Ensure member's clinical information is furnished timely and appropriately to care needs and in compliance with state laws for members who express suicidal or homicidal ideation or intent.

Behavioral health referrals - resources

- Consult the WellSense Behavioral Health Referral Guide when considering a referral to a behavioral health specialist.
- Utilize the WellSense Provider Directory to search for behavioral health providers or call Member Service at 855-833-8128.
- New Hampshire Care Management Referral Forms can be submitted for behavioral health referrals to BHCMReferrals@Wellsense.org or providers may call 855-833-8119.
- Contact Member Service with member questions about their plan, coverage and providers. Memberquestions@wellsense.org or call us at 855-833-8128 (TTY users call 711)
- NH Rapid Response / 988 Partnership. Call or text 1 833-710-6477 | 24/7 crisis response and triage across the state.
- Community Mental Health Centers (10 statewide) NHCBHA Member Locations| NH Community Behavioral Health Association. Comprehensive outpatient, emergency, and specialty behavioral health services across New Hampshire.
- NH Department of Health & Human Services – Behavioral Health Portal Behavioral Health. Central directory for state and community behavioral health programs.
- 988 Suicide and Crisis Lifeline. Call or Text 988 for immediate support.

Behavioral health referrals - Screening tools

WellSense Behavioral Health Toolkit contains a number of screening tools, including the below:

- The CRAFFT Screening Interview
- Patient Health Questionnaire (PHQ-9) .
- NIMH Toolkit: Brief Suicide Safety Assessment (youth outpatient)
- Columbia Depression Scale (Ages 11 and over)
- Mood Disorder Questionnaire (MDQ)
- PCL-5 Posttraumatic Checklist for DSM-5
- Edinburgh Postnatal Depression Scale 1 (EPDS)

Behavioral health provider responsibilities

Members may access outpatient behavioral health and substance use disorder services by self-referring to a network provider, by calling WellSense Care Management, through acute or emergency room encounters, or through their PCP. A PCP referral is never required for behavioral health services.

Behavioral health providers should review the complete list of provider responsibilities, section 4.2 of the New Hampshire WellSense Provider Manual, which includes the following specific to behavioral health providers:

- Furnish the member's clinical information to other providers as necessary to ensure proper coordination and behavioral health treatment of members who express suicidal or homicidal ideation or intent, subject to a member's consent.
- Request written consent from the member to release personally identifiable or protected health information to coordinate care regarding behavioral health services and primary care. If the member's consent is not given, the provider should notify WellSense in writing within two business days of the consent request and include, if possible, the reason that consent was not given.
- See section 4.5 Access to Care standard. All New Hampshire Medicaid providers must comply with time and distance and wait standards.

Behavioral health provider responsibilities, when to refer for medical care

Behavioral health providers should refer a member for medical care when there are indications a physical cause may be a contributing or exacerbating factor of mental health symptoms, or when their condition requires medical intervention outside the scope of behavioral health practice.

Key referral indicators include:

- Physical or medical condition or symptoms that may be contributing factors, such as endocrine disorders, neurological conditions, metabolic imbalances, chronic pain or infections.
- Symptoms with possible medical etiology such as unexplained fatigue, weight changes, sleep disturbances or neurological signs that could be due to treatable medical issues.
- Chronic or complex medical conditions that significantly impact mental health or require behavioral health input in the plan of care.
- Suicidal or self-harm risk is identified where a medical provider can assess and manage acute safety needs, coordinate crisis care, or initiate hospitalization if necessary.

Behavioral health provider responsibilities, how to refer for medical care

- Behavioral health providers should refer a member to their PCP to receive medical care and medical care coordination.
- Contact WellSense Provider Services Center at 877-957-1300 to identify the member's PCP or have the member contact the Member Service Department at the same number, 877-957-1300.
- New Hampshire Care Management Referral form may be completed and emailed to NHCare.Management@Wellsense.org or faxed to 866-409-5657.
- Discuss the information that will be shared as part of referral process and obtain a Release of Information (ROI) from the member.
- Help the member connect with their PCP.

Questions?

Thank you for your time