

WellSense Health Plan **Provider Manual**

Massachusetts



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Section 1: General Information

1.1 About WellSense Health Plan

WellSense Health Plan (WellSense), formerly BMC HealthNet Plan, was founded in 1997 by Boston Medical Center to expand the hospital's mission to provide excellent and accessible care to all in need regardless of status or ability to pay. Our legal name remains Boston Medical Center Health Plan, Inc., although we operate under our trade name, WellSense Health Plan.

WellSense was licensed by the Massachusetts Division of Insurance as a Health Maintenance Organization (HMO) in October 2008. As a provider-sponsored health plan, we view our participating providers as partners with whom we collaborate.

Health Coverage Programs

We offer the following Massachusetts health coverage programs:

MassHealth: This Medicaid program is offered through the following contracts with the Massachusetts Executive Office of Health and Human Services (EOHHS):

- Accountable Care Organization Partnership Plan (ACO)
- Managed Care Organization (MCO)

Clarity plans and Qualified Health Plans (QHP): QHPs were established as part of the Affordable Care Act. The Massachusetts QHP program consists of the following qualified health plans, which we offer through the Health Connector to individuals/families and small groups under the name WellSense Clarity plans:

- WellSense Clarity ConnectorCare
- WellSense Clarity Platinum
- WellSense Clarity Gold
- WellSense Clarity Silver
- WellSense Clarity Bronze

In addition we offer Clarity plans directly through our off-exchange vendor. We also offer QHP plans directly to certain small groups and these plans are referred to as Employer Choice Direct plans.

Senior Care Options Program (SCO): WellSense has contracts with the Massachusetts Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare and Medicaid Services (CMS) to offer a Medicare Advantage Special Needs Plan, which serves members ages 65 or older who have MassHealth Standard and Medicare Part A and Part B (individuals who only have MassHealth Standard are eligible for our

Medicaid-only SCO plan). Under the SCO program, WellSense provides a fully integrated geriatric model of care. We authorize, coordinate, and arrange for the delivery of all services currently covered by Medicare and MassHealth Standard, including primary care, acute care, and specialty care; community and institutional long-term care; behavioral health; medical transportation, and prescription drugs.

1.2 WellSense Provider Networks

WellSense has the following provider networks:

MassHealth ACO: We are contracted with eight Partnership Plan ACOs.

- East Boston Neighborhood Health WellSense Alliance
- WellSense BILH Performance Network ACO
- WellSense Boston Children's ACO
- WellSense Care Alliance
- WellSense Community Alliance
- WellSense Mercy Alliance
- WellSense Signature Alliance
- WellSense Southcoast Alliance

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

Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct): Starting in 2024, we will contract with one provider network for all Clarity and QHP plans called the Clarity network.

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

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

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

- Verify and ensure the provider participates in the appropriate WellSense provider network. Please visit our online Provider Directory at wellsense.org > Find a Provider to search for participating providers in the applicable provider network, or call the Provider Service Center at 888-566-0008 for more information; and,

- Verify if the service requires prior authorization by reviewing the Provider CPT Look-Up Tool and Pre-Authorization Matrix for WellSense. Please visit our website at wellsense.org for a list of services requiring prior authorization by product line.

Providers should be aware that several of the above product lines have a high level of retroactive additions and terminations. Eligibility should be verified frequently. Contracted providers are responsible for obtaining prior authorizations from WellSense when required.

1.3 Using this Provider Manual

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

1.4 Revisions to the Manual

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

1.5 Contacts Directory

For a complete directory of WellSense contact information, visit wellsense.org.

1.6 Primary Care Team (PCT)

We provide information to each member to assist him/her with selecting a provider (e.g., physician specialty, geographic location, and experience with special populations). When necessary, our Member Service department provides interpreter services for members when they call and/or if requested by the member. If

we do not obtain a Primary Care Physician (PCP) selection from the member or the member's designee, we assign an appropriate PCP immediately after the member's enrollment date in WellSense.

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

- If a member was previously enrolled in WellSense, the PCP assignment will be the member's most recent PCP (if the assignment remains appropriate).
- If the member has not been enrolled in WellSense before, we consider the following criteria when assigning a PCP to the member:
 - Geographic proximity of the PCP's site to the member's current residence
 - PCP site's accessibility to public transportation
 - PCP site's ability to accommodate the member's disability, if applicable
 - The member's age should be appropriate for the PCP's specialty and training:
 - Pediatrics: birth to age 21
 - Internal Medicine: age 18 or older
 - Family Medicine: all age categories
 - Geriatric Medicine: age 65 or older
 - An obstetrician/gynecologist (OB/GYN) can serve as a PCP if selected by a female member aged 10 and older and other transgender and gender diverse individuals who need Obstetric and/or Gynecologic care, but WellSense will not assign a member to an OB/GYN practice for primary care services without a member request.
- If the member does not select their own PCP, we will inform the member of the PCP assignment. Our Member Services department can also assist the member in scheduling an initial appointment with the PCP.

Request for a PCP Change

Product	Timeframe for requesting a PCP change
MassHealth (including CarePlus) members	Any time
Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct) members	Voluntary requests – up to three times a year
Senior Care Options (SCO) members	Any time

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

Online Portal

Log in to the appropriate member portal at wellsense.org and submit the request online.

PCP Selection Form

Members may complete, sign, and fax a [Primary Care Provider Selection Form](#) to our Enrollment department. Enrollment in the new PCP's member panel is effective the date the member signs the form.

Call the Plan directly

MassHealth and QHP members may call the Member Service department at the following numbers 8 a.m. to 6 p.m., Monday through Friday (except holidays). SCO members may call the Member Service department 8 a.m. to 8 p.m., Monday through Friday. 8 a.m. to 8 p.m., 7 days a week, October 1 through March 31st.

Product	Contact
MassHealth (including CarePlus)	888-566-0010
Clarity plans (including QHP, ConnectorCare and Employer Choice Direct)	855-833-8120
SCO	855-833-8125

For assignments requested via member call, enrollment in the new PCP's panel will be effective the next business day. However, we will transfer the member to the new PCP's panel the same day if the member indicates they are in the provider's office at the time of the call and requests the transfer be effective immediately.

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

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

Section 2: Member Eligibility

2.1 Verifying Member Eligibility

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

Steps to verify eligibility for: MassHealth, Clarity plans (including QHP, ConnectorCare and Employer Choice Direct), and Senior Care Options eligibility.

Verify member eligibility for MassHealth	
Step One	<p>Providers first must verify that an individual is enrolled in MassHealth before determining membership in WellSense. An individual is only eligible to participate in WellSense if the state has determined they are eligible for MassHealth. Since MassHealth has frequent retroactive additions and terminations, eligibility should be verified frequently.</p> <p>Verify eligibility for MassHealth in one of two ways:</p> <ul style="list-style-type: none"> • Call MassHealth’s automated voice response (AVR) at 800-554-0042, or • Access MassHealth’s WebEVS website at sso.hhs.state.ma.us/. <p>You must use the member’s identification number or certain personal attributes (gender, name, and date of birth).</p> <p>To contact MassHealth Provider Service: (800) 841-2900, TTY: at (800) 497-4648, Fax: (617) 988-8974, or email MassHealth Customer Service Center for Providers at: providersupport@mahealth.net.</p>
Step Two	<p>Once you confirm that an individual is enrolled in MassHealth, you may check member eligibility for WellSense in any of the following ways:</p> <ul style="list-style-type: none"> • Access our online eligibility tool after logging in at wellsense.org. • Use our Interactive Voice Response (IVR) line by calling 888-566-0008 and selecting option 1. • During business hours (8 a.m. to 6 p.m., Mon.–Fri.) speak directly with a Provider Service Representative by calling 888-566-0008 and selecting option 3. <p>Member panel reports are not an accurate method for verifying eligibility. These reports are only intended to inform you of the member’s assignment to your panel. If you find a discrepancy in eligibility between MassHealth and WellSense, use the MassHealth eligibility tools noted above and notify us of the discrepancy by calling our provider line at 888-566-0008. We will update the membership information once we have confirmed the information with MassHealth.</p>

Verify member eligibility for Clarity plans (including QHP, ConnectorCare and Employer Choice Direct)

Step One

Access our online eligibility tool after logging in at wellsense.org > Provider Login link.

During business hours (8 a.m. to 6 p.m., Mon.–Fri.), call our provider line at 888-566-0008.

Eligibility timeframes

MassHealth members	Eligibility may change daily.
Clarity plans (including QHP, ConnectorCare and Employer Choice Direct)	Eligibility is usually effective on the first day of a given month and terminates on the last day of the appropriate month.

Verify member eligibility for Senior Care Options members

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

- Access our online eligibility tool after logging in at wellsense.org.
- Use our Interactive Voice Response (IVR) line by calling 888-566-0008 and selecting option 1.

Verify member eligibility for Clarity plans (including QHP, ConnectorCare and Employer Choice Direct) newborns

Step One	Check the mother's eligibility for WellSense on the date of birth of the newborn.
Step Two	If the mother is enrolled in WellSense on the newborn's date of birth, the hospital or treating provider must bill well-newborn charges under the mother's ID number. Sick-newborn charges should be billed to the appropriate health plan MCO once the newborn has been enrolled in a health plan and their permanent member ID number is available.

Step Three	<p>Clarity plan members (including QHP, ConnectorCare and Employer Choice Direct) must enroll newborns within 60 days of the newborn's date of birth via the Connector. The Connector then enrolls the newborn in a managed care plan. If the mother remains a member of WellSense, the newborn may be retroactively enrolled in our Clarity plan product as of the newborn's date of birth.</p> <p>Employer Choice Direct members must contact their Group Administrator to enroll the newborn into WellSense, subject to Group Administrator and WellSense eligibility guidelines. If the mother remains a member of WellSense, the newborn may be retroactively enrolled in our Employer Choice Direct Plan.</p>
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It is the provider's responsibility to verify member eligibility at the time of service to ensure that services rendered are eligible for WellSense reimbursement. However, if delivering emergency services, providers may verify member eligibility after delivering the service. Providers will be denied payment for services if the member is not eligible on the date of service.

Please note that verification of eligibility for the date of service is not an authorization for any services requiring WellSense prior authorization. See wellsense.org for instructions on how to obtain WellSense prior authorization.

Summary of plan eligibility verification process

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

See the Member pages of our website for a list of covered benefits. For MassHealth members, there are also certain additional benefits covered directly by MassHealth known as "wraparound" benefits. Providers should bill MassHealth directly for these additional "wraparound" benefits.

Newborns

Hospitals treating our MassHealth members must complete a MassHealth Notification of Birth (NOB-1) form and submit it directly to the MassHealth Enrollment Center Notification of Birth Unit in a timely manner, no later than 30 calendar days after the delivery. Please indicate birth weight and gestational age on this form.

We encourage providers to deliver prenatal, third-trimester, and post-partum visits as appropriate. See Section 8: Utilization Management and Prior Authorization in this manual:

- [Maternity Program related notification requirements](#) for more maternity program guidelines and requirements.

- See wellsense.org for a description of how our Care Management program is involved with pregnant members and their babies.

2.2 Member ID Cards

Product type	Member ID card information
MassHealth (including ACO and MCO)	<p>Each MassHealth member receives two member identification (ID) cards:</p> <ul style="list-style-type: none"> • A MassHealth member ID card, and • A WellSense member ID card. <p>Our member ID card includes a WellSense member ID number, the member's MassHealth-issued ID number, the name of the member's ACO (when applicable) and important phone numbers.</p> <p>Presentation of the member's ID cards does not ensure member eligibility. Please note that you will need to verify that the member is currently enrolled with both MassHealth and WellSense on each date of service.</p>
Clarity plans (including QHP, ConnectorCare and Employer Choice Direct)	<p>Clarity plan members are issued one WellSense member ID card.</p> <p>This card includes a member ID number and important phone numbers. We inform members that they must present this card to providers on each date of service.</p> <p>Presentation of the member's ID card does not ensure member eligibility.</p> <p>For Clarity plan (including QHP, ConnectorCare and Employer Choice Direct) members, you will need to verify that the member is currently enrolled with WellSense on each date of service.</p>
Senior Care Options	<p>Each SCO member receives two ID cards:</p> <ul style="list-style-type: none"> • A MassHealth member ID card, and • A WellSense member ID card. <p>Dually eligible (MassHealth and Medicare) members also receive a Medicare member ID card.</p> <p>Our member ID card includes a WellSense member ID number, the member's MassHealth-issued ID number, and important phone numbers.</p> <p>Presentation of the member's ID cards does not ensure member eligibility. Please note that you will need to verify that the member is currently enrolled with both MassHealth and WellSense on each date of service.</p>

Section 3: Credentialing

3.1 Overview

All credentialing information below applies to providers participating in all WellSense products, except when noted otherwise. Credentialing information for Behavioral Health providers can be found at carelonbehavioralhealth.com.

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

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

3.2 WellSense Credentialing/Re-credentialing Policies and Procedures

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

Responsibility

Our Quality Improvement Committee (QIC) is responsible for overseeing the Plan's credentialing and re-credentialing program, which includes but is not limited to the oversight of the Credentialing Committee. Our Credentialing Committee, which is a peer review committee, approves or denies practitioner participation based upon review of the application, supporting documents, and results of the credentialing verification process.

Delegation

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

WellSense and HealthCare Administrative Solutions, Inc. (HCAS)

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

Steps to become credentialed and enrolled in WellSense

Step	Process
Step One	Complete an HCAS Enrollment Form .
Step Two	Complete a WellSense Provider Data Form .
Step Three	Ensure that the CAQH application is completed, and that the applicant has a current attestation. WellSense must also be granted permission to access each CAQH account.
Step Four	<p>Please submit completed forms to WellSense through one of the following methods:</p> <ul style="list-style-type: none"> • Email: Provider.ProcessingCenter@wellsense.org • Fax: 617-897-0818 • Mail: <p>Attn: Provider Processing Center WellSense Health Plan 529 Main Street, Suite 500 (address will be changing late spring 2024) Charlestown, MA 02129</p>

3.3 Credentialing and Re-credentialing Process

Types of providers credentialed

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

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

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

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

- An [HCAS Enrollment Form](#) and [WellSense Provider Data Form](#) with an indication that the provider requests locum tenens status.
- A [Locum Tenens Credentialing Form](#).
- A malpractice face sheet.

- Hospital admitting privileges. If the physician does not have current admitting privileges, they must provide their applicable coverage arrangements.

All contracted providers using locum tenens physician services must comply with the guidelines specified in this section of the Provider Manual. These services may be extended past the initial 90 days when required by the practice. If a locum tenens physician needs to be in place beyond 90 days, they must become fully credentialed by us. To facilitate an extension beyond 90 days, notify WellSense at least 30 calendar days prior to the end of the locum tenens physician's term so we can conduct the full credentialing process.

Failure to notify us will result in claim denials. Locum tenens physicians are also required to bill for their services according to the guidelines established in [Section 9: Billing and Reimbursement](#).

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

3.4 Credentialing and Re-credentialing Criteria

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

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

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

Contract: Practitioners must be contracted to provide services to Plan members without evidence that they are in breach of their contractual obligations to the Plan.

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

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

- **National Practitioner Identifier (NPI):** All provider types that may obtain an NPI must have one in accordance with 45 CFR Part 162, Subpart D.

Medicaid Participation: All WellSense providers covered under this policy are required to be enrolled or contracted with MassHealth. Providers may become enrolled with the Plan for up to 120 days pending the outcome of MassHealth's enrollment process.

License: Practitioners must have a current and unrestricted license in the state in which they provide care to Plan members. Additional certifications may be required, as applicable to the practitioner's specialty.

Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) Certification: A DEA or CDS certificate must be issued in the state where the practitioner prescribes. If a practitioner chooses not to possess an active certificate, they must sign a waiver and provide the name of the individual who will prescribe on their behalf. (This requirement applies to Physicians [MDs & DOs], Podiatrists, Oral & Maxillofacial Surgeons, Nurse Practitioners, and Physician Assistants only.)

Professional Liability Insurance: Practitioners must possess and maintain a current malpractice liability insurance policy with a minimum coverage of \$1,000,000 per claim/\$3,000,000 annual aggregate, unless otherwise required by state or federal law. Dentists must have and maintain a minimum coverage of \$1,000,000 per claim/\$2,000,000 annual aggregate, unless otherwise required by state or federal law.

Malpractice liability coverage may also be issued under the Federal Tort Claims Act (FTCA). Under this coverage, services may only be provided to members who are patients of the entity that is covered by the FTCA, or are otherwise deemed to be covered under the FTCA.

Board Certification: In accordance with the WellSense Board Certification Policy, Physicians, Podiatrists, Certified Nurse Midwives, Oral & Maxillofacial Surgeons, Nurse Practitioners, and Physician Assistants must:

Be board certified by a WellSense recognized specialty board; or

Be in the process of achieving initial board certification by a WellSense recognized specialty board, and achieve board certification in a time frame relevant to the guidelines established by the applicable specialty board. Waivers may be considered by WellSense only when necessary for us to maintain adequate member access. Waivers may require additional approval by MassHealth, for those providers participating in our MassHealth programs.

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

Alternative Admitting Arrangements: If the practitioner does not have an active affiliation and admitting privileges at a Plan-contracted hospital, they must provide an explanation of what arrangements are in place for their patients to be admitted to a Plan-contracted hospital (e.g., covering physician who has current privileges at a Plan-contracted hospital, or through the use of a hospitalist program at a Plan-contracted hospital).

Supervising Physician or Qualified Healthcare Professional: For the purpose of engaging in prescriptive practice, Nurse Practitioners and Certified Registered Nurse Anesthetists must provide the name of their Plan-participating supervising qualified healthcare professional at the time of initial credentialing if they have been licensed for less than 2 years. Physician Assistants must provide the name of their Plan-participating supervising physician at the time of initial credentialing. Thereafter, the Physician Assistant is required to notify WellSense of any change to this information.

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

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

Compliance with Legal Standards: Practitioners must be in compliance with all applicable legal requirements relating to the practice of their profession, including meeting all required continuing education requirements.

Quality Care and Service: Practitioners can be reasonably expected to provide quality and cost-effective clinical care and service to Plan members. In evaluating whether this criterion has been met, the following credentialing information is required:

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

- Ten years of pending or closed disciplinary actions or alterations in privileges; professional performance, integrity, judgment, clinical skills; ability to perform the essential obligations of the affiliation agreement;
- The extent and nature of practitioner's professional liability claims history. This includes any malpractice cases that are currently open, closed and/or paid during the last 10 years preceding the signature date on practitioner's credentialing application;
- Results of Plan site visits (if applicable);
- Sanction activity;
- Information internally generated by the Plan's Quality Improvement Program, such as member complaints and appeals, quality of care, appropriate utilization of services, and member satisfaction surveys (applies to re-credentialing applicants only).
- Please note: The Credentialing Committee may, in its discretion, look back further than 10 years if necessary to appropriately inform its decision making.
- Practitioners must not have engaged in behaviors which may adversely impact member care or service, including but not limited to, behaviors which:
- Negatively impact the ability of other participating practitioners/providers to work cooperatively with the practitioner;
- Reflect a lack of good faith and fair dealing in his or her dealings with the Plan, its provider network or its members;
- Reflect a lack of commitment to managed care principles or a repeated failure to comply with the Plan's managed care policies and procedures;
- Indicate a lack of cooperation with the Plan's Quality Improvement or Utilization Management Programs; or
- Constitute unlawful discrimination against a member under any state or federal law or regulation.
- Practitioners have not engaged in any behaviors which could harm other health care professionals, patients, or Plan employees. Such behavior includes, but is not limited to, acts of violence committed within or outside the practitioner's practice, whether or not directed towards other health care professionals, patients, or Plan employees, and must be judged by the Credentialing Committee to create a significant risk to other health care professionals, patients or Plan employees.

Primary Care Provider (PCPs): In addition to meeting the above criteria, applicants applying for credentials as PCPs must be one of the following:

- An Allopathic (MD) or Osteopathic (DO) Physician that is trained and/or board certified in Family Medicine, Internal Medicine, General Practice, Geriatric Medicine, Adolescent & Family Medicine, Pediatric Medicine or Obstetrical & Gynecological Medicine (for female members aged 10 and older and other transgender and gender diverse individuals who need Obstetric and/or Gynecologic care only);
- A Nurse Practitioner (NP) that is board certified as an Adult Nurse Practitioner, Pediatric Nurse Practitioner or Family Nurse Practitioner, or Physician Assistant (PA).

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

Senior Care Options Requirements: Practitioners serving as a PCP in the Senior Care Options network must meet the following requirements:

- Physicians:
 - Be licensed by the Massachusetts Board of Registration in Medicine;
 - Obtain annual continuing medical units in geriatric practice;
 - Have at least two years' experience in the care of persons over the age of 65; and
 - Be a provider in good standing with the federal Medicare program.
- Nurse Practitioners:
 - Be licensed by the Massachusetts Board of Registration in Nursing;
 - Obtain annual continuing education units in geriatric practice; and
 - Be certified as a geriatric nurse practitioner or demonstrate at least two years' professional experience in the care of persons over the age of 65.
- Physician Assistants:
 - Be licensed by the Board of Registration of Physician Assistants;
 - Obtain annual continuing education units in geriatric practice; and
 - Demonstrate at least two years' professional experience in the care of persons over the age of 65.
- **Addiction Specialists:** For a physician to prescribe or dispense buprenorphine for opioid dependency treatment (i.e., Suboxone®), they must possess a current Medication-Assisted Treatment (MAT) physician waiver with the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The physician must continue to meet Plan's board certification policy requirements.
- **Access and Availability:** As part of its credentialing determinations, the Credentialing Committee may consider, in its discretion, network access, and availability needs.
- **Waiver:** The Credentialing Committee may waive any credentialing requirement which is not required by contract, statute, regulation, or accreditation standard when, in its discretion, to do so will advance patient care or service and the Plan's objectives.

3.5 Re-credentialing

WellSense re-credentials all practitioners who have a current contractual arrangement with the Plan to provide services to its members. Re-credentialing is generally completed within a 24-month cycle, based on the practitioner's date of birth, but shall not exceed 36 months from the decision date of when the practitioner was previously credentialed. The application process will be initiated directly by the Plan's Credentialing Verification Organization (CVO) vendor, and without notice to the practitioner.

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

3.6 Notice of Rights

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

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

- **Reviewing information:** You have a right to review information that we have obtained to evaluate your credentialing application. This may include the application, attestation, and CV, and may include information from outside sources, except for references, recommendations, or other peer-review protected information.
- **Requesting the status of your application:** You have a right to be informed, upon request, of the status of your application at any time during the credentialing process. When you make such an inquiry, the Credentialing Department will respond to your questions, inform you of any outstanding information needed to complete your application, and if none, the date that the application is scheduled to be reviewed for a final credentialing determination.

3.7 Credentialing file review, determinations, notice, and reporting

- **File Review and Determination:** After all necessary information has been collected and verified, WellSense's Medical Director and/or the Credentialing Committee will review the applications to determine if the practitioner meets our Credentialing Criteria outlined in this section. Based on this review, practitioners may be approved (i.e., credentialed), approved with conditions, denied initial credentials, or terminated.
- **Notice to practitioners:** All applicants granted initial credentials are notified in writing of the approval no later than 60 calendar days from the approval date. Note that the effective date for a practitioner is the credentialing date or contract effective date, whichever is later.

An initial applicant who is denied WellSense credentials, or a participating practitioner whose credentials are approved with conditions or terminated, is notified in writing of the action and the reasons no later than 10 calendar days from the Committee's decision. Practitioners who are re-credentialed in the ordinary course do not receive written notice.

- **Notice to members:** If a practitioner is terminated for any reason, we are required to notify members who have been obtaining services from these practitioners that the practitioner is no longer affiliated with WellSense.
- **Reporting:** WellSense complies with all regulatory and government reporting requirements. All denials, conditional approvals, or terminations that constitute disciplinary actions under state law and/or adverse professional review actions under federal law will be reported as required.

3.8 Ongoing Monitoring and Off-Cycle Credentialing Reviews and Actions

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

If information we receive through the monitoring process causes the Medical Director and/or the Chief Medical Officer to believe that a practitioner has placed or is at substantial risk for placing a member in imminent danger, and that failure to summarily suspend credentials is contrary to the immediate best interests of member care, they may summarily suspend a practitioner's credentials. In such event, we notify

the practitioner in writing immediately, including the reasons for the action, and the subsequent procedure to be followed by WellSense. Any summary suspension will be reviewed by the full Credentialing Committee at its next regularly scheduled meeting. The Committee may reinstate the practitioner, or take any action described in the preceding paragraph.

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

3.9 Credentialing appeals process for practitioners

Right of appeal

- If the Credentialing Committee denies your initial credentials, credentials you with conditions, or terminates your credentials, and such action constitutes a "disciplinary action" as defined in WellSense's Credentialing Policies, you are entitled to appeal the disciplinary action. A disciplinary action is an adverse action taken by WellSense's Credentialing Committee, up to and including termination from WellSense, on the basis of a Committee determination that the practitioner does not meet WellSense Credentialing Criteria related to the competence or professional conduct of the practitioner (i.e., quality of care or service). Examples include a denial or termination due to the volume or nature of malpractice suits against the practitioner, or the quality or quantity of adverse clinical events generated during a practitioner's affiliation with WellSense.
- Practitioners have no right of appeal from an action that is based on a directive from MassHealth, CMS, or other regulatory authority to terminate or suspend a practitioner who participates in WellSense's MassHealth, SCO, or Clarity plan (including QHP, ConnectorCare and Employer Choice Direct) programs.

Disciplinary notice

- If the Credentialing Committee recommends a disciplinary action, the practitioner will be notified in writing within 10 calendar days following the decision date. The notice will contain a summary of the reasons for the disciplinary action and a description of the appeal process.

Practitioner request for appeal

- The practitioner may request an appeal in writing by sending a letter to WellSense's Director of Credentialing postmarked no more than 30 calendar days following your receipt of WellSense's notice of disciplinary action. We will not accept provider appeals after the 30-calendar-day period. You have a right to be represented in an appeal by another person of your choice (including an attorney). Your appeal should include a statement indicating the foundation of your appeal, and any supporting documentation you wish to submit, including but not limited to, any new or relevant information that you believe may not have been originally considered by the Credentialing Committee.
- When we receive a timely appeal, we will send you an acknowledgement within three business days. The Director of Credentialing will arrange for your case to be sent back to the Credentialing Committee for reconsideration.
- If we do not receive an appeal request by the filing deadline, the Credentialing Committee's action will be considered final.

Credentialing Committee reconsideration

- Upon timely receipt of an appeal request, the Credentialing Committee will review the appeal and reconsider its original decision. Upon reconsideration, if the Committee reverses its original decision, we will notify you in writing within ten business days. If the Committee upholds its original decision or modifies it such that another type or level of disciplinary action is taken, we will notify you in writing within ten business days, that an independent review Appeals Panel will be automatically assembled to review the appeal. We will request your availability for a hearing, and will provide you with additional administrative details.

Appeals Panel hearing and notice

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

- You will be notified of the Appeals Panel’s decision and the reasons for the decision no later than ten business days from the date of the hearing. If the disciplinary action is reversed during the appeal process, WellSense shall take all steps to reverse the disciplinary action within three calendar days.

Re-application following denial or termination

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

3.10 Role of the credentialed practitioner

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

Role of the credentialed primary care provider (PCP)

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

PCPs are physicians practicing in one of the following specialties: Family Medicine; Internal Medicine, General Practice, Adolescent and Family Medicine, Geriatric Medicine, Pediatric Medicine and Obstetrics/Gynecology (for female members aged 10 and older and other transgender and gender diverse individuals who need Obstetric and/or Gynecologic care only). Nurse practitioners (NPs) and Physician Assistants also may function as PCPs if they are trained in Internal Medicine, Pediatrics, Family Medicine, or Women's Health.

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

Role of the credentialed specialist

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

3.11 Organizational providers

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

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

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

- Ultrasound/vascular imaging providers
- Mammography providers

Standards for Participation

All providers must submit documentation and meet the following criteria to participate in the WellSense network, unless otherwise stated.

- Current and complete credentialing application
- Completion of a Federally Required Disclosures (FRD) form. As further detailed in our Federally Required Disclosures form policy, you must inform WellSense on an annual basis of any changes to the information submitted on the Federally Required Disclosures form submitted with your provider application, if your contract with WellSense auto-renews. The Federally Required Disclosures form policy is available upon request.
- Copy of current state license issued by the Department of Public Health or appropriate state agency. If license is not current, the provider must provide a letter from the Department of Public Health indicating the licensure status.
- Completion of the Massachusetts Hospital Attestation form to demonstrate that the provider has met the patient safety standards, as required in 45 CFR 156.1110. The form will include the provider's

Medicaid-only CMS Certification Number (CCN). (This requirement applies only to hospitals participating in the WellSense Clarity network or Qualified Health Plan network, with fifty beds or greater).

- Providers must not be currently debarred, suspended, or otherwise excluded from participation in Medicare, Medicaid or any other federal or state health care programs.
- Copy of current malpractice liability policy with a minimum coverage amount of \$1,000,000/\$3,000,000.
- Copy of current Clinical Laboratory Improvement Amendments (CLIA) certification, or waiver of a certificate of registration with a CLIA identification number (applies to providers with laboratories only)
- Accreditation, Site-Survey, or Plan On-Site Quality Assessment
- Copy of current accreditation certificate with one of the following Plan-recognized accreditation agencies:
 - Accreditation Association for Ambulatory Health Care (AAAHC)
 - Accreditation by the American College of Radiology (ACR)
 - Accreditation Commission for Health Care (ACHC)
 - American Association of Blood Banks (AABB)
 - Commission on Accreditation of Rehabilitation Facilities (CARF)
 - College of American Pathologists (CAP)
 - Commission on Office Laboratory Accreditation (COLA)
 - Community Health Accreditation Program (CHAP)

- Continuing Care Accreditation Commission (CCAC)
 - Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL)
 - Joint Commission for Accreditation of Healthcare Organizations (JCAHO)
 - National Association of Childbearing Centers (NACC)
-
- The provider must submit evidence that it has participated in a survey with the Centers for Medicare & Medicaid Services (CMS) or Department of Public Health (DPH) within the past 36 months. The Plan requires a letter or report from the agency that includes the results of the survey as well as any deficiencies that may have been discovered. If the provider has been asked for a plan of correction, the Plan must receive a letter showing that the plan of correction has been accepted by CMS or DPH.
 - If the provider does not hold an accreditation, has not participated in a survey within the past 36 months, or does not have a survey that meets Plan standards, the Plan will complete an on-site quality assessment ("Site Visit"). During the Site Visit, the Plan will use the appropriate form addressing the specific criteria for each provider. The Site Visit may include interviews with the provider's senior management, chiefs of major services and key personnel in nursing, quality management and utilization management. The Plan will also review the provider's process for credentialing the practitioners employed at the organization. The Plan adopts Massachusetts site-visit standards for Skilled Nursing Facilities and Urgent Care Facilities.
 - A provider may be considered exempt from having to meet this requirement if it is located within a Rural Area, as defined by the US Census Bureau.

Re-credentialing

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

Quality of Care Issues

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

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

This notice applies to any doctor of medicine, osteopathy, or dental science, or a registered nurse, social worker, doctor of chiropractic, or licensed psychologist, or an intern, or a licensed resident, fellow, or medical

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

For a list of Consumer Protections for Clarity plan products, please see the [Addendum](#) at the end of this Provider Manual.

Provider requirements under the Frail Elder Waiver

In addition to the provider credentialing requirements established in our credentialing policies, certain providers who may render services to Senior Care Options' Frail Elder Waiver members must meet the qualifications, certifications, and other requirements such as staff CORI checks and annual trainings, as required in the Frail Elder Home and Community Based Services Waiver. A provider's adherence to these requirements will be assessed through onsite reviews at the provider's place of business. At the provider level, onsite review by Plan staff will take place at least once during the first six months from the provider's contract effective date, and thereafter every 2–3 years depending on provider type.

Section 4: Provider Responsibilities

We are your partners in delivering the best possible care to your WellSense patients. We know that delivering excellent care comes with many responsibilities. If you have questions or need help verifying a member's enrollment, check the Provider section of our website wellsense.org.

4.1 Overview

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

Providers must ensure WellSense has current and accurate provider information. As such, we require written notification of any Tax Identification Number (TIN) changes prior to claim submissions, and no later than 30 calendar days prior to the effective date of the requested change. This will allow WellSense to complete any necessary system updates and safeguard against payment disruption.

Submit a completed Change/Termination Form as soon as possible when changes occur using one of the following submission channels:

Email: Provider.ProcessingCenter@wellsense.org or Fax: 617-897-0818.

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

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

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

- Language(s) you speak and other cultural competencies
- W-9
- ACH form for electronic payment with appropriate documentation

You may also visit our website at wellsense.org to access our Letter of Interest Form located in the [Provider Section](#), under Join our Network.

Mail Letters or Letter of Interest Forms with your W-9 to:

WellSense Health Plan
Provider Engagement Department
529 Main Street Suite 500 (address will be changing late spring 2024)
Charlestown, MA 02129

Or email the documents to: provider.info@wellsense.org or Provider.ProcessingCenter@wellsense.org.

If a new provider joins a WellSense contracted entity:

All providers treating WellSense members must be credentialed by WellSense. We, or our credentialing designee, must credential any provider joining a practice, facility, or ancillary site contracted with us before treating members.

A provider joining a WellSense contracted entity must:

Complete the [WellSense Provider Data Form](#) available on our website at wellsense.org, as well as, an [HCAS Enrollment Form](#) (for a new individual professional medical/surgical provider or for a new facility affiliated with a WellSense contracted facility), also available on our website.

Submit forms in one of the following ways:

- **Fax** the documents to 617-897-0818.
- **Email** the documents to WellSense at Provider.ProcessingCenter@wellsense.org.
- **Mail** the documents to:

WellSense Health Plan
Provider Processing Center
529 Main Street, Suite 500 (address will be changing late spring 2024)
Charlestown, MA 02129

- After receiving the appropriate forms, we will notify the new provider of their credentialing status and assist with the credentialing process, as needed.

Changes in federal Medicaid law (set forth at 42 CFR § 438.602) require all managed care entity (MCE) network providers, including WellSense network providers, to enroll with MassHealth. This means all WellSense network providers must have two provider contracts in place: (1) a network provider contract with WellSense; and (2) a provider contract with MassHealth.

MassHealth has developed the [MassHealth Nonbilling Managed Care Entity \(MCE\) Network-only Provider Contract](#) for MCE network providers who do not already have a provider contract with MassHealth. This specific MassHealth provider contract does not require WellSense network providers to render services to MassHealth fee-for-service members.

- Visit mass.gov/forms/submit-the-masshealth-nonbilling-managed-care-entity-network-only-provider-contract to complete a [MassHealth Nonbilling MCE Network-only Provider Contract](#) under this requirement within 30 days of receiving confirmation of your WellSense enrollment.

To request WellSense participation of an additional provider site:

- Complete the [WellSense Provider Data Form](#) available on our website at wellsense.org, as well as, an [HCAS Enrollment Form](#) (for a new individual professional medical/surgical provider or for a new facility affiliated with a WellSense contracted facility), also available on our website.
- Submit forms to the Provider Processing Center in one of the ways listed above. After receiving the forms, we will notify you when we have credentialed the additional location and when members may be treated at this location.

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

If you are an existing provider and would like to participate in an additional WellSense product, please send a Letter of Intent requesting product participation to:

WellSense Health Plan
Provider Engagement Department
529 Main Street, Suite 500 (address will be changing late spring 2024)
Charlestown, MA 02129

You may also email the documents to: provider.info@wellsense.org or provider.processingcenter@wellsense.org.

Based on product network necessity, we will notify you if the new product line can be added to your existing agreement.

Responsibilities by Provider Type

General requirements for all providers

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

You must comply with the obligations specified in your WellSense provider agreements and with the most current version of this manual including Network Notifications. Network Notifications may be issued throughout the year and are sent to all contracted providers. The [Provider Manual](#) and [Network Notifications](#) are also posted at wellsense.org. In instances when providers are not in compliance with WellSense requirements, we will work with them to implement corrective actions, as appropriate. The Plan puts forth best efforts to notify you in writing **60 calendar days** in advance of changes to our policies or procedures, unless a policy and/or procedure is required to be implemented sooner due to regulatory compliance reasons.

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

Contract requirements for all providers

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

Care coordination requirements for all providers

- Supervise, coordinate, and provide medically necessary WellSense covered services in accordance with accepted standards of clinical practice by provider type.
- Request a benefit modification if you believe that a member's health is jeopardized because a particular service or item is medically necessary but not covered. See [Section 8: Utilization Management and Prior Authorization](#) for guidelines on submitting a benefit modification request.
- Complete a behavioral health assessment upon initial contact with the member to identify the member's need for behavioral health treatment. If a member requires behavioral health services, promptly direct him/her to a behavioral health provider according to Carelon Behavioral Health guidelines at carelonbehavioralhealth.com or by calling 866-444-5155.
- Maintain the confidentiality of member information and records at all times.
- Make best efforts to provide foster parents with current medical information about young members placed in their care in a timely manner.

- Treat members promptly and courteously in a clean, comfortable environment, with staff that is mindful of the members' needs for dignity and respect.
- Accept and treat members without regard to race, age, gender, sexual preference, national origin, religion, health status, economic status, or physical disabilities. No provider may engage in any practice that constitutes unlawful discrimination under any state or federal law to any WellSense member.
- Providers must not discriminate against an individual/member on the basis of gender identity or an individual seeking gender re-assignment/transgender services.
- Communicate freely with members about their treatment options, regardless of the benefit coverage limitations.
- Maintain complete medical records consistent with all statutory and regulatory requirements and WellSense policies. Medical records must be available to us to fulfill our quality management responsibilities. See Section 14: Quality Management for the medical record charting standards for participating physicians.
- Comply with any advance directive instructions that a member or their proxy has given you, and note it in the member's medical record as mandated by state law.
- Comply with our authorization and notification guidelines by service type for:
 - Medical/surgical services, as specified in Section 8: Utilization Management and Prior Authorization.
 - Pharmacy services, as outlined in the [Pharmacy](#) section of our website wellsense.org.
 - Behavioral health services at carelonbehavioralhealth.com or 866-444-5155.
- Notify us as soon as possible, but no later than three business days of each confirmed pregnancy of a WellSense member by contacting our Prior Authorization department; call the provider line at 888-566-0008 and select the medical prior authorization option. Please note: this guideline does not apply to ancillary providers.
- Report immediately to WellSense any adverse medical incident, and to Carelon Behavioral Health any behavioral health reportable adverse incident related to a WellSense member. See [Section 14: Quality Management](#) for a description of the adverse incidents and carelonbehavioralhealth.com for a description of the behavioral health reportable adverse incidents, including policy information and instructions on the appropriate notification process by incident category.
- Direct members to other WellSense participating providers for needed medical and behavioral health services, unless the required medical services are unavailable through a WellSense participating provider. Providers must seek prior authorization from WellSense prior to referring members to non-participating providers. If notification is required, providers must agree to notify WellSense no later than the next business day following an emergency referral.
- Assist WellSense staff with care coordination and care management activities for members.
- Review WellSense's utilization reports related to care management, care coordination, or quality improvement activities, as appropriate. Work collaboratively with WellSense staff to evaluate level of care, appropriateness of service or treatment for a member's condition, and under and over-utilization of services for a WellSense member.

- For MassHealth and SCO members, providers cannot refuse to deliver services to members who have missed appointments or who have an outstanding debt to you from a time prior to the time that individual became a WellSense member. Please work with MassHealth members (if applicable) and WellSense to help members keep their appointments.
- Furnish member clinical information, with lawful member consent, to other providers, as necessary, to ensure proper coordination and behavioral health treatment of members who express suicidal or homicidal ideation or intent.
- In accordance with Section 1944 of the SSA, providers must check the prescription drug history of the patient through the Prescription Drug Monitoring Program (PDMP) database prior to prescribing controlled substances to patients,
- If providers are unable to check the PDMP, have protocols in place to document good faith efforts, including reasons why the check was not conducted
- Have protocols in place to document and address contradictory information the PDMP from information received by patients
- For providers participating in our SCO network, additional responsibilities include:
- Participate in member Primary Care Team (PCT), as necessary.
- Attend PCT meetings for SCO members as necessary and be available to communicate through PCT meetings, as needed.
- Request an organizational determination if you believe that a member's health is jeopardized because a particular service or item is medically necessary but not covered. See [Section 8: Utilization Management and Prior Authorization](#) for guidelines on submitting an organizational determination request.
- Direct the member to contact WellSense to request an organizational determination when there is member disagreement with a provider decision related to a service or course of treatment.
- Provide WellSense with updates to the information in the provider directory in a timely manner, and respond to WellSense outreach requests for accuracy of the provider directory information on at least a quarterly basis.

Primary Care Provider requirements

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

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

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

Product	Member Service
MassHealth	888-566-0010
Clarity plans (including QHP, ConnectorCare and Employer Choice Direct)	855-833-8120
Senior Care Options	855-833-8125

- Or, request that their PCP assist in completing and faxing to our Enrollment department a [Primary Care Provider Selection Form](#) available on our website at wellsense.org.
- Schedule a baseline physical examination for each new member according to the access to care standards outlined in this section (unless you determine that the exam has been previously performed and documented within our approved timeframes for the member's age/gender category).
- Be available to respond to urgent healthcare needs of WellSense members 24 hours a day, seven days a week, with a telephone answered by a live voice, or have arrangements for such coverage by another WellSense participating PCP. A WellSense medical director must approve coverage arrangements that are not in compliance with this requirement.
- Meet our applicable appointment availability and office waiting time standards outlined in this section.
- For medical/surgical admissions, admit or arrange to admit WellSense members to a participating hospital (if clinically appropriate) in the member's WellSense network and coordinate the medical care of the member while hospitalized.
- PCPs should direct members to other WellSense participating providers for needed medical and behavioral health services, unless the required services are unavailable through a WellSense participating provider. Providers must seek prior authorization from us prior to referring members to non-participating providers. If notification is required, providers must agree to notify us no later than the next business day following an emergency referral.
- In addition, if a PCP refers a member to an out-of-network provider, they must inform the member that the provider is out of network and must ask the member to contact the health plan before seeing the out-of-network provider.

- Follow the latest Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) schedule for MassHealth members under age 21. To ensure that the schedule is current we recommend that you visit the Massachusetts Health Quality Partners (MHQP) website at mhqp.org.
- Review your enrollment report that lists all eligible members in your panel as of the time the report was printed. We generate reports to identify new members, dis-enrolled members, and those who have historically been seeking care at the health site. These reports include member name, address, WellSense member ID number, and gender. Your panel report does not guarantee current member eligibility or PCP assignment. Please follow the instructions in [Section 2: Member Eligibility](#) to determine member eligibility.
- For PCPs participating in our Senior Care Options network, additional responsibilities include:
 - Participate in the development of members' Individualized Care Plans.
 - Participate in the member's Primary Care Team meetings and be available to communicate with member's Care Manager or Care Coordinator, as necessary.

PCPs must coordinate all WellSense members' behavioral health and medical care needs by communicating with members' behavioral health providers. PCPs must request written consent from the member to release information for these purposes. The consent form must conform to the requirements set forth in 42 CFR Part 2 when applicable. Visit wellsense.org for a copy of the [Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form](#). PCPs also must document all instances in which consent was not given and, if possible, the reason why.

For members enrolled in the Long Term Services and Supports (LTSS) or Behavioral Health Community Partners (BHCP) Program, PCPs will:

- Participate in a member's Care team.
- Help with the development of the person-centered care plan.
- Designate a care team point of contact responsible for communicating updates regarding members' care from each PCP practice to the CPs.
- Make referrals to medically necessary specialty care for which the ACO, MCO, or MassHealth requires referrals.
- Conduct Medication Reconciliation as part of patient care transitions.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and Preventive Pediatric Health-Care Screening and Diagnosis (PPHSD) services are available to WellSense's MassHealth members under age 21. This important screening requirement applies to:

- EPSDT: MassHealth Standard and CommonHealth
- PPHSD: MassHealth Family Assistance

WellSense pays for these members to see their PCPs on a periodic schedule. At all well-child visits, PCPs perform a series of health screens, including approved, standardized behavioral health screens, as outlined on MassHealth's website at mass.gov.

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

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

Covering physicians

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

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

See [Section 8: Utilization Management and Prior Authorization](#) for additional information about this requirement. Also, please refer to our Prior Authorization Matrix available on the [Prior Authorization Resources](#) page of our website at wellsense.org. The matrix is at the bottom of the page.

Responsibilities of contracted hospitals

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

- Work collaboratively with our hospital care coordinators on concurrent review and discharge planning activities for medical/surgical services.

- Contracted hospitals and Critical Access Hospitals must deliver the Medicare Outpatient Observation Notice (MOON) to any SCO beneficiary who receives observation services as an outpatient for more than 24 hours.
- Coordinate a member's behavioral healthcare services with our behavioral health care managers.
- Immediately contact an Emergency Services Program (ESP), listed in [Section 12: Behavioral Health Management](#) when a member presents in a behavioral health crisis.

Hospital responsibilities related to medical/surgical services

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

Please see [Section 14: Quality Management](#) for detailed information and guidelines on Serious Reportable Events (SRE), Adverse Incidents, and Provider Preventable Conditions.

Provider training for Senior Care Options participating providers

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

Topics may include:

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

Training can be conducted through different mechanisms, such as in person, through a Learning Management System (LMS), or online. Once training is finished, providers will be asked to attest they have completed the training. If the MOC training is accomplished through LMS, completion within that system is considered to be sufficient documentation. If training is completed online, once the provider completes the self-study/online training, they will be asked to attest they have completed the training by completing an online survey. If a provider receives the training through a meeting or takes it independently, they will be

asked to sign the attestation at the back of the training presentation and to return it to their designated representative.

Provider Engagement will track the attestations as evidence of the completed training. For providers who do not attest to taking the training, WellSense Provider Engagement Staff will outreach via phone or visit the provider office to obtain the attestation. If the training is done in person, WellSense will compile and record a list of attendees as evidence of the completed training.

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

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

Federally Required Disclosures

As further detailed in our Federally Required Disclosures form policy, you must inform WellSense on an annual basis of any changes to the information submitted on the Federally Required Disclosures form submitted with your provider application, if your contract with WellSense auto-renews. The Federally Required Disclosures form policy is available upon request.

4.3 Fraud, Waste and Abuse

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

- Medically necessary in the provider's reasonable judgment;
- Performed by the provider or under a licensed clinician's supervision;
- Filed accurately, using appropriate coding; and
- Properly documented in the member's medical records.

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

Any amount billed by a provider in violation of this policy, if paid by WellSense, constitutes an overpayment and is subject to recovery by WellSense. If medical records are not provided for a service, it is considered to not have been documented or provided, and is subject to recovery by WellSense. Any amounts billed to and paid by members in violation of this policy must be immediately refunded to the member.

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

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

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

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

- Calling our anonymous, independent Fraud Hotline, available 24 hours a day, seven days a week, at 888-411-4959
- Emailing the Special Investigations Unit at FraudandAbuse@wellsense.org.
- Faxing the Special Investigations Unit at 866-750-0947
- Mailing to WellSense at:

WellSense Health Plan

Attn: Special Investigations Unit

529 Main Street, Suite 500 (address will be changing late spring 2024)

Charlestown, MA 02129

Concerns involving a WellSense employee should be reported by:

- Calling the anonymous, independent Fraud Hotline at 888-411-4959
- Mailing to WellSense at:

WellSense Health Plan

Attn: Compliance Officer

529 Main Street, Suite 500 (address will be changing late spring 2024)

Charlestown, MA 02129

4.4 Provider Demographic Changes

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

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

Submit to:

WellSense Health Plan
Provider Engagement Department
529 Main Street, Suite 500 (address will be changing late spring 2024)
Charlestown, MA 02129

Or email to: Provider.ProcessingCenter@wellsense.org

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

Providers must ensure WellSense has current and accurate provider information. Failure to submit updated information timely may affect payments. WellSense requires written notification of any Tax Identification Number (TIN) changes prior to claim submission, and no later than 30 calendar days prior to the effective date of the change. This will allow WellSense to complete any necessary system updates and safeguard against payment disruption.

4.5 Access to Care Standards

To ensure that members have timely access to care, providers must comply with the standards outlined below. We perform quality assessments of provider practices to ensure our appointment availability standards are met. We monitor access using provider self-reported data and validate with site audits.

Access to care standards for behavioral health providers as well as consumer satisfaction measurement guidelines for behavioral health providers are available by visiting Carelon Behavioral Health's website at [carelonbehavioralhealth.com](https://www.carelonbehavioralhealth.com) or by calling 866-444-5155.

Service	Access Standard
Hours of Operation	Hours offered to our members must be no less than the hours offered to commercial enrollees (or MassHealth fee-for-service enrollees if the provider serves only WellSense members and other individuals enrolled in any MassHealth program).
Office/Service Waiting Time	20 minutes or less
After Hours Services	Provide one of the following: <ul style="list-style-type: none"> • 24-hour answering service with option to page the physician, or • Advice nurse with access to the PCP or on-call physician
Emergency and Psychiatric Services	Immediately upon entrance to delivery site, including in-network and out-of-network facilities 24 hours a day, seven days a week
Primary Care Services MassHealth (MCO & ACO) and Clarity plans (including QHP)	<ul style="list-style-type: none"> • Routine, non-symptomatic: 45 days, unless otherwise required by the EPSDT Periodicity Schedule • Non-urgent, symptomatic: 10 days • Urgent: 48 hours
Outpatient Specialty Services and Newborn Care MassHealth (MCO & ACO) and Clarity plans (including QHP)	<ul style="list-style-type: none"> • Non-symptomatic care: 60 days • Non-urgent, symptomatic care: 30 days • Urgent care: 48 hours • Initial prenatal visit: 21 days • Initial family planning visit: 10 days • Initial newborn care visit: 14 days of hospital discharge
Primary Care Services Senior Care Options (SCO)	<ul style="list-style-type: none"> • Non-symptomatic care: 14 days • Urgent care/symptomatic care: 48 hours
Outpatient Specialty Services Senior Care Options (SCO)	<ul style="list-style-type: none"> • Non-symptomatic care: 14 days • Urgent care/symptomatic care: 48 hours

Members affiliated with the Massachusetts Department of Mental Health (DMH), children in care or custody of the Department of Children and Families (DCF) (formerly DSS), and youth affiliated with the Massachusetts Department of Youth Services (DYS)	<ul style="list-style-type: none"> • A DCF or DYS screening within seven calendar days • Initial comprehensive medical evaluation (including EPSDT screens) within 30 calendar days, unless otherwise required by the EPSDT Periodicity schedule. • Communicate and inform DMH, DYS, and DCF caseworkers assigned to members of services provided through WellSense that support our members.
Other Healthcare Services	For MassHealth members, provide services in accordance with MassHealth standards and guidelines available at mass.gov . All WellSense rules apply.

4.6 Physician Panel Closing

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

- Keep the panel open to all WellSense members who were provided services prior to the panel closing;
- Submit the request in writing at least 60 days prior to the effective date of closing the panel (or such other period of time provided in your provider contract) to:

WellSense Health Plan

Provider Engagement Department

529 Main Street, Suite 500 (address will be changing late spring 2024)

Charlestown, MA, 02129

- Or submit via email to Provider.ProcessingCenter@wellsense.org. You also must submit written notice to WellSense of the re-opening of the panel, including a specific effective date.

4.7 Requesting a Change in a Member's PCP Assignment

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

MassHealth ACO members	MassHealth ACO members may change their PCP to another PCP within their ACO at any time. Members who want to change to a PCP not within their assigned ACO must contact MassHealth.
Clarity plan members	Clarity plan members (including QHP, ConnectorCare and Employer Choice Direct) request a PCP change only three times per year.
SCO members	Senior Care Options members may request a PCP change at any time.

See Section 7: WellSense Product Information for information about member selection and assignment of PCPs.

You must provide WellSense with 60 calendar days' notice before the effective date of the member change from your panel. To initiate the PCP Change Request, complete a [Member PCP Transfer Request Form](#) available on our website at wellsense.org. Please include all appropriate documentation and fax the form to the Enrollment department (using the fax number on the form). If you don't have a copy of the form, contact your dedicated Provider Relations Consultant. The Plan will initiate the outreach and reassignment of the member to ensure there is no interruption in care or services.

4.8 Member Transfer or Involuntary Termination

The PCP is expected to make all reasonable efforts to support and furnish services to all members, including members who exhibit disruptive behavior which may impair the provider's ability to furnish services to that member or other members.

In an extremely limited number of circumstances, the involuntary disenrollment of a member from a primary care provider (PCP) panel or from a Plan ACO may be considered.

Consistent with EOHHS requirements, including applicable federal and state law, guidance issued by CMS related to comparable requirements for Medicare-Medicaid plans, and any forthcoming amendments to the regulations, WellSense follows a defined process applied when requesting involuntary disenrollment of a member:

- The Transfer or Involuntary disenrollment of a member is reserved for rare and extraordinary circumstances only and will not be considered under the following circumstances:
- An adverse change in the member's health status
- The member's utilization of medical services
- The member's diminished mental capacity

- Missed appointments
- The member exercises their option to make treatment decisions with which the Provider or Plan disagrees, including the option to decline treatment or diagnostic testing
- The member's uncooperative or disruptive behavior resulting from his or her special needs (except when the member's enrollment seriously impairs the provider's and other staff's ability to furnish services to the particular member or other members)

"Serious Efforts" Requirements

The Plan must make serious efforts to work with the member to resolve any issues, including, but not limited to:

- Follow up and communication with the member or guardian (e.g., in-person discussions, phone calls) regarding the precipitating event(s)
- Provision of reasonable accommodations as appropriate (e.g., for individuals with mental or cognitive conditions, including mental illness and developmental disabilities)
- Provide other resources to meet the member's needs (e.g., BH services, care management, involvement of Community Partner, referral to other state agencies like the Department of Developmental Services or the Department of Mental Health, available housing supports such as a Community Support Program for the chronically homeless or Flexible Services)
- Furnish medically necessary services to the member through at least three (3) providers before plan-level disenrollment is considered, unless circumstances warrant consideration of immediate termination
- Work with the member to ensure they are aware of their ability to voluntarily change their PCP, and their ability to voluntarily change plans during the Plan Selection Period or by requesting a Fixed Enrollment Exception.

Primary Care Level Involuntary Disenrollment

Provider Actions

Except in circumstances involving an immediate safety concern, the provider must first attempt serious and reasonable efforts to work with the member to resolve the issue(s) presented and provide the member with at least one written notice in advance of further action.

If those efforts are not successful and the provider still wishes to disenroll the member from their panel, the PCP must then submit the request to the Plan.

Plan Actions

The Plan must review the request and make further serious efforts to work with the member to resolve the issue(s) presented (e.g., referral to Care Management).

The Plan will consider whether there is valid cause to disenroll the member from the PCP panel, and if so, may disenroll the member directly after review of appropriate documentation.

Documentation/Reporting Requirements

The involuntary disenrollment request must include the following details:

- Situation Details:
 - A thorough, objective explanation of the reason for the request detailing how the member's behavior has impacted the Plan's ability to arrange for or provide services to that member or to other members of the Plan
 - Statements from the provider(s) describing their experience with the member
 - Any information provided by the member (e.g., complaints, statements)
 - Any police reports or internal security reports
- Member Details
 - Member age, diagnosis, mental and functional status
 - A description of the member's social support systems
 - Any other relevant information
- Follow up/Interim Steps
 - Outline and supporting documentation of the serious efforts to resolve the problem with the member, including the provision of reasonable accommodations
 - Attestation that the member received at least one written notice in advance
 - Other
 - Establish that the member's behavior is not related to the use, or lack of use, of medical, BH or other services
 - Describe any extenuating circumstances

Operationalization

The ACO/MCO will:

- Contact the member and assist in assigning them to a new PCP of their choice within the relevant ACO or MCO network.
- Send a Planned Action Notice to the member informing them of the good cause basis for disenrollment and the right to appeal.
- Report, in a form and format specified by EOHHS, any Primary Care Level disenrollments approved.

If the member is unreachable after three (3) documented outreach attempts (at least one of which must be written) over three (3) consecutive days, the member will be assigned to the PCP of the ACO/MCO's choice.

To begin this PCP transfer process or involuntary termination process, complete the [Member PCP Transfer Request Form](#) or [Involuntary Member Disenrollment Request Form](#), as appropriate. Both forms are available on our website at wellsense.org. Please include all appropriate documentation and fax the form to the Enrollment department (using the fax number on the form).

We will also:

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

For more information, please refer to the policy titled *Involuntary Member Transfer or Plan Disenrollment Request* available in the Policies section of our website at wellsense.org.

4.9 Second Opinion

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

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

4.10 Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and Preventive Pediatric Health-Care Screening and Diagnosis (PPHSD) services are available to WellSense's MassHealth members under age 21. This important screening requirement applies to:

- EPSDT: MassHealth Standard and CommonHealth
- PPHSD: MassHealth Family Assistance

We pay for these members to see their PCPs on a periodic schedule. At all well-child visits, PCPs perform a series of health screens, including approved, standardized behavioral health screens, as outlined on MassHealth's website at mass.gov. If the member's behavioral health screen indicates the need for

behavioral health follow up, we pay for further assessment, diagnosis, and treatment services. We also pay for visits to primary care doctors or nurses between periodic visits when there might be something wrong.

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

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

In addition:

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

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

EPSDT Medical Protocol and Periodicity Schedule

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

Providers eligible for reimbursement of behavioral health screening tools

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

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

Reimbursement terms

The Plan will reimburse you for administering one standardized behavioral health screening tool per MassHealth member, per day, regardless of the number of behavioral health screening tools administered on the same day for a given member. See the Preventive Services payment policy for details. You must submit an encounter form every time you conduct the standardized behavioral health and developmental screening services. See [Section 9: Billing and Reimbursement](#) for specific details.

4.11 Adult Health Screening

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

4.12 Advance Directives

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

- **Living Will:** This is a legal document that outlines specific information on which life-prolonging measures one does and does not want to be taken if that individual becomes terminally ill or incapacitated. Many measures can be considered, including but not limited to the use of dialysis and

breathing machines, tube feeding, organ and tissue donation, and whether or not individuals want healthcare professionals to save their lives if their heartbeat or breathing stops.

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

PCPs should ask whether members have made an advance directive and ask for a copy of the advance directive for the member's record. PCPs should instruct members to report to WellSense the existence and terms of their advance directive. The PCP should keep a copy in the patient's medical records and the member should keep a copy at home.

Hospitals, including critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of personal care services, and hospices must maintain written policies and procedures concerning advance directives, including providing written information to members about their rights, educating the member about any limitations on the provider's ability to honor an advance directive, and notifying members that their care will not be conditioned based on whether they have executed an advance directive. This information must be given to the member at the time of admission as an inpatient, or, for home health, hospice, or personal care, coming under the agency's care.

Call the Member Service department (see contact information outlined in [Section 6: Member Information](#) for questions about Advance Directives).

4.13 Provider Preventable Conditions

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

PPCs are categorized as follows:

- **Health Care Acquired Conditions (HCACs):** any condition identified on Medicare's full list of hospital-acquired conditions (HACs).
- **Other Provider-Preventable Conditions (OPPCs):** conditions that could apply in any health care setting, as follows:
 - Wrong surgical or other invasive procedure performed on a patient
 - Surgical or other invasive procedure performed on the wrong body part
 - Surgical or other invasive procedure on the wrong patient

- Events identified by the National Quality Forum (NQF) as Serious Reportable Events (SREs) found in Section 14, heading 14.5 Provider Reporting of Serious Reportable Events (SREs), Provider Preventable Conditions (PPCs) and Adverse Incidents.

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

4.14 ADA Guidelines

People living with disabilities

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

4.15 Cultural Competency & Health Equity

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

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

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

WellSense collaborates with its providers to take action to advance health equity for members and the communities in which they live. “Health equity” is achieved when every individual has the opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential because of their race, ethnicity, socioeconomic status, or any other determinant of health.

Achieving health equity requires addressing and reducing the systemic barriers that prevent certain populations from accessing resources and opportunities to achieve their full health potential. Health equity activities may include health-related interventions focused on specific marginalized populations, diversity and equity initiatives within the healthcare workforce, initiatives to address health-related social needs, and incorporating patient and community input to organizational strategy.

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

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

WellSense providers must ensure that:

- Members know they have access to medical interpreters, signers, and TDD/TTY services or alternative formats, such as Braille, large font, audio tape, video tape, and Enrollee Information read aloud to an Enrollee by an Enrollee services representative to facilitate communication, without cost to them.
- Care is provided with consideration for the member’s race/ethnicity, disability, sexual orientation, gender identity, and language and how it impacts the member’s health or illness.
- Staff members with routine access to patients have cultural competency training and development.
- All staff members that interact with patients through operations, delivery of services, or other patient-facing roles, receive trainings periodically related to the advancement of health equity, aligned to the topics listed below. For providers that do not offer trainings on these topics already, WellSense will offer training resources upon request, or can provide consultation in identifying training vendors.

Health equity-related training topics should include:

- An overview of the organization’s health equity strategy, including populations prioritized for intervention;
- The role(s) trainees can play to promote and achieve health equity;
- The importance of and best practices related to:
- Collecting self-reported social risk factor data such as race, ethnicity, language, disability, sexual orientation, and gender identity;
- Addressing inequities experienced by enrollees with social risk factors, including but not limited to race, ethnicity, language, disability, sexual orientation, and gender identity
- Adherence to CLAS standards
- The role of trauma-informed practices for marginalized individuals
- Identifying and mitigating the impact of implicit biases on delivery of high quality, equitable health care
- Anti-racism, including topics such as but not limited to the role of structural and institutional racism in health care
- A description of how health equity training content reinforces the organization’s mission, values, and priorities and how trainees have applied or are expected to apply the training to their work
- Staff responsible for data collection makes reasonable attempts to collect member self-reported data regarding race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors. Staff members explain categories so members can identify themselves and their children.
- Treatment plans and clinical guidelines are followed with consideration of the member’s race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.
- Office sites have posted and printed materials in English and Spanish, and any other required non-English language.
- A provider cannot rely on a member’s child to provide interpretive services. A provider cannot rely on the member’s family and/or friends to interpret unless the member makes this request.
- If a member refuses an interpreter, the provider makes an effort to explain possible consequences of proceeding without the assistance of an interpreter and documents the member’s declination.
- If the member speaks a language that is not prevalent in the community, WellSense will provide telephonic language assistance services at the member’s request. The provider or member may call WellSense’s Member Service department (see the Contact page at [wellsense.org](https://www.wellsense.org)). We will connect them to the appropriate interpreter telephonically.

Health Equity

WellSense collaborates with its providers to take action to advance health equity for members and the communities in which they live. “Health equity” is achieved when every individual has the opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential because of their race, ethnicity, socioeconomic status, or any other determinant of health.

Achieving health equity requires addressing and reducing the systemic barriers that prevent certain populations from accessing resources and opportunities to achieve their full health potential. Health equity activities may include health-related interventions focused on specific marginalized populations, diversity and equity initiatives within the healthcare workforce, initiatives to address health-related social needs, and incorporating patient and community input to organizational strategy.

WellSense providers must ensure that:

- Care is provided with consideration for the member’s race/ethnicity, disability, sexual orientation, gender identity, and language and how it impacts the member’s health or illness.
- Staff members with routine access to patients have cultural competency training and development.
- All staff members that interact with patients (through operations, delivery of services, or other patient-facing roles (e.g., security officer or receptionist)) receive trainings periodically related to the advancement of health equity, aligned to the topics listed below. For providers that do not offer trainings on these topics already, WellSense will offer training resources upon request or can provide consultation in identifying training vendors.

Health equity-related training topics should include:

- An overview of the organization’s health equity strategy, including populations prioritized for intervention;
- The role(s) trainees can play to promote and achieve health equity;
- The importance of and best practices related to:
- Collecting self-reported social risk factor data such as race, ethnicity, language, disability, sexual orientation, and gender identity;
- Addressing inequities experienced by enrollees with social risk factors, including but not limited to race, ethnicity, language, disability, sexual orientation, and gender identity
- Adherence to CLAS standards
- The role of trauma-informed practices for marginalized individuals
- Identifying and mitigating the impact of implicit biases on delivery of high quality, equitable health care
- Anti-racism, including topics such as but not limited to the role of structural and institutional racism in health care
- A description of how health equity training content reinforces the organization’s mission, values, and priorities and how trainees have applied or are expected to apply the training to their work

Staff responsible for data collection makes reasonable attempts to collect member self-reported data regarding race, ethnicity, language, disability, sexual orientation, gender identity, and other social risk factors. Staff members explain categories so members can identify themselves and their children.

Treatment plans and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.

4.16 Members Held Harmless for Charges

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

For Senior Care Options members, services that have not been pre-authorized by WellSense SCO or meet limited exceptions for non-contracted providers will be denied as provider responsibility. Non-contracted providers must sign a [Waiver of Liability Statement](#), available at wellsense.org to appeal WellSense's denial.

4.17 Legal Notice

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

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

due to alcohol or drug use. Certain exemptions to this reporting requirement, as to a physician who is in compliance with the requirements of a drug or alcohol program satisfactory to the BORIM, are described in the BORIM regulation 243 CMR 2.00.

For a list of Consumer Protections for Clarity plan products, please see the [Addendum](#) at the end of this Provider Manual.

4.18 Members with Special Health Care Needs

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

Members with Special Health Care Needs are members who:

- Have complex or chronic medical needs requiring specialized health care services, including multiple chronic conditions, co-morbidities, co-existing functional impairments, and physical, mental/substance use, and developmental disabilities;
- Are children/adolescents with, or at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally;
- Are at high risk for admission/readmission to a 24-hour level of care within the next six months;
- Are at a high risk of institutionalization;
- Are diagnosed with a Serious Emotional Disturbance, a Severe and Persistent Mental Illness, or a substance use disorder, or otherwise have significant behavioral health needs;
- Are chronically homeless;
- Are at high risk of inpatient admission or Emergency Department visits; or
- Receive care from other state agency programs.

Section 5: Provider Resources

5.1 Introduction

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

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

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

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

5.2 Secure Provider Portal

Our secure online provider portal, [The Provider Portal](#), offers you a convenient way to access information and resources. To comply with state and federal privacy laws and regulations, including HIPAA, we require a log-in and password to access member information and certain online provider website functions. Because these features are protected, you must register for a secure portal log-in ID request via our portal at [provider portal](#) and click on Provider log-in.

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

- Check the status of a claim
- Check member eligibility
- Check PCP assignment
- View Remittance Advice history
- View reports such as the Membership Panel report

To request a Log-In ID for our secure Provider Portal, visit wellsense.org and from our Provider page, select **Provider Login**. The Provider Registration Training Guide can be found in the [Training and Support](#) section of our website.

If you need to reach your Provider Relations Consultant and are not sure who that is, you may [Find Your Provider Relations Consultant](#) tool in the [Training and Support](#) section of our Provider portal. You do not need to log in to use this feature.

5.3 Additional Website Features

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

“Find A Provider” tool

Our online provider lookup contains the most current provider listings for our MassHealth, Senior Care Options, and commercial plan networks, including QHP. Search results for PCPs, specialists (including behavioral health), and ancillary services providers contain the following demographic information:

- Location
- Hospital affiliation
- Specialty type
- Address and telephone number
- Whether PCPs are accepting only existing patients
- Languages spoken by provider or skilled medical interpreter at the site
- Whether a provider’s office is accessible to disabled members
- Our online Provider Directory also includes contracted pharmacies and hospitals

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

- **Tool for Prior Authorization Requests:** CPT & HCPCS Look-Up Tool that provides a quick and efficient method of verifying if your procedure or service requires prior authorization. Available on the Provider page of our website at wellsense.org.
- **Resources for claims submission:** To help you submit accurate claims and get paid faster, the website includes clinical editing guidelines and other reimbursement resources.

- **Network Notifications:** A library of important notices we have informed you about. Network Notifications are written notices that make changes to or update this Provider Manual and related WellSense policies and procedures.
- **Provider notices:** A library of the communications we've sent to you.
- **Provider-specific reports:** Requested available reports specific to inpatient census, member panels, member redetermination, and emergency department utilization. Speak to your Provider Relations Consultant for more information.
- **Other material available online:** Our website provides links to WellSense's policies, forms, information on electronic data interchange, and other useful information. At your request, we distribute approved member and provider marketing literature, including brochures, posters, and other collateral materials.
- **Online drug formulary:** Available on the [Pharmacy page](#) of our website, allows access to verify coverage of a specific drug or an entire drug class.

5.4 Provider Engagement Department

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

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

Additionally, your dedicated Provider Relations Consultant:

- Orients and educates providers and their staff on our policies and procedures, helps you access reports (for example, inpatient census, member panel, emergency department utilization, and ad hoc data requests).
- Responds promptly to questions and concerns, as well as, provides ongoing education and support via their role as your dedicated liaison for WellSense.

Please utilize [The Provider Portal](#), our improved secure Provider Portal, for verifying eligibility, checking claim status, submitting claims, submitting prior authorization requests, and submitting corrected claims and appeals. You should also request member PCP changes via our Provider Portal.

To request a Log-In ID for our secure Provider Portal, visit wellsense.org and select **Login**. The Provider Registration Guide can be found in the Training and Support section of the website.

If you need to reach your Provider Relations Consultant and are not sure who that is, you may visit our website and utilize our Find Your Provider Relations Consultant tool under the Provider section of our portal. You do not need to log in to use this feature.

If you have any questions or concerns and need to call our Provider Service Center, you may do that by dialing 888-566-0008. Staff is available 8 a.m. to 5 p.m., Monday–Friday.

This provider line is available to provide you with the following information:

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

Provider Training

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

- Member eligibility
- Provider responsibilities
- Provider Policies – how to access
- Understanding your provider reports
- Provider Portal training
- Care Management – how to access
- Billing and claims submission
- Cultural Competency
- Administrative, Clinical, and Payment policies and procedures
- Fraud and abuse reporting

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

Care Management Department phone line

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

5.5 Provider Service Center

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

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

5.6 “Quick Reference” Charts and Code Lists

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

Medical/Surgical Prior Authorization Reference Charts

- Our Medical/Surgical Authorization Requirements Matrix is located on our website at wellsense.org. Select I am a Provider > Prior > Authorizations > Service or Procedure > then the [Look-up Tool: Prior Authorization Matrix](#) option.
- Tool for Prior Authorization Requests: CPT & HCPCS Look-Up Tools that provide a quick and efficient method of verifying if your procedure requires prior authorization. Available on the [Prior Authorization](#) page of our website at wellsense.org.
- DMEPOS services requiring prior authorization by either WellSense or Northwood. See the [Prior Authorization Matrix](#) available on our website at wellsense.org.
- Information regarding limitations on cosmetic procedures can also be found on our website at wellsense.org.

Member information reference charts

- Chart of WellSense Covered Benefits and Services, available on our website at wellsense.org in each member section.
- Instructions for verifying member eligibility. See Section 2: Member Eligibility.
- Pharmacy Reference Charts See Section 13: Pharmacy Services.
- WellSense [Pharmacy benefits](#) available on the Providers page at wellsense.org. Also see [Section 13: Pharmacy Services](#).

5.7 Provider Education and Communication

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

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

We develop and email "Provider News," a newsletter for network providers, which is also posted to our website at wellsense.org. Sample topics include administrative and clinical guidelines, pharmacy news, quality

initiatives, and other information relevant to network providers. We welcome your ideas for newsletter topics. If you want to receive Provider News electronically, please provide your email address by contacting your Provider Relations Consultant, or email us at provider.info@wellsense.org.

5.8 Positive Provider/Member Relationship

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

We provide PCPs with a member panel report, which is a list of your assigned members. You can access this report via our secure provider portal at bmchp-wellsense.healthtrioconnect.com with a secure login and an arrangement with your Provider Relations Consultant.

You should make your best efforts to schedule an initial appointment with every new member on your member panel. You may also obtain enrollment and PCP assignment information by calling our provider line at 888-566-0008 and selecting the member eligibility option.

5.9 Special Programs and Items for WellSense Members

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

5.10 Provider Complaints

Providers have the right to initiate a formal complaint regarding dissatisfaction with any WellSense Health Plan administrative policy or process.

This type of complaint may be filed:

Method	Contact Info
By Phone	Please call your dedicated Provider Relations Consultant who will document and escalate your complaint. The main number to our Provider Service Department is 888-566-0008
By Email	Send your complaint to Provider.Info@wellsense.org .
In Writing	WellSense Health Plan Attn: Provider Engagement Department 529 Main Street, Suite 500 Charlestown, MA 02129

Provider complaints will be reviewed by WellSense Health Plan's Network Management department leadership team.

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

Please refer to the Plan's Provider Manual for guidelines on the I Am A Provider page at wellsense.org
Provider Resources are located in this section.

Section 6: Member Information

6.1 Member Information

We offer a variety of products to eligible Massachusetts residents and employer groups. Further information on WellSense options are outlined under “Shop Plans” at wellsense.org.

6.2 Member Enrollment in WellSense

Plan Type	Overview
MassHealth membership	<p>To become a member of WellSense, a Massachusetts resident first must qualify through MassHealth or the Health Connector. Many community-based organizations, hospitals, and community health centers will assist those seeking membership and help them apply through the electronic application. The law requires that an applicant provide the Commonwealth of Massachusetts with income information, an employment record, any disability or illness information, a list of family members, proof of citizenship, identity (e.g., government-issued identity card), or immigration status and additional details. The Commonwealth of Massachusetts will then notify the applicant if he or she is eligible for WellSense.</p> <p>If the Commonwealth determines that an applicant is eligible, he or she becomes a WellSense member in one of the following ways:</p> <ul style="list-style-type: none"> • The individual chooses WellSense; or • MassHealth/the Health Connector enrolls the individual in WellSense; or the individual is transferred to WellSense from another managed care organization (MCO) or Accountable Care Organization (ACO).

Clarity plans (including QHP and ConnectorCare)	<p>Eligibility is determined on an individual basis. Members will be eligible as of the first of the month after their confirmed MCO selection. Once an individual is enrolled in WellSense, he or she is typically a member for the remainder of the benefit year (January 1 through December 31).</p> <p>Eligible Massachusetts residents may enroll in one of our QHPs through one of the following ways:</p> <ul style="list-style-type: none"> • Through the Health Connector: The Health Connector offers WellSense Clarity plans to eligible individuals and their families, and to the employees (and their dependents) of small employer groups (1–50 employees). Eligibility determinations for QHPs are made by the Health Connector. • Directly through WellSense: Eligible small groups (6–50 employees) may enroll directly through us into one of our small group plans—known as “Employer Choice Direct”—by calling us directly. We will make eligibility determinations according to our eligibility and participation policies. • Through HSA, our off exchange administrator. At this time HSA only offers the Silver 2000 and the Silver 3000 plans.
Senior Care Options	<p>Eligibility is determined on an individual basis. Members will be eligible as of the first of the month after they have enrolled in the SCO program. Members who disenroll are disenrolled at the end of the month.</p>

WellSense’s membership records are dependent on the enrollment notifications we receive from state and federal agencies. These notifications may require member retroactive additions and terminations. The Plan may recoup claims paid for members not enrolled in WellSense on the applicable date of service, regardless of the age of payment or date of service.

6.3 MassHealth Membership: Overview

MassHealth benefit categories and eligibility criteria for WellSense membership

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

- MassHealth CarePlus
- MassHealth Family Assistance
- MassHealth Standard

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

MassHealth CarePlus plan

MassHealth CarePlus includes MassHealth-eligible individuals who:

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

MassHealth Family Assistance plan

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

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

MassHealth Standard plan

This benefit category includes both Standard Disabled and Standard Aid to Families with Dependent Children (AFDC) populations. Members are eligible for the MassHealth Standard plan if they meet the income standard and belong to one of the groups listed below:

- Pregnant individuals at or below 200% of the FPL
- Children under age one, at or below 200% of the FPL
- Children aged one through 18, at or below 150% of the FPL
- Parents or caretaker relatives of children under age 19, at or below 133% of the FPL
- Disabled adults, at or below 133% of the FPL

6.4 Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct): Overview

WellSense Clarity plans, formerly called Qualified Health Plans, are available to eligible individuals and groups through the state exchange, known as the Health Connector. There are also individual Clarity plans available through WellSense's off exchange vendor. These are the WellSense Clarity plans offered through the Health Connector:

ConnectorCare plans

ConnectorCare plans are federal- and state-subsidized QHPs. There are three ConnectorCare plan types: **I**, **II**, and **III**. These plans are offered only through the Health Connector to eligible individuals. ConnectorCare plans use our "Silver Network." ConnectorCare ID cards will reference "ConnectorCare" and have both WellSense and the Health Connector logos.

Metallic plans

These are the metallic Clarity plans:

- Platinum
- Gold
- Low Gold
- Silver A
- Silver A II
- Silver B
- Low Silver
- Bronze

These are the Clarity plans offered off-exchange:

- Silver 2000
- Silver 3000

Each metallic Clarity plan has different member cost-sharing obligations. Members purchasing these plans may be eligible for federal subsidies depending on if their income is under 500% of the FPL. The maximum that a member may spend on health insurance is 8.5% of their income. All WellSense 2024 Clarity plans use our "Clarity Network." ID cards for these Clarity plan members enrolled through the Health Connector will reference the specific metallic plan and will contain both WellSense and Health Connector logos. ID cards for members enrolled through WellSense's off-exchange vendor will contain only our logo.

Employer Choice Direct plans: In addition to the WellSense Clarity plans offered through the Health Connector, we also offer the same metallic Clarity plans (described above) directly to eligible groups (those with 6–50 employees).

When these plans are made available to groups directly from WellSense (not through the Health Connector), they are referred to as “Employer Choice Direct” plans. Employer Choice Direct ID cards will contain only our logo.

6.5 Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct): Membership Overview

ConnectorCare eligibility categories

We offer the following three ConnectorCare benefit plan types:

- **ConnectorCare Plan Type I:** For Individuals whose income is up to 100% of the FPL
- **ConnectorCare Plan Type II:** For individuals whose income is between 100.1% and 200% of the FPL
- **ConnectorCare Plan Type III:** For individuals whose income is between 200.1% and 500% of the FPL

The Health Connector (**not WellSense**) is responsible for all ConnectorCare eligibility determinations. If eligible for ConnectorCare, individuals self-select a managed care organization (MCO) participating in the ConnectorCare program. Individuals can change plans if they have a Qualifying Life Event (QLE) during the plan year.

ConnectorCare eligibility criteria

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

- Uninsured and ineligible for health insurance through Medicaid/Medicare, their employer, or their spouse's employer for at least the last six months;
- Income before taxes is at or below 300% of FPL;
- U.S. citizen or a U.S.-qualified alien or alien with special status (AWSS);
- Massachusetts residency;
- Age 19 or older. (Some eligible persons under age 19 may be covered by MassHealth. WellSense participates in both programs.)

6.6 Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct): Membership Overview

Qualified Health Plans (QHPs) offered by WellSense are now called Clarity plans and individual plan names have been updated as noted below:

2023 Plan Name	NEW: 2024 Plan Name
WellSense QHP Platinum	WellSense Clarity Platinum 0 Deductible
WellSense QHP Gold	WellSense Clarity Gold 0 Deductible
WellSense QHP Silver A	WellSense Clarity Silver 2000
WellSense QHP Bronze	WellSense Clarity Bronze HSA 3600
WellSense QHP ConnectorCare Plan 1	WellSense Clarity ConnectorCare 1
WellSense QHP ConnectorCare Plan 2	WellSense Clarity ConnectorCare 2
WellSense QHP ConnectorCare Plan 3	WellSense Clarity ConnectorCare 3
WellSense QHP Silver B	WellSense Clarity Silver 3000
WellSense QHP Silver A II	WellSense Clarity Silver 2000 II
WellSense QHP Low Gold	WellSense Clarity Gold 1500
WellSense QHP Group Platinum 2024	WellSense Clarity Platinum 0 DeductibleSG
WellSense QHP Group Gold 2024	WellSense Clarity Gold 0 DeductibleSG
WellSense QHP Group Silver A 2024	WellSense Clarity Silver 2000SG
WellSense QHP Group Bronze 2024	WellSense Clarity Bronze HSA 3600SG
WellSense QHP Group Silver B 2024	WellSense Clarity Silver 3000SG
WellSense QHP Group Low Gold 2024	WellSense Clarity Gold 1500SG
WellSense QHP Group Low Silver 2024	WellSense Clarity Silver HSA 2000SG

Who is eligible for Clarity plans?

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

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

6.7 Senior Care Options (SCO): Eligibility

The eligibility criteria for WellSense SCO membership is:

- Must have or qualify for MassHealth Standard with a SCO-eligible aid category
- Must be age 65 or older
- Must reside in our Service Area (currently Barnstable, Bristol, Hampden, Plymouth, & Suffolk Counties for SCO members)
- May also have Medicare Part A & B

6.8 Overview of WellSense's Benefits

MassHealth and Clarity Plan Benefits Overview

We offer comprehensive benefit packages for **MassHealth, Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct members)**. Please see [Section 7: WellSense Product Information](#) for information on the products available under WellSense.

Member self-referral services for MassHealth and Clarity plans (including QHP, ConnectorCare and Employer Choice Direct members)

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

See 'Your Benefits' in the member section of wellsense.org for a list of medical/surgical services for which members may self-refer for care if delivered by a network provider.

A member may also self-refer for certain outpatient behavioral health services rather than being directed by their PCP if the service is delivered by a contracted Carelon Behavioral Health participating provider. We contract with Carelon Behavioral Health to manage our behavioral health program. Please direct all behavioral health inquiries to Carelon Behavioral Health at carelonbehavioralhealth.com or call 866-444-5155.

Go to 'Your Benefits' in the member section of wellsense.org for information on the benefits available to WellSense members.

Special programs and items for members

In addition to the clinical programs available to our members, we offer members several special programs and items that supplement their benefits.

For qualified **MassHealth** members, these extra programs and items include:

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

For **Clarity plan members (including QHP, ConnectorCare and Employer Choice Direct members)**, these extra programs may include:

- Reimbursements for WW® (Weight Watchers), fitness club memberships, and fitness trackers
- Free shipping on Mom's Meals, a healthy heat-and-eat meal delivery service
- Member Service department and Behavioral Health hotline to answer members' questions
- Care management for special populations
- Free access to our Nurse Advice Line
- Eyewear Discounts: At Vision Services Provider ("VSP") participating eye care provider
- 20% off the retail price of complete sets of prescription glasses frames and lenses.
- 15% off the professional fee for prescription contact lens fitting and evaluation.
- Diabetes Incentive Program: Members with diabetes will receive a \$25 gift card for completing all of the following activities within a calendar year (or plan year for members enrolled through an employer group)
 - PCP visit
 - Eye exam
 - One HbA1c test
 - Kidney function test

Senior Care Options Benefits Overview

We offer a comprehensive benefits package for **SCO** members. Member Referral Services for SCO members:

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

See 'Your Benefits' in the member section of wellsense.org for information on the benefits available to WellSense members.

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

- Over-the-Counter Card of \$115 per calendar month, without a rollover, to be used towards food, produce, and OTC items each month.
- Routine vision services are now provided through VSP. These services include one (1) routine eye exam per year, one pair/set of eyeglasses (prescription lenses, frames, a combination of lenses and frames) or contact lenses up to the allowed amount per calendar year is covered. Vision program includes up to \$325 annually for prescription eyeglasses or sunglasses. In addition to the members vision benefit, they are eligible for this vision hardware supplemental benefit. They may get glasses frames, lenses, and contact lenses through any participating or non-participating vision provider. As a participating provider, you may bill the health plan directly using standard coding for contact lenses, eyeglass frames and lenses, including upgrades (such as V2025 for deluxe frames and V2700 – V2788 for upgrades on lenses).
- SilverSneakers® fitness membership offering access to thousands of locations across the country. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2022 Tivity Health, Inc. All rights reserved.
- Emergency care is covered outside of the United States and its territories.

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

6.9 Member Eligibility

Always check member eligibility—before delivering services—on the date of service and daily during inpatient admissions. See [Section 2: Member Eligibility](#) for instructions on how to check member eligibility.

6.10 Primary Care Provider Selection and Assignment

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

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

- If a member was previously enrolled in WellSense, the PCP assignment will be the member's most recent PCP (if the assignment remains appropriate).
- If the member has not been enrolled in WellSense before, we consider the following criteria when assigning a PCP to the member:
 - Geographic proximity of the PCP's site to the member's current residence
 - PCP site's accessibility to public transportation
 - PCP site's ability to accommodate the member's disability, if applicable
- The member's age should be appropriate for the PCP's specialty and training:
 - Pediatrics: birth to age 21
 - Internal Medicine: age 18 or older
 - Family Medicine: all age categories
 - Geriatric Medicine: age 65 or older
- An obstetrician/gynecologist (OB/GYN) can serve as a PCP if selected by a female member aged 10 and older and other transgender and gender diverse individuals who need Obstetric and/or Gynecologic care, but WellSense will not assign a member to an OB/GYN practice for primary care services without a member request.
- If the member does not select their own PCP, we will inform the member of the PCP assignment.
- Our Member Service department can also assist the member in scheduling an initial appointment with the PCP.

Request for a PCP Change

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

- Member Portal
- For MassHealth, Clarity plan (including QHP), and SCO members, login to the member portal at wellsense.org and submit the request online.
- If this is the member's first PCP selection, the PCP assignment will be effective on the member's

Product	Timeframe for requesting a PCP change
MassHealth (including CarePlus) members	Any time
Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct) members	Voluntary requests – up to three times a year
Senior Care Options (SCO) members	Any time

enrollment date with WellSense. Participating providers may assist members with a PCP selection or PCP transfer.

PCP Selection Form

- MassHealth, Clarity plan (including QHP), and SCO members may complete, sign, and fax a [Primary Care Provider Selection Form](#) to our Enrollment department. Enrollment in the new PCP's member panel is effective the date the member signs the form.
- Call the Plan directly
- Members can call the Member Service department at the following numbers between 8 a.m. and 6 p.m., Monday through Friday (except holidays).

Product	Contact
MassHealth, including CarePlus	888-566-0010
Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct)	855-833-8120
Senior Care Options	855-833-8125

- For assignments requested via member call, enrollment in the new PCP's panel will be effective the next business day. However, we will transfer the member to the new PCP's panel the same day if the member indicates they are in the provider's office at the time of the call and requests the transfer be effective immediately.

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

6.11 Continuity of Care for New and Existing WellSense Members

New WellSense members

When medically necessary, we will arrange for a new WellSense member to continue receiving treatment from their current, non-network provider as further described below.

Product	Continuity of Care
MassHealth (including CarePlus) members	<p>We cover services for up to 30 calendar days from the member's WellSense enrollment date if the member:</p> <ul style="list-style-type: none"> • Has a life-threatening, degenerative, or disabling disease or condition; • Has significant health care needs or complex medical conditions; • Receives ongoing services; • Is hospitalized; • Is receiving treatment for behavioral health or substance use; • Is pregnant; or • Has received prior authorization for services, including scheduled surgeries; out-of-area specialty services; durable medical equipment (DME), prosthetics, orthotics, and supplies (POS); physical therapy (PT); occupational therapy (OT); speech therapy (ST); or nursing home admission. <p>For members with autism spectrum disorder, the continuity of care period for ABA Services is 90 days.</p>

Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct)	<p>We cover services delivered by non-network physicians, nurse practitioners, or physician assistants for up to 30 days from the member's effective date of coverage if any of the following apply:</p> <ul style="list-style-type: none"> • The provider does not participate in any other health plan option offered by the member's group (if applicable); and the provider is delivering an ongoing course of treatment or is the member's PCP. • The member is pregnant and in her second or third trimester, in which case we will cover through the member's first postpartum visit. • The member has a terminal illness, in which case we will cover until the member's death. <p>Other accommodations may be made for upcoming appointments, ongoing treatments or services, pre-existing prescriptions, scheduled and unscheduled inpatient care, and other medically necessary services.</p> <p>Additional conditions for coverage of continuity of care apply. Call us for further information.</p>
SCO	<p>We provide for the transition of existing services, equipment, and other resources to ensure safe, efficient continuity of care at enrollment as follows:</p> <ul style="list-style-type: none"> • Referring each new enrollee to the appropriate network providers • Assuring each new enrollee has access to services consistent with the access they previously had, and is permitted to retain their current provider for 90 days if that provider is not in the Plan's network.

Existing WellSense members

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

Product	Continuity of Care
MassHealth (including CarePlus) members	<p>We may provide coverage for services delivered by recently terminated providers in the following circumstances. (In these cases the provider must not have been disenrolled from WellSense due to fraud or quality of care issues.):</p> <ul style="list-style-type: none"> • We may allow affected members continued access to their terminated practitioner for up to 90 calendar days after the effective date of the practitioner's termination from WellSense if the member is undergoing active treatment for a chronic or acute medical condition. We will cover continued treatment through the current period of active treatment, or for up to 90 calendar days (whichever is shorter). • We may allow members who are in their second or third trimester of pregnancy continued access to a terminated WellSense practitioner whom they had been seeing in connection with their pregnancy through the postpartum period.
Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct)	<p>We may provide coverage for services delivered by recently terminated (former) network providers in the following circumstances (Note: in these cases the provider must not have been disenrolled from WellSense due to fraud or quality of care issues.):</p> <ul style="list-style-type: none"> • We may allow affected members continued access to their terminated PCP for at least 30 days after the effective date of the PCP's termination from WellSense. • If the member is undergoing active treatment for a chronic or acute medical condition, we cover continued treatment with the PCP or treating specialist through the current period of active treatment, or for up to 90 calendar days (whichever is shorter). • We will allow members who are in their second or third trimester of pregnancy continued access, through the postpartum period, to a terminated WellSense provider whom they had been seeing in connection with their pregnancy. • We will allow members who are terminally ill continued access to an involuntarily terminated practitioner until the member's death.

SCO	<p>We may allow impacted members continued access to covered services from the provider in the following circumstances:</p> <ul style="list-style-type: none"> • Up to 30 calendar days if the provider is the member's PCP; • Up to 90 calendar days if the provider, including the member's PCP, is providing the member with active treatment for an acute or chronic medical condition or until that active treatment is completed, whichever is shorter; or • Until death, with respect to services provided in connection with a terminal illness.
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Additional conditions for coverage of continuity of care apply. Call us for further information.

6.12 Confidentiality and Provider Access to Member Information

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

6.13 Member Rights and Responsibilities

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

Providers are responsible for ensuring member rights, as applicable.

Member Rights

In general, all members, regardless of product, have the following rights:

- Members have the right to get information from us about your MCO, ACO, QHP, or SCO Plan, our Covered Services, Network Providers, and your rights and responsibilities.

- Members have the right to get the Medically Necessary services in your Covered Services List.
- Members have the right to get a notice about any major changes to our Provider Network. These include when a PCP, Specialist, hospital, or facility leaves our Network and you are affected.
- Members have the right to be respected and have your dignity and right to privacy recognized.
- Members have the right to be free from all restraint (being placed under control) or seclusion being (isolated) used to force you, punish you, or get back at you or for anyone else's convenience.
- Members have the right to get a copy of your medical records. You have the right to ask that they be changed or corrected as allowed by law.
- Members have the right to have an honest discussion about health care treatment options in a way that you understand. This is the case no matter the cost or benefit coverage.
- Members have the right to take part in decisions regarding your health care. This includes refusing treatment.
- Members have the right to exercise your rights without it affecting you in a bad way or in how we and our Network Providers treat you.
- Members have the right to ask for a Second Opinion for suggested treatment and have us pay for the Second Opinion visit.
- Members have the right to file a Complaint when you're not happy with us, your Providers, or the quality of care or services you get (See [Section 10: Appeals, Inquiries, and Grievances](#).)
- Members have the right to an Internal Appeal or External Board of Hearings Appeal to ask us to change our mind about an Adverse Action (denial) decision that we made (See [Section 10: Appeals, Inquiries, and Grievances](#).)
- Members have a right to leave (Disenroll from) the Plan in some cases. To find out more, see [Section 12: Behavioral Health Management](#).
- Members have the right to request a written summary of our physician incentive plans.
- Members have the right to be told whether we have moral or religious reasons that would keep us from covering counseling or a referral service. You may also get information about how you can get this service.
- Members have the right to make suggestions about these Rights and Responsibilities.

Member Rights specific to MassHealth

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

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

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

Member Responsibilities: Below are some important things Members need to do:

- Get to know your Covered Services and the rules you must follow to get Covered Services.
- Help your Providers care for you.
- Clearly tell them about your health complaints, health history, and other health information.
- Ask them questions. Your Providers will explain things in a way you can understand. If you ask a question and do not understand the answer, ask again.
- Learn as much as you can about your health conditions and any recommended treatment. Consider the treatment before it is given.
- Follow the treatment plans and instructions that you and your doctors agree to.
- Remember that refusing recommended treatment might harm you.
- Allow your PCP to get copies of all your health records. This will help your PCP better care for you.
- Make sure your Providers know all of the drugs you take. This includes over-the-counter drugs, vitamins, and supplements.
- Work with your Provider to understand your health problems. Work out treatment plans and goals as much as possible.
- You must tell us if you have any health insurance coverage or drug coverage in addition to this Plan. Please call our Member Service Department to let us know.
- Tell your Providers you are enrolled in WellSense Health Plan. Show providers your WellSense Plan Member ID Card and your MassHealth Medicaid ID Card when you get Covered Services.
- Keep your appointments. Be on time. Call in advance if you’re going to be late or must cancel.
- Be considerate. Our Members should respect the rights of other patients. We also expect you to act in a way that helps your Providers’ offices run smoothly. Treat your Provider with respect.
- Pay what you owe. You are responsible to pay required copayments. If you get medical services or drugs that are not covered by us or by other insurance you have, you must pay the full cost.
- Tell us right away if you move or change your phone number. Please call the Member Service Department at 888-566-0010.

6.14 Member Outreach and Communication

Member Marketing

We provide marketing materials to potential members who express interest in WellSense membership. If contacted by potential members, WellSense representatives inform them of eligibility guidelines, enrollment

processes, role of the PCP, PCP selection process, and covered benefits. WellSense staff complies with all marketing standards established by MassHealth, the Health Connector, the Division of Insurance, the Massachusetts Executive Office of Health and Human Services, and the Centers for Medicare and Medicaid Services as these requirements relate to each program.

Providers may post approved marketing materials provided by WellSense in provider offices. Senior Care Options providers are also allowed to promote their affiliation with WellSense to their patients using an approved letter which we can provide upon request. Providers are otherwise prohibited from steering prospective members towards one specific health plan and must not engage in activities designed to influence patients to enroll with WellSense. If you wish to make WellSense materials available, you must first obtain approval from WellSense as some materials may require regulatory approval. WellSense is responsible for obtaining regulatory approval of all applicable materials.

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

Member Service Department

Our Member Service department is available to members:

Product	Member Service Hours
MassHealth and Clarity plans (including QHP)	Mon.–Fri. 8 a.m. to 6 p.m. (except holidays)
Senior Care Options	April 1 through Sept 30: Mon.–Fri. 8 a.m. to 8 p.m. October 1 through March 31: seven days a week 8 a.m. to 8 p.m.

Please refer to the Member Service telephone numbers available at wellsense.org to determine which inquiry line is most appropriate for the member to call. If necessary, a Member Service Representative will arrange for another staff member to speak with a WellSense member in their primary language, use an interpreter (free of charge), coordinate TTY/TDD services for members who are deaf or hearing-impaired, or use an alternative language device so the member can effectively communicate their needs to a Member Service Representative.

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

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

Behavioral Health Hotline

Our toll-free Behavioral Health **provider hotline number** is 866-444-5155 and is available 24 hours a day, seven days a week. No referral is necessary in an emergency situation.

Members can contact Behavioral Health at:

Product	Behavioral Health Contact Info
MassHealth and CarePlus	888-217-3501
Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct)	877-957-5600
Senior Care Options	855-833-8125

Nurse Advice Line

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

Product	Nurse Advice Line Contact Info
MassHealth and CarePlus	800-973-6273
Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct)	866-763-4695

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

New-Member Materials

We provide all new members with a member enrollment packet. This packet contains directions on how to find the Member Handbook or the Evidence of Coverage (EOC), for all programs. The Senior Care Options new member packet also contains an Annual Notice of Change, Summary of Benefits, and formulary. All new members receive the following information in their enrollment packets:

- Information on accessing our online Provider Directory
- A description of WellSense covered services and applicable copayments and other cost-sharing (such as deductibles and coinsurance)
- A description of the role of the PCP, and information on how members may select or change a PCP
- How members can obtain information about network providers
- How members can access medical/surgical and behavioral health services
- How members can get prescription drugs and related pharmacy copayments
- How members can obtain emergency services, including guidelines on when to access emergency services directly, when to use 911 services, and how to access alternatives to emergency room care
- How members can obtain care and coverage when out of our service area

Member Orientation

We make our best efforts to contact each new member by telephone. As part of this contact, we welcome him/her to WellSense and provide an orientation to our administrative guidelines, covered benefits, role of the PCP, network composition, and methods of communicating with us. We also urge all new MassHealth and Clarity plan (including QHP, ConnectorCare and Employer Choice Direct) members to complete assessments, enabling us to follow up with members identified as high-risk or who may have a chronic medical condition. SCO members are scheduled to meet with their Care Manager who will perform a comprehensive assessment in person.

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

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

Ongoing Member Communications

- We maintain ongoing communication with our members as follows:

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

Section 7: WellSense Product Information

This section describes the products we offer and some information specific to those products. For more information on the benefits available under each product, please visit the Member sections of our website at wellsense.org.

7.1 MassHealth

Any MassHealth member who is eligible to enroll in a Managed Care Organization (MCO) or Accountable Care Organization (ACO) may enroll in WellSense. Our members have a wide range of health care services covered through WellSense as well as services covered directly by MassHealth. Services covered directly by MassHealth are known as “wraparound” or “non-MCO” benefits. To review WellSense covered and excluded services and MassHealth wraparound benefits, please refer to the Covered Services List and Member Handbook available in the Member sections of wellsense.org.

We offer the following MassHealth coverage types:

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

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

7.2 Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct)

We offer Qualified Health Plans (QHPs), which are made available to eligible individuals and groups through the state exchange, known as the Health Connector. Starting in 2024, our QHP plans will be called Clarity plans. Clarity plans offered through the Health Connector are as follows:

- **ConnectorCare Plans:** ConnectorCare plans are federal and state-subsidized QHPs. There are three ConnectorCare plan types: I, II and III. These plans are offered only through the Health Connector to eligible individuals.
- **Metallic Plans including Platinum, Gold, Silver, Bronze** (these may change from year to year so please see the Member section of wellsense.org). Each metallic Clarity plan has different member cost-sharing obligations. Members purchasing these plans may be eligible for federal subsidies—depending on their income levels.

Starting in 2024, the Platinum, Gold, Bronze, Silver, and ConnectorCare plans may use providers in our Clarity Network.

ID cards: Clarity plan ID cards indicate whether the member is enrolled in a ConnectorCare plan or the specific metallic plan. These member ID cards have both WellSense and Health Connector logos.

Employer Choice Direct plans: In addition to the QHP plans offered through the Health Connector, we also directly offer the same metallic Clarity plans (described above) to eligible groups of 6–50 employees.

When these plans are made available to groups directly from us (not through the Health Connector), they are referred to as “Employer Choice Direct” plans. Employer Choice Direct ID cards have only our logo.

PCPs and provider networks: Each Clarity plan requires members to choose (or be assigned) a PCP who is responsible for managing or providing the member's care. PCPs must coordinate members' care with other WellSense participating providers in the Clarity Network—depending on the member's plan enrollment. Except in an emergency or when authorized in advance by us, members enrolled in our Clarity plans must

obtain all their covered health care services from our Clarity network. If you have any questions about whether you participate in our Clarity network, please call your dedicated WellSense Provider Relations Consultant. To identify your Provider Relations Consultant, visit the provider section of our website under [Training and Support](#).

Prior authorization: Some services require prior authorization by WellSense. Please follow the process for obtaining prior authorization described in [Section 8: Utilization Management and Prior Authorization](#) of this manual.

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

Covered and excluded services: Clarity plans covered (and excluded) services are described in the member's Evidence of Coverage and associated Schedule of Benefits. Both can be found in the Member section of our website at wellsense.org. Examples of services not covered by us include:

- Services that are not medically necessary
- Cosmetic services, devices, drugs, and surgery except when they are prior authorized by WellSense and are performed to correct or repair damage following an injury, illness or congenital deformity causing functional impairment, and/or to perform mastopexy following mastectomy
- Reversal of voluntary sterilization and services or fees related to achieving pregnancy through a surrogate
- Please visit wellsense.org, or the Connector's website, at mass.gov and search for more information on Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct).

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

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

covered services is prohibited without an advance written agreement by a member to pay for the specific non-covered services. In accordance with state and federal regulations, WellSense Health Plan members cannot be balance billed and are only responsible for their in-network cost share for emergency services or services rendered by a non-participating provider at an in-network facility. Preventive services, as defined by the Affordable Care Act (ACA), are covered with no cost-sharing. For more information about which preventive services are included, see the federal government's website at [healthcare.gov](https://www.healthcare.gov).

Cost-sharing terms and definitions applicable to Clarity plans are as follows:

- **Deductible:** The specific dollar amount a member may pay for certain covered services in a benefit year before WellSense is obligated to pay for those covered services. Once a member meets their deductible, they pay either nothing, or the applicable copayment or coinsurance for those covered services for the remainder of the benefit year. Deductible amounts are in the member's Schedule of Benefits posted on our website.
- **Copayment:** A fixed amount a member may pay for certain covered services. Copayments are paid directly to the provider at the time the member receives care (unless arranged otherwise). Copayment amounts are in the member's Schedule of Benefits posted on our website.
- **Coinsurance:** The percentage of costs a member may pay for certain covered services.
- Coinsurance amounts are in the member's Schedule of Benefits posted on our website.
- **Out-of-Pocket Maximum:** This is the maximum amount of cost-sharing a member is required to pay in a benefit year for most covered services. Out-of-pocket maximum amounts, if any, are in the member's Schedule of Benefits posted on our website.

7.3 Senior Care Options

We offer Senior Care Option plans to MassHealth seniors, age 65 and older, who have MassHealth Standard. Many of these seniors are also enrolled in Medicare Part A and B, commonly known as the "Duals or dually eligible."

ID cards: There are two different versions of the SCO ID cards. The ID card will have a WellSense name reference being either Senior Care Options (SCO) for members who only have MassHealth, or Senior Care Options (HMO D-SNP) for members who are dually eligible. Both member ID cards will have the WellSense logo.

PCPs and provider networks: The SCO program requires members to choose (or be assigned) a PCP who is responsible for managing or providing the member's care. PCPs must coordinate the member's care with other WellSense participating providers in the SCO network with the following exceptions as described in the member EOC:

- Emergency or urgent care
- Out-of-area renal dialysis

If you have any questions about whether you participate in the Senior Care Options network, please call your dedicated WellSense Provider Relations Consultant. To identify your Provider Relations Consultant, visit the provider section of our website under [Training and Support](#).

Member cost sharing: Senior Care Options members do not have any copayments, coinsurance, or deductibles. **Balance billing of covered services is not permitted.**

Prior authorization: Some services require prior authorization by WellSense. Please follow the process for obtaining prior authorization described in [Section 8: Utilization Management and Prior Authorization](#) of this manual.

Covered and excluded services: SCO covered (and excluded) services are described on our website at [wellsense.org](https://www.wellsense.org) in the member's Evidence of Coverage and associated Summary of Benefits.

Examples of services not covered by us include services that are not medically necessary, such as cosmetic services, devices, drugs, and surgery except when they are prior authorized by WellSense and are performed to correct or repair damage following an injury, illness or congenital deformity causing functional impairment, and/or to perform mammoplasty following mastectomy.

Please visit [wellsense.org](https://www.wellsense.org) for more information on WellSense's Senior Care Options program.

7.4 Services Managed by Our Vendor Partners

Note: Please refer to [Section 8: Utilization Management and Prior Authorization](#) for important authorization details. For questions, contact Provider Service at 888-566-0008,

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

Type of Service	Partner	Contact Information
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Retail Pharmacy Services	Express Scripts Mail Order: Cornerstone Health Solutions	<p>Call 888-566-0010 option 4, and then 1.</p> <p>To search covered drugs, search for an in-network pharmacy, or submit a prior authorization request, visit wellsense.org/providers/ma.</p> <p>Mail Order: Cornerstone Health Solutions</p> <ul style="list-style-type: none"> • Call 844-319-7588 or TTY 711 • Fax 781-805-8221 <p>Visit: CornerstoneMailOrderPharmacy@bmc.org</p> <p>Mail: Cornerstone Health Solutions</p>
Mental Health and Substance Use Disorder Services	Carelon Behavioral Health, LLC	<p>MassHealth members call 888-217-3501.</p> <p>Clarity plan members (including QHP, ConnectorCare and Employer Choice Direct) call 877-957-5600.</p> <p>Visit carelonbehavioralhealth.com or wellsense.org/find-a-provider.</p>
Non-Emergency Transportation Services	Coordinated Transportation Solutions, Inc. (CTS)	Call: 855-833-8125 (For SCO members only)

Type of Service	Partner	Contact Information
Preventive dental services for SCO members	DentaQuest	<p>Call Provider Service: 844-234-9829.</p> <p>Claims/payment issues (fax): 262-241-7379.</p> <p>Claims to be processed (fax): 262-834-3589. All other inquiries (fax): 262-834-3450.</p> <p>Claims Questions (email): denclaims@dentaquest.com. Visit dentaquest.com.</p> <p>Hours: Mon.–Fri., 8 a.m. to 8 p.m.</p>

Durable Medical Equipment, (DME) medical Supplies and prosthetic/orthotics Includes management of prosthetics, orthotics, medical supplies, medical formulas, oxygen, respiratory	Northwood, Inc. (NW)	<p>Provider Call Center: 866-802-6471 (8:30 a.m. to 5 p.m., Mon.–Fri.)</p> <p>Fax: 877-552-6551</p> <p>Visit northwoodinc.com/.</p> <p>Provider Portal: providerportal.northwoodinc.com. Email: provideraffairs@northwoodinc.com.</p> <p>Write: P.O. Box 510, Warren, MI 04809</p>
<p>Advanced Elective Radiology - Includes MRIs/MRAs, CT/CTA, PET scans and Nuclear cardiology studies</p> <p>Interventional pain (spinal injections, spinal implants), joint surgery (large joint replacement), and spine surgery (spinal implants, cervical/thoracic/lumbar) and genetic testing (outpatient, diagnostic, elective)</p>	eviCore Healthcare	<p>Radiology/Cardiology: 888-693-3211 prompt #4, 844-725-4448 prompt #1</p> <p>Genetic Testing (Lab Management): 844-725-4448 prompt #2</p> <p>MSK-Spine, Joint, Pain: 844-725-4448 prompt #3 (Physical Medicine)</p> <p>Visit evicore.com/pages/providerlogin.aspx to complete and process a web-based submission form</p> <p>To find a complete list of Current Procedural Terminology (CPT) codes that require prior authorization, please visit the Provider Lookup Tool: https://www.wellsense.org/providers/prior-authorization</p>
Dental services ADA	Dental Claim Form	<p>WellSense has partnered with DentaQuest to manage preventive dental service for SCO. Providers are encouraged to use the web portal at dentaquest.com/ to submit claims; however, DentaQuest will also allow claims via clearinghouse and paper. Providers must submit paper claims on an ADA approved claim form. For DentaQuest's billing information, see Quick Start Guide available on our Provider website at wellsense.org.</p>

Type of Service	Partner	Contact Information
		<ul style="list-style-type: none"> • Claims processing and adjudication • Data reporting • Member and Provider Service related to DMEPOS requests • Prior authorization of DMEPOS • Provider contracting, credentialing and management • Provider inquiries, grievances, and appeals <p>Exception: For SCO members, grievances and appeals are managed by WellSense</p> <p>Northwood claims submission address can be found in our Important Contact Information sheet, available on our website.</p>
Optometry services	CMS-1500	<p>VSP Vision Care manages vision benefits for MassHealth WellSense members. Please forward all claims and find reimbursement information directly from VSP. See the Contact Us page available on our website.</p> <p>Note: For Clarity members (including QHP, ConnectorCare, and Employer Choice Direct) members, VSP will manage WellSense's discount program for vision hardware. Please note that VSP is not managing the vision medical benefit. WellSense's medical network will be used for the vision medical benefit. See the Contact Us page available on our website.</p> <p>Note: For Senior Care Options members, vision benefits including vision hardware are managed by WellSense.</p>

Section 8: Utilization Management and Prior Authorization

8.1 General Information

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

- Evidence-based and scientifically derived, if practicable
- Developed in accordance with the standards created and adopted by nationally accredited organizations
- Developed with input from Boston Medical Center Health Plan, Inc. d/b/a WellSense Health Plan (WellSense) practicing physicians, external specialty consultants, and/or advisory boards, as needed
- Developed in accordance with applicable contractual obligations and regulatory requirements
- Applied in a manner that considers the individual clinical circumstances of the member
- Used for making medical necessity decisions but are not a substitute for professional clinical judgment
- Reviewed on an annual basis with input from actively practicing practitioners with appropriate credentials and clinical expertise in the applicable clinical area who have the opportunity to submit comments on clinical review criteria utilized for Plan members; clinical review criteria are updated as new treatments and applications for existing technologies are adopted as generally accepted professional clinical practice
- Approved for implementation by the Utilization Management Committee (UMC) for medical coverage or the Pharmacy & Therapeutics Committee (P&T for pharmaceutical coverage). For MassHealth, WellSense fully aligns with EOHHS's formulary coverage and policy criteria.

Providers can access Boston Medical Center Health Plan, Inc. d/b/a WellSense Health Plan (WellSense)'s [Medical Policy Criteria or Pharmacy Policy Criteria](#) used to render clinical review decisions at [wellsense.org](https://www.wellsense.org) or by calling the provider line at 888-566-0010.

Secure Online Provider Portal

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

Clinical Review Decisions

We require that qualified licensed health care professionals render or supervise all clinical review decisions. Under certain circumstances, non-clinical staff may authorize requests for coverage based on explicit instructions and coverage criteria. All utilization review decisions concerning coverage are made by qualified, licensed physicians, or other licensed clinicians with the appropriate clinical expertise, as allowed by law. For example, pharmacy adverse determinations are rendered by licensed pharmacists. We conduct annual testing to ensure that criteria are applied in a consistent manner.

Our Medical Directors are available to providers by phone to discuss coverage denial determinations that were based on medical necessity. In addition, as required by applicable law, providers may request reconsideration of WellSense's initial or concurrent decision to deny coverage from a board-certified, actively practicing, clinical peer reviewer in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

The Plan conducts audits to ensure that the application of criteria is performed in a consistent manner. We do not reward practitioners, providers, or employees who perform utilization reviews, including delegated entities, for not authorizing health care services. No one is compensated or provided incentives to encourage denials, limit authorization, or encourage decisions that result in under-utilization and/or discontinue medically necessary (or lack of documentation of medical necessity), covered services. Adverse determinations are based on lack of medical necessity, failure to follow prior authorization or notification guidelines, or because a service is not a covered benefit. We also do not make decisions about hiring, promoting, or terminating our practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

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

Utilization Management Vendors

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

Vendor	Service	Contact Information
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Carelon Behavioral Health LLC	Behavioral Health	Call 866-444-5155 for help finding a network provider 24 hours/day, seven days/week Visit carelonbehavioralhealth.com
Northwood, Inc. (NW)	Durable Medical Equipment and Prosthetics/Orthotics (DMEPOS)	DMEPOS providers call 866-802-6471 8:30 a.m. to 5 p.m., Mon.–Fri. for urgent requests only. For non-urgent requests please reach us via our portal. Visit NorthwoodInc.com Provider Portal: providerportal.northwoodinc.com Email: provideraffairs@northwoodinc.com P.O. Box 510, Warren, MI 48090
DentaQuest (SCO only)	Dental Services	Call 844-234-9829 Mon.–Fri. 8 a.m. to 8 p.m. Visit dentaquest.com Fax 262-834-3450 Claims/payment issues fax: 262-241-7379 Claims to be processed fax 262-834-3589 Claims questions email: denclaims@dentaquest.com

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eviCore Healthcare	Non-emergent, outpatient radiology services, such as MRIs/MRAs, CT/CTA, PET scans, and nuclear cardiology studies	<p>Call Radiology/Cardiology: 888-693-3211 prompt #4, 844-725-4448 prompt #1</p> <p>Genetic Testing (Lab Management): 844-725-4448 prompt #2</p> <p>MSK-Spine, Joint, Pain: 844-725-4448 prompt #3 (Physical Medicine)</p> <p>Fax:</p> <p>Radiology/Cardiology: 888-693-3210</p> <p>Genetic Testing (Lab Management): 844-545-9213</p> <p>MSK-Spine, Joint, Pain: 855-774-1319</p> <p>Visit evicore.com/pages/providerlogin.aspx to complete and process a web-based submission form</p>
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	Interventional pain (spinal injections, spinal implants), joint surgery (large joint replacement, arthroscopy), and spine surgery (spinal implants, cervical/thoracic/lumbar), and genetic testing (outpatient, diagnostic, elective)	To find a complete list of Current Procedural Terminology (CPT) codes that require prior authorization through a, please visit: https://www.evicore.com/healthplan/well-sense
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Express Scripts & WellSense	Prescription Drugs	<p>Call 877-417-1822 (MassHealth); 877-417-0528 (QHP); 877-417-1828 (SCO)</p> <p>Visit: wellsense.org/</p> <p>Fax 833-951-1680 (MassHealth/QHP) or 877-251-5896 (SCO)</p> <p>Visit wellsense.org/providers/ma/pharmacy/prior-authorizations to complete and process a web-based submission form</p>
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8.2 Inpatient Utilization Management

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

Through acute care coordination, WellSense:

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

Acute Inpatient Hospital Review

WellSense's Inpatient Utilization Management (IUM) clinicians perform medical utilization management functions under the direction of Plan's Chief Medical Officer or designee and licensed Clinical Manager. The

staff works to ensure that the level of care during an inpatient stay is appropriate. They also work with hospital Case Managers, Discharge Planners, and Attending Physicians to facilitate a timely and appropriate transition between levels of care, through the following processes:

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

Pre-Hospitalization Review

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

Post-Acute Care Review

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

The Plan allows after hours, weekend and expedited transfers to Skilled Nursing Facilities (SNF) for members who meet skilled levels of care. SNFs which are contracted with WellSense may accept a patient without prior authorization from the health plan in advance of the admission. The SNF will be required by day three to notify the health plan of the admission and to request an authorization for a continued stay. Supporting clinical information, including a comprehensive assessment, should be sent with the notification. Upon notification, we will review and provide a determination within 24 hours/1 business day. Without notification and approval for continued stay at day three, the SNF will risk denial of services starting on day 4 of the admission.

Preadmission Screening and Resident Review (PASRR)

As part of the authorization review process for nursing facility admissions for Massachusetts MCO, ACO, and SCO members, WellSense will require documentation of the facility's compliance with the Preadmission

Screening and Resident Review (PASRR) process. Nursing facilities should submit a copy of the completed Level I PASRR form, and the Level II PASRR determination notice if required, with the original authorization request. If the Level I PASRR screening results in a 30-day exemption from the Level II assessment requirement, and the length of stay goes beyond 30 days, a copy of the completed revised Level I form will be required by day 30 of the admission. Failure to provide the required PASRR documentation could result in administrative denials.

Requirement	Timing	Send Information To:
Preadmission Screening and Resident Review (PASRR)	<p>Copy of completed Level I PASRR form must be submitted at time of request for approval to admit the member to the Nursing Facility</p> <p>If the Level I form indicates a positive screen, but the admission qualifies for a 30-day exemption from the Level II assessment requirement, a revised Level I form will be required by day 30 of the admission if the length of stay goes beyond 30 days</p> <p>If the Level I form indicates a positive screen, and the admission does not qualify for a 30-day exemption from the Level II assessment requirement, the Level II determination form will also be required at the time of request for approval to admit the member</p>	<p>Inpatient Utilization Management Fax: 617-897-0892</p> <ul style="list-style-type: none"> • Level I form with original request for authorization to Inpatient Utilization Management • Revised Level I form when length of stay goes beyond 30 days to Inpatient Utilization Management • Level II determination notice (when required) with original request for authorization to Inpatient Utilization Management

Guidelines and Requirements for WellSense Members with Admissions and Discharges from Nursing Facilities

Senior Care Options

When a SCO community member is admitted to a nursing facility, the instructions below will guide contracted facilities through the process to satisfy MassHealth SCO guidelines.*

This process is specific to SCO members only, not to be confused with ACO/MCO members. No screen is required by elder services for SCO members to enter long term care.

Section 8: Utilization Management and Prior Authorization

- *Short-Term Admissions:* If admission to the nursing facility is a short term/skilled admit, the SC-1 is not required on admission or on discharge.
- *Long-Term Admissions:* If a member is admitted long-term care/custodial or, if the status changes from skilled to custodial during a facility stay, the contracted facility submits an SC-1 to MassHealth Enrollment Center with a MassHealth Requested Payment Date (section 3, box 19) that corresponds to the date the member was deemed custodial. The facility then confirms acceptance of the SC-1 by MassHealth. "SCO Member" must be written across the top of the SC-1 or the SC-1 may not be accepted. Once the SC-1 is successfully recorded with MassHealth and enough clinical information has been gathered, the facility completes and submits to MassHealth an initial MMQ with MMQ submission every six months thereafter. The facility must also complete MDS assessments at required intervals. A long-term care application may be requested by MassHealth, which the facility completes and submits. **Copies of all SC-1/MMQ and MDS 3.0's must be sent to WellSense after submission to MassHealth.** Please see the grid below.
- Once these items have been submitted and accepted by MassHealth, the member changes to an "institutional" status. SCO members in long-term care never revert back to straight MassHealth; they remain on the WellSense Plan for the duration of their long term care stay.
- If a custodial member transfers from one long term care facility to another, a discharge SC-1 must be completed by the discharging facility and an admission SC-1 must be completed by the accepting facility who then takes over MMQ/MDS submission to MassHealth. If a member discharges back to the community from long term care, a discharge SC-1 must be completed by the discharging facility.
- *Failure to complete above requirements may result in payment suspension from WellSense until all requirements are met.

Requirement	Specifics	Send Information To:
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Section 8: Utilization Management and Prior Authorization

Facility to submit SC1 form, MMQ, and MDS 3.0 to the MassHealth Enrollment system. A long-term care application may also need to be submitted if prompted by MassHealth.	SC1/MMQ/LTC form only submitted when the level of care changes from skilled to custodial or if a member is admitted custodial. Facility must confirm acceptance by MassHealth of all submissions.	<i>MassHealth Enrollment Center</i> Fax: 617-889-3285
Submit all copies of the SC-1 Form, MMQ, and MDS 3.0's along with fax confirmation to WellSense	Within 5 business days of submission to MassHealth.	<i>SNF Transitions of Care Nurse</i> Fax: 617-951-3427 Email: SCO.TOC@wellsense.org
Submit Status Changes to MassHealth, along with copy of documentation to WellSense	Submit SC1 electronically through MassHealth Enrollment Center for all long term care transfers or discharges back to community.	<i>MassHealth Enrollment Center</i> Fax: 617-889-3285 <i>SNF Transitions of Care Nurse</i> Fax: 617-951-3427 Email: SCO.TOC@wellsense.org

MassHealth (ACO & MCO)

For ACO/MCO members in long-term care, please follow these mandatory requirements to ensure correct payment from WellSense*:

- WellSense sends an SC1 reminder letter to Skilled Nursing Facilities and Chronic Disease and Rehabilitation Inpatient Hospitals when the member has used 70 days of their skilled nursing benefit in a benefit year.
- The facility completes the Massachusetts Executive Office of Health and Human Services Status Change for Members in a Nursing Facility or Chronic Disease and Rehabilitation Inpatient Hospital (SC1) form and sends the (SC1) form and MassHealth screen received from Elder Services to MassHealth utilizing the usual MassHealth process.
- The facility must fax a copy of the SC1 form, MassHealth screen, and the fax that confirmed MassHealth's receipt of the SC1 Form and MassHealth screen to WellSense at (617) 897-0892 within five business days of submission to MassHealth and no later than 30 calendar days of receipt of WellSense's Notice of Requirements for 100-Day Benefit Letter.

- The facility must complete and submit any and all additional long-term care information required by MassHealth to MassHealth to complete the conversion process when appropriate.

*Failure to complete above requirements may result in payment suspension from WellSense until all requirements are met.

The Inpatient UM staff is responsible for:

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

8.3 SCO Care Transitions Program

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

The Care Manager (CM) serves as the lead and advocate in all member care transitions to ensure that the member's safety and well-being are maintained across all health care settings. Communication with the member begins upon notification of an unscheduled admission or prior authorization for acute, SNF, or other inpatient level of care. Once the CM becomes aware of the admission, they contact the member and/or caregiver to discuss the admission to ensure that the member is involved in decision making and planning.

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

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

The transition team or the Care Manager for SCO members:

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

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

Once the member has returned home after an inpatient stay, the CM contacts the member telephonically or in person within 72 hours of discharge. The CM uses motivational interviewing to educate the member and family/caregiver to ensure adherence with post-discharge regimens, improve self-management of chronic conditions, and perform medication reconciliation. The CM assesses the member for chronic health conditions and educational needs and conducts a depression screening.

Once the assessment is complete, the clinician discusses the assessment results with the member and creates or updates the existing IPC, in collaboration and in agreement with the member. For SCO members, the PCT is also included in this process and the process is completed for every member discharged to home regardless of the admission diagnosis. In all care transitions, the CM ensures a post-discharge appointment is made with the member's PCP or specialist and evaluates the need for home health services, long-term services and supports, DME, and transportation. They continue to follow member intensely post-discharge to home, collaborating with the member and PCT on an ongoing and as-needed basis. The goal is to mitigate 30-day member readmissions and to ensure the member's health care needs are maintained at the most appropriate level of care.

8.4 Prior Authorization

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

The review process includes:

- Verification of member eligibility and benefits.
- Validation of the servicing providers' participation within the member's plan.
- Entering the service requests and supporting information within WellSense's clinical documentation system to facilitate claims adjudication.
- Evaluation of medical appropriateness of the requested level and location of care for the member's reported diagnosis and/or symptoms.
- Evaluation of service requests using nationally recognized criteria such as InterQual® clinical criteria, WellSense's internal medical policy criteria, internal pharmacy policy criteria, EOHHS-approved pharmacy policy criteria, or guidance from the Centers for Medicare & Medicaid services (CMS) for the Plan's Senior Care Options members, including but not limited to national coverage determinations, local coverage determinations, local coverage articles, and documentation included in Medicare manuals.
- Secondary review by a Plan Physician Reviewer or other qualified, licensed clinician when the initial review fails to meet WellSense's criteria.
- Communication of WellSense's coverage determination to providers and or members.
- Identification of members for referral to care management programs.

8.5 WellSense Authorization Requirements

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

To request prior authorization:

- Providers may submit an authorization request via [The Provider Portal](#), our improved secure Provider Portal.
- Providers may also submit prior authorization requests via fax, and standard mail using the [WellSense Medical Prior Authorization Request Form](#) available at wellsense.org.
- Our Prior Authorization (PA) staff is available 8:30 a.m. to 5 p.m., Monday–Friday (except holidays).
- See Section 13 for pharmacy prior authorization information.

Even if prior authorization has been obtained, providers must check eligibility on the date of service prior to delivering services. Providers must check the member's eligibility daily for all inpatient admissions as MassHealth members' eligibility may change from day to day. Eligibility changes on the first of the month for our QHP and SCO members; however, we still recommend that providers verify eligibility prior to the date of service. See [Section 2: Member Eligibility](#) for guidelines and step-by-step instructions on how to determine member eligibility in WellSense. A provider may contact our Member Service team at any time to determine member benefits and eligibility, PCP assignment, and provider participation.

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

8.6 Authorization Requests: Requirements and Timeframes

Prior (pre-service) authorization request

Prior authorization is a requirement that WellSense must review and approve requests for services or items that require WellSense determination in advance of the service or item being rendered, or the item being furnished.

Failure to follow the prior authorization requirements in this section will result in denial of claims payment. The provider will be liable for the service and the member may not be billed. Please see the WellSense Prior Authorization Matrix for specific requirements by service type and the WellSense Code Look-Up Tools for prior authorization requirements by billing code; both the matrix and the look-up tools are available at wellsense.org.

If a service is denied for lack of prior authorization, see [Section 9: Billing and Reimbursement](#) for further actions.

Prior authorization requirements for specialty care

At the time a specialist visit is requested, providers should always verify that the specialist is in-network by checking the specialist's and hospital affiliation within the product-specific online [Provider Directory](#) available at wellsense.org, or when applicable, the online Provider Directory of our vendors.

Authorization requests may be submitted by the PCP or by the specialist, using [The Provider Portal](#) or by submitting the Prior Authorization request form.

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

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

Second opinions

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

8.7 Member Access to Emergent and Urgent Services

Emergency and urgent services

We cover emergency care for all members. Determination of emergency services is based upon the circumstances of the individual case and not on lists of diagnoses or symptoms. See [Section 4: Provider Responsibilities](#) for a description of a hospital's responsibilities related to emergency care, WellSense notification, and PCP communication guidelines.

An emergency medical condition is defined as a medical condition manifesting itself by symptoms of acute severity, including severe pain, whether physical or mental, in the absence of prompt medical attention, and could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, in the absence of immediate medical attention to result in: (a) placing the health of the individual

(or, with respect to a pregnant individual, the health of the individual or the individual's unborn child), in serious jeopardy; (b) serious impairments to bodily function; or (c) serious dysfunction of any bodily organ or part.

Urgent care is medically necessary care that is required to prevent serious deterioration of a member's health when they have an unforeseen illness or injury. It does not include emergency or routine care.

Out-of-area emergent (including post-stabilization) and urgent care

We recognize that members may have medical emergencies or require urgent care when they travel outside our service area. WellSense does not cover out-of-area non-emergent or non-urgent services, medications, or procedures unless previously authorized.

Type of Service	Out-of-Area Coverage
Emergency Services (including Post Stabilization services)	<p>WellSense covers emergency services (including medications or procedures deemed necessary during the course of the emergency treatment) provided to members who are out-of-area when members cannot safely wait to obtain services from an in-network provider.</p> <ul style="list-style-type: none"> • MassHealth: coverage is provided if the emergent care occurs in the United States and its territories • QHP: coverage is worldwide • SCO: coverage is provided if the emergent care occurs in the United States and its territories
Urgent Care Services	<p>WellSense covers urgent care services that are provided out-of-area when the illness or injury is unexpected; and the illness or injury requires medical care that cannot be delayed until the member returns home, and the care must be received from an out-of-area provider.</p> <ul style="list-style-type: none"> • MassHealth: coverage is provided if the urgent care occurs in the United States and its territories • QHP: coverage is worldwide • SCO: coverage is provided if the urgent care occurs in the United States and its territories
Out-of-Area Renal Dialysis	For our SCO members, out-of-area renal dialysis is covered.

8.8 Utilization Management Timeframe Requirements

Timeliness of utilization review decisions and notifications

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

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

Timeframes are based on Receipt of Request (ROR), which is considered the date a requested is submitted via The Provider Portal or a fax is received or the received date stamp on a letter of medical necessity. For pharmacy requests, timeframes are based upon the date a request is submitted via ePA, fax, or phone where there is sufficient clinical information provided attempting to satisfy the pharmacy policy criteria. For concurrent inpatient reviews, the "request date" is considered the date of the request.

Utilization Management Request Turnaround Timeframes

MassHealth ACO & MCO; SCO Medicaid

Request Type	TAT	Notification Type and Recipient
<i>MassHealth ACO & MCO; SCO Medicaid</i> Standard/ non-urgent preservice	Notice of decision as expeditiously as the Enrollee/Member's health requires, but within 14 calendar days from ROR	Approval: <ul style="list-style-type: none"> Verbal: N/A Written: Notice to provider via fax/letter Electronic: Decision available to Enrollee/Member & Provider via respective portal Denial: <ul style="list-style-type: none"> Verbal: N/A Written: Notice to Enrollee/Member via letter; notice to provider via fax/letter Electronic: Decision available to Enrollee/Member & Provider via respective portal
Extensions WellSense may extend the timeframe once, by up to 14 calendar days , under the following conditions: <ol style="list-style-type: none"> 1) The Enrollee/Member or Provider requests an extension, or 2) The extension is in the Enrollee/Member's interest; and 3) WellSense needs additional information and: <ol style="list-style-type: none"> a) Performs at least one documented attempt to obtain the necessary information b) There is a reasonable likelihood that receipt of information would lead to approval of the request c) There is a reasonable expectation that WellSense will receive the outstanding information within 14 calendar days. 4) WellSense informs the Enrollee/Member and Provider of the right to file a grievance if they disagree with WellSense's decision to extend the timeframe. 5) WellSense notifies the Enrollee/Member and provider of the authorization decision as expeditiously as their health condition requires, but no later than the expiration of the extension. 		

Request Type	TAT	Notification Type & Recipient
<p><i>MassHealth ACO & MCO; SCO Medicaid</i></p> <p>Urgent/expedited preservice</p>	<p>Notice of decision as expeditiously as the Enrollee/Member's health requires but, within 72 hours from ROR</p>	<p>Approval:</p> <ul style="list-style-type: none"> • Verbal: N/A • Written: Notice to provider via fax/letter • Electronic: Decision available to Enrollee/Member & Provider via respective portal <p>Denial:</p> <ul style="list-style-type: none"> • Verbal: N/A • Written: Notice to Enrollee/Member via letter*; notice to Provider via fax/letter • Electronic: Decision available to Enrollee/Member & Provider via respective portal <p><i>*Contract requirements are more stringent than the NCQA standards (UM 5: Timeliness) and do not allow for an exception to Enrollee/Member notice for urgent preservice denials.</i></p>
	<p>Extensions</p> <p>WellSense may extend the timeframe once, by up to 14 calendar days, under the following conditions:</p> <ol style="list-style-type: none"> 1) The Enrollee/Member or provider requests an extension, or 2) The extension is in the Enrollee/Member's interest; and 3) WellSense needs additional information and: <ol style="list-style-type: none"> a) Performs at least one documented attempt to obtain the necessary information b) There is a reasonable likelihood that receipt of information would lead to approval of the request c) There is a reasonable expectation that WellSense will receive the outstanding information within 14 calendar days. 4) WellSense informs the Enrollee/Member and Provider of the right to file a grievance if they disagree with WellSense's decision to extend the timeframe. 5) WellSense notifies the Enrollee/Member and Provider of the authorization decision as expeditiously as their health condition requires, but no later than the expiration of the extension. 	

Request Type	TAT	Notification Type & Recipient
<p><i>MassHealth ACO & MCO; SCO Medicaid</i></p> <p>Urgent concurrent/ continued stay</p>	<p>Notice of decision as expeditiously as the Enrollee/Member's health requires, within 72 hours from ROR</p>	<p>Approval:</p> <ul style="list-style-type: none"> • Verbal: N/A • Written: Notice to provider via fax/letter • Electronic: Decision available to Enrollee/Member & Provider via respective portal <p>Denial:</p> <ul style="list-style-type: none"> • Verbal: Notice to Provider • Written: Notice to Provider via fax/letter* • Electronic: Decision available to Enrollee/Member & Provider via respective portal <p><i>*NCQA Standards (UM 5: Timeliness) notes urgent concurrent denials as an exception to member notification: "for urgent denials, NCQA considers the attending or treating Practitioner to be acting as the Member's representative".</i></p>
	<p>Extensions</p> <p>WellSense may extend the timeframe once, by up to 14 calendar days, under the following conditions:</p> <ol style="list-style-type: none"> 1) The Enrollee/Member or Provider requests an extension, or 2) The extension is in the Enrollee/Member's interest; and 3) WellSense needs additional information and: <ol style="list-style-type: none"> a) Performs at least one documented attempt to obtain the necessary information b) There is a reasonable likelihood that receipt of information would lead to approval of the request c) There is a reasonable expectation that WellSense will receive the outstanding information within 14 calendar days. 4) WellSense informs the Enrollee/Member and Provider of the right to file a grievance if they disagree with WellSense's decision to extend the timeframe. 5) WellSense notifies the Enrollee/Member and Provider of the authorization decision as expeditiously as their health condition requires, but no later than the expiration of the extension. 	

WellSense Clarity plans

Request Type	Decision TAT	Notification: Type, Recipients & Additional TAT Requirements
Clarity Non-urgent/ standard preservice	<p>Decision* within 2 business days of obtaining all necessary information.</p> <p>Decision and all notices NOT to exceed 15 calendar days from receipt of request (ROR).</p> <p><i>*State DOI requirements are more stringent than NCQA standards</i></p>	<p>Approval:</p> <ul style="list-style-type: none"> Verbal: Notice to Provider via telephone within 24 hours of decision* Written: <ul style="list-style-type: none"> Notice to Enrollee/Member via letter within 2 business days of verbal notice to provider* Notice to Provider via fax/letter within 2 business days of verbal notice* Electronic: Decision available to Enrollee/Member and Provider via respective portal <p>Denial:</p> <ul style="list-style-type: none"> Verbal: Notice to Provider via telephone within 24 hours of decision* Written: Notice to Enrollee/Member via letter within 1 business day of verbal notice to provider* Notice to Provider via fax/letter within 1 business day of verbal notice* Electronic: Decision available to Enrollee/Member and Provider via respective portal <p><i>*State DOI requirements are more stringent than NCQA standards</i></p>
<p>Extensions</p> <p>If the request lacks clinical information, WellSense may extend the non-urgent preservice time frame for up to 15 calendar days, under the following conditions:</p> <ol style="list-style-type: none"> Before the end of the timeframe, WellSense asks the Enrollee/Member or Representative for the information necessary to make the decision, and WellSense gives the Enrollee/Member or Representative at least 45 calendar days to provide the information The extension period, within which a decision must be made by WellSense, begins on the sooner of: <ol style="list-style-type: none"> The date when WellSense receives the Enrollee/Member's response (even if not all of the information is provided), or The last date of the timeframe given to the Enrollee/Member to supply the information, even if no response is received from the Enrollee/Member or Representative. <p>WellSense may deny the request if we do not receive the information within the timeframe, and the Enrollee/Member may appeal the denial.</p>		

Request Type	Decision TAT	Notification: Type, Recipients & Additional TAT Requirements
<i>Clarity</i> Urgent/expedited preservice	<p>Decision within 2 business days of obtaining all necessary information.</p> <p>NOT to exceed 72 hours from receipt of request (ROR).</p>	<p>Approval:</p> <ul style="list-style-type: none"> Verbal: Notice to Provider via telephone within 24 hours of decision* Written: <ul style="list-style-type: none"> Notice to Enrollee/Member via letter within 2 business days of verbal notice to provider Notice to Provider via fax/letter within 2 business days of verbal notice Electronic: Decision available to Enrollee/Member and Provider via respective portal <p>Denial:</p> <ul style="list-style-type: none"> Verbal: Notice to Provider via telephone within 24 hours of decision* Written: <ul style="list-style-type: none"> Notice to Enrollee/Member via letter within 1 business day of verbal notice to provider** Notice to Provider via fax/letter within 1 business day of verbal notice Electronic: Decision available to Enrollee/Member and Provider via respective portal <p><i>*State DOI requirements are more stringent than NCQA standards</i> <i>**State DOI requirements are more stringent than the NCQA standards (UM 5: Timeliness) and do not allow for an exception to enrollee/member notice for urgent preservice denials.</i></p>
Extensions		
<p>WellSense may extend the urgent preservice time frame once due to lack of information, for 48 hours, under the following conditions:</p> <ol style="list-style-type: none"> When within 24 hours of receipt of the urgent preservice request the enrollee/member or representative is asked by WellSense for the information necessary to make the decision, and WellSense gives the Enrollee/Member or Representative at least 48 hours to provide the information, and The extension period, within which a decision must be made by the WellSense, begins on the sooner of: <ol style="list-style-type: none"> The date when WellSense receives the Enrollee/Member's response (even if not all of the information is provided), or The last date of the time period given to the Enrollee/Member to provide the information, even if no response is received from the Enrollee/Member or Representative. 		

Request Type	TAT	Notification Type & Recipients
<i>Clarity</i> Concurrent urgent/ continued stay	Notice of decision within 24 hours of ROR	Approval: Verbal: Notice to Provider via telephone Written: Notice to Provider via fax/letter Electronic: Decision available to Enrollee/Member and Provider via respective portal Denial: Verbal: Notice to Provider via telephone Written: Notice to Enrollee/Member via letter*; Notice to Provider via fax/letter Electronic: Decision available to Enrollee/Member and Provider via respective portal <i>*State DOI requirements are more stringent than NCQA Standards (UM 5: Timeliness) for concurrent reviews "the service shall be continued without liability to the enrollee/member until the enrollee/member has been notified of the determination".</i>
		Extensions 1) WellSense may extend the decision notification timeframe if the request to extend urgent concurrent care was made less than 24 hours prior to the expiration of the previously approved time period or number of treatments. WellSense may treat the request as urgent preservice and send a decision notification within 72 hours . 2) WellSense may extend the decision notification time frame if the request to approve additional days for urgent concurrent care is related to care not previously approved and makes at least one documented attempt and to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, WellSense has up to 72 hours to make the decision.

SCO DSNP

Request Type	TAT	Outreach Attempts for Additional Information	Notification Type & Recipients
SCO DSNP Non-urgent/ standard Preservice <i>*Timeliness for decisions and notices are compliant with the applicable integrated plan provisions set forth in §§ 422.629 through 422.634 of the Code of Federal Regulations.</i>	Items and services: Notice of decision as expeditiously as the Enrollee/Member's health condition requires, within 14 calendar days from Receipt of Request (ROR) Part B drugs: Notice of decision as expeditiously as the Enrollee/Member's health condition requires, within 72 hours from Receipt of Request (ROR)	<p>When there is not enough information to make an authorization decision, WellSense makes a minimum of one outreach attempt to request needed information.</p> <p>If additional information is needed from a non-contract Provider, WellSense requests the necessary information within 24 hours of receipt of the request.</p>	Approval or Denial <ul style="list-style-type: none"> Written notice: Sent to the Enrollee/Member within applicable timeframes. Verbal notice:
	Extensions <p>In rare situations, WellSense may extend the timeframe once, by up to 14 calendar days, under the following conditions:</p> <ol style="list-style-type: none"> 1) The Enrollee/Member or Provider requests an extension, or 2) The extension is in the Enrollee/Member's interest; and 3) WellSense needs additional information and: <ol style="list-style-type: none"> a) Performs at least one documented attempt to obtain the necessary information b) There is a reasonable likelihood that receipt of information would lead to approval of the request c) There is a reasonable expectation that WellSense will receive the outstanding information within 14 calendar days. 4) WellSense informs the Enrollee/Member and Provider of the right to file a grievance if they disagree with WellSense's decision to extend the timeframe. 5) WellSense notifies the Enrollee/Member and Provider of the authorization decision as expeditiously as their health condition requires, but no later than the expiration of the extension. <p>WellSense does not extend Part B drug timeframes.</p>		

Request Type	TAT	Outreach Attempts for Additional Information	Notification Type & Recipients
SCO DSNP Urgent/ expedited preservice <i>*Timeliness for decisions and notices are compliant with the applicable integrated plan provisions set forth in §§ 422.629 through 422.634 of the Code of Federal Regulations.</i>	Items & services: Notice of decision as expeditiously as the Enrollee/Member's health condition requires, within 72 hours after Receipt of Request (ROR) Part B drugs: Notice of decision as expeditiously as the Enrollee/Member's health condition requires, within 24 hours after Receipt of Request (ROR)	When there is not enough information to make an authorization decision, WellSense makes a minimum of one outreach attempt to request needed information. If additional information is needed from a non-contract Provider, WellSense requests the necessary information within 24 hours of receipt of the request.	Approval: Verbal or written notice to the Enrollee/Member (and the Provider involved, as appropriate)
			Denial: Written notice to the Enrollee (and the Provider involved, as appropriate)
	Extensions In rare situations, WellSense may extend the timeframe once, by up to 14 calendar days , under the following conditions: 6) The Enrollee/Member or Provider requests an extension, or 7) The extension is in the Enrollee/Member's interest; and 8) WellSense needs additional information and: a) Performs at least one documented attempt to obtain the necessary information b) There is a reasonable likelihood that receipt of information would lead to approval of the request c) There is a reasonable expectation that WellSense will receive the outstanding information within 14 calendar days. 9) WellSense informs the Enrollee/Member and Provider of the right to file a grievance if they disagree with WellSense's decision to extend the timeframe. 10) WellSense notifies the Enrollee/Member and Provider of the authorization decision as expeditiously as their health condition requires, but no later than the expiration of the extension. WellSense does not extend Part B drug timeframes.		

MassHealth ACO/MCO and Clarity plan Pharmacy

Review Type and Product	Total Turnaround Time	Notification Type
Standard Exception Request (Non-Urgent)	<p>Clarity plans/QHP: 2 business days and no later than 72 hours from receipt of request</p> <p>MH: 24 hours</p>	<p><u>Approval:</u></p> <p><u>Verbal:</u></p> <ul style="list-style-type: none"> • MH: No verbal notification required • Clarity plans/QHP: Verbal notification is not specified under 45 C.F.R. 156.122 (c); rather only “notify the enrollee or the enrollee’s designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following receipt of the request.” Electronic fax to provider with proof of successful transmittal will suffice and documentation of verbal outreach to provider if fax not successful. This must be performed within 24 hours of the decision and no later than 72 hours from receipt of request. <p><u>Written:</u></p> <ul style="list-style-type: none"> • MH: Letter sent to provider within 24 hours of ROR • Clarity plans/QHP: Letter sent to member and provider within 24 hours of decision and no later than 72 hours from receipt of request. <p><u>Denial:</u></p> <p><u>Verbal:</u></p> <ul style="list-style-type: none"> • MH: No verbal notification required • Clarity plans/QHP: Verbal notification required is not specified under 45 C.F.R. 156.122(c); rather only “notify enrollee or the enrollee’s designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours following receipt of the request.” Electronic fax to provider with proof of successful transmittal will suffice and documentation of verbal outreach to provider if fax not successful. <p><u>Written:</u></p> <ul style="list-style-type: none"> • MH: Letter sent to member and provider within 24 hours of ROR • Clarity plans/QHP: Letter sent to member and provider within 24 hours and no later than 72 hours from receipt of request.

<p>Expedited Exception Request (Urgent)</p>	<p>Clarity plans/QHP: 24 hours</p> <p>MH: 24 hours</p>	<p><u>Approval:</u></p> <p><i>Verbal:</i></p> <ul style="list-style-type: none"> • MH: No verbal notification required • Clarity plans/QHP: Verbal notification is not specified under 45 C.F.R. 156.122(c); rather only “notify enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours following receipt of the request.” Electronic fax to provider with proof of successful transmittal will suffice and documentation of verbal outreach to provider if fax not successful. <p><i>Written:</i></p> <ul style="list-style-type: none"> • MH: Letter sent to provider within 24 hours of ROR. • Clarity plans/QHP: Letter sent to member and provider within 24 hours of receipt of request. <p><u>Denial:</u></p> <p><i>Verbal:</i></p> <ul style="list-style-type: none"> • MH: No verbal notification required • Clarity plans/QHP: Verbal notification required is not specified under 45 C.F.R. 156.122(c); rather only “notify enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours following receipt of the request.” Electronic fax to provider with proof of successful transmittal will suffice and documentation of verbal outreach to provider if fax not successful. <p><i>Written:</i></p> <ul style="list-style-type: none"> • MH: Letter sent to provider and member within 24 hours of ROR. • Clarity plans/QHP: Letter sent to member and provider within 24 hours of receipt of request.
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SCO Pharmacy

Review Type	Total Turnaround Time	Notification Requirements
Pre-Service Drug Requests (Non-Urgent)	Medicaid Only: 24 hours from Receipt of Request (ROR) DSNP: 72 hours from ROR	<u>Medicaid Only:</u> Verbal: by telephone or other telecommunication device within 24 hours of ROR Written: Letter sent to member and provider within 24 hours of decision <u>DSNP:</u> written notification within 72 hours of decision
Pre-Service Drug Requests (urgent)	Medicaid Only: 24 hours from ROR DSNP: 24 hours from ROR	<u>Medicaid Only</u> Verbal: by telephone or other telecommunication device within 24 hours of ROR Written: Letter sent to member and provider within 24 hours of decision <u>DSNP:</u> Written notification within 24 hours of ROR unless verbal notification is provided. If verbal notification is provided, written notification must be delivered within 72 hours

8.9 Services that Require Plan Notification

Maternity

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

Maternity Program related notification requirements

Type of Service	Notification Instructions	Notification Timeframe	Party Responsible for Notification
Newborn Birth	Fax all newborn statistical information to the Enrollment department at 617-897-0838. Note: See Section 2: Member Eligibility for additional information related to notification of birth.	One business day of a newborn delivery.	Servicing facility
Confirmed Pregnancy	Telephone or fax notification of confirmed pregnancy to the Prior Authorization department: <ul style="list-style-type: none"> • Phone: 888-566-0008. • Fax: 617-951- 3464. 	Three business days for each confirmed pregnancy.	Obstetric provider

Maternity-related special circumstances

- Third trimester pediatrician visits: We support the American Academy of Pediatrics Prenatal Visit to the Pediatrician initiative and will reimburse pediatric clinicians who provide this service to prenatal members. This service does not require WellSense authorization.
- Out-of-network exceptions for pregnant members: A WellSense member who is pregnant must receive care from a contracted provider in the appropriate WellSense network. However, we will consider exceptions to this policy if one of the following applies:
 - The member was pregnant when she became a WellSense member, and she has an established relationship with a non-participating obstetrical provider;

- The member's participating provider becomes non-participating while the member is in her second or third trimester;
- The member speaks a language not spoken by any network obstetrician; or
- The member lives more than 30 miles away from any network obstetrician.

We must authorize all out-of-network maternity care, including delivery at the facility where the non-network obstetrician is affiliated.

Postpartum home care visits

WellSense prior authorization is not required for an initial postpartum follow-up home care visit when mother and baby are discharged at the same time. This visit includes services for both the mother and newborn(s); therefore, a separate claim form or claim line cannot be billed for the newborn. Additional home care services rendered beyond the initial postpartum follow-up home visit require WellSense prior authorization. This applies to both the mother and the newborn(s).

- If the newborn is discharged after the mother, all newborn home care visits require prior authorization.
- If during the postpartum visit it is determined that the newborn or mother requires urgent or emergent services, the home health provider should refer the member to the PCP and/or to an emergency room, whichever is clinically appropriate.
- If during the postpartum visit it is determined that the newborn or mother requires immediate services, the home health provider is required to refer the member to the emergency department after first rendering appropriate care in anticipation of transport.
- The home health provider is required to refer the member to the PCP, if it is determined that the newborn or mother require physician services during the initial postpartum visit.
- Decision-making (triage) for referral and provision of care under the previous two clinical circumstances is included in the reimbursement for the postpartum follow-up visit.
- Other
- Urgent/Emergent Admissions related notification requirements: Acute care facilities are required to notify the Plan within 1 business day following admission date.

8.10 New Technology, Experimental Diagnostics, and Experimental Treatment

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

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

For **Clarity plan (including QHP, ConnectorCare, and Employer Choice Direct)** members, experimental or investigational treatment is defined as a treatment, service, procedure, supply, device, biological product, or drug (collectively "treatment") for use in diagnosing or treating a medical condition if any of the following is true:

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

*"Authoritative evidence," as used in this definition, means only the following:

- Reports and articles of well-designed and well-conducted studies published in authoritative English-language medical and scientific publications that are subject to peer review by qualified medical or scientific experts prior to publication. In evaluating this evidence, the Plan considers both the quality of the published studies and the consistency of results; or
- Opinions and evaluations by national medical associations, other reputable technology assessment bodies, and healthcare professionals with recognized clinical expertise in treating the medical condition or providing the treatment. In evaluating this evidence, the Plan considers the scientific quality of the evidence upon which the opinions and evaluations are based; or

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

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

The WellSense Utilization Management Committee (UMC) regularly reviews information from clinically appropriate sources including peer-reviewed medical literature, professional societies, and regulatory agencies, and obtains expert opinions from specialist providers to determine whether a new or emerging technology is still investigational or whether it constitutes an accepted standard of practice.

The UMC uses all of the following five criteria to evaluate the related scientific literature and reach a coverage decision:

- The service, treatment, or item (e.g., medical device, biological product, medical drug management) requiring final approval to market must have final approval for the specified indication from the appropriate governmental regulatory body(ies) with the authority to regulate the clinical technology (e.g., the U.S. Food & Drug Administration); and
- The scientific evidence from reputable sources, including objective peer-reviewed literature and evaluations by national medical associations, must permit conclusions concerning the safety and effectiveness of the service, treatment, or item on health outcomes for the specified indication; and
- The service, treatment, or item must improve the net health outcome and should outweigh any harmful effect; and
- The service, treatment, or item must be as beneficial as any established alternative for the specified indication, including interventions considered the standard of care; and
- The documented, favorable health outcomes must be attainable outside the investigational settings.

The fact that a service, treatment, or item is offered *as a last resort* does not mean that it is not an experimental or investigational treatment.

Section 9: Billing and Reimbursement

9.1 Overview

WellSense is committed to efficiently and promptly reimbursing providers for covered services rendered to our members. In this section we outline the requirements that providers must follow when submitting a claim for reimbursement. It is important for providers to comply with these requirements in order to avoid delays in payment. Forms, guidelines, and policies that are referenced in this section can be found on our website at wellsense.org. Due to the Plan's contractual obligations with its contract holders, it must align its payment policies with MassHealth.

9.2 Provider Reimbursement

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

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

- The contracted reimbursement rates in your participating agreement with WellSense.
- Compliance with our administrative guidelines including Plan prior authorization and claim submission; see [Section 8: Utilization Management and Prior Authorization](#) for medical/ surgical services and pharmacy prior authorization guidelines.
- Verification of medical necessity.
- Verification that the service is a covered benefit.
- Eligibility of the member on the date of service.
- Adherence to proper CPT/HCPCS and other nationally recognized coding and billing guidelines.
- Participation in the MassHealth Primary Care Sub-Capitation program, as outlined in WellSense's participation agreements with its ACO Partners
- Participating providers in WellSense MassHealth ACOs may be paid a monthly capitated rate in lieu of fee-for-service reimbursement for certain included codes. The reimbursement methodology for

this program has been defined by MassHealth. Please refer to the WellSense website section on Primary Care Sub-Capitation further information <https://www.wellsense.org/providers/ma/sub-capitation>.

9.3 Member Eligibility

Providers must check member eligibility before delivering services, on the date of service, and daily for inpatient admissions. Member eligibility may change from day to day for MassHealth members and on a monthly basis for Clarity plans (including QHP, ConnectorCare and Employer Choice Direct) and Senior Care Options members. Providers should be aware that several of the above product lines have a high level of retroactive additions and terminations. Eligibility should be verified frequently. Note: Clarity plan members are generally locked in to their respective plans for a full benefit year. However, a member's or employer group's failure to pay premiums, or changes in a member's employment status, may result in coverage termination at the end of any given month.

Terminations that occur retroactively due to failure to pay premiums or for other legitimate reasons will result in retroactive claims retractions. See below for special rules under the Affordable Care Act.

MassHealth members receive two ID cards at enrollment: a MassHealth member ID card and a WellSense member ID card. Clarity plan members (including QHP, ConnectorCare and Employer Choice Direct) receive only one WellSense member ID card. Senior Care Options members receive one member ID card. See [Section 2: Member Eligibility](#) for guidelines and step-by-step instructions on how to confirm member eligibility in WellSense.

Cost-sharing (deductibles, coinsurance, and copayments)

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

For the **MassHealth** program:

- The only service requiring copayment collection is pharmacy.
- Providers may not bill or refuse to provide services to MassHealth members for missed appointments.
- Providers should assist MassHealth members in keeping their appointments.
- Providers may not refuse to provide services to MassHealth members based on a member's outstanding debt with you from a time prior to becoming a WellSense member.

For **Clarity plan (including QHP, ConnectorCare and Employer Choice Direct) programs**, many services require the collection of copayments, coinsurance, and deductibles.

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

Senior Care Options members have no copayments, coinsurance, or deductibles.

For complete information on cost sharing, please see the applicable Summary of Benefits available on our website at wellsense.org.

Prohibition on balance billing for covered services

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

- You deliver a covered service (not requiring prior authorization) to a member. Providers may collect permitted cost-sharing, but may not balance-bill.
- You fail to get prior authorization from WellSense before delivering a covered service requiring prior authorization (for example, speech therapy).

Providers may bill a member for the following:

- Permitted cost-sharing identified in the applicable Summary of Benefits at wellsense.org.
- Non-covered services, provided that for MassHealth members, the requirements for billing non-covered services (as described below) are satisfied.
- For SCO members, for a member to be financially liable the member must request an organization determination. If after receiving denial of the organization determination, the member then receives the service, the member can be held financially liable.

Please refer to [Section 4: Provider Responsibilities](#) for information about SCO Organization Determination requirements.

Billing MassHealth members for non-covered WellSense services

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

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

Clean claims

Our goal is to process clean claims and reimburse providers within 30 calendar days of receipt of the claim. To be considered clean, a claim must have all of the following characteristics:

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

Clean claims late payment

In connection with our Clarity plan (including QHP, ConnectorCare and Employer Choice Direct) program Qualified Health Plan programs, WellSense, within 45 days after receipt of a clean claim for reimbursement for covered services, will either (a) make payment to the provider;

(b) notify the provider in writing of the reasons for nonpayment; or (c) notify the provider in writing of what additional information or documentation is necessary to complete the claim form for reimbursement. For Senior Care Options members this timeframe is 30 days. There is no late payment penalty for MassHealth claims.

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

For Senior Care Options the interest rate is currently 1.125 % per year; the rate is subject to change on January 1 and July 1. The rate is set by the United States Department of Treasury. Interest accrued is equal to the number of days from date of payment minus 30 divided by 365 times the interest rate. This interest rate will not apply to claims which require additional development by WellSense, denied claims and claims where no additional money is due.

Affordable Care Act (ACA) grace period for delinquent premium payments for Clarity plans (including QHP, ConnectorCare and Employer Choice Direct)

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

WellSense will process and pay claims for covered services rendered during the first month of the grace period. WellSense will also process and pay claims for covered services rendered in the second and third months of the grace period—but will give you required notice that these claims are subject to later denial and payment retraction by us if the member does not pay their premium by the end of the grace period. This notice will be in the Remittance Advice and the Electronic Remittance Advice (835). If the member does not pay the premium by the end of the grace period, the Massachusetts State Health Connector and WellSense will terminate the member retroactively to the first day of the second month of the 90-day period.

WellSense will retract payment for all claims for services rendered during the second and third months of the 90-day grace period.) In this circumstance, Providers are entitled to bill the member for covered services rendered during the last two months of the grace period.

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

Pharmacy claims: Pharmacy claims with dates of service during the second and third months of the grace period will be processed in accordance with all WellSense pharmacy rules, but not covered by WellSense. During this time period, members will be responsible for 100% of the prescription cost. If the member pays

their premium in full by the end of the 90-day grace period, the member may seek reimbursement from WellSense's pharmacy benefit manager.

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

9.4 National Provider Identifier (NPI) and Tax ID Requirements

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

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

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

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

Taxonomy Codes

Providers must submit their billing taxonomy code for claims processing. Absence of a taxonomy code may result in an incorrect payment, delay in payment or claim denial. If billing for SCO members for Medicare covered services, providers must have a National Plan and Provider Enumeration System (NPPES) primary taxonomy that is a [Medicare approved taxonomy](#).

9.5 WellSense Specific Billing Guidelines by Service

WellSense adopted the standards set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for service and business transactions, including billing codes, modifiers, units of service, and claims

submission guidelines. Detailed information on coding and billing requirements are contained in our payment policies and billing guidelines. See our [Payment Policies](#) page at [wellsense.org](#) to view policies.

To ensure accurate claims payment and encounter reporting, all claims must be submitted in compliance with HIPAA standards. Failing to bill according to these payment terms will cause your claim to be denied.

In addition to our Payment Policies at [wellsense.org](#), providers must follow the guidelines below.

Service	Billing Guidelines
Billing primary care services	<p>WellSense pays for primary care services if the member is assigned to the treating PCP's panel or assigned to a PCP in the covering group. Physicians who provide specialty care services and also carry a primary care panel will need to use the appropriate modifier to identify specialty care services when billing us. We must approve and credential physicians with dual specialties in both specialties.</p> <p>In addition, providers must use a modifier when billing for primary care services delivered after hours. If you do not use the appropriate modifier, we will deny claims submitted for care rendered to members who are not part of the PCP's panel or the PCP's covering group.</p>

Primary Care Modifiers

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

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

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

If providers have a dual specialty approved and recognized by WellSense and provide both specialty care services and have an assigned primary care panel, you will need to use the TS modifier to identify specialty

care services if the member you are treating is not on your primary care panel. If you do not use this modifier, we will deny your specialty care claims.

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

9.6 Compliance: Deficit Reduction Act and HIPAA requirements

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

To ensure compliance with the DRA, WellSense provides all its employees, provider networks, contractors, and agents with information about the False Claims Acts and published [WellSense Fraud and Abuse Policy](#) internally as well as on the provider's page of our website at wellsense.org.

WellSense employees, contractors, and providers are expected to immediately report any potential false, inaccurate, or questionable claims or any other type of suspected fraud, waste, or abuse to our Fraud and Abuse Coordinator, or the Chief Compliance Officer or the Compliance hotline (888-411-4959) in accordance with the [WellSense Fraud and Abuse Policy](#).

WellSense is prohibited by law from retaliating in any way against anyone who reports, in good faith, a perceived problem, concern, fraud, waste, or abuse issue. Please review and adhere to the complete [WellSense Fraud and Abuse Policy](#), available on our website at wellsense.org.

9.7 Remittance Advice

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

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

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

Each billed item on the remittance advice includes:

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

9.8 Other Party Liability

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

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

WellSense's membership records are dependent on the enrollment notifications we receive from state and federal agencies. These notifications may require member retroactive additions and terminations. The Plan may recoup claims paid for members not enrolled in WellSense on the applicable date of services, regardless of the age of payment or date of service.

Provider's role:

Providers are required to perform "due diligence" to:

- Notify us of all instances of other party coverage by indicating the other carrier on the claim, calling our Coordination of Benefits and Third Party Liability department at 617-748-6188 or by submitting a completed [Coordination of Benefits Indicator Form for MassHealth](#), or [Coordination of Benefits Indicator Form for Senior Care Options](#)—both available on our website at wellsense.org.
- Obtain payment from all other liable parties prior to billing us. This includes billing the primary carrier for previously paid claims when notified of the existence of other coverage by WellSense.
- Submit to WellSense for consideration any balance when payment or denial is received from the primary payer. When submitting the claim to WellSense, include the explanation of benefits, remittance advice, or denial letter from the other payer. You have 150 days to bill WellSense after receipt of the primary payer's determination for MassHealth and SCO, and 90 days for QHP (including ConnectorCare). We strongly suggest that providers submit COB claims electronically as this is the fastest and most accurate submission method. Please be sure to enter the other carrier's payment and denial amounts at the line level versus the claim level.

Role of our Other Party Liability Department

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

Coordination of benefits (COB)

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

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

For the MassHealth program:

- Notify MassHealth that the member has other insurance. MassHealth will verify this information and update the Eligibility Verification System (EVS). EVS may not always reflect COB information immediately and is not a guarantee of payment, especially if the member has another insurance that is primary.

- WellSense will notify MassHealth providers by mail 60 days prior to adjusting any previously paid claims with dates of service during the effective dates of the other insurance.

For the Senior Care Options program:

- Notify WellSense that a member has other insurance. Providers may mail COB information to:
WellSense Health Plan
PO Box 55282
Boston, MA 02205-5282

For all programs:

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

Third-party liability (TPL)

TPL occurs when members are injured as a result of a liability accident. In these instances another party may be liable for the payment of the member's medical claims. The most common types of TPL cases are motor vehicle accidents, workers' compensation injuries, and slip-and-fall injuries. Auto insurance, workers' compensation insurance, and general liability insurance are the primary payers for all WellSense members.

WellSense members who are MassHealth and Senior Care Options members are entitled to \$8,000 in Personal Injury Protection (PIP) benefits per automobile accident. Clarity plan (including QHP, ConnectorCare and Employer Choice Direct) recipients are entitled to \$2,000.

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

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

9.9 Claims Submission

Claims may be submitted electronically or via mail. We encourage you to submit your claims electronically.

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

See the [Submit Claims](#) page of our website at wellsense.org for more information on electronic claims submission.

Submitting an electronic claim

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

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

Ways to submit claims electronically

There are two ways providers can submit claims electronically: directly to WellSense via our provider portal or via a third party. We accept and process claims electronically from two clearinghouse entities:

- TriZetto
- NEHEN (New England Healthcare EDI Network)

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

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

When your submission requires an attachment

We have updated our Provider Portal capabilities to accept claims that can't otherwise be accepted through EDI. You can now submit COB, TPL, Corrected Claims, and Appeals, with required attachments, via the Plan's Provider Portal.

Submitting a paper claim

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

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

SCO Only:

WellSense Health Plan
PO Box 55991
Boston, MA 02205-5049

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

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

When providers must submit a claim to a vendor

The following claims must be submitted directly to our subcontracted vendors and will not be accepted by WellSense:

- Behavioral Health: Carelon Behavioral Health, LLC at [carelonbehavioralhealth.com](https://www.carelonbehavioralhealth.com)
- Durable Medical Equipment: Northwood, Inc. at [northwoodinc.com](https://www.northwoodinc.com)
- Non-Emergency Medical Transportation: Coordinated Transportation Solutions, Inc. (CTS) at [ctstransit.com](https://www.ctstransit.com) (For SCO members only)
- Dental Services: Dental Services of Massachusetts (DentaQuest) (for SCO only) at [dentaquest.com](https://www.dentaquest.com)

Time limits on Claims

For MassHealth claims:

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

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

For Clarity plan (including QHP, ConnectorCare and Employer Choice Direct) claims:

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

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

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

Claims submitted for an administrative appeal must be received by WellSense's Provider Appeals Unit within the timeframe specified in 9.11 Administrative Appeals. A completed Request for Claim Review form must be included with all appeals and can be found at [wellsense.org](https://www.wellsense.org).

Timeframes for administrative appeal determination

Retroactive adjustment beyond this time period is considered at WellSense's discretion, but the adjustment may not exceed one year from the date of service.

For Senior Care Options claims:

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

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

9.10 Resubmitting a Claim

A resubmission is any previously filed claim that is resubmitted due to incorrect claims processing by us, or previously denied for additional documentation such as medical records, invoice or itemized bill. For **MassHealth and SCO claims**, we must receive resubmitted claims **no later than 300 days from the date of service**. For **Clarity plan claims** (including QHP, ConnectorCare and Employer Choice Direct), we must receive resubmitted claims **no later than 180 days from the date of service**.

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

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

Payment retraction or adjustment

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

Rejected or denied claims

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

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

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

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

Rejected Claim: A claim that was not properly submitted cannot be processed.

Possible reasons:

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

See [Payment retraction or adjustment](#) in this section for information on submitting a corrected claim.

Denied Claim: After processing properly submitted claims, a claim may be denied for several reasons, including:

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

Administrative Appeals of denied claims

Submit a [Request for Claim Review Form](#) available on our website at [wellsense.org](https://www.wellsense.org) via the Plan's Provider Portal at [wellsense.org](https://www.wellsense.org) or in writing to WellSense's Provider Service Center to the attention of the Provider Appeals

For questions about Administrative Appeals, please see Section 9.11 below or call the Provider Service Center at 888-566-0008 Mon.–Fri. (except holidays), 8 a.m. to 5 p.m.

Submit a corrected claim: Any previously filed paid or denied claim a provider resubmits with changed or corrected information

WellSense must receive all corrected claims as follows:

- MassHealth and SCO: within 150 days of the original process remit date, not to exceed 300 days from the date of service
- QHP: within 90 calendar days of the original process remit date, not to exceed 180 days from the date of service.
- Corrected claims are related to one or more of the following:

Incorrect provider name; if submitting with a new provider name or number, the provider must submit for a retraction and then submit a new claim

- Incorrect member name or member ID number; if submitting with a new member name or member ID, the provider must submit for a retraction and then submit a new claim.
- Incorrect line item details (e.g., procedures, modifier, units, or charges)
- Incorrect place of service
- Providers may not resubmit a claim that was rejected for a missing NPI number as a corrected claim. Provider must re-bill such claim as a new claim with updated information.
- Claims that have been previously denied and are being resubmitted with requested information such as itemizations, invoices, or operative notes, should not be submitted as corrected claims. These can simply be resubmitted with the additional documentation.
- Items submitted for reconsideration of timely filing denials, clinical edit denials, or partial payment denials are considered Appeals and must be submitted with appropriate documentation using the Administrative Appeals process outlined in this section.

The claims submission address for corrected paper claims is:

WellSense Health Plan
P.O. Box 55282
Boston, MA 02205-5049

SCO Only

WellSense Health Plan
P.O. Box 55991
Boston, MA 02205-5049

Corrected claims only apply to claims that were previously submitted and paid or denied. They do not apply to original or first-time submissions.

The corrected claims must:

- Include the original claim number
- Include an indication of the item(s) needing correction
- Not have handwritten changes
- Be submitted within the stated guidelines not include any correction fluid on the paper claim.

EDI can process replacement claims, which allow correction of most billing items.

However, for member and/or provider changes (provider name, NPI number, member name, or member ID number), process such change as, a void claim, with a new submission.

- If a claim is considered a corrected claim, please submit via EDI using the frequency code of 7 and make necessary corrections, submit via the provider portal or for paper submissions, please indicate this at the top of the claim and include WellSense claim number, which can be found on the remittance advice. Additionally, all corrected claim information should be circled when the claim is resubmitted. Corrected paper claims that are not submitted in this manner may have delays in processing.

Electronic claims are processed automatically.

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

For member and/or provider changes (provider name, NPI number, member name, or member ID number), process such a change as a **void** claim with a new submission

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

- The claim is not at the finished status. Finished claims are those printed on a remittance advice with an assigned claim number, or those claims in the claims inquiry section on the Administrative Resources page at wellsense.org with a status of "finished." Claims identified with a status of "in process" or "adjudicated" are not considered finished.
- The claim is "split" (e.g., a request for a claim that crosses a calendar year span).

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

Questions should be directed to your assigned Provider Relations Team or WellSense's EDI department.

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

Rejected Claim: A claim that was not properly submitted cannot be processed.

Possible reasons:

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

See [Payment retraction or adjustment](#) in this section for information on submitting a corrected claim.

9.11 Administrative Appeals

This section applies to all WellSense Health Plan products.

If providers wish to appeal a claim we have denied, submit a [Request for Claim Review Form](#) available on our website at wellsense.org. If you have a question about an Administrative Appeal, call the provider line at

888-566-0008 and select option 2 to speak with a Provider Service Representative. Staff is available from 8:30 a.m. to 5 p.m., Monday through Friday, except holidays. Providers may submit a provider administrative claims appeal to WellSense if you are requesting that a previously denied claim be overturned due to circumstances outlined below. Providers may request that we review a claim that was denied for an administrative reason rather than for medical necessity of services. The administrative appeal process is only applicable to claims that have already been processed and denied. An administrative appeal cannot be requested for services rendered to a member who was not eligible on the date(s) of service, or for benefits that are not administered or covered by WellSense. We provide a thorough, timely, and unbiased review of an administrative appeal: The following types of provider administrative claim appeals are IN SCOPE for this process:

- Level of Compensation/Reimbursement
- Timely Filing of Claims
- Retroactive Member 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

The following are OUT OF SCOPE for this process and must be sent to the appropriate departments:

- Standard and expedited internal member appeals. (See Section 10: Appeals, Inquiries, and Grievances)
- Claim adjustment or corrected claim: any previously filed claim that is resubmitted with information that has been changed by the provider. (Must be sent to the Claims Department.)
- Claim resubmission: Any previously filed claim that is resubmitted due to incorrect claim processing by WellSense. (Must be sent to the Claims Department.)
- Claims involving coordination of benefits, motor vehicle accident, and workers' compensation appeal.*
- *Note: Claims issues involving OPL/TPL/COB are not necessarily appeals involving OPL/TPL/COB claims. Providers are responsible for sending their requests to the appropriate address via the required method(s).

- MassHealth ACO Primary Care Sub-Capitation Monthly Payments: Questions or requests about monthly payments should be directed to your Provider Relations contact for appropriate internal review and triage for resolution.

Internal administrative appeal

We offer one level of internal administrative review to providers. 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.

Information required for administrative appeals

General Rules for Submission of Provider Administrative Claim Appeals

- Provider administrative claims appeals may be submitted via the Provider Portal, which can be accessed via the Provider Page of our website wellsense.org and logging in with your secure ID.
- Provider administrative claims appeals may also be submitted via mail through the United States Postal Service.
- All provider administrative claims appeal must include a **completed*** Request for Claim Review Form which can be located on our website at: [Documents and Forms | Providers - Massachusetts | WellSense Health Plan](#)
- Forms must be submitted with all required information, including but not limited to completion of all fields denoted with an asterisk (*) and the correct Review Type box. If using "Other" on the form, providers must document specific information pertaining to their request.

*Appeals with incomplete forms will be dismissed. A dismissal letter will inform the submitting provider that they may resubmit their appeal with the completed form. The provider's request will not be processed unless/until a completed form is received with the original appeal within the original appeal timely filing timeframes. Once the appeal is received with a completed Universal Request for Claim Review Form, the effective date of receipt of the provider administrative claim appeal will be the date the resubmitted appeal and completed form is received at the Plan. If an appeal resubmission is not received by the Plan within the original timeframes to appeal, it will be dismissed by the Plan as untimely.

- Forms submitted must be legible. Appeals that contain a Request for Claim Review Form that cannot be interpreted or are illegible will be dismissed as unable to process.
- All appeals must **be accompanied by a written narrative** explaining in full detail the discrepancy or the rationale for the appeal of the denial. Appeals that do not contain a written narrative detailing the request and rationale will be dismissed as unable to process.
- All appeals must include a copy of the claim(s) in question, the remittance advice, applicable OPT/TPL/COB documents (example: EOB from another carrier, PIP letter, etc.) and any Plan issued correspondence.

- All appeals must include **all necessary** information the provider wishes to have considered during the review. The Plan will not accept additional information for review after an appeal decision has been rendered by the Plan.
- All appeals must be received by the Plan within the following timeframes:
- **MCO/ACO**: 150 calendar days from the original denial date and no later than 300 calendar days from the date of service.
- **Clarity plans** (including QHP, ConnectorCare and Employer Choice Direct): 90 calendar days from the original denial date and no later than 180 calendar days from the date of service. The 90 calendar days are from either the date of service, the date of hospital discharge or, in the case of multiple insurers, the date of the primary insurer's explanation of benefits (EOB).
- **Senior Care Options (SCO)**: 150 calendar days from the original denial date and no later than 300 calendar days from the date of service.
- Providers must complete the Universal Request for Claim Review Form accurately. Mislabeling of the form may result in misrouting of review requests and will likely delay the outcome.
- Providers should refer to their provider contracts to verify specified timeframe for submission.
- Provider Administrative Claims Appeals received after the required timeframes will be dismissed as untimely.
- Providers must submit administrative claims appeals to WellSense with the required documentation to the following address:

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

Required data elements for administrative appeals

The following data elements must be present on the [Request for Claim Review Form](#) and must be legible:

- Provider name
- Assigned provider identification (ID) number/NPI
- Contact name
- Contact telephone number
- Member name
- Member ID number
- Claim number
- Date of service
- Procedure code being appealed
- Charge amount

- Total claim charges
- Denial code

Recommended documentation for administrative appeals

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

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

Documentation checklist sorted by type of administrative appeal

Reimbursement appeal:

- Include a written narrative (explanation) of the requested change(s).
- Include the remittance advice and identify the claim we should review.
- All supporting documentation in the form of invoices, operative notes, office notes, or any necessary medical record information.
- Include a completed Universal Request for Claim Review Form, available on our website at wellsense.org, if submitting via mail.

Claim denied for lack of WellSense authorization:

- Include a written narrative (explanation) detailing the request and any extenuating circumstance that prevented the provider from contacting the Plan for prior authorization or extending an existing authorization to cover the date(s) of service for a member's treatment.
- Include all pertinent clinical documentation including medical records.
- Include a copy of the claim and the remittance advice.
- If prior authorization was required but not obtained, you must supply a written narrative detailing any extenuating circumstances that prevented you from contacting us for prior authorization or extending an existing authorization to cover the date(s) of service for a member's treatment. In the

instance of eligibility verification, you must include documentation of internal and/or external systems.

- If prior authorization was required and obtained, you must supply proof to us that you followed our prior authorization procedure. Proper supporting documentation includes a copy of your original information faxed/submitted to us, the reference number received verbally or in writing from us and any written authorization notification(s) from us.

WellSense reviews claims denied for lack of authorization in certain situations which may include:

- The member was added retroactively to WellSense after the service was rendered.
- The member was added retroactively to WellSense during a course of continuing treatment.
- A provider notified a different insurance company not realizing the member was active with WellSense. In these instances, timely notification to the other insurance company must be submitted with the appeal.

If an administrative claims appeal is approved, WellSense will adjust the claim. If an administrative claims appeal is upheld, WellSense will send written notification to providers. In the event WellSense approves an administrative denial and the appeal requires clinical review, the appeal will be sent to a clinical nurse reviewer for application of clinical coverage criteria to determine if the service(s) were medically necessary. If the nurse reviewer is unable to approve the review, the case will be sent to a Plan Physician Reviewer, MD, for final review and determination. If an appeal is approved because the service(s) met the clinical criteria for coverage, the claim will be adjusted accordingly. When it is determined that the service was not medically necessary due to not meeting clinical criteria for coverage, the claim denial will be upheld and a denial letter will be sent to the provider.

Claim denied for submission over the filing limit:

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

- If the initial claim submission is after the filing limit and the circumstance for the late submission was beyond your control, you may appeal by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing limit. Please include the original claim form. You must send us the appeal within the timeframe specified in this section.
- If the member did not identify him/herself as a WellSense member, you must supply proof to WellSense, that the member had been billed within our timely filing limits.

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

- Computer printout of patient account ledger
- EOB from primary insurer
- Proof that another insurance carrier was billed

A provider who submits electronic claims (either through a clearinghouse or directly to WellSense) must attach the applicable electronic data interchange (EDI) transmission report. The EDI transmission report will provide proof of prior-submission and indicate that we did not reject the claim.

Method of EDI Submission	EDI Transmission Report	EDI Message
Directly to WellSense	Claims Acceptance Acknowledgement	Claims accepted or rejected by WellSense with reject reason.

NEHEN (New England Health EDI Network) and TriZetto are the Plan's contracted vendors specializing in electronic solutions.

Claim denied because member ineligible on the date of service

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

Claim denied for coding and clinical editing

- Appeals must include all pertinent information, including RA denial code. The specific procedure codes being appealed must be identified and all necessary clinical documentation must be included.
- E/M encounters require documentation of history, exam, and medical decision-making and the documentation for each service must be able to stand alone and support the levels billed. This includes:
 - A clear statement of the reason for the encounter
 - Appropriate history and physical examination
 - Review of any labs, X-rays, and other ancillary services
 - The reason for and results of diagnostic tests
 - Relevant health risk factors
 - The member's progress, including response to treatment, change in treatment, and member's noncompliance
 - Assessment plan of care including treatments and medications (specify frequency and dosage), referrals and consults, member/family education, specific instructions for follow-up, and discharge summary and instructions
- You must attach a copy of the claim and the remittance advice.
- A completed [Request for Claim Review Form](https://www.wellsense.org) must be included with all appeals and can be found at [wellsense.org](https://www.wellsense.org).

Timeframes for administrative appeal determination

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

9.12 Claims Payment

Inquiring about the status of a claim

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

Online claims status inquiry and remittance advice

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

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

Clean Claims Payment

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

Electronic funds transfer (EFT)

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

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

How to Request payment by EFT

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

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

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

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

9.13 Clinical Audit

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

- Ensure the appropriateness and accuracy of provider billing practices, including but not limited to, consistency between medical record documentation, procedure code selection, where relevant, and provider Charge Description Master ("CDM" or "charge master");
- Evaluate WellSense and provider compliance with contract rights and obligations related to claims, including, but not limited to, adherence to medical and payment policies.

Verify the financial accuracy of claims payment

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

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

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

Provider's role

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

- Designate someone with relevant knowledge and experience to coordinate audit activities

- Respond to the notification, providing preparatory information such as the itemized bill and/or other documentation requested within the designated time period.
- Notify us at least ten working days in advance if an onsite audit must be rescheduled or if you are unable to provide documentation for a desk audit within the designated time period. Any such cancelled audits must be rescheduled within 45 days of the initial audit date.
- Provide full, complete clinical (medical) records and any additional documentation that supports the claim(s) in question or helps our auditors understand the exact nature of charges and charge description masters spanning the service dates of the claims at a mutually agreed upon time and location for onsite audits or in the documentation packet for desk audits. Such additional documentation could include, but is not limited to, signed and dated ancillary department records/logs, signed and dated charge tickets, descriptions and provider's cost of any services, supplies, or implants billed as "miscellaneous" items and, upon request, provider's inflators (i.e., "mark-up" rates), and policies developed, adopted, and periodically reviewed by clinical staff, as evidenced by dates of implementation and review and signatures of policy owner(s).
- Identify and present, at the beginning of an onsite audit or in the documentation packet of a desk audit, any charges omitted from the final bill or billed in insufficient quantity on the final bill that you would like considered for payment. Under-billed or unbilled charges not presented at the beginning of an audit will not be reviewed or considered for payment.
- Provide a suitable work area for onsite audits.
- Attend an exit conference or, per mutual agreement, receive audit results at the conclusion of an on-site audit or receive audit results via regular or electronic mail at the conclusion of a desk audit.
- Respond to initial audit findings within 30 days of the initial Audit Summary Report date, unless otherwise agreed upon in writing in advance.
- Submit late charge type bills for any agreed upon previously unbilled or under-billed charges directly to WellSense's auditor within 30 days of the initial Audit Summary Report date. Do not submit corrected claims or late charge bills via the usual claims submission process or through Provider Appeals.

Our Clinical Audit Department's role

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

In the performance of these audits, we will:

- Identify the audit sample using internal criteria and random sampling methodology.
- Select claims for audit with a final bill-paid date that is not more than two years prior to the proposed audit date (unless otherwise agreed to in your contract), except in the case of suspected fraud, waste, or abuse, in which case there is no restriction on the look-back period.
- Notify you in writing of our intent to audit not less than 30 days prior to the proposed audit date, providing sufficient information regarding the nature of the audit and the specific claims to be audited as is required to allow you to comply with your responsibilities as described above.
- Employ auditors knowledgeable in clinical practice, coding and billing and possessing the highest degree of integrity and professionalism.
- Verify service descriptions and prices against the charge description master (CDM) in effect on the date of service.
- Accept all documentation that contains sufficient information to identify both the member receiving the service(s) and the individual(s) completing the documentation along with their credentials as evidence that a specific service was provided. However, we will not accept amended/altere d medical records that are either unsigned, lacking credentials, and/or undated. We will not accept medical records or other documentation amended/altere d more than 30 days after the date of service.
- Give you written results at the conclusion of the audit for each claim reviewed, either as an individual initial Audit Summary Report for each claim reviewed on-site or as a combined Audit Summary Report individually detailing the findings for all claims reviewed by desk audit.
- Allow you a response period of 30 days for all claims with audit discrepancies, unless otherwise agreed upon in writing at the time of audit.
- Accept late charge bills submitted within 30 days of the initial Audit Summary Report for any agreed upon previously unbilled or under-billed services/items you identified at the beginning of an onsite audit or submitted with the documentation packet for a desk audit.
- Provide a final Audit Summary Report, one for each claim for which an individual initial Audit Summary Report was presented at the conclusion of an audit or a combined final Audit Summary Report for all claims for which a combined initial Audit Summary Report was presented at the conclusion of an audit.
- Note: WellSense's membership records are dependent on the enrollment notifications we receive from state and federal agencies. These notifications may require member retroactive additions and

terminations. The Plan may recoup claims paid for members not enrolled in WellSense on the applicable date of service, regardless of the age of payment or date of service.

WellSense's contracted audit agent's role

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

In the performance of these audits, the contracted audit agent will:

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

In connection with an audit, whether conducted directly by WellSense or by a contracted agent, we may:

- Expand the scope of the audit if additional areas of concern are identified during the course of an audit.
- Extrapolate findings of an audit sample to a designated universe of claims.
- Adjust or retract claim payments, as indicated on the final written report, via offset of future claims' payment, identifying audit-related retractions, and/or claim adjustments on the remittance advice, or, upon written mutual agreement, accept refund of overpayments.

- Issue a technical denial and retract payment(s) when a provider fails to respond to a request for medical records.
- Escalate the audit to the Special Investigations Unit for further review.

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

9.14 Special Investigations Unit

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

In addition to the rights and responsibilities of both WellSense and Provider noted above in the Clinical Audit section, during the investigation review process, providers will be required to adhere to any reasonable requests made by WellSense for supporting documentation. In no circumstance does WellSense pay a fee for the copying of records associated with an investigation. For any provider under review, WellSense shall have the right to evaluate through inspection, evaluation, review or request, or other means, including on-site visits whether announced or unannounced, any record pertinent to the review. These records may include, but are not limited to, medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness, and timeliness of services. Such evaluation, inspection, review, or request,

when performed or requested, shall be executed with the immediate cooperation of the Provider. The Provider shall assist in such reviews and provide complete copies of the applicable requested documentation.

If you dispute the investigative findings on a final written report, you may submit a first level appeal directly to the Special Investigations Unit within 30 days, as follows:

- Your appeal must be submitted in writing;
- All claims that you would like to appeal, related to the final written report, must be included in one appeal package;
- The appeal should be directed to the Special Investigations Unit department; and
- The appeal package must be accompanied by all clinical documentation related to the investigative citation(s) in question, any relevant policies, date-relevant documentation, and any other supporting information you would like us to consider.

Your appeal related to Special Investigations Unit final findings should not be submitted:

- claim by claim separately; and
- as an administrative appeal.

We will make best efforts to review the appeal and notify you in writing of the final determination within 60 days of receipt of the appeal, provided, however, that we reserve the right to extend the review period if necessary to complete a full and final review. If the review period is extended beyond 60 days, we will notify you in writing of the extension. You will be notified of the results of your first level appeal, including any findings that were upheld, overturned or partially overturned.

You also have the right to a second level appeal, to be submitted within thirty days of receipt of the first level appeal results letter. Please follow the same process as noted above when submitting your second level appeal. Any second level appeal will be handled by an independent reviewer not a party to the initial appeal or SIU final determination.

Our appeal determinations are final. We will process any claim adjustments resulting from the final determination of an appeal within 30 days of the final appeal determination.

9.15 Credit Balance

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

Provider's role

Providers are required to perform due diligence to identify and refund overpayments to WellSense within 60 days of receipt of the overpayment. Credit balances are usually discovered through a review of your credit balance report. Providers should not submit refund checks for credit balance payments; instead, please contact us using the methods below and we will adjust your claim(s) and recover the credit balances through future payment offsets.

The preferred method is to upload the request to the [HealthTrio online portal](#). If you haven't signed up for the portal, please contact your Provider Relations Consultant. Please upload the [Claim Review Form](#), [Credit Balance Refund Data Sheet](#), and any supporting document necessary. Both forms are available on our website.

Providers can also submit the Credit Balance Refund Data Sheet, and any supporting document necessary using one of the traditional methods below. Again, please do not send us refund checks.

- **Fax:** 617-897-0811
- **Mail:** Same address for WellSense Health Plan (MA) and (NH)

WellSense Health Plan
Attn: Credit Balance
529 Main Street, Suite 500 (address will be changing late spring 2024)
Charlestown, MA 02129

If for any reason, providers must send us a refund check because providers can't submit a retraction request, please mail the refund check along with the Credit Balance Refund Data Sheet and any supporting document(s) necessary by mail to the address below. Please note: this is **not** a preferred method and may take longer to process.

WellSense Health Plan
Attn: Finance Department
529 Main Street, Suite 500 (address will be changing late spring 2024)
Charlestown, MA 02129

Role of our Credit Balance Department

When providers notify us of an overpayment, we will adjust the claim(s) to reflect the correct payment. The reason for the adjustment will be identified on the remittance advice.

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

- Provide a report identifying all findings to the provider's designee
- Review all findings with your designated representative.
- Allow you 30 days to review and either approve or contest the findings.
- Retract overpayments approved by the provider or, in the absence of a provider approval or contest, 30-60 days after findings were reported to the provider.
- Indicate the reason for the adjustment on the remittance advice.

9.16 Process to Address Negative Balances

Negative balances arise when WellSense re-adjudicates a claim and the subsequent claims processing results in an amount due the provider that is less than the amount paid at the first processing of the claim.

WellSense's process to address negative balances is described below:

1. WellSense's Finance Department runs weekly reports to identify any negative balances and reviews and validates the content of the reports.
2. In order to recoup negative balances, WellSense will take the following actions related to negative balances created greater than 120 days from the week of the report:
3. WellSense may, at its sole option, transfer (offset) negative balances from one or more lines of business to other lines of business or from one provider payee to other provider payees; and apply those negative balances to outstanding claims due to provider; or
4. WellSense may seek to recoup negative balances directly from the provider by notifying provider to send payment to WellSense. The notice will include documentation of claims and amounts owed, and a timeframe in which provider must repay WellSense. In the event repayment is not received by WellSense within the stated timeframe, WellSense may, at its sole option, transfer negative balances from one or more lines of business to other lines of business or from one provider payee to other provider payees; and apply those negative balances to outstanding claims due to provider.
5. If WellSense is unable to successfully implement the transfers described in item 2.a. because there are not sufficient outstanding claims to offset the negative balance, and/or the provider has not refunded payment in accordance with item 2.b., WellSense reserves the right to pursue other appropriate collection efforts to address negative balances.

9.17 Forms and Instructions

Billing requirements for medical/surgical services

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

CMS-1500 claim form requirements

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

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

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

Providers must include the required claim data elements identified in the [Billing Requirements for Institutional Claims](#) and [Billing Requirements for Professional Claims](#) available on our website at wellsense.org.

Section 10: Appeals, Inquiries, and Grievances

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

10.1 Overview

We have processes for receiving and promptly resolving member inquiries, grievances, and appeals, and administrative appeals (provider appeals). The member appeals process includes the right of a member, or person acting on behalf of the member (Authorized Representative) to use our member appeals and grievances processes. All references to the Office of Medicaid Board of Hearings (BOH) refer to external appeals for MassHealth members. Clarity plan (including QHP, ConnectorCare and Employer Choice Direct) members must pursue external appeals via the Office of Patient Protection. Under certain circumstances, Senior Care Options members may appeal externally to organizations contracted with the Center for Medicare and Medicaid Services (CMS) and/or the Office of Medicaid Board of Hearings. Member/consumer protections (inquiries, grievances, and appeals) differ between MassHealth, Clarity plans and our Senior Care Options products. This section of the Provider Manual describes these differences.

10.2 MassHealth Appeals: Related Definitions

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

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

Authorized Representative

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

Appeals and Grievances Specialist

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

Adverse Action

An Adverse Action is an occurrence that falls into one of the following categories:

- The failure of a provider to deliver covered services in a timely manner in accordance with the access to care guidelines and waiting time standards.
- A WellSense denial or limited authorization of a requested service, including the determination that a requested service is not a covered service.
- WellSense reduction, suspension, or termination of a previous authorization for a service.
- WellSense's failure to act within the required timeframes described in the utilization management section of this document.
- WellSense's failure to act within the required timeframes for reviewing an internal appeal and issuing a decision.
- The denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue. Procedural denials for requested services do not constitute Adverse Actions. These include but are not limited to denials due to the provider's failure to:
 - Follow WellSense prior authorization procedures
 - Follow WellSense referral rules
 - File a timely claim

- Follow other WellSense guidelines

Board of Hearings (BOH)

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

Board of Hearings (BOH) Appeal

An external appeal is available to members who have exhausted our internal appeals process and are requesting an external review. A BOH appeal is a written request to BOH by a member or the member's Authorized Representative to review a final, internal appeal decision made by WellSense.

Continuing services

Covered services that we previously authorized, and are the subject of an internal appeal or BOH appeal involving a decision by WellSense to terminate, suspend, or reduce the previous authorization. We provide continuing services pending the resolution of the internal appeal or a BOH appeal. Continuing services will be provided if the request is made within ten calendar days from the date of the Adverse Action.

Date of action

The effective date of an Adverse Action.

Expedited internal appeal

An internal appeal that has been expedited because WellSense determines, or a physician on behalf of a member asserts, that taking the time for a standard resolution could seriously jeopardize the member's life or health, or the member's ability to attain, maintain, or regain maximum function.

Standard internal appeal

The internal review of a request by a member or member's Authorized Representative for review of an Adverse Action.

Grievance

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

Inquiry

An inquiry is any oral or written question by a member or member's Authorized Representative to WellSense's Member Service Department regarding an aspect of WellSense's operations that does not express dissatisfaction about WellSense or invoke WellSense's grievance, coverage or appeals process, such as a routine question about a benefit.

Provider

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

10.3 Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct) Appeals: Related Definitions

Below are definitions to be used for the Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct) plans sections of this manual.

Adverse Determination

A WellSense determination, based on a review of information provided, to deny, reduce, modify or terminate an admission, continued inpatient stay or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness. These are often known as "medical necessity denials" because in these cases WellSense has determined that the service is not medically necessary for a member. Please note that the appeal rights issued with such initial denials will explain who may file the appeal based on liability (member versus provider). For example, appeals regarding readmissions, level of care denials or the MassHealth "24 hour observation rule" are participating provider administrative appeals.

Authorized Representative

An Authorized Representative is any individual that WellSense can document has been authorized, in writing, by the member to act on the member's behalf with respect to all grievances, internal appeals or external appeals. Such standing authorization may be revoked by the member at any time. A member may verbally authorize a practitioner to act on their behalf to initiate an appeal, however, a signed authorization is required. A member may be represented by anyone they choose, including an attorney or a provider. An Authorized Representative may be a family member, agent under a power of attorney, healthcare agent under a

healthcare proxy, a healthcare provider, attorney, or any other person appointed in writing to represent the member in a specific grievance or appeal. We may require documentation that an Authorized Representative meets one of the above criteria.

Appeals and Grievances Specialist

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

Appeal

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

- **Benefit denial:** A WellSense decision, made before or after the member has obtained services, to deny coverage for a service, supply, or drug that is specifically limited or excluded from coverage in the Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct) member's applicable Evidence of Coverage (EOC).
- **Adverse determination:** A WellSense decision, based on a review of information provided, to deny, reduce, modify or terminate an admission, continued inpatient stay or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care or effectiveness. These are often known as medical necessity denials because in these cases WellSense has determined that the service is not medically necessary for the member.

Grievance

A grievance is any formal complaint, oral or written, submitted by a member or member's Authorized Representative including a provider on behalf of a member, regarding dissatisfaction with:

- WellSense administration (how WellSense is operated): Any action taken by a WellSense employee(s), any aspect of WellSense's services, policies or procedures, or a billing issue.
- Aspects of interpersonal relationships such as rudeness of a provider or a provider staff member.
- Quality of care: The quality of care a member received from one of our participating providers.
- A **Commercial / QHP "Grievance"** is defined as follows: Grievance means any oral or written complaint submitted to the carrier that has been initiated by an insured, or the insured's authorized representative, concerning any aspect or action of the carrier relative to the insured, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, rescission of coverage, quality of care and administrative operations, in accordance with the requirements of 958 CMR 3.000

Inquiry

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

Office of Patient Protection (OPP)

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

Provider

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

10.4 Senior Care Options Appeals: Related Definitions

Below are some definitions to help you understand our processes for certain inquiries, grievances, appeals and other Senior Care Options-related communications.

Adverse Action

An Adverse Action is when any one of the following actions or inactions by WellSense occurs:

- The failure to provide Covered Services in a timely manner in accordance with the accessibility standards;
- The denial or limited authorization of a requested service, including the determination that a requested service is not a Covered Service;
- The reduction, suspension, or termination of a previous authorization by the Contractor for a service;
- The denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute Adverse Actions, including but not limited to denials based on the following:

- Failure to follow prior authorization procedures;
- Failure to follow referral rules;
- Failure to file a timely claim;
- The failure to act within the timeframes for making authorization decisions;
- The denial of a member's request to dispute financial liability; and
- The failure to act within the timeframes for reviewing a WellSense Appeal and issuing a decision.
- An adverse decision on a determination to the extent not otherwise included in items above.

Appeal of Part C Services (Part C appeal)

An appeal of Part C Services is defined as any of the procedures that deal with the review of adverse organization determinations on the health care services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by WellSense, and if necessary, an independent review entity (IRE), hearings through the Board of Hearings at EOHHS, hearings before Administrative Law Judges (ALJ), review by the Medicare Appeals Council (MAC), and judicial review.

Disputes involving optional supplemental benefits offered by WellSense will be treated as appeals.

Appeal of Part D Services (Part D appeal)

An appeal of Part D Services is defined as any of the procedures that deal with the review of adverse coverage determinations made by WellSense on the benefits under a Part D plan the member believes he or she is entitled to receive, including a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the member), or on any amount the member must pay for drug coverage, as defined in 42 CFR 423.566(b). These procedures include redeterminations by WellSense, reconsiderations by the independent review entity (IRE), hearings through the Board of Hearings at EOHHS, Administrative Law Judge (ALJ) hearings, reviews by the Medicare Appeals Council (MAC), and judicial reviews.

Appeals and Grievances Specialist

Our Appeals and Grievances Specialist is responsible for coordinating, investigating, documenting, and resolving all member appeals and grievances. For member appeals, this Specialist acts as a liaison between WellSense and the external review organizations.

Appeal Representative

Any individual that the Plan can document has been authorized by the member in writing to act on the member's behalf with respect to all aspects of a Grievance or Appeal (whether internal or external). The Plan must allow a member to give a standing authorization to an Appeal Representative to act on their behalf for all aspects of Grievances and internal Appeals. The member must execute such a standing authorization in writing according to the Plan's procedures. The member may revoke such a standing authorization at any time. Unless otherwise stated, the representative will have all of the rights and responsibilities of a member

or party in obtaining an Organization Determination, Coverage Determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described in Section 2.8 of the SCO Contract and at 42 CFR Part 405.

Appointment of Representative (AOR) Form (or equivalent written notice)

The CMS AOR form is OMB-approved Form [CMS-1696](#), and this form applies for a Medicare beneficiary's representative appealing or grieving on the beneficiary's behalf. An equivalent notice meets the requirements outlined in CMS Regulations "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance" Section 20.2 The use or application of an AOR (or equivalent written notice) applies to SCO members who are also part of WellSense's DNSP plan as it pertains to Medicare or overlap benefits.

Board of Hearings (BOH)

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

Board of Hearings (BOH) Appeal

An external appeal is available to members who are Medicaid eligible and have exhausted our internal appeals process and are requesting an external review. A BOH appeal is a written request to the BOH by a member or the member's Authorized Representative to review a final, internal appeal decision made by WellSense.

Coverage Determination for Part D Services

A Coverage Determination is any decision made by or on behalf of WellSense regarding payment or benefits of Part D benefits to which a member believes he or she is entitled.

Date of Action

The effective date of an Adverse Action

Expedited Reconsideration (Appeal) of Part C Services

An Expedited Appeal is an internal review by WellSense of a request by a member or Authorized Representative that has been expedited because WellSense determines, or a physician on behalf of a member asserts that, taking the time for a standard resolution could seriously jeopardize the member's life or health, or the member's ability to attain, maintain, or regain maximum function. The timeframe to review and resolve an Expedited Appeal is 72 hours from the time it is received at WellSense, unless an extension of up to 14 calendar days is necessary.

- Note, as it applies to Medicare beneficiaries, CMS 10.5.2 states: For standard requests, the processing timeframe begins when the plan, any unit in the plan, or a delegated entity (including a

delegated entity that is not responsible for processing) receives a request. For expedited requests, the processing timeframe begins when the appropriate department receives the request.

Expedited Redetermination (Appeal) of Part D Services

An Expedited Appeal is an internal review by WellSense of a request by a member or Authorized Representative that has been expedited because WellSense determines, or a physician on behalf of a member asserts that, taking the time for a standard resolution could seriously jeopardize the member's life or health, or the member's ability to attain, maintain, or regain maximum function. The Expedited Redetermination timeframe is 72 hours from receipt at WellSense.

- Note, as it applies to Medicare beneficiaries, CMS 10.5.2 states: For standard requests, the processing timeframe begins when the plan, any unit in the plan, or a delegated entity (including a delegated entity that is not responsible for processing) receives a request. For expedited requests, the processing timeframe begins when the appropriate department receives the request.

Fast-Track Appeal

A Fast-Track Appeal is an Expedited Appeal review process conducted by a Quality Improvement Organization (QIO) when a member disagrees that their covered skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) services should end, or when member disagrees with their discharge from an inpatient hospital stay. CMS contracts with QIOs to conduct fast-track appeals.

Grievance – Part C Services (Part C Grievance)

A Part C Grievance is any expression of dissatisfaction by a member or Appeal Representative about any action or inaction by the Plan other than an organization determination (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 the Plan, or failure to respect the member's rights regardless of whether remedial action is requested. Grievances include a member's right to dispute an extension of time proposed by the Plan to make an authorization decision or the failure of the Plan to expedite an organization determination or reconsideration. Grievances include integrated grievances, as defined in 42 CFR § 422.561. A member or their Authorized Representative may make the complaint or dispute, either orally or in writing, to WellSense, a provider, or a facility. An expedited grievance may also include a complaint that WellSense refused to expedite an Organization Determination or Reconsideration, or invoked an extension to an Organization Determination or Reconsideration time frame. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Grievance – Part D

A Part D grievance is any expression of dissatisfaction by a member or Appeal Representative about any action or inaction by the Plan other than a Coverage Determination (Adverse Action) or Redetermination (Appeal). Possible subjects for Grievances include, but are not limited to, any aspect of the operations, activities, or behavior of a Part D plan sponsor or failure to respect the member's rights regardless of whether remedial action is requested. Grievances include a complaint that a Part D sponsor refused to expedite a Coverage Determination or Redetermination. Grievances include integrated grievances, as defined in 42 CFR § 422.561

Types of Part C and D Grievances

- **Administrative Grievance:** a member Grievance related to billing issues or a member's dissatisfaction with WellSense's staff, policies, processes or procedures or involuntary disenrollment by WellSense. An Administrative Grievance may also include a member's dissatisfaction with the attitude of a provider or provider staff member, provider office policies or wait times.
- **Expedited Administrative Grievance:** a member Grievance related to WellSense's extension of timeframes for Organization Determinations or Reconsiderations (Appeals) or the refusal of WellSense to grant a request for an expedited Organization Determination, Reconsideration (Appeal), Coverage Determination, or Redetermination (Part D Appeal).
- **Clinical Grievance (i.e., Quality of Care Grievance):** a member Grievance regarding the health care and/or services that a member has received or is trying to receive.
- **Expedited Clinical Grievance (i.e., Expedited Quality of Care Grievance):** a member Grievance regarding a clinical issue of such an urgent nature that it is deemed that a delay in the review process might seriously jeopardize: 1) the life and/or health of the member, and/or 2) the member's ability to regain maximum functioning, or 3) is an issue that poses an interruption in the ongoing immediate treatment of the member.

Independent Review Entity

An independent entity contracted by CMS to review WellSense's adverse reconsiderations or redeterminations of organization determinations and coverage determinations.

Inquiry

An Inquiry is any oral or written request to WellSense, a provider or facility, without an expression of dissatisfaction (e.g., a request for information or action by a member).

Medically Necessary Services

- Per Medicare, services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y.
- Per MassHealth, services:
- That are provided in accordance with MassHealth regulations at 130 CMR 450.204;
- Which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and
- For which there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly. Medically Necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

Services must be provided in a way that provides all protections to the member provided by Medicare and MassHealth (Medicaid).

Organization Determination

An Organization Determination is any determination made by WellSense with respect to the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
- Payment for any other health services furnished by a provider other than WellSense that the member believes are covered under Medicare, or if not covered under Medicare, should have been furnished, arranged for, or reimbursed by WellSense.
- WellSense's refusal to provide or pay for services, in whole or in part, including the level of services, that the member believes should be furnished or arranged for by WellSense.
- Reduction or premature discontinuation of a previously authorized ongoing course of treatment.
- Failure of WellSense to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.

Provider

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

Quality Improvement Organization (QIO)

A Quality Improvement Organization is an organization comprised of practicing doctors and other health care experts under contract with the federal government to monitor and improve the care given to Medicare members. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for members receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs).

Reconsideration

A Reconsideration is a member's first step in the Part C appeal process which involves WellSense reevaluating an adverse Organization Determination, the findings upon which it was based, and any other evidence submitted or obtained.

Redetermination

A Redetermination is a member's first step in the Part D appeal process, which involves WellSense reevaluating an adverse Coverage Determination, the findings upon which it was based, and any other evidence submitted or obtained.

Standard Appeal

A Standard Appeal is an internal Reconsideration or Redetermination by WellSense of a request by a member or Authorized Representative, authorized in writing by the member, to review an adverse Organization or Coverage Determination. The timeframe to review and respond is anywhere from seven (7) to thirty (30) calendar days from date of receipt at WellSense. Extensions are only allowed for Reconsiderations and no extensions are allowed for Part B Appeals (Medical Drug Appeals for Medicare beneficiaries).

10.5 Clinical Right of a Provider to Discuss an Adverse Action/Determination

Our Medical/Surgical Prior Authorization, Pharmacy Prior Authorization, and Inpatient Utilization Management staff are responsible for processing preauthorization (pre-service) requests for all products and concurrent authorization requests (when guidelines are met) for MH and QHP products. The staff refers

all provider requests that do not meet medical necessity review criteria, level-of-care criteria, or medical policy to WellSense's medical director or designee or clinical licensed pharmacist for pharmacy requests for review and determination. Adverse Actions/Determinations (i.e., authorization denials) resulting from a determination of medical appropriateness or necessity are made by WellSense's medical director or designee or clinical pharmacist for pharmacy requests.

At your request and with appropriate documentation, a WellSense medical director or designee or clinical pharmacist will be available to discuss the adverse action/determination with you. Requests to discuss the adverse action are detailed in the Adverse Action/Determination letter (following the reason(s) for the denial) that you and the member receive. We encourage you to follow the specifics documented in the letter because processes and phone numbers differ by product. Requests may be sent to us in writing to the attention of the medical director or their designee, with any additional clinical information that was not previously provided or used in our decision; this information should be received by our medical director or designee prior to the discussion. You may also request a discussion via telephone by calling our provider line at 888-566-0008 and selecting the appropriate department based on the type of service to be discussed (i.e., Medical Prior Authorization Department, Care Management Department, or Pharmacy Department).

The medical director or designee or clinical pharmacist will communicate alternative care or an alternative treatment plan for the member, when appropriate.

10.6 MassHealth Member Inquiries, Grievances, and Appeals

We have an effective process to respond to member inquiries and grievances, and resolve member appeals in a timely manner. If the inquiry deals with medical necessity or a service coverage issue, we offer the member assistance and inform him/her of the appeals process. If the inquiry cannot be resolved immediately or within one business day, the issue is addressed as a grievance. A member or a member's Authorized Representative has the right to file a grievance or appeal with us or MassHealth. You may assist in resolving a member issue by furnishing documentation and other information that we request, and may be appointed as an Authorized Representative by the member to act on the member's behalf regarding a grievance, internal appeal or BOH appeal.

A member or member's Authorized Representative may submit three types of appeals for Adverse Actions related to medical/surgical and/or pharmacy services covered by WellSense.

- Standard internal appeal
- Expedited internal appeal
- BOH external appeal

An appeal of an Adverse Action is a standard internal appeal or an expedited internal appeal filed with Boston Medical Center Health Plan, Inc. d/b/a WellSense Health Plan (WellSense) by a member or a member's Authorized Representative. An external review appeal is directed to the BOH and can only be filed after exhausting WellSense's internal appeal process and a final internal appeal decision has been rendered by WellSense. **Member internal appeals must be submitted to WellSense within 60 calendar days of the date on the notice of Adverse Action to the member.** We may reject as untimely any WellSense appeals submitted later than 60 calendar days after the notice of an Adverse Action date.

How a member submits an inquiry, grievance, or appeal

When a member has a concern about the care, service, or access to service provided by WellSense or a participating provider, the member or member's Authorized Representative may submit an inquiry, grievance, or appeal in any of the following ways:

- The member or member's Authorized Representative may make oral inquiries or file an oral appeal or grievance by calling our Member Service Department at 888-566-0010 or dial 711 for Telecommunications Relay Service. Use of language services is free of charge to the member or member's Authorized Representative. See [Section 6: Member Information](#) for information on the Member Service Department, including hours of operation and services provided.
- If a minor is able (under the law) to consent to a medical procedure, that minor can request an appeal of the denial of such treatment without parental/guardian consent.
- The member or member's Authorized Representative may send written appeals and/or grievances to us via fax at 617-897-0805 or by mail to:

Boston Medical Center Health Plan, Inc. d/b/a WellSense Health Plan (WellSense)
Member Appeals and Grievances
529 Main Street, Suite 500 (address will be changing late spring 2024)
Charlestown, MA 02129

- The member or member's Authorized Representative may submit a grievance or appeal to a WellSense representative in person at our WellSense office location (at the address above) during regular business hours, 8:30 a.m. to 5 p.m., Monday through Friday (except holidays). The member or member's Authorized Representative must contact WellSense in advance to schedule a date and time to meet with a WellSense staff person.
- The member or member's Authorized Representative may call a health benefits advisor at the MassHealth Customer Service Center. The MassHealth Customer Service Center is available Monday through Friday, 8 a.m. to 5 p.m. (except holidays). See the [Contact Us](#) page available on our website at wellsense.org for the telephone numbers for MassHealth.

- The member or member's Authorized Representative may submit an external appeal request to the BOH after exhausting the WellSense internal appeal process. This section provides an overview of the BOH appeals process.

We will provide instructive materials and forms to assist a member who submits a grievance or appeal. If the member requests it, we will give him or her reasonable assistance completing the forms and following procedures applicable to the internal appeals process. This includes, but is not limited to, providing interpreter services free of charge and toll-free numbers with TTY/TDD and interpreter capability.

We will send written acknowledgement of the receipt of any grievance or internal appeal to members and/or Authorized Representatives, if applicable, within one business day of receipt by WellSense.

We will complete the resolution of grievances and send written notice to affected parties, no more than 30 calendar days from the date WellSense received the grievance. See below for notice of resolution for appeals.

Monitoring grievances

We maintain reports of all grievances for trending and analysis. These reports include, but are not limited to, the following information:

- Member name and ID number
- Date of grievance (when the event occurred)
- Date grievance reported/received by WellSense
- Type and nature of grievance
- Staff responsible for follow-up
- How grievance was addressed
- Date of correspondence/communication with provider/practitioner
- How the grievance was resolved
- Date response letter sent to member or Authorized Representative
- What, if any, corrective action taken

Monitoring member appeals

We maintain reports of all member appeals (including both internal appeals and external appeals submitted to the BOH). These reports include, but are not limited to, the following information:

- Member name and ID number
- Date appeal reported/received by WellSense

- Level of appeal
- Type and nature of the appeal
- How each appeal was addressed
- Outcome of the appeal
- What, if any, corrective action was taken related to the appeal
- The provider involved in the appeal

We review these data and our grievances appeals policies annually, and make any necessary modifications or improvements.

Standard internal appeal

We offer one level of internal review for standard appeals. Appeal reviews are conducted by healthcare professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action, and who have not been involved in any prior review or determination of the particular internal appeal and who are not the subordinate of someone who was involved. During the appeal review process, we will consult, if appropriate, with same or similar actively practicing, board-certified specialty providers who typically treat the medical condition, perform the procedure, or provide, or prescribe, the treatment involved in the appeal. Information regarding the internal appeal process and the BOH appeal process is included in any notice following the resolution of an Adverse Action or internal appeal. Appeals must be filed by the member or member's Authorized Representative within 60 calendar days of the date of the notice of the Adverse Action. We will not take punitive action against providers who support a member's internal appeal.

Our standard internal appeal process and written notice to affected parties will conclude no more than 30 calendar days from the date we received the member's request for an internal appeal (unless the timeframe is extended).

We will allow a member or member's Authorized Representative, before and during the internal appeals process, the opportunity to examine the member's case file, including medical records, and any other documentation and records considered during the internal appeals process. We will also allow reasonable opportunity for a member or member's Authorized Representative to present evidence and allegations of fact or law in person as well as in writing. Members or their Authorized Representative also have a right to a copy of their standard internal appeal case file, before or after the standard internal appeal decision, free of charge.

The timeframe for the standard appeal may be extended for up to 14 calendar days if the member or member's Authorized Representative requests the extension, or WellSense can justify to MassHealth, upon request, that:

- The extension is in the member's interest; and

- There is a need for additional information where there is a reasonable likelihood that receipt of this information would lead to approval of the request, if received; and this outstanding information is reasonably expected to be received within five calendar days.

For any extension not requested by the member or member's Authorized Representative, WellSense will provide the member or member's Authorized Representative with written notice of the reason for the delay. The member or member's Authorized Representative has the right to file a grievance regarding an extension decision made by WellSense.

We will provide the member with continuing services, if applicable, pending resolution of the review of an internal appeal, if the member submitted the request for the internal appeal within ten calendar days of the Adverse Action, unless the member specifically indicates that he or she does not want to receive continuing services.

Expedited internal appeal

A member or member's Authorized Representative may request an expedited internal appeal after receiving notification of an Adverse Action for urgent or time-sensitive care. See the definitions section above for a definition of an urgent or time-sensitive case eligible for an expedited appeal. We do not require written permission from the member for providers to file expedited appeals on the member's behalf, and we will not take punitive action against providers who request an expedited resolution on behalf of a member.

We offer one level of internal review for an expedited appeal. The review is conducted by a healthcare professional 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. A determination will be made within 72 hours of the receipt of the expedited internal appeal unless this timeframe is extended as outlined below.

We will allow reasonable opportunity for a member or member's Authorized Representative to present evidence and allegations of fact or law in person as well as in writing. We will also remind a member or member's Authorized Representative of the limited time available for this opportunity. In the case of an expedited appeal, members or their Authorized Representatives have a right to a copy of the expedited internal appeal case file free of charge.

We may reject the request of a member or member's Authorized Representative for an expedited appeal. In the event the request is rejected, WellSense will:

- Transfer the internal appeal to the timeframe for standard internal appeal resolution, and
- Make reasonable efforts to give the member or member's Authorized Representative oral notice of the denial, and will send written notice within two calendar days.

We may only reject a provider's request on behalf of a member for an expedited appeal if we determine that the request is unrelated to the member's health condition.

The timeframe for the expedited appeal determination may be **extended for up to 14 calendar days** if the member or member's Authorized Representative requests the extension, or if we can justify to MassHealth, upon request, that:

- The extension is in the member's interest; and
- There is a need for additional information where there is a reasonable likelihood that receipt of this information would lead to approval of the request, if received, and this outstanding information is reasonably expected to be received within 14 calendar days.

For any extension not requested by the member or member's Authorized Representative, we will provide the member or member's Authorized Representative with written notice of the reason for the delay. The member or member's Authorized Representative has the right to file a grievance regarding an extension decision made by WellSense.

We will provide the member with continuing services, if applicable, pending resolution of the expedited appeal if the member submitted the request for the expedited appeal within 10 calendar days of the Adverse Action, unless the member specifically indicates that he or she does not want to receive continuing services.

We will make reasonable attempts to notify the member, member's Authorized Representative (if applicable), and treating provider by telephone and in writing of our decision related to the expedited internal appeal. A member or member's Authorized Representative may submit an external appeal request to the BOH after the resolution of an expedited internal appeal with us.

Board of Hearings (BOH) appeal

A member may request an external appeal review with the BOH after we have rendered an internal appeal decision, standard or expedited. The member must file a hearing request within 120 calendar days of the date of WellSense's notification of an internal appeal denial. We will include the BOH Fair Hearing Application and other instructive materials that the member or member's Authorized Representative may need to complete to request a fair hearing with the BOH. We will assist the member in submitting the BOH appeal request and completing the BOH form if an external appeal is requested by the member or member's Authorized Representative.

If the member or member's Authorized Representative does not understand English and/or is hearing or sight impaired, the BOH will make sure that an interpreter and/or assistive device is available at the hearing.

We will make best efforts to ensure that a provider, acting as an appeal representative, submits all applicable documentation to the BOH, the member and WellSense within ten business days prior to the date of the hearing, or if the BOH appeal is expedited, within one business day of being notified by the BOH of the date of the hearing. Applicable documentation will include, but will not be limited to, any and all documents that will be reviewed at the hearing.

We will provide the member with continuing services, if applicable, pending the resolution of the BOH appeal if the following occurs: the member or member's Authorized Representative submits the request for the BOH appeal within 10 calendar days from the date of the decision on the member's standard internal appeal or expedited internal appeal. This is unless the member specifically indicates that he or she does not want to receive continuing services. If the member receives continuing services while the BOH appeal happens, the member may have to pay MassHealth back.

We will allow a member or member's Authorized Representative access to the member's appeal files during the BOH appeal process, and we will implement the BOH appeal decision immediately if our decision is overturned.

Member or Authorized Representative pharmacy copayment appeal process

A member or member's Authorized Representative may submit a pharmacy copayment appeal to WellSense if they believe that the copayment cap is met earlier than documented by WellSense. If the member does not agree with our decision, the member or member's Authorized Representative may appeal to WellSense using the standard internal appeal process outlined in this section (or the expedited internal appeal process also outlined in this section, if necessary criteria are met). A member or member's Authorized Representative may also request another level of appeal through the BOH. A description of the BOH appeal process is outlined above.

10.7 Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct) Member Inquiries, Grievances and Appeals

Internal inquiry process

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

The internal inquiry process is an informal process used to resolve most inquiries. Members or their Authorized Representatives can initiate this process by calling the Member Service Department at 877-492-6967 for Clarity plans (including QHP, ConnectorCare, and Employer Choice Direct) members.

The internal inquiry process is not used to resolve concerns about the quality of care received by members or an adverse determination (coverage denial based on medical necessity). If a concern involves the quality of care received from a provider, Member Service will refer the concern directly to its internal grievance

process. If a concern involves an adverse determination, Member Service will refer the concern directly to our internal appeals process (see below).

Member Service will review and investigate inquiries and respond to a member or Authorized Representative by phone within three working days. When communicating the findings, Member Service will determine whether the member is satisfied with the outcome. If the member or the member's Authorized Representative is not satisfied, or WellSense was unable to resolve the inquiry within three working days, we will offer to start a review of the concern through our formal internal grievance or appeal process (see below). The process used depends on the type of inquiry.

Internal grievance process

We do not use the internal grievance process to resolve complaints about a denial of coverage. We address complaints relating to Adverse Determinations through the internal appeals process. We categorize internal grievances as follows:

- **Administrative Grievances (how WellSense operates):** Grievances related to billing issues or a member's dissatisfaction with our staff, policies, processes, or procedures that have no impact on the member's medical care or access to medical care. Administrative Grievance may also reference a member's dissatisfaction with a provider's attitude or that of their staff, the cleanliness, or lack thereof of a provider's office or wait times.
- **Clinical Grievances (Quality of Care Grievances):** Grievances relating to the healthcare, and/or services, that a member received from a WellSense participating provider, or, is trying to receive.
- **Expedited Clinical Grievances (Expedited Quality of Care Grievances):** Grievances relating to clinical issues of an urgent nature such that it is deemed that a delay in the review process might seriously jeopardize:
 - The life and/or health of the member, and/or
 - The member's ability to regain maximum functioning, or is an issue that poses an interruption in the ongoing immediate treatment of the member.

The preferred way for a member or member's Authorized Representative to file a grievance is to put it in writing and send it to us by mail or fax. A grievance also may be delivered in person to our office or may be submitted orally by calling the Member Service Department at 877-492-6967 (Clarity plan members, including QHP, ConnectorCare and Employer Choice Direct). If a member wishes to deliver a grievance in person, they must contact WellSense to arrange a date and time to meet with a WellSense staff person. If the grievance is filed orally, the Appeals and Grievances Specialist will write a summary of their understanding of the grievance and send a copy to the member or member's Authorized Representative within 48 hours of receipt (unless the time limit is extended by mutual written agreement). This summary will serve as both a

written record of the grievance as well as an acknowledgment of our receipt of it. These time limits may be extended by mutual written agreement.

Written grievances should include name, address, WellSense ID number, daytime telephone number, detailed description of the grievance (including relevant dates and provider names), and any applicable documents that relate to the grievance (such as billing statements).

Written grievances should be faxed to 617-897-0805 or mailed to:

WellSense Health Plan
Member Appeals and Grievances
529 Main Street, Suite 500 (address will be changing late spring 2024)
Charlestown, MA 02129

A grievance may be filed any time within 180 days of the date of the applicable event, situation, or treatment. We encourage the member or member's Authorized Representative to file grievances as soon as possible.

Once the written grievance is filed, we send a letter ("acknowledgement") to the member or member's Authorized Representative explaining that we have received the grievance. We send this letter within 15 working days of the receipt of the grievance.

If the grievance requires us to review medical records, a signed [Consent Form for the Release of Medical Information](#), available at wellsense.org, must be submitted to us. When signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided. If a [Consent Form for the Release of Medical Information](#) is not included with the grievance, we will promptly send a blank form to the member or member's Authorized Representative. If we do not receive this form within 30 calendar days of the date of the grievance, we may respond to the grievance without having reviewed relevant medical information. In addition, if we receive the form but a provider does not give us the medical records in a timely fashion, we will ask the member or Authorized Representative to agree to extend the time limit for us to respond to the grievance. If we cannot reach agreement on a timeline extension, we may respond to the grievance without having reviewed relevant medical information.

All grievances will be processed by an Appeals and Grievances Specialist. Reviews will be performed by appropriate healthcare professionals who are knowledgeable about the type of issues involved in the grievance. Responses will be based on the terms of the Clarity plan's Evidence of Coverage, the WellSense clinical policies and guidelines, the opinions of the treating providers, the opinions of WellSense professional reviewers, applicable records provided by providers, and any other relevant information available to WellSense.

We will send a written response to the member or member's Authorized Representative within 30 calendar days of receipt of the grievance. The 30 calendar day period begins as follows:

- If the grievance requires WellSense's review of medical records, the 30 calendar day period begins from the date of receipt but we cannot truly review all necessary documents until WellSense receives a signed consent
- If the grievance does not require a WellSense review of medical records, the 30 calendar day period begins on the next working day following the end of the three-working-day period for processing inquiries through the internal inquiry process, if the inquiry was not addressed within that time period, or on the day WellSense was notified of the member's lack of satisfaction with the response to the inquiry.

These time limits may be extended by mutual written agreement between the member or member's Authorized Representative and WellSense. Any extension will not exceed 30 calendar days from the date of the mutual agreement. If WellSense does not respond to a grievance that involves benefits within the timeframes described in this section, including any mutually agreed upon written extension, the grievance will be deemed decided in the member's favor. Our written response to a grievance will describe other options, if any, for further WellSense review of a grievance.

We will not consider a grievance received until it is actually received by us at the appropriate address, fax or telephone number listed. Members are entitled to free access to and copies of any of their medical information related to their grievance that is in WellSense's possession and under WellSense's control.

Member or Authorized Representative Clarity plans (including QHP, ConnectorCare and Employer Choice Direct) pharmacy copayment grievance process

A member or member's Authorized Representative may submit a pharmacy copayment grievance to WellSense if they believe that the copayment cap is met earlier than documented by WellSense. If the member does not agree with our decision, the member or Authorized Representative may file a grievance with us using the internal grievance process.

Internal appeals process

The preferred way for a member or member's Authorized Representative to file an appeal is to put it in writing and send it to us by mail or fax. The appeal may also be delivered in person to our office or may be submitted orally by calling our Member Service department at 877-492-6967 (Clarity plans, including QHP, ConnectorCare, and Employer Choice Direct). If a member wishes to deliver an appeal in person, they must contact WellSense to schedule a date and time to meet with a WellSense staff person. If a written appeal has been filed, we will send a letter ("acknowledgment") to the member or member's Authorized Representative explaining that the appeal has been received. We send this letter within 15 working days of receipt of the appeal. If the appeal is filed orally, the Appeals and Grievances Specialist will write a summary of the appeal and send a copy to the member or member's Authorized Representative within 48 hours of receipt (unless the time limit is extended by mutual written agreement). This summary will serve as both a written record of

the appeal as well as an acknowledgment of WellSense's receipt. These time limits may be extended by mutual written agreement.

Written appeals should include the member's name, address, WellSense ID number, daytime phone number, detailed description of the appeal (including relevant dates and provider names), any applicable documents that relate to the appeal, such as billing statements, and the specific result that has been requested. Written appeals can be faxed to 617-897-0805 or mailed to:

WellSense Health Plan
Member Appeals and Grievances
529 Main Street, Suite 500 (address will be changing late spring 2024)
Charlestown, MA 02129

To submit an appeal in person, a member may go to WellSense's office location at the address listed above. Members must contact WellSense to arrange a date and time to meet with a WellSense staff person.

Locations are listed in [Section 1: General Information](#) of this Provider Manual.

An appeal can be filed at any time within 180 days of the date of the original coverage denial. We encourage members and their Authorized Representatives to file any appeals as soon as possible.

- For the purposes of Clarity plans, Providers may act as Appeal Representatives but cannot independently bring expedited, standard internal or external appeals without a signed authorization from the member.
- A provider may request an appeal without the written consent of a QHP member only while the insured is an inpatient, then a health care professional or a representative of the hospital may be the insured's authorized representative without a written authorization by the insured.

Release of medical records

If the appeal requires us to review medical records, a signed [Consent Form for the Release of Medical Information](#) available on our website at wellsense.org must be submitted to us. This form authorizes providers to release medical information to us. It must be signed and dated by the member or member's Authorized Representative. If the Consent Form is not included with the appeal, the Appeals and Grievances Specialist will promptly send a blank form to the member or member's Authorized Representative. This form must be signed and dated by the member or member's Authorized Representative. When signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided. If we do not receive this form within 30 calendar days of the date of receipt of the appeal, we may respond to the appeal without having reviewed relevant medical information. In addition, if we receive the form but a provider

does not give the medical records to us in a timely fashion, we will ask the member to agree to extend the time limit for a response.

All appeals will be processed by an Appeals and Grievances Specialist. Appeal reviews will be performed by appropriate individuals who are knowledgeable about the issues relating to the appeal. Appeals regarding Adverse Determinations will be reviewed by health care professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Determination, who have not been involved in any prior review or determination of the particular appeal and who are not the subordinate of someone who was involved. During the appeal review process, WellSense will consult, if appropriate, with same or similar, actively practicing, board- certified specialty providers who typically treat the medical condition, perform the procedure, or deliver the treatment involved in the appeal. Decisions will be based on the terms of the member's Evidence of Coverage, the opinions of the member's treating providers, the opinions of our professional reviewers, applicable records provided by the member or providers, and any other relevant information available to us.

We will send a written response within 30 calendar days of receipt of the appeal. The 30-calendar-day period begins as follows:

- If the appeal requires us to review a member's medical records, the 30 calendar day period does not begin until we receive a signed [Consent Form for the Release of Medical Information](#).
- If the appeal does not require us to review a member's medical records, the 30 calendar day period begins on the next working day following the end of the three working day period for processing inquiries through the internal inquiry process if the inquiry was not addressed within that time period, or on the day WellSense was notified that the member was not satisfied with the response to the inquiry.

These time limits may be extended by mutual written agreement. Any extension will not exceed 30 calendar days from the date of the mutual agreement.

No appeal will be considered received by us until it is actually received at our appropriate address, fax or telephone number listed above.

Written responses to Adverse Determinations will explain further avenues of appeal for the member, if applicable, such as the member's right to request an External Review from an Independent External Review Agency through the Massachusetts Health Policy Commission/Office of Patient Protection.

If we don't respond to the appeal within the timeframes described in this section, including any mutually agreed upon written extension, the appeal will be deemed decided in the member's favor. Members are entitled to free access to and copies of any of their medical information related to their appeal that is in our possession and under our control.

Expedited internal appeals process

An expedited appeal is a faster process for resolving an appeal. This faster process can be used when there has been a denial of coverage involving immediate or urgently-needed services. Examples of appeals that are eligible for the expedited appeals process are appeals involving substantial risk of serious and immediate harm; inpatient care; certain durable medical equipment; and terminal illness. Expedited appeals will not be used to review a benefit denial, which is a denial of coverage for a service, supply or drug that is specifically limited or excluded as outlined in the member's Clarity plan (including QHP, ConnectorCare, and Employer Choice Direct) EOC.

An expedited appeal will be reviewed and resolved within 72 hours if it includes a signed certification by a physician that, in the physician's opinion, the service is medically necessary; a denial of such service would create a substantial risk of serious harm; and the risk of serious harm is so immediate that the provision of such service should not await the outcome of the standard internal appeals process. The Appeals and Grievances Specialist will make reasonable attempts to notify the member, member's Authorized Representative, and treating provider orally of decisions involving expedited appeals. The Appeals and Grievances Specialist will also send written resolution to the member and/or member's Authorized Representative within 72 hours of the request.

Inpatient care: The appeal will be expedited if the member is an inpatient in a hospital and the appeal concerns an Adverse Determination by us that inpatient care is no longer medically necessary. This means we will review and resolve the expedited appeal before discharge. If our decision continues to deny coverage of continued inpatient care, we will send a written decision to the member upon discharge. The Appeals and Grievances Specialist will also make reasonable attempts to orally notify the member, member's Authorized Representative, and treating provider. Reminder, if the member is inpatient, a health care professional or a hospital representative may be the member's Authorized Representative *without* the member having to complete an Authorized Representative Form.

Durable medical equipment (DME) needed to prevent serious harm: Upon receipt of an expedited internal appeal, the Plan will automatically reverse an initial denial for durable medical equipment within 48 hours or less, pending the outcome of the internal appeal, if the Plan receives certification from the member's provider responsible for the treatment proposed noting that in the provider's opinion: 1. the durable medical equipment is medically necessary; 2. denial of coverage for the durable medical equipment would create a substantial risk of serious harm to the member; 3. such risk of serious harm is so immediate that the provision of durable medical equipment should not await the outcome of the standard appeals process; and 4. the provider must further certify as to the specific, immediate and severe harm that will result to the patient absent action within the 48-hour time period. The Appeals and Grievances Specialist will also make reasonable attempts to orally notify the member, member's Authorized Representative, and treating provider.

Terminal illness: The appeal will be expedited if the member has a terminal illness (an illness likely to cause death within six months) and the member, member's Authorized Representative, or treating provider submits

an appeal for coverage of services. This means we will provide a written resolution within five working days of receipt of the appeal. If our decision continues to deny coverage, the member may request a conference with us to reconsider the denial. We will schedule the conference within ten days of receipt of the request. If the member's physician, after consulting with our medical director, decides that the effectiveness of the proposed service would be materially reduced if not furnished at the earliest possible date, we will schedule the hearing within 72 hours. The member or member's Authorized Representative may attend the conference. Following the conference, we will issue a written decision. The Appeals and Grievances Specialist will also make reasonable attempts to orally notify the member, member's Authorized Representative, and treating provider.

We will decide all other expedited appeals within 72 hours of receipt. If we do not respond to the expedited appeal within these timeframes, including any mutually agreed upon written extension, the expedited appeal will be deemed in the member's favor.

If an appeal concerns the termination of ongoing coverage or treatment, the disputed coverage remains in effect at our expense through the completion of the standard internal appeals process or expedited internal appeals process (regardless of the outcome of the process) if **all** of the following are true:

- The appeal was filed on a timely basis;
- The services were originally authorized by WellSense prior to the member or member's Authorized Representative filing an appeal (except for services sought due to a claim of substantial risk of serious and immediate harm);
- The services were not terminated due to a specific time or episode related exclusion in the member's EOC; and
- The member continues to be an enrolled member

Reconsideration of a final Adverse Determination

We may offer the member or member's Authorized Representative the opportunity for reconsideration of its final appeal decision on an Adverse Determination. We may offer this when, for example, we received relevant medical information too late for us to review it within the 30 calendar days, time limit for standard appeals, or we did not receive it but expect it to become available within a reasonable time following our written decision on the member's appeal. If the member or member's Authorized Representative requests reconsideration, the member or member's Authorized Representative must agree, in writing, to a new review time period not to be more than 30 calendar days from the agreement to reconsider the appeal.

Independent external review process

External review process for your appeal: The External Review process allows the member to have a formal independent review of a final Adverse Determination made by us through our standard internal appeals process or expedited internal appeals process. Only final Adverse Determinations are eligible for external review. WellSense benefit denials (i.e., denials based on coverage limitations and specific exclusions) are not eligible for external review.

External reviews are performed by an independent organization under contract with the Office of Patient Protection (OPP) of the Commonwealth of Massachusetts Health Policy Commission. Members can request the external review or can ask for an Authorized Representative, including a healthcare provider or attorney, to act on the member's behalf during the external review process. A member may be represented by anyone he or she chooses, including an attorney.

How to request an external review: To request external review, the member or member's Authorized Representative must file a written request with the OPP within four months of receipt of WellSense's written notice of the final appeal decision. A copy of the OPP's external review forms and other information will be enclosed with our notice of its decision to deny a member's appeal.

Expedited external review: The member or member's Authorized Representative can request an expedited external review. To do so, a physician must submit a written certification explaining that a delay in providing or continuing the health services that are the subject of the appeal would pose a serious and immediate threat to the member's health. If the OPP finds that such a serious and immediate threat to the member's health exists, it will qualify the request as eligible for an expedited external review.

A member or Authorized Representative may file a request for an expedited external review either after receipt of WellSense's final written decision on their expedited internal appeal; or at the same time as the member files a request for an expedited internal appeal.

Requirements for an external review: The request must be submitted on the OPP's application form called External Review Form available on the OPP's website at mass.gov. We will send the form with the appeal denial response letter. Copies of this form may also be obtained by calling our Member Service Department at 877-492-6967 (Clarity plans, including QHP, ConnectorCare and Employer Choice Direct), by calling the OPP at 800-436-7757, or from the OPP's website at mass.gov/hpc/opp.

- The form must include the member or member's Authorized Representative's signature consenting to the release of medical information.
- A copy of our final appeal decision must accompany the form.

Coverage during the external review period: If the subject of the external review involves termination of ongoing services (outpatient or inpatient), the member or member's Authorized Representative may apply to the External Review Agency to seek the continuation of coverage for the service(s) during the period the review is pending. Any request for continuation of coverage must be made to the review panel before the end of the second working day following the receipt of our final decision about the appeal. The review panel may order the continuation of coverage if it finds that substantial harm to the member's health may result from termination of the coverage or for such other good cause as the review panel shall determine. The continuation of coverage will be at WellSense's expense regardless of the final external review decision.

Access to information: The member or member's Authorized Representative may have access to any medical information and records related to the external review that are in WellSense's possession or under WellSense's control.

Review process: The OPP will screen requests for external review to determine whether the member's case is eligible for external review. If the OPP determines that the case is eligible for external review, it will be assigned to an External Review Agency that contracts with the OPP. OPP will notify the member, the member's Authorized Representative (if applicable) and WellSense of the assignment. The External Review Agency will make a final decision and send it in writing to the member, member's Authorized Representative (if applicable), and WellSense. For non-expedited external reviews, the decision will be sent within 45 calendar days of the External Review Agency's receipt of the case from the OPP. For Expedited External Reviews, the decision will be sent within 72 hours from the External Review Agency's receipt of the case from the OPP. The decision of the External Review Agency is binding on WellSense.

If the OPP determines that a request is not eligible for external review, the member or member's Authorized Representative will be notified within ten working days of receipt of the request or, in the case of requests for expedited external review, within 72 hours of the receipt of the request.

How to reach the Office of Patient Protection (OPP):

Health Policy Commission Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109

Telephone: 800-436-7757 Fax: -617-624-5046

Website: mass.gov/hpc/opp

10.8 Senior Care Options Complaints, Grievances, and Appeals

We have an effective process to respond in a timely manner to member complaints, grievances, and appeals. If the complaint deals with medical necessity or a coverage issue, we offer the member assistance and inform him/her of the appeals process. You may assist in resolving a member issue by furnishing documentation and

other information that we request, and may be appointed as an Authorized Representative by the member to act on the member's behalf regarding a grievance, internal or external appeal.

Member Grievance Process

The member grievance process begins upon WellSense's receipt of a verbal or written complaint. Members can also file quality of care grievances with the QIO as well as WellSense.

The preferred way for a member or the member's Authorized Representative to file a grievance is to put it in writing and send it to us by mail or fax. A grievance also may be delivered in person to our office or may be submitted orally by calling the SCO Member Service Department at 855-833-8125. If a member wishes to file a grievance in person, they must contact WellSense to arrange a date and time to meet with a WellSense staff person.

Written grievances should include name, address, WellSense ID number, daytime telephone number, detailed description of the grievance (including relevant dates and provider names), and any applicable documents that relate to the grievance (such as billing statements). Written grievances should be faxed to 617-897-0805 or mailed to:

WellSense Senior Care Options
Member Grievances Department
529 Main Street, Suite 500 (address will be changing late spring 2024)
Charlestown, MA 02129

Members, or their Authorized Representatives, may also file a Grievance at any time with CMS.

In addition, whenever WellSense disapproves a member or an Authorized Representative's request for an expedited Organization Determination, expedited Coverage Determination, expedited Appeal, or extends the times for resolving an Organization Determination or Reconsideration (Appeal), members or their Authorized Representatives can file an Expedited Grievance.

Grievances are considered according to the following process:

- An Appeals and Grievance specialist acknowledges the receipt of the grievance in writing.
- Grievances are reviewed within 30 calendar days (or within 24 hours if the grievance is expedited). Under certain circumstances, grievances may be extended up to 14 calendar days.
- Reviews will be performed by appropriate healthcare professionals who are knowledgeable about the type of issues involved in the grievance.
- If a Grievance is related to the quality of a Provider's office, WellSense may conduct an office site visit based on the severity of the issue or if the office site has had two or more similar Grievances within three months or three or more Grievances within six months of the Grievance receipt date.

It is the expectation of WellSense that you kindly respond to our requests for information relating to grievances in a timely manner.

Member Appeals

Fast-Track Appeals

A fast-track appeal is when a member disagrees with the coverage termination decision from a SNF, HHA, or CORE, or upon discharge notification from an inpatient hospital. To initiate a fast-track appeal, a member must make their request timely to the QIO, Kepro, authorized by Medicare to review the aforementioned services. Members and/or Authorized Representatives are given instructions in their discharge notification about how to contact Kepro to initiate the fast-track appeal process.

When a member files a fast-track appeal, the QIO will notify WellSense, and WellSense will notify the facility that the member, or their Authorized Representative, has filed the Appeal. WellSense will then require a copy of the Notice of Medicare Non-Coverage (NOMNC) or Important Message (IM) and the member's entire medical record from the facility or agency. Once the information is received it will be reviewed by an appropriate health care professional who will prepare the appropriate response letter being either a Detailed Explanation of Non-Coverage (DENC) or Detailed Notice of Discharge (DNOD). WellSense will fax to the QIO the applicable notices and complete the medical record the day the Fast-Track Appeal is received or by close of business the day before the member is due to be discharged from services. WellSense may request provider assistance in delivery of the response letter to the member (DENC or DNOD).

Standard and Expedited Reconsideration (Appeal) for Part C Services

WellSense's Standard Reconsideration Process is inclusive of one level of internal appeal and the process may not exceed more than 30 calendar days from the date WellSense receives the member's or Authorized Representative's request for Appeal, unless the timeframe is extended. A Standard Appeal will be considered a final level of internal review. Members or their Authorized Representative may request Standard Appeals. A provider may also file a Standard Appeal on behalf of the member. The Plan will not take any punitive action against a provider who files an appeal on behalf of a member or who supports a member's request for an appeal. Part B Medical Drug Appeals allow 7 days for standard, 72 hours for expedited, and no extensions are allowed.

WellSense's Expedited Reconsideration Process consists of one level of internal review and will conclude no more than 72 hours from the time WellSense received the member's or Authorized Representative's request for expedited appeal, unless the timeframe is extended. An Expedited Appeal will be considered a final level of internal review.

Timeframes for Standard and Expedited Reconsideration may be extended for up to 14 calendar days.

Extensions may only be granted if:

- The member and/or Authorized Representative requests or voluntarily agrees to the extension, or
- WellSense can justify (upon request) that the extension is in the member's interest, and
- There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received.
- Part B Medical Drug Appeals do not allow extensions.

or any extension not requested by the member and/or Authorized Representative, WellSense shall provide the member and/or Authorized Representative written notice of the reason for the extension. It should be noted that members have the right to file an Expedited Grievance on an extension decision made by WellSense.

If an Appeal does not qualify for an extension, WellSense must make the appeal decision within the allotted time frame based on the information available.

WellSense may dismiss a Standard or Expedited Reconsideration if:

- A person other than the member files the Appeal on the member's behalf and the member does not submit written authorization for that person to serve as their Authorized Representative prior to the deadline for resolution of the Appeal, or
- WellSense becomes aware that the member has obtained the service before WellSense completes its Appeal review
- The member or Authorized Representative filed Standard or Expedited Appeal beyond the 60 calendar day filing limit (60 days from when WellSense provided the Member notice of the adverse Organization Determination), unless the member shows good cause.
- A non-participating provider files a retrospective appeal on behalf of a member and does not submit the required Waiver of Liability form.

Standard and Expedited Redetermination (Appeal) for Part D Drugs

- **WellSense's Standard Redetermination Process** is inclusive of one level of internal appeal and the process may not exceed more than seven calendar days from the date WellSense receives the member's or Authorized Representative's request for Appeal. A Standard Appeal will be considered a final level of internal review.
- **WellSense's Expedited Redetermination Process** consists of one level of internal review and will conclude no more than 72 hours from the time WellSense received the member's or Authorized

Representative's request for expedited appeal. Redeterminations may not be extended. An Expedited Appeal will be considered a final level of internal review.

Depending upon plan type and service(s) requested, members may be eligible for certain external appeal options. For example, SNP members may be eligible for external appeals through the MassHealth BOH or the CMS IREs, Maximus or C2C, or both. The member's reconsideration and redetermination letters will provide specific instructions on their options and how to proceed if members and/or their Authorized Representative wish to file an external appeal.

10.9 Provider Reviews Related to Inquiries, Grievances, and Appeals

Monitoring provider performance

We monitor the performance of physicians, hospitals and other participating healthcare providers related to member inquiries, grievances, and appeals by:

- Conducting concurrent and retrospective chart reviews
- Reviewing utilization patterns
- Analyzing results of member satisfaction surveys
- Compiling information from member inquiries, grievances, and appeals

Provider quality issues

We routinely send you feedback on a case-by-case basis as we identify quality issues. When we determine that a quality issue exists, the following procedure applies:

- Our quality manager or a WellSense medical director notifies you of the issue. You must respond orally or in writing to us within 30 calendar days of the notification. Your response is reflected in the final determination of the severity level. The severity rating ranges from "no quality of care issue was identified" to "a quality of care issue with confirmed significant adverse impact to the member."
- Upon receipt of your response, the medical director, and/or the clinician reviewer, in conjunction with you, determines if a corrective action plan is required. Decisions are based on the severity level of the issue and your response.

- The medical director and/or clinician reviewer collaborates with you to develop, implement, and evaluate the corrective action plan. Modifications to the plan are made, as appropriate. If you do not comply with the final plan, the medical director may take further action to resolve the concern.
- Based on the severity of the quality of care issue, the medical director may require the Credentialing Committee to conduct an off-cycle review of your practice.

We place documentation in your credentialing file, which we review when re-credentialing you.

For further details about this process, please review [Section 14: Quality Management](#), or call your designated Provider Relations Consultant.

Section 11: Care Management

11.1 Important contact information

For assistance or to refer a member to our Care Management Program, please call 866-853-5241.

Staff answers and returns calls from 8:30 a.m. to 5 p.m., Monday–Friday. A voicemail box is available for messages, and there are faxing capabilities after hours and on holidays. The Care Management line allows providers to access care management services for members who require medical, social, or behavioral health care management.

Care Management Referral Forms can also be found on our website. Care management referrals for MCO and QHP can be faxed to the Care Management Department at 617-951-3426 or emailed to CM.Tel@wellsense.org. Care Management referrals for ACO members can be faxed to 857-366-7800 or emailed to ACOCMReferral@wellsense.org.

For additional information on our Care Management Program, visit wellsense.org > Member > Massachusetts > Manage Your Health > [Care Management Program](#).

We contract with Carelon Behavioral Health to manage our behavioral health program. Please direct behavioral health inquiries to Carelon Behavioral Health:

- Call 855-834-5655 for help finding a network provider 24 hours a day.
- Call the TTY/TDD line at 866-727-9441.
- Visit carelonbehavioralhealth.com, or
- Visit wellsense.org and search the provider network.

11.2 Overview of Care Management Services

Well Sense is committed to improving the health status of its members who have multiple chronic and high-risk conditions with unmet needs. The program's approach is to provide holistic medical, social, and behavioral health care management services for members throughout the continuum of care. The objective is to assess the member clinically as well as the member's readiness to make behavioral changes in order to actively

participate in their care plan by establishing and meeting care plan goals. Our Care Management Model integrates physical health, behavioral health, pharmacy management, community resources and wellness programs, enabling us to work with providers to fully respond to all of a member's healthcare needs.

This collaborative approach helps ensure that we fully assess the member's overall health status, facilitating coverage for medically necessary services, and advocating for the member as he or she navigates the healthcare system. All eligible members have the right to participate or to decline to participate in all of the offered Care Management Services.

Who is involved?

The program involves the member, his or her health care provider, and the Plan working together so members can reach optimal health. Our care managers will reach out to members to check on their progress and help coordinate care with all necessary health care providers and other resources.

The Care Management staff includes registered nurses, licensed social workers, and trained Care Management specialists. We work with members to ensure they understand and can access the right services and information to manage their needs and be as healthy as possible.

Care Management Services

WellSense's priority is to help members with all their health-related needs. The goal is for members to regain optimum health or improved functional capability and aims to proactively identify and engage our members, their families, and significant supports in a way that integrates CM with medical, social, environmental, behavioral health, and community support. We focus on what matters to members through coordination of services, and collaboration with providers and other Plan resources and departments (Utilization Management, Pharmacy, Member Service, Provider Relations) and maximize value through the most efficient use of available resources and technology. This results in improved health outcomes and overall member experience. Clinical and/or non-clinical professionals use a multi-disciplinary approach, providing goal oriented and culturally competent services to members. With an emphasis on prevention, self-management, and care coordination across providers and health settings, the approach ensures necessary services by primary care physicians, licensed professionals, community agencies, and care givers.

11.3 Components of the Care Management Program

WellSense's Care Management Program consists of the following components:

- Care coordination for medical, behavioral, and social needs
- Support of patient-centered medical homes and health homes

- Coordination of non-emergency medical transportation
- Wellness and prevention programs
- Chronic condition care management programs
- High-cost/high-risk member management programs
- Coordination and integration with social services and community care

Identifying members for enrollment in care management

Care Management identifies members for enrollment through different methods, including algorithms based on analysis of medical, pharmacy, radiology, and/or laboratory claims, as well as health risk assessments or referrals from providers. Members are also identified by Plan staff, such as inpatient Utilization Management clinicians, Prior Authorization clinicians, Carelon Behavioral Health staff, Northwood staff, or member/ self or care give referral.

Assessing members' medical, social, and behavioral health needs

Members who agree to participate in care management are assigned a Care Manager and/or care management specialist and an assessment is conducted with the member either by phone or in person. The assessments provide direction to develop an individualized and comprehensive person-centered plan of care. Care management collaborates with members and providers in developing this plan of care. This may include interdisciplinary provider and Plan care management meetings with or without the participation of the member.

Individual and comprehensive person-centered care plans include identifying problems, interventions, and goals unique to the individual to meet their health needs, with interventions identified through available benefits to the member and community based services. Providers may collaborate in developing the care plan along with the member and primary caregivers.

11.4 Care Management Levels of Intervention and Members Targeted

Our Care Management program includes three levels of intervention:

- I. Care management education and wellness
- II. Low to moderate risk care management and disease management
- III. Complex medical care management

We also have a Senior Care Options program, which provides targeted interventions to members over 65 which we will discuss in the next section.

I. Care management education and wellness

This level of care offers educational coaching and information that helps members successfully manage illness and stay healthy. We coach members and share culturally and linguistically appropriate materials, tools, and resources that promote wellness and disease prevention.

Educational initiatives include but are not limited to:

- Smoking cessation program information
- Childbirth education classes
- Nutritional counseling
- Stress management
- The importance of physical activity and self-care training, including self-examination
- Education on taking over-the-counter and prescribed medications appropriately and how to coordinate these medications

Members and caregivers receive personalized information regarding signs and symptoms of common diseases and conditions—such as stroke, diabetes, asthma and depression—and their potential complications. The program focuses on teaching patients the importance of self-managing their own health, along with working with their healthcare provider, in order to accomplish their health-related goals. We emphasize that early intervention and risk reduction strategies can help avoid complications that occur with disability and chronic illness.

As a partner in fostering the health of our members, WellSense works with providers to integrate health education, wellness, and disease prevention into members' care.

II. Low to moderate risk care management and disease management

This level of care offers population management (including disease management), an intermediate-level care management program with a focus on helping members develop self-management skills, arranging services and providing health education for members with specific medical, behavioral and social needs. This level offers a more involved approach where Care Managers work directly with members, either by telephone or in person. They assess a member's condition, coordinate care, and review available benefits. The Care Manager can help set up services such as family support and community resources. Additionally, the Care Manager develops and implements individualized care plans for each member, emphasizing psychosocial and

socioeconomic support, self-management goals, care coordination, ongoing monitoring, and appropriate follow-up. The Care Managers assist in coordinating physical, social, and behavioral health services and benefits that will help maintain a member's optimum health.

Examples of targeted conditions include:

- Asthma (disease management)
- Diabetes (disease management)
- Heart failure
- Chronic obstructive pulmonary disease
- Obesity
- Hypertension
- Depression
- Severe and persistent mental illness (SPMI)
- Severe emotional disturbance (SED)
- Substance Use Disorder

III. Complex medical care management

The complex level of intervention addresses the needs of the highest risk members, including those with special health care needs, who are the most complex members of the Plan's disease management program. These members typically have comorbidities and psychosocial and socioeconomic needs that can significantly diminish their quality of life and may cause them to be unable to adhere to treatment plans designed by their providers. Care Management staff members use a multidisciplinary approach to comprehensively assess members' conditions. They conduct face-to-face meetings if appropriate, and with the member's cooperation, coordinate care through the health care continuum, which helps determine benefits and needed resources, including family and community resources.

An individualized care plan is developed and implemented for each member, emphasizing psychosocial support, socioeconomic support, self-management goals, care coordination, coordinating with staff in other agencies, or community service organizations. The plan also identifies barriers to meeting goals, assesses the member's ability to comply with treatment goals, provides ongoing monitoring, performs appropriate follow-up, and modifies the plan as needed. Care Managers and coordinators work with and educate members to navigate the health care system. Members are provided with information relevant to their needs and stage of readiness, with a goal of averting the need for more intensive medical services.

Medical conditions that may be appropriate for a care management referral include, but are not limited to:

- Cancer
- Bariatric Surgery
- HIV
- CVA or other degenerative neurologic or neuromuscular disorders
- Spinal cord injury/traumatic brain injury/anoxic brain injury
- Members younger than one year old and on Synagis or discharged from a NICU or Level II Nursery with complex or serious ongoing medical problems.
- Neonatal abstinence syndrome/shaken baby syndrome
- Members with congenital anomalies of the nervous system, encephalopathies, central nervous system tumors or other mass lesions, traumatic brain injury, spinal cord injury, neuromuscular disorders, degenerative neurological, metabolic, or genetic diseases, cerebral vascular accident, advanced/active AIDS, COPD, certain rare diseases such as multiple sclerosis, hemophilia, sickle cell, Parkinson's, rheumatoid arthritis, myasthenia gravis, Gaucher's, lupus, dermatomyositis, polymyositis, and amyotrophic lateral sclerosis.

Indications that a member may benefit from a referral to complex care management for any medical condition (including one managed through a population-based program) include, but are not limited to:

- Members who show evidence of having certain functional impairments that impact personal skills and/or clinical needs.
- Members with a high risk score, who are also high cost and/or who have high emergency department, inpatient, or pharmacy usage
- Members who are experiencing or are at risk of homelessness
- An illness or event that has caused a change or decline in ability to self-manage
- Five or more different specialists
- An acute inpatient stay with length of stay greater than seven days
- Multiple admissions/readmissions

Maternal and Child Health

We also offer a comprehensive high risk pregnant mothers' maternal child health program. This program focuses on prevention through early identification of problems, education, and coaching on the expectations of delivering a complex newborn, coordination of prenatal and parenting programs, prenatal and postpartum physician appointments, and coordination of psychosocial and socioeconomic needs. The Care Management team monitors the member's care during pregnancy and the postpartum period for high risk pregnancies and coordinates care for the complex newborn through the first year of life. This includes providing a care manager nurse for the family who helps determine benefits and needed resources, including family and community resources.

Community Partners– Care Management and Coordination

The Community Partner Program impacts providers in Accountable Care Organizations (ACO) and Managed Care Organizations (MCO), as well as members with significant behavioral health and Long Term Services and Supports (LTSS) needs across Massachusetts.

A Community Partner is a community-based organization that works with a member and his or her ACO's or MCO's primary care provider and health plan to help coordinate and manage health care services.

Behavioral Health Community Partners support members with serious behavioral health needs. Long Term Services and Supports Community Partners work with members who need help meeting their needs for self-care and basic activities of daily living. Community Partners may be able to help assess members' needs, assist providers with planning the right treatments and services for members, work with providers to change the type of care a member receives (e.g., inpatient to outpatient care), manage and check medications, provide health and wellness information to members, identify community and social services programs that can support members, and assist members in selecting culturally sensitive providers. Each PCP practice must identify a care team point of contact responsible for communicating updates regarding the member's care to the Community Partners.

Additional information about the PCP's role in the PCP program is outlined in the PCP Responsibilities section of this manual.

11.5 Care Management Process

Our Care Management Program uses the care management process with clinical, social, and behavioral health care managers, community health workers, and coordinators who handle:

- Assessment

- Planning
- Implementation
- Evaluation

11.6 Community Service Resource Support

Our Care Management Program coordinates access for our members to appropriate community resources such as food stamps, housing and clothing, as well as medically necessary transportation services.

11.7 Contacting the Care Management Staff

WellSense encourages Providers to contact our Care Management Department during business hours Monday-Friday at 866-853-5241 if you feel a member could benefit from Care Management services.

11.8 Care Transition Team

Comprised of clinicians and non-clinicians, the Care Transitions Team outreaches to members after they are discharged from any setting through the healthcare continuum (acute inpatient, post-acute facilities). The Care Transitions Program aims to meet the goal of reducing inpatient readmission within 30 days for specific targeted conditions showing high rates of readmission. Through the member assessment and individualized plan of care, the program also aims to provide available benefit services and resources to keep the member in the least restrictive setting. The team supports member transitions by ensuring that members receive and understand their discharge instructions, have a follow-up PCP and/or specialist appointment scheduled, have and understand their medications, have transportation to medical appointments and identify and resolve social determinants barriers to care such as housing and food insecurity. The care management team may provide assistance with arranging transportation or facilitating appointments with the PCPs and specialists engaged in the member's care, and the completion of applications such as those for food stamps, housing, and utilities. For certain individuals, especially those discharged on eight or more medications or newly prescribed anticoagulants, a Plan pharmacist may outreach to the member and conduct medication reconciliation. The transition team also:

- Identifies ongoing health issues after discharge
- Identifies cultural barriers which may impact their health and wellness
- Contacts the primary care physician for specialist referrals or identified durable medical equipment needs
- Assists with ordering visiting nurse or personal care attendant referrals
- Refers to medical, social, or behavioral health care management, or other care management specialists for ongoing coordination and educational needs

11.9 Senior Care Options—Care Management

Overview of the Model of Care

WellSense has designed a model of care that enables us to provide comprehensive, coordinated care which integrates Medicare and Medicaid services for individuals age 65 and older. The core elements of the model of care include:

- Target population
- Measurable goals
- Primary care teams
- Provider network that address unique needs of target population
- Model of care training for personnel and provider network
- Health Risk Assessment
- Individualized Plan of Care
- Communication network
- Caring for vulnerable populations element
- Performance and health outcome measurement

Goals of the Model of Care

- Increase access to essential services, such as medical, mental health and social services;
- Improve access to affordable care;
- Improve coordination of care through an identified point of contact, improving seamless transitions of care across healthcare settings, providers, and health services;
- Improve access to preventative health services;
- Assure appropriate utilization of services;

- Improve beneficiary health outcomes; and
- Facilitate access to Long-Term Services and Supports.

Senior Care Options Program Description

The Senior Care Options Program is a comprehensive health plan which coordinates both the delivery of Medicare and Medicaid services. Our goal is to provide enhanced care that reduces health disparities, improves health and functionality, and supports a person-centered approach to healthcare.

WellSense's SCO program addresses the unique and complex needs of each individual, age 65 and older by combining health services with social support services. WellSense does this by coordinating care and specialized geriatric support services, long-term care services, along with respite care for families and caregivers.

Each member who joins WellSense's SCO program receives an Individualized Plan of Care (IPC), as well as a devoted team—their Primary Care Team (PCT)—to manage their specific needs. Our program begins with an individual assessment of each member which forms the basis for the creation of the member's patient-centered IPC. WellSense's SCO Care Manager (CM) convenes the member's PCT and is responsible for ensuring communication across the team, coordinating relevant information to the Members' plan of care and including the Member in PCT discussions.

The Primary Care Team

Each member's specific needs and priorities determine the composition of their PCT. The PCT is responsible for the assessment, coordination and monitoring of a member's care. The PCT consists of the member, their designated caregivers, WellSense's SCO CM, the member's primary care provider, the member's geriatric support service coordinator ("GSSC") and other professionals and para-professionals as needed.

Primary Care Provider Role

The PCP and the PCT play a central role in the coordination and provision of care to members. Each WellSense SCO member has a PCT with the following responsibilities:

- Maintaining the health and wellness of the member;
- Engaging the personnel necessary to support person-centered care;
- Supporting the member's strengths and expressed preferences and needs; and
- Collaborating to create and execute the member's Individualized Plan of Care leading to informed decision-making and quality outcomes.

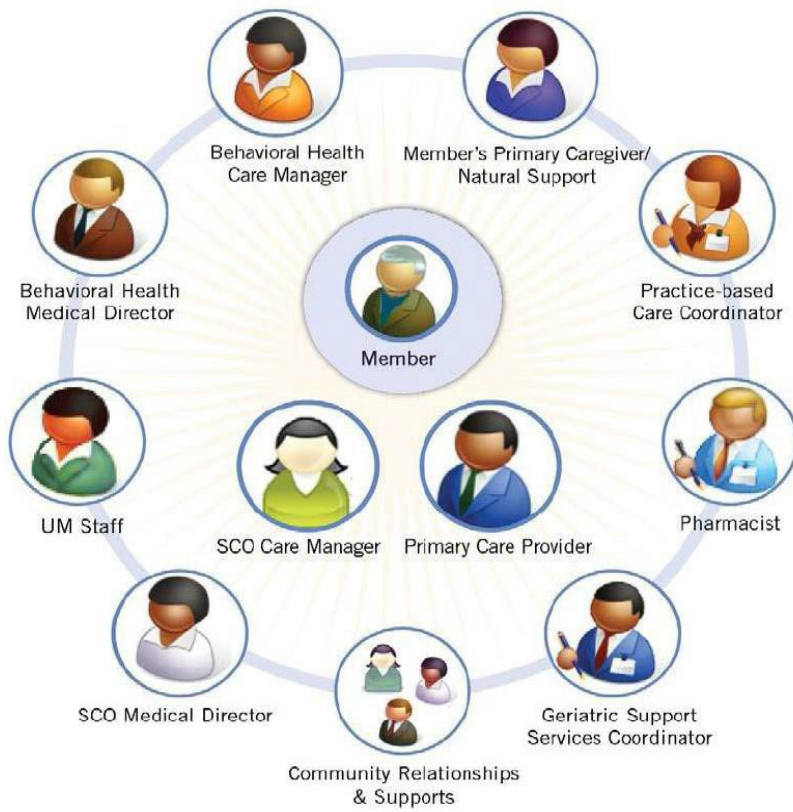
In collaboration with the member's SCO CM, the PCP is ultimately responsible for organizing and convening the PCT. At any time, if the PCP determines that a member's health or status requires a reassessment or a change in their care plan, the PCP may convene the PCT by contacting the member's SCO CM. PCT meetings may range from a single direct conversation between the PCP and the SCO CM (with or without their GSSC), to a conversation between the SCO CM and the GSSC with the member in his or her home. If circumstances warrant, a full meeting convening all of the member's PCT members may occur. The SCO CM will ensure the convening of all required members of the PCT including for periodic assessments and transitions from one care setting to another.

Other Members of the Primary Care Team

The composition of the member's PCT will vary depending on his or her specific needs, priorities expressed by the member or their caregivers/family, and information provided by the key assessments, the Minimum Data Set (MDS), Plan Health Risk Assessment (HRA), and other sources. Centered around the member, the PCT always includes the PCP, the SCO Care Manager, the member, the member's primary caregiver/natural support, if applicable, the GSSC, a practice-based care coordinator (if available), and, as appropriate, the SCO Social Work Care Manager, and Behavioral Health Care Manager(s). The SCO CM or the care coordinator is responsible for ensuring communication across the team, coordination of materials, and inclusion of the member in PCT discussions.

Depending on the member's needs, preferences and priorities, other team members may include: a geriatrician, a registered nurse, a physician assistant, specialists, pharmacists, home care providers, friends/family/informal caregivers, a behavioral health provider, a personal care attendant (PCA), nutritionist, transportation personnel, advocates, state agency and other care managers, and any other person the member wishes to have as part of the team. WellSense and Carelon Behavioral Health medical directors (medical and behavioral health) become ad hoc members of the PCT and provide clinical consultation and guidance to the team. The member can make changes to the members of the PCT at any time.

Participants of the Primary Care Team



Roles of the Primary Care Team members

Primary Care Team Member	Responsibilities
Member	Provide information, advise selection of team members, learn about his or her conditions and self-management, participate in Individualized Plan of Care (IPC) development, prioritize goals, and adhere to the IPC, as well as bringing any barriers to the attention of the PCT.
Primary Care Provider	Provide care (preventative, acute, chronic), coordinate and arrange care, facilitate communication and information exchange among the member's various treatment providers and participate on the PCT as a source of information regarding needs, barriers, treatment planning, and progress toward goals, care plan development, and interaction with the member.
SCO Care Manager (medical, behavioral, or social)	<ul style="list-style-type: none"> • Perform or arrange member initial assessment and reassessments. • Coordinate, implement, and manage the member's IPC, work with the member and his or her PCP to facilitate care from specialty, ancillary and tertiary providers, behavioral health providers, and coordinate the member's Medicare and MassHealth benefits. • Facilitate member access to psychosocial supports. • Monitor services for quality, appropriate utilization and efficacy, and coordinate transitions across the continuum of settings. • Foster communication between all PCT parties, including the member. • Determine IPC review frequency • Research and share community resources with members and peers. • Promote and encourage member collaboration with the primary care provider, PCT, other health care providers and social services agencies. • Assist members in developing wellness strategies and self-management skills to effectively access and use services. • Assist the member, when necessary, in placing calls, completing applications, and advocating for available supports/services. • Monitor for gaps in care.
Member's Primary Caregiver/Natural Support	Provide information, learn about the member's condition and its management, participate with the PCT in the development of the IPC, and engage with the member and other PCT members to best represent the member's wishes and preferences.

Primary Care Team Member	Responsibilities
Pharmacist	Provide medication reconciliation, member outreach, recommendations to the PCT on member medication management and oversight of the Medication Therapy Management Program, with notification to the PCT.
Geriatric Support Services Coordinator (GSSC)	Oversee the evaluation, assessment, and plan of care functions related to long-term services and supports to ensure service delivery and intended outcomes are achieved.
Community Relationships and Supports	Participate as ad hoc members of the PCT and the member's IPC to fulfill community-based resources and supports for the member.
WellSense's Medical Directors	Provide ongoing support, which may include clinical consultation, communication facilitation with providers and clinical guidance to the PCT, utilization review, and prior authorization determinations.
Utilization Management (UM) Staff	Provide medical necessity admission review, prior review and authorization of services, where indicated.
Behavioral Health Medical Director	Provide ongoing support, which may include behavioral health and substance use disorder (SUD) consultation, communication facilitation with providers and behavioral health and SUD guidance to the PCT.
Other	Other specialists, based on the member's specific needs and preferences, may include a registered nurse, physician assistant, BH provider, home health nurse, or a medical specialist.

Initial Assessment and Individualized Plan of Care

All members will receive an initial assessment within 30 calendar days of enrollment. Ideally, members will be evaluated in their homes because it is the optimal way to develop a holistic understanding of their needs, goals, and preferences. Community-dwelling members who decline an in-home evaluation will be offered evaluation at their PCP's office, adult day center, or other community setting. Members residing in institutional settings will be evaluated in their institution of residence.

WellSense uses the Minimum Data Set-Home Care (MDS-HC) and a developed Health Risk Assessment (HRA) to assess community-dwelling members. Members residing in institutional settings are evaluated using the Minimum Data Set-3.0 (MDS-3.0).

The PCP is also responsible for completing a medical history, physical exam, and evaluation to provide current diagnoses, medications and a medical treatment plan. When combined with the member's MDS/HRA, the PCT will have a complete set of information on which to develop the member's IPC. A member's

individual plan of care is developed within 30 calendar days of the completion of their assessments. Once the member's IPC is developed, it must be agreed to and signed by the member or their designated representative. The member or their designated representative will receive a copy of the signed IPC.

Members will be assessed at least every six months, or more frequently as needed to include when the member experiences a major change that is:

- Not temporary;
- Impacts more than one area of health status; and
- Requires interdisciplinary review or revision of the IPC.

Members that are considered moderate or high risk will be assessed quarterly and have their IPC updated as necessary. Specific attention will be paid to member assessments, member/caregiver feedback, and IPC progress on reaching member goals. Additional assessments and potential changes in a member's IPC are triggered by changes in enrollment status, hospital admission or other transition, or at the request of the PCP, any member of the PCT, or the Member/family. These comprehensive initial and ongoing assessments are a key part of WellSense's efforts to identify and meet the member's care needs.

Member IPCs are available electronically to the member and to their PCT through WellSense's Centralized Enrollee Record. Members may also call the customer concierge line at WellSense to have a copy of their IPC mailed or faxed to them.

Who is responsible for care coordination?

WellSense's SCO care manager holds primary responsibility for care coordination of the member and will ensure the coordination of all communication with the member's PCT. Care Managers are licensed Registered Nurses. The WellSense CM will work collaboratively with the Behavioral Health CM, the Social CM, GSSC, practice-based CM (if one exists), and Utilization Management staff, care coordinator, and all members of the PCT to ensure all needs of the member's IPC are coordinated.

11.10 Care Management Process

Care management is an ongoing process.

- The PCT is used through the assessment and reassessment process and during PCT meetings, to coordinate the Member's care.
- The Care Manager is responsible for ongoing communication between PCT meetings, for coordinating with providers and programs needed to support the Member. When socioeconomic

needs are identified as part of the IPC, the CM may use a WellSense Social CM to support members in overcoming barriers such as working with housing organizations in placing members into permanent housing. In the event behavioral health issues are the primary concern for the member, the behavioral health Care Manager may assume responsibility for coordinating care across all behavioral health and SUD providers and programs. The BH care managers will provide the ongoing coordination of the behavioral health goals, interventions, and provider contact when needed, documenting the coordination between the PCP, PCT and the behavioral health providers. Recommended treatment referrals will be coordinated with the WellSense CM, Member, caregiver/family, and members of the PCT.

Members have continual access to their IPC and can contact a PCT member directly at any time about their IPC, or work more centrally through their Care Manager or PCP. WellSense's BH Care Manager may use community outreach workers to support Members in non-clinical ways, such as regular meetings with transient members at homeless shelters or community centers.

Members who refuse involvement or cannot be reached

Some members may refuse care coordination and/or care management services or cannot be reached, despite our best efforts. The goal is for all members to have an IPC, however, creation of the IPC requires member assessment for IPC implementation, including any LTSS. Care Management will attempt to work with all members of the PCT to reach the member in an attempt to meet their needs and create an individualized plan of care.

Coordination with Community Care Facilities

Based on the individual needs of each member, the PCT will work with Social CMs and others to tailor services to individual needs and ensure we reach individuals who may be transient. This includes nursing homes, long-term care facilities, substance use disorder treatment program and mental health facilities. If a member's IPC calls for coordination with community care facilities, professionals from those facilities may be part of the PCT as necessary.

Section 12: Behavioral Health Management

12.1 Helpful contact information

We contract with Carelon Behavioral Health (Carelon Behavioral Health) to manage our behavioral health program. For more information, refer to the Carelon Behavioral Health-WellSense Policy and Procedure Manual available from Carelon Behavioral Health at [carelonbehavioralhealth.com](https://www.carelonbehavioralhealth.com) > Providers > Carelon Behavioral Health Providers. Under Provider Dashboard select network specific info and scroll to Boston Medical Center Health Plan, Inc. d/b/a WellSense Health Plan (WellSense) or SCO. Under Provider Spotlight choose Provider Manual. Providers can also call Carelon Behavioral Health at 866-444-5155.

Providers should contact our behavioral health service line, staffed by Carelon Behavioral Health representatives, at

866-444-5155 for the following:

- Prior authorizations
- Concurrent reviews (MassHealth, QHP)
- Reporting behavioral health adverse incidents 24 hours a day, seven days a week
- Behavioral health services
- Carelon Behavioral Health-WellSense policy and procedure manual
- Detailed description of each level of care
- Level of care clinical criteria
- All claims submission information, including companion guides, information on eServices, and EDI services

12.2 Overview

Carelon Behavioral Health is responsible for managing many aspects of our behavioral health program for all members, including:

- Provider credentialing and contracting
- Claims processing and adjudication
- Quality management and improvement
- Medical management/utilization review
- Member grievances and appeals (except for Senior Care Options which are managed directly through WellSense). See [Section 10: Appeals, Inquiries, and Grievances](#)

- Member Service
- Management of CBHI or BHCA services

Behavioral health providers must contract with and be credentialed by Carelon Behavioral Health in order to provide services to our members. Providers may access the Carelon Behavioral Health-WellSense Policy and Procedure Manual by visiting carelonbehavioralhealth.com > Providers > Provider Resources > Provider Dashboard. Under Provider Dashboard select network specific info and state. Select WellSense-MA/Qualified Health Plans or WellSense Senior Care Options. Under Provider Spotlight choose Provider Manual.

Carelon Behavioral Health supports PCPs as the locus of treatment for a wide variety of BH diagnoses. To that end, Carelon Behavioral Health developed a toolkit to help with identification and next steps in treatment of BH conditions. Visit this toolkit at providertoolkit.carelonbehavioralhealth.com/

We and Carelon Behavioral Health have designed a Behavioral Health Management Program to guide and support providers in delivering and coordinating care for our members. This program is part of our Health Services Program described above.

Carelon Behavioral Health's contact information

Method	Contact Information
Carelon Behavioral Health's website	Visit carelonbehavioralhealth.com
Behavioral health provider line	Call 866-444-5155
Behavioral health preauthorization	Call 866-444-5155
Behavioral health CBHI team	Call 866-444-5155
Behavioral health member lines	MassHealth: call 888-217-3501. Clarity plans: call 877-957-5600 SCO: call 855-833-8125
Behavioral health member TTY/TDD line	Call 711

Forms: The [Combined MCE Behavioral Health Provider PCP Communication Form](#)

For emergency behavioral health services available 24 hours/day, contact your local Mobile Crisis Intervention (MCI)/ Community Behavioral Health Center (CBHC), listed in this section: Behavioral Health Crisis Services-12.5

Behavioral Health Department activities

A range of emotional, social, and behavioral issues pose a major threat to the overall health and quality of life of some WellSense members. Therefore, our behavioral health program plays a central role in overseeing and managing the mental health and addiction treatment needs of members, as well as coordinating these needs with medical services. Behavioral health activities focus on:

- Evaluating behavioral health services based on clinical criteria.
- Coordinating effective and efficient care through our continual review process if additional behavioral health services are required beyond those given prior authorization by Carelon Behavioral Health.
- Using care management approaches to tailor services to our members' needs, considering their medical and behavioral health conditions.
- Ensuring that our members' care is provided in a context of cultural and linguistic competency to the greatest extent possible.
- Monitoring members closely whose level of acuity and/or utilization patterns suggest a need for additional assistance and care coordination.
- Developing and maintaining contractual arrangements with available community resources and providers that represent a full continuum of mental health and substance use disorder care.
- Working collaboratively with providers to coordinate members' care; and providing timely and accurate information in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Utilization management decision making is based on the appropriateness of care and service, and the applicable member benefits. Neither WellSense nor Carelon Behavioral Health provides financial or other types of incentives to providers, practitioners, employees or other individuals for issuing denials of coverage or services.

PLEASE NOTE: All inpatient and outpatient behavioral health services rendered by non-participating providers require prior authorization from Carelon Behavioral Health, except for emergency services.

WellSense requirements by categories of care

WellSense notification, prior authorization, coordination of care, and discharge planning are essential elements of care management, and are described in detail in the Carelon Behavioral Health-WellSense Health Plan Policy and Procedure Manual available via Carelon Behavioral Health at

carelonbehavioralhealth.com. Our behavioral health program covers the following major categories of care:

- Inpatient/diversionary services for mental health
- Inpatient/diversionary services for addiction treatment
- Outpatient mental health and addiction services
- Psychiatric consultation on medical units

- Emergency services
- Children’s Behavioral Health Initiative (CBHI) (for MassHealth members) and Behavioral Health Services for Children and Adolescents (BHCA) services for Clarity/QHP members.

Each category of care requires effective and timely discharge planning by the treating provider. We review all clinical decisions using our behavioral health clinical criteria. For additional information, including a detailed description of each level of care in the behavioral health system and the level of care clinical criteria, please refer to the Caredon Behavioral Health–WellSense Health Plan Policy and Procedure Manual available from Caredon Behavioral Health at [caredonbehavioralhealth.com](https://www.caredonbehavioralhealth.com), or contact Caredon Behavioral Health directly at 866-444-5155.

12.3 Communication and Coordination of Member Treatment

WellSense and Caredon Behavioral Health collaborate with you to manage the care of members and ensure that each member’s needs are met in the setting most clinically appropriate, considering both behavioral and medical needs. We are committed to improving the quality of care delivered to our members. Toward that end, for SCO if applicable, the Behavioral Health providers would be part of the care team as described in [Section 11: Care Management](#). For MassHealth and QHP we have joined with the other managed care organizations in Massachusetts to develop a joint [Combined MCE Behavioral Health Provider PCP Communication Form](#) to increase the frequency and the quality of the content of communication between behavioral health clinicians and PCPs. With informed member consent, this form can be used by PCPs and by behavioral health providers to communicate with one another. The advantages of using only one form include:

- Less administrative burden for providers—one form limits the time needed to locate the correct form and link to the member’s health plan.
- Consistency in the provision of information shared between behavioral health providers and PCPs.
- Clear and consistent information request and exchange, resulting in timely collaboration
- The “two-way” communication form can be faxed (along with appropriate documentation from the

Member for release of information) and can be easily placed in the member’s record.

Communication between behavioral health providers and PCP, other treatment providers

Outpatient behavioral health providers are expected to communicate with the member’s PCP and other outpatient behavioral health providers if applicable, as follows:

- Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first

- Updates at least quarterly during the course of treatment
- Notice of initiation and any subsequent modification of psychotropic medications
- Notice of treatment termination within two weeks

Behavioral health providers may use Carelon Behavioral Health's Authorization for Behavioral Health Provider and PCP to Share Information and the Behavioral Health-PCP Communication Form for initial communication and subsequent updates (both available on the Carelon Behavioral Health's website at carelonbehavioralhealth.com), or their own form that includes the following information:

- Presenting problem/reason for admission
- Date of admission
- Admitting diagnosis
- Preliminary treatment plan
- Currently prescribed medications
- Proposed discharge plan
- Behavioral health provider contact name and telephone number

Request for PCP response by fax or mail within three business days of the request to include the following health information:

- Status of immunizations
- Date of last visit
- Dates and reasons for any and all hospitalizations
- Ongoing medical illness
- Current medications
- Adverse medication reactions, including sensitivity and allergies
- History of psychopharmacological trials
- Any other medically relevant information

Outpatient providers' compliance with communication standards is monitored through requests for authorization submitted by the provider, and through chart reviews.

Communication between inpatient/diversionary providers and PCPs, other treatment providers

With the member's informed consent, acute care facilities should contact the PCP by phone and/or by fax, within 24 hours of a member's admission to treatment. Inpatient and diversionary providers must also alert the

PCP 24 hours prior to a pending discharge, and must fax or mail the following member information to the PCP within two days post-discharge:

- Date of discharge
- Diagnosis
- Medications
- Discharge plan
- Aftercare services for each type, including:
 - Name of provider;
 - Date of first appointment
 - Recommended frequency of appointments
- Treatment plan

Inpatient and diversionary providers should make every effort to provide the same notifications and information to the member's outpatient therapist, if there is one.

Acute care providers' communication requirements are addressed during continued stay and discharge reviews and documented in Carelon's member record.

Transitioning Members from One Behavioral Health Provider to Another

If a member transfers from one behavioral health provider to another, the transferring provider must communicate the reason(s) for the transfer along with the information above (as specified for communication from behavioral health provider to PCP), to the receiving provider.

Routine outpatient behavioral health treatment by an out-of-network provider is not an authorized service covered by Carelon Behavioral Health. Members may be eligible for transitional care within 30 days after joining the health plan, or to ensure that services are culturally and linguistically sensitive, individualized to meet the specific needs of the member, timely per Carelon Behavioral Health's timeliness standards, and/or geographically accessible.

12.4 Carelon Behavioral Health: Claims and Provider Contracting

Claims

Claims for behavioral health services rendered to our members must be submitted directly to Carelon Behavioral Health within 60 days of the date of service through Carelon Behavioral Health's EDI Gateway

and eService's electronic transaction portal, available at: carelonbehavioralhealth.com > Providers >. Under Provider Portal choose e-Services & EDI.

For all information for claims submission, including companion guides, information on eServices, and EDI services, visit carelonbehavioralhealth.com > Providers > Under Provider Portal choose ProviderConnect.

Contracting and Credentialing

Providers interested in joining the Carelon Behavioral Health provider network to provide services to our members must contact Carelon Behavioral Health's Provider Relations department directly to inquire about credentialing and other network participation requirements, including execution of a Provider Service Agreement. Call Carelon Behavioral Health's Provider line 866-444-5155 or visit carelonbehavioralhealth.com > Providers > Join Our Network.

12.5 Behavioral Health Crisis Services

Community Behavioral Health Centers (CBHCs) integrate crisis, and community based treatment by combining mobile teams, crisis stabilization, and care coordination. CBHCs can be accessed 24 hours a day, 7 days a week for crisis evaluation. Members are still able to utilize Emergency Departments for behavioral health emergencies. See below for current list of CBHCs.

Community Behavioral Health Center	Services Offered				Cities/Towns Served
Services	Core Clinic Services	Crisis Services	Adult Community Crisis Stabilization (Adult CCS)	Youth Community Crisis Stabilization (YCCS)	
Description	<ul style="list-style-type: none"> • Same-day assessment • Same or next day individual/family/group therapy, psychiatric consultation and psychopharmacology, peer support services, Medication Assisted Treatment (MAT) • Individualized outpatient treatment for mental health and addictions • Care coordination 	<ul style="list-style-type: none"> • Triage and evaluation • Intervention and de-escalation • At the clinic or mobile to your home or other community location 	Overnight crisis stabilization program for adults.	Overnight crisis stabilization program for children and youth.	Statewide
Hours	weekdays 8 am to 8 pm weekends 9 am to 5 pm	Mobile, walk-in 24/7/365	24/7/365	24/7/365	Statewide

Advocates	675 Main Street Waltham, MA 02452 354 Waverly St., Framingham, MA 01702 (800) 640-5432		28 Mill St. Marlboro, MA 01752 (508) 786- 1580	Wayside 1 Frederick Abbot Way, Framingha m, MA 01701 (800) 640-5432	Acton, Ashland, Arlington, Bedford, Belmont, Boxborough, Burlington, Carlisle, Concord, Framingham, Holliston, Hopkinton, Hudson, Lexington, Lincoln, Littleton, Maynard, Marlborough, Natick, Northborough, Sherborn, Southborough, Stow, Sudbury, Waltham, Watertown, Wayland, Westborough, Wilmington, Winchester, and Woburn
Community HealthLink	40 Spruce St. Leominster, MA 01453 (800) 977-5555			Wayside 1 Frederick Abbot Way, Framingha m, MA 01701	Ashby, Ayer, Barre, Berlin, Bolton, Clinton, Fitchburg, Groton, Hardwick,

Community HealthLink	12 Queen St. Worcester, MA 01610 (866) 549-2142	72 Jaques Ave. Worcester, MA 01610 (508) 860-1283	Wayside 1 Frederick Abbot Way Framingham, MA 01701 (800) 640-5432	Auburn, Boylston, Grafton, Holden, Leicester, Millbury, Paxton, Shrewsbury, Spencer, West Boylston and Worcester
Riverside Community Care	176 West St. Milford, MA 01757 (800) 294-4665	32 Hamilton St. Milford, MA 01757 (508) 478-2325	Wayside 1 Frederick Abbot Way, Framingham, MA 01701 (800) 640-5432	Bellingham, Blackstone, Brimfield, Brookfield, Charlton, Douglas, Dudley, East Brookfield, Franklin, Holland, Hopedale, Medway, Mendon, Milford, Millville, Northbridge, North Brookfield, Oxford, Southbridge, Sturbridge, Sutton, Upton, Uxbridge, Wales, Warren, Webster, and West Brookfield
Clinical & Support Options	205 School St. Gardner, MA 01440 (800) 562-0112	269 Federal St. Greenfield, MA 01301 (413) 772-0249	Center for Human Development 104 Massachusetts Ave. Springfield, MA 01109	Ashburnham, Gardner, Hubbardston, Templeton, Westminster, Winchendon
Beth Israel Lahey Behavioral Health Services	12 Methuen St. Lawrence, MA 01840 (877) 255-1261	12 Methuen St. Lawrence, MA 0184 (978) 6920-1770	Wayside 1 Frederick Abbot Way Framingham, MA 01701 (800) 640-5432	Andover, Lawrence, Methuen, and North Andover
Vinfen	40 Church St Lowell, MA 01852 (866) 388-2242	12 Methuen St. Lawrence, MA 0184 (978) 620-1770	Wayside 1 Frederick Abbot Way Framingham MA 01701 (800) 640-5432	Billerica, Chelmsford, Dracut, Dunstable, Lowell, Tewksbury, Tyngsboro, and Westford
Eliot Community Human Services	95 Pleasant St. Lynn, MA 01901 (800) 988-1111		Wayside 1 Frederick Abbot Way, Framingham, MA 01701 (800) 640-5432	Lynn, Lynnfield, Nahant, North Reading, Reading, Saugus, Stoneham, Swampscott, and Wakefield

Eliot Community Human Services	10 Harbor St. Danvers, MA 01923 (866) 523-1216	Knights Inn 225 Newbury St. Danvers, MA 01923 (978) 619-6800	Wayside 1 Frederick Abbot Way Framingham, MA 01701 (800) 640-5432	Amesbury, Beverly, Boxford, Danvers, Essex, Georgetown, Gloucester, Groveland, Hamilton, Haverhill, Ipswich, Manchester by the Sea, Marblehead, Merrimac, Middleton, Newbury, Newburyport, Peabody, Rockport, Rowley, Salem, Salisbury, Topsfield, Wenham, and West Newbury
Cambridge Health Alliance	1493 Cambridge St. Cambridge, MA 02139 (833) 222-2030	Boston Medical Center 85 E. Newton St, 6th floor Boston, MA 02118 (617) 414-8316	Wayside 1 Frederick Abbot Way Framingham, MA 01701 (800) 640-5432	Cambridge, Somerville, Everett, Malden, and Medford
North Suffolk Mental Health Association	14 Porter St. East Boston, MA 02128 (888) 309-1989	Boston Medical Center 85 E. Newton St, 6th floor Boston, MA 02118 (617) 414-8316	Wayside 1 Frederick Abbot Way Framingham, MA 01701 (800) 640-5432	Chelsea, Revere, East Boston, Winthrop, and Charlestown
Boston Medical Center	85 E. Newton Street, Boston, MA 02118 (800) 981-4357	85 E. Newton St, 6th floor, Boston, MA 02118 (617) 414-8316	Wayside 1 Frederick Abbot Way Framingham, MA 01701	Boston, Brighton, and Brookline
Riverside Community Care	190 Lenox St. Norwood, MA 02062 (800) 529-5077	15 Beacon Ave. Norwood, MA 02062 (781) 769-1342	Wayside 1 Frederick Abbot Way Framingham, MA 01701 (800) 640-5432	Canton, Dedham, Dover, Foxboro, Medfield, Millis, Needham, Newton, Norfolk, Norwood, Plainville, Sharon, Walpole, Wellesley, Weston, Westwood,

Aspire Health Alliance	460 Quincy Ave. Quincy, MA 02169 (800) 528-4890	460 Quincy Ave, 2nd Floor Quincy, MA 02169 (617) 774-6078	Child & Family Services 543 North St. New Bedford, MA 02740	Braintree, Cohasset, Hingham, Hull, Milton, Norwell, Quincy, Randolph, Scituate, and Weymouth
Clinical & Support Options	8 Atwood Dr. Northampton, MA 01060 (800) 562-0112	29 N. Main St. Florence, MA 01062 (413) 586-2973	Center for Human Development 104 Massachusetts Ave. Springfield, MA 01109 (413) 301-8801	Amherst, Chesterfield, Cummington, Easthampton, Florence, Goshen, Hadley, Hatfield, Middlefield, Northampton, Pelham, Plainfield, Westhampton, Williamsburg, and Worthington
Clinical & Support Options	1 Arch Place Greenfield, MA 01301 (800) 562-0112 2033 Main St. Athol, MA 01331	269 Federal St. Greenfield, MA 01301 (413) 772-0249	Center for Human Development 104 Massachusetts Ave. Springfield, MA 01109 (413) 301-8801	Ashfield, Athol, Bernardston, Buckland, Charlemont, Colrain, Conway, Deerfield, Erving, Gill, Greenfield, Hawley, Heath, Leverett, Leyden, Millers Falls, Montague, New Salem, Northfield, Orange, Petersham, Phillipston, Rowe, Royalston, Shelburne, Shutesbury, Sunderland, Turners Falls, Warwick, Wendell, and Whately

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Behavioral Health Network	417 Liberty St., Springfield MA 01104 77 Mill St., Westfield, MA 01085 (800) 437-5922	417 Liberty St., Springfield, MA 01104 (413) 301-9355	Center for Human Development 104 Massachusetts Ave., Springfield, MA 01109 (413) 301-8801	Agawam, Blandford, Chester, East Longmeadow, Granville, Hampden, Huntington, Indian Orchard, Longmeadow, Montgomery, Russell, Southwick, Springfield, Tolland, Westfield, West Springfield, and Wilbraham
Center for Human Development	1109 Granby Rd. Chicopee, MA 01020 (833) 243-8255	51 Old Lyman Rd. South Hadley, MA 01075 (413) 333-4566	104 Massachusetts Ave. Springfield, MA 01109 (413) 301-8801	Belchertown, Bondsville, Chicopee, Granby, Holyoke, Ludlow, Monson, Palmer, South Hadley, Southampton, Thorndike, Three Rivers, and Ware

The Brien Center	334 Fenn St. Pittsfield, MA 01201 (800) 252-0227	121 Seymour St. Pittsfield, MA 01201 (413) 997-0067	Center for Human Development 104 Massachusetts Ave. Springfield, MA 01109 (413) 301-8801	Adams, Alford, Becket, Cheshire, Clarksburg, Dalton, Egremont, Florida, Great Barrington, Hancock, Hinsdale, Lanesboro, Lee, Lenox, Monroe, Monterey, Mount Washington, New Ashford, New Marlboro, North Adams, Otis, Peru, Pittsfield, Richmond, Sandisfield, Savoy,
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				Sheffield, Stockbridge, Tyngham, Washington, West Stockbridge, Williamstown, and Windsor
High Point	10/20/30 Meadowbrook Dr. Brockton, MA 02301 (888) 725-9066	10 Meadowbrook Rd. Brockton, MA 02301 (774) 901-2373	Child & Family Services 543 North St. New Bedford, MA 02740 (508) 992-0444	Abington, Avon, Bridgewater, Brockton, East Bridgewater, Easton, Holbrook, Rockland, Stoughton, West Bridgewater, and Whitman
Child and Family Services	1061 Pleasant St., New Bedford, MA 02740 (877) 996-3154	543 North St., New Bedford, MA 02740 (877) 996-3154	543 North St. New Bedford, MA 02740 (508) 992-0444	Acushnet, Carver, Dartmouth, Duxbury, Fairhaven, Halifax, Hanover, Hanson, Kingston, Marion, Marshfield, Mattapoisett, New Bedford, Pembroke, Plymouth, Plympton, Rochester, and Wareham
	68 Industrial Park Rd. Plymouth, MA 02360 (877) 996-3154			
Child and Family Services	160 Osborn St. Fall River, MA 02724 (508) 676-5708	1052 Pleasant St. Fall River, MA 02723 (877) 996-3154	543 North St. New Bedford, MA 02740 (508) 992-0444	Fall River, Freetown, Somerset, Swansea, and Westport

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Community Counseling of Bristol County	1 Washington St., Taunton, MA 02780 (800) 660-4300	108 West Main St. Norton, MA 02766 (508) 952-6513	Child & Family Services 543 North St. New Bedford, MA 02740 (508) 992-0444	Attleboro, Berkley, Dighton, Lakeville, Mansfield, Middleborough, North Attleboro, Norton, Raynham, Rehoboth, Seekonk, and Taunton
Bay Cove Human Services	116 Camp St. Hyannis, MA 02601 (833) 229-2683	Child & Family Services 543 North St. New Bedford, MA 02740 (508) 992-0444		Barnstable, Bourne, Brewster, Chatham, Chilmark, Cotuit, Dennis, Eastham, Falmouth, Harwich, Hyannis, Mashpee, Orleans, Osterville, Provincetown, Sandwich, Truro, Wellfleet, Woods Hole, and Yarmouth
Fairwinds Center	20 Vesper Ln. Nantucket, MA 02554 (888) 323-3447	Child & Family Services 543 North St. New Bedford, MA 02740 (508) 992-0444		Nantucket

Section 13: Pharmacy Services

13.1 Pharmacy contacts for providers

In addition to the pharmacy information in this manual, we have a [Pharmacy](https://wellsense.org/providers) section on our website at wellsense.org/providers. It provides additional information and resources.

Up-to-date medication coverage information, including over-the-counter (OTC) drugs	View the Pharmacy formulary at wellsense.org/providers/ma For MassHealth and Clarity plan members (formerly QHP): call WellSense at 888-566-0008. For Senior Care Options members: call Express Scripts at 888-566- 0008.
Prior authorization forms and clinical policy criteria	View Prior Authorization forms and clinical guidelines at wellsense.org/providers/ma . For MassHealth and Clarity plan members (formerly QHP): call WellSense at 888-566-0008. For Senior Care Options members: call Express Scripts at 888-566- 0008.
Mail Order Pharmacy Program	View the Mail Order Pharmacy Program at wellsense.org/providers/ma . Contact the Mail Order Pharmacy, Cornerstone Health Solutions at 844-319-7588, or visit them online at cornerstonehealthsolutions.org
90-Day Supply Program that includes mandatory and allowable dispensing limits for certain medications	View the Pharmacy formulary at wellsense.org/providers/ma .

List of Drugs restricted to Specialty Pharmacy

View the pharmacy page at
wellsense.org/providers/ma.

13.2 General Information

To ensure that members receive quality, affordable healthcare, we contract with a pharmacy benefit manager (PBM) to provide a pharmacy network and manage the pharmacy benefits offered to members. In addition, the pharmacy program offers a comprehensive utilization management program.

Pharmacy and Therapeutics Committee

We maintain a Pharmacy and Therapeutics Committee (P&T Committee) composed of both internal and external physicians, pharmacists, and other practitioners who are actively practicing in the community. This committee reviews and approves our drug formulary recommendations to ensure coverage reflects current evidence-based clinical practice. It also helps to maintain compliance with all applicable legal, regulatory and accreditation standards.

In addition, the P&T Committee evaluates the most current medical literature and approves clinical coverage criteria used to administer our pharmacy utilization management programs. These programs include prior authorization, step-therapy edits, and quantity limitations. Clinical coverage criteria are updated at least annually and approved by the P&T Committee.

For MassHealth, WellSense adheres to the Unified Pharmacy Product List (UPPL) and pharmacy policy criteria as administered by the Executive Office of Health and Human Services (EOHHS) unified formulary requirements. The formulary coverage is presented to the P&T Committee for informational purposes.

The P&T Committee may also advise WellSense on other pharmacy-related issues as needed to enhance our ability to provide a comprehensive pharmacy benefit to our members and to improve the quality of the pharmacy management program.

Drug Utilization Evaluation Program

Pursuant to our Drug Utilization Evaluation Policy as approved by the P&T Committee, Pharmacy Services can evaluate physician prescribing patterns, pharmacist dispensing activities, and member use of medications. This involves a comprehensive review of members' prescription medication data before, during, and after dispensing to ensure appropriate medication decision-making and positive member outcomes. We then may recommend interventions to physicians, pharmacists, and members, as necessary. To determine effectiveness, WellSense monitors utilization and compliance with the identified interventions.

13.3 Prescription Drug Monitoring Program

The Prescription Drug Monitoring Program (PDMP) identifies a member population at risk for inappropriate use of medications that have potential for abuse, including schedule II-IV controlled substances and high risk non-controlled substances. Members are automatically enrolled into the program if they are identified through algorithms that incorporate pharmacy claims and medical service utilization data.

The program incorporates both automatic interventions and clinical pharmacist review of member cases for interventions depending on the specific algorithm triggered. All cases referred into the program by internal staff or providers are evaluated by a clinical pharmacist. As part of the review process, the clinical pharmacist evaluates the member's medical history including emergency room visits, patterns of medication use, and gaps in coordination of care among prescribers to determine the appropriate intervention(s) to be completed, if any.

Intervention actions may include direct provider communication, restriction of medication access through a single pharmacy and/or physician (physician group), as well as referrals to our fraud and abuse team for further evaluation. The goal of the program is to assist health care providers be better informed of their patients' medication use patterns and to promote proactive management to minimize the potential for medication misuse.

In addition to regularly identifying individuals for enrollment, the PDMP also enrolls members through provider referrals. To learn more or to enroll a member, call the provider line at 888-566-0008 and select the "pharmacy" option.

Members enrolled in Senior Care Options (SCO) Medicaid are also enrolled in the PDMP program.

13.4 Medication Therapy Management Program

The Senior Care Options program offers a medication therapy management (MTM) program to dually eligible members who have multiple chronic diseases, take a number of different medications, and have high annual drug costs. Members who meet the qualifying criteria are automatically enrolled in the program each year and are eligible for extra education regarding their medications and a comprehensive review with a pharmacist or other qualified healthcare professional. The goal of the program is to improve medication use and reduce adverse drug events. Any identified medication recommendations or interventions may be directly communicated to providers.

13.5 Drug Monitoring Program (DMP)

The Drug Monitoring Program (DMP) identifies Senior Care Options (SCO) members who are potentially over-utilizing frequently abused drugs (FADs). Members are identified for enrollment into the program through internal reports as well as reports provided by the Centers for Medicare and Medicaid (CMS). The goal of this program is to address overutilization of FADs while maintaining access to such drugs as medically necessary.

The program consists of a pharmacy case management program that will review overutilization to assess member safety, fraud, waste, and abuse. After clinical review, a pharmacist will perform coordination of care through prescriber outreach and consultation to determine if medication use is appropriate. If medication use is determined to be inappropriate members will be considered at-risk beneficiaries and interventions may include restriction of medication access through point-of-sale quantity limits, single pharmacy restrictions, or restrictions to a single prescriber. Outcomes of case management review and interventions will be reported to CMS.

13.6 Pharmacy Benefits

Pharmacy Benefit Manager (PBM)

The pharmacy benefit manager (PBM) administers our prescription drug benefits. This includes making a comprehensive network of retail pharmacies available to our members. Use the “[Find a Pharmacy](#)” search tool at wellsense.org to access a list of retail pharmacies that are in-network.

Our formulary

Our formulary is the primary source of information on medications available through the prescription pharmacy benefit. The formulary contains information on medication coverage, applicable pharmacy program and copayment tier status. Please use the formulary as a reference when prescribing medications to WellSense members. We update the formulary every three months or more frequently if necessary with new medications and medication coverage changes, including as required by regulatory agencies for unified formularies. Changes to the formulary are posted to wellsense.org/providers/ma and are also mailed to our provider network as needed.

For MassHealth, WellSense adheres to the Unified Pharmacy Product List (UPPL) and pharmacy policy criteria as administered by the Executive Office of Health and Human Services (EOHHS) unified formulary requirements.

Over-the-counter formulary

Over-the-counter (OTC) coverage includes many commonly used OTC medications and select medical devices that are available through the retail pharmacy network for specific WellSense members; coverage may vary by plan type. For covered OTC items, see the formulary available at wellsense.org/providers/ma. A prescription must be written for the covered item so that it can be processed as a pharmacy claim.

13.7 Pharmacy Utilization Management Programs

The Pharmacy Utilization Management (UM) programs are designed to manage the utilization of drugs that can be obtained through retail pharmacies, specialty pharmacies, or in a provider setting. These programs include prior authorization, step therapy, quantity limitations, mandatory generic substitution, and new-to-market medication program. Medications managed with any of these programs require submission of a Prior Authorization Request available at wellsense.org/providers/ma. A utilization review decision will be rendered on the coverage of the requested medication. These programs are updated regularly based on WellSense's P&T Committee's formulary approvals or as required by regulatory agencies for unified formularies and reflect the ever-changing field of pharmaceuticals.

If we deny a pharmacy prior authorization request, the member and/or his or her authorized appeal representative have the right to appeal the decision. If appealing the decision, the member or representative may submit any additional information for consideration during the internal appeal process. An internal appeal must be submitted within 60 calendar days of the denial letter for MassHealth, within 180 calendar days for Clarity plans (including QHP, ConnectorCare and Employer Choice Direct), and within 60 calendar days for Senior Care Options. See [Section 10: Appeals, Inquiries, and Grievances](#) for additional information.

Pharmacy Utilization Management (UM) Program Descriptions

Pharmacy Prior Authorization (PA) Program

We use clinical guidelines/criteria for coverage of certain medications that are not considered first-line therapy by clinical practice guidelines, have specific indications for use or are subject to use for non-FDA approved indications. Medications managed under the PA program require prior approval for coverage.

If a provider feels it is medically necessary for a member to take a drug managed under our pharmacy programs, a Prior Authorization Request should be submitted via an online electronic prior authorization tool available at wellsense.org/providers/ma or to the fax number indicated on the form or via phone. A licensed clinical pharmacist will review the request, and we will notify the provider of the decision in accordance with applicable regulatory and accreditation standards. See [Section 8: Utilization Management and Prior Authorization](#) for our timeframe requirements.

See our Prior Authorization requirements and Clinical Policies available at wellsense.org/providers/ma to access a listing of medications that are in the PA Program.

Step Therapy Program

The Step Therapy Program is a form of prior authorization. It generally requires the use of cost-effective or first-line medication(s) before approval of a second-line medication is granted. If the required therapeutic benefit is not achieved using the first-line medication, the prescriber may request the use of a second-line medication and submit a prior authorization request. See WellSense's Prior Authorization requirements and Clinical Policies available at wellsense.org/providers/ma.

Quantity Limitation Program

The Quantity Limitation program ensures the safe and appropriate use of a select number of medications by covering only a specified amount of the medication to be dispensed at any one time. Prior authorization is required when requesting quantities greater than what WellSense allows. Please see quantity limitation guidelines available on our website at wellsense.org/providers/ma.

Mandatory Generic Medication Program

The US Food and Drug Administration (FDA) has determined certain generic medications to be therapeutically equivalent ("AB rated") to their brand counterparts. This means that these generic medications are as effective as the brand. The Commonwealth of Massachusetts requires the interchanging of "AB rated" generics unless the practitioner indicates that the brand medication is medically necessary. In addition, coverage for most brand medications with generic equivalents is subject to our prior authorization requirements unless brand is specifically preferred over generics as indicated on the formulary or required by regulatory agencies for unified formularies. Refer to our formulary and Clinical Policies available at wellsense.org/providers/ma.

New-to-Market Medication Program

WellSense reviews all new-to-market drugs before adding them to the formulary or covering them under our pharmacy benefit. The P&T Committee evaluates these drugs to determine whether the new-to-market

medications are safe for prescribing to members and to determine the coverage status. Refer to our formulary and Clinical Policies at wellsense.org/providers/ma.

Medication Exception Process or Step Therapy Exceptions Process

The medication exception process allows a provider the ability to request coverage of a non-covered medication, a non-formulary medication, or a step therapy exception for a member based upon medical necessity. Medications specifically excluded from coverage by federal or state regulations (such as Medicaid or Medicare), and those specifically excluded in the Commercial plans' Evidence of Coverage are not subject to this policy.

The provider must submit a letter of medical necessity or a completed prior authorization request available on our website at wellsense.org/providers/ma, along with any corresponding documentation relevant to the medical necessity of the non-covered medication or the non-formulary medication to WellSense for review.

13.8 Pharmacy Networks Affiliated with WellSense

Retail Pharmacy

Our members may fill prescriptions at any retail pharmacy in our pharmacy network. The network includes more than 250 pharmacies throughout Massachusetts. To find the location and contact information of a specific retail pharmacy, use the [Find a Pharmacy](#) search tool available at wellsense.org.

Specialty pharmacy

We contract with an exclusive network of specialty pharmacies, which have experience managing the dispensing of specific medications used to treat certain complex conditions. Our specialty pharmacies can mail members' specialty prescriptions directly to their homes, doctor's office, or other designated address. Visit the [Pharmacy Programs page](#) at wellsense.org to see a list of our network specialty pharmacies, find our specialty drug list, and access the Specialty Pharmacy program details.

90-Day Supply

MassHealth has established a 90-Day Supply Medication Initiative that includes mandatory and allowable dispensing of certain medications. The initiative includes 3 aspects of dispensing limits.

- **Mandatory 90-day (M90):** Drugs that must be filled as a 90-day supply after an initial fill of a medication. The initial fill can be for up to a 30-day supply.

- Allowable 90-day (A90): Drugs that may be filled as a 90-day supply. There are no initial fill requirements.
- Excluded 90-day: All other drugs (those not designated as M90 or A90) are excluded from a 90-day supply.

QHP Members may obtain up to 90-day supplies of eligible medications at WellSense's Mail Order Pharmacy or at a participating network retail pharmacy.

See the formulary at wellsense.org/providers/ma for eligible drugs. Exceptions to the dispensing limits may be applicable.

Mail order pharmacy

We offer a mail order pharmacy program that allows members to fill 90-day supplies of maintenance medications through our mail order pharmacy, Cornerstone Health Solutions. Members save time and money by filling prescription in bulk supplies. Some medications are not available through this benefit, such as over-the-counter products, controlled substances, and specialty medications provided by our specialty pharmacies.

For more information regarding the Mail Order Pharmacy Program, visit wellsense.org or to enroll in the program call Cornerstone Health Solutions at 844-319-7588, or visit them online at cornerstonehealthsolutions.org

13.9 Pharmacy Copayments

Member cost-sharing amounts

MassHealth members are charged a copayment for medications with the exception of the following:

- The member is under the age of 21 years.
- The member is pregnant; members must notify their doctor to submit a WellSense Medical Prior Authorization Form, available at wellsense.org.
- The member's pregnancy ended in the last 60 days; members must notify their doctor to submit a Medical Prior Authorization Form, available at wellsense.org.
- The member is in hospice care.
- The member is a Native American or Alaska Native from a federally recognized tribe.

- The member is receiving care as an inpatient in an acute hospital, nursing facility, chronic disease hospital, rehabilitation hospital, or intermediate-care facility for the developmentally delayed.
- Medications used for preventive services assigned a grade of 'A' or 'B' by the U.S. Preventive Services Task Force (USPSTF)
- Vaccines as recommended by the Advisory Committee on Immunization Practices (ACIP)
- Smoking cessation products
- Detoxification and maintenance treatment for SUD

Clarity plan members (including QHP, ConnectorCare and Employer Choice Direct) are charged copayments, coinsurance, and/or deductibles for medications, and may have specific pharmacy deductibles—depending on the applicable benefit package in which they are enrolled.

Senior Care Options member have no copayments, coinsurance, or deductibles for covered medications. See [Section 6: Member Information](#) for additional details regarding copayment amounts.

Monthly/Annual cost-sharing caps

MassHealth members are responsible for paying copayments for all dispensed medications, including retail, specialty, and mail-order, until they have reached their monthly copayment “cap” or maximum. Members become exempt from paying copayments once they have reached the maximum. See [Section 7: WellSense Health Plan Product Information](#) for details.

Clarity plan members (including QHP, ConnectorCare and Employer Choice Direct) also may have out-of-pocket maximums that may include deductibles, copayments, or coinsurance paid by the member for medications.

The member will receive a letter notifying him/her when the monthly, annual or benefit year maximum has been reached.

Senior Care Options members have \$0 cost share for all covered medications throughout the benefit year.

Pharmacy copayment compliance

We expect all pharmacies to comply with the cost-sharing rules applicable to all plans.

- For Clarity plan members (including QHP, ConnectorCare and Employer Choice Direct): Pharmacies must collect the required deductible, copayment, and/or coinsurance. For clarification, please see information about Prescription Copayments available at [wellsense.org](https://www.wellsense.org).
- For MassHealth members, please note the following: In accordance with 130 CMR 450.130, providers, including pharmacies, may not refuse services or withhold prescriptions if the member reports they are unable to pay the copayment at the time of service/receipt of prescription.

WellSense action with non-compliant pharmacies for MassHealth members

Our Pharmacy staff will immediately follow up with any pharmacy that denies a medication to a MassHealth member based on the member's reported inability to pay the pharmacy copayment at the time of service/receipt of prescription. Our standard operating procedure includes:

- Outreach to the member who was denied the medication to ensure that he or she receives the needed medication in a timely manner.
- Informing the pharmacy that denying prescription drugs to MassHealth members based on a member's inability to pay their copayment at the time of service/receipt of prescription is a violation of MassHealth regulations and federal Medicaid law.
- Providing MassHealth with a list of pharmacies that demonstrate a pattern of inappropriately denying prescription drugs to members, and documenting steps WellSense takes to resolve the situation. If necessary, the Plan takes disciplinary action against a noncompliant pharmacy.

Section 14: Quality Management

14.1 General Information

The Plan's Quality Management Program helps ensure that our participating providers and we deliver quality services to members. Providers are required to participate in the program as part of their agreement with the Plan.

Providers may be asked to participate in clinical programs (e.g., to increase HEDIS rates), surveys, (e.g., appointment lead times), or other initiatives aimed at improving quality of care or member satisfaction. The Plan develops these programs and initiatives to meet contractual, regulatory and accreditation requirements and to address opportunities for improvement identified through the analysis of available data (e.g., HEDIS and CAHPS). Some of these programs, such as HEDIS, involve the use of practitioner data.

14.2 Scope of the Quality Improvement Program

Through the Quality Improvement Program (QIP), the Plan monitors and oversees the following aspects of medical and behavioral health care and service:

- Ongoing evaluation of the quality of care and service (including access and availability to quality clinical care);
- A planned systematic approach to Continuous Quality Improvement (CQI)/Total Quality Management (TQM) for improving clinical and non-clinical outcomes
- Clinical care guidelines
- Patient safety
- Customer satisfaction, including evaluating grievances and appeals
- Utilization management, to include mechanisms to detect both underutilization and overutilization
- Mechanisms to assess and address disparities in the quality of, access, and appropriateness of care for members with special health care needs
- Care coordination, disease management and population health
- Continuity and coordination of care
- Credentialing
- Network management

14.3 WellSense Quality Improvement Goals

The QIP identifies the annual Quality Improvement (QI) work plan priorities and focus. The Plan considers many factors when deciding on QI initiatives or projects for the annual plan. Some of these factors include those projects that:

- Support our mission and strategic goals
- Were identified through monitoring quality metrics, evaluating previous QI work plans, and input from practitioners and/or members
- Improve the overall health, well-being and safety of members
- Improve member and provider satisfaction
- Improve member access to health care
- Achieve and maintain health plan accreditation from NCQA
- Fulfill other state and federal regulatory requirements

The Plan utilizes the following quality improvement tactics throughout the year:

- Collects information and data relevant to objectives and measures of QI goals
- Implements well-designed, innovative, targeted, and measurable interventions to achieve objectives; Evaluates the effectiveness of interventions
- Implements a provider incentive program to reward the achievement of specific goals and share best practices for sustaining goals
- Identifies barriers and social determinants of health to reduce the potential for unmet needs
- Plans and initiates processes to sustain achievements and continue improvements Examples of QI goals include:
 - Monitoring the use of high risk medications and intervening as necessary to assist providers with
 - monitoring of members on multiple medications to improve coordination of care
 - Identifying members with asthma, diabetes, and other chronic conditions, and continuously improving processes to facilitate managing these populations
 - Increasing appropriate medication utilization, promoting self-management, addressing social determinants of health, and decreasing emergency department and inpatient hospital utilization

14.4 Healthcare Effectiveness Data and Information Set Guidelines (HEDIS)

HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed care plans. HEDIS

measures cover many aspects of health care, including preventive care, such as screening tools, management of physical and behavioral health conditions, access to and availability of care management of chronic conditions and utilization of services. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA), which defines standards for accreditation of health plans in the U.S. CAHPS is sponsored and maintained by the Agency for Healthcare Research and Quality (AHRQ). HEDIS performance measures are reported on an annual basis according to state and federal requirements.

HEDIS data collection

HEDIS measure data is collected in a variety of ways. The Plan uses administrative data captured on the systems (e.g., claims data) and medical record data to capture information not available in claims. Medical records are requested and reviewed by health plan staff.

HEDIS medical record data collection timeframes	
January–April	Record requests distributed to providers
Five days after receipt of the medical record request from WellSense	Return requested medical records documentation
March–May	WellSense will follow up with provider offices who have not submitted the requested records or if the required documentation was incomplete
May	WellSense completes review of the medical record documentation

Providers' prompt attention and response to requests for chart information is critical and is greatly appreciated.

Member Experience of Care Survey: Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS is a nationally recognized member satisfaction survey tool for managed care used by NCQA and the Centers for Medicare and Medicaid Services (CMS). CAHPS is sponsored, supported, and maintained by the Agency for Healthcare Research and Quality (AHRQ) and is used to assess the member's subjective experience when accessing health care. The Plan administers the Member Experience of Care CAHPS survey on an annual basis.

Provider profiling

We may collect and report necessary data for developing an improvement strategy for us, and give providers important feedback on quality of care guidelines. We may evaluate provider performance using clinical, administrative, and member satisfaction quality indicators in the following manner:

- Develop reports to identify performance by specific provider and/or provider group
- Develop and use benchmarks to measure quality indicators
- Provide feedback regarding performance results and compare it to overall network performance
- Collect feedback from providers regarding disseminated reports, and use this feedback to revise reports as necessary
- Identify opportunities for improvement and work with providers to establish quality improvement goals and action plans
- Periodically measure providers' progress in achieving the goals specified in the action plans

14.5 Provider Reporting of Serious Reportable Events (SREs), Provider Preventable Conditions (PPCs) and Adverse Incidents

Providers **must report all serious reportable events** (SREs) and provider preventable conditions (PPCs) within thirty days of the event, and adverse incidents related to a WellSense member within a reasonable timeframe. (See below for definitions of these terms.) You must report as follows.

- For SREs/PPCs/adverse events unrelated to behavioral health care, notify our Quality Department at 617-897-0899 to report the event.
- For SREs/adverse events related to behavioral health care, call our partner, Carelon Behavioral Health (Carelon Behavioral Health), at 866-444-5155 (TTY/TDD line 711) to report the event. Learn more in [Section 12: Behavioral Health Management](#).

Provider preventable conditions (PPC)

Under Section 2702 of the Affordable Care Act (ACA) and federal regulations at 42 CFR 447.26, Medicaid providers must report PPCs to Medicaid agencies, and Medicaid agencies are prohibited from paying providers for PPCs in violation of the federal requirements. PPCs are conditions that meet the definition of a

“Health Care Acquired Condition” or an “Other Provider Preventable Condition” as defined by CMS (see federal regulations at 42 CFR 447.26). **These must be reported to the Plan within thirty days.**

Serious reportable event (SRE)

An SRE is an event that occurs on premises covered by a hospital’s license, office based practice, ambulatory surgery center, or skilled nursing facility that results in an adverse patient outcome, is clearly identifiable and measurable, usually or reasonably preventable, and is serious in consequences (such as resulting in death or loss of a body part, injury more than transient loss of a body function or assault). These events are also characterized as adverse in nature, represent a clear indication of a health care provider’s lack of safety systems, and/or are events that are important measures for public credibility or public accountability as established by guidelines issued by the National Quality Forum (NQF) as Serious Reportable Events (SREs).

These must be reported to the Plan within thirty days.

Adverse event

An adverse event is an unexpected occurrence that results in or has the potential to result in serious harm to the well-being of a member who is receiving services managed by the Plan or has recently been discharged from services managed by the Plan.

Examples of adverse events include:

- Unexpected death
- Death which was not anticipated as a significant possibility 24 hours before the death OR where there was a similarly unexpected deterioration in the patient’s condition leading to or precipitating events which led to death
- Death not expected as the outcome from progression of an illness or disease
- Death from a condition not present on admission and/or caused by medical management rather than due to the patient’s underlying disease
- Death related to a surgical or invasive procedure
- Fetal death at > 24 weeks
- Newborn death
- Intrapartum maternal death
- Death within one week of an elective ambulatory procedure
- Serious bodily injury, permanent loss of function or life threatening situation not expected as foreseeable outcomes of member’s condition/treatment
- Any other event during the member’s care or treatment that results in or has the potential to result in serious harm to the member

Critical Incident

Critical Incidents are defined as events which may include death due to unnatural causes, exposure to hazardous materials, medication errors, unauthorized restraints, natural disaster, serious physical injuries, criminal activity impacting the participant, serious neglect, missing persons, and significant property damage. Such events occurring in the community on the premises of an Adult Day Health, Group Adult Foster Care, Adult Foster Care (including where Adult Foster Care services may be provided, such as a private residence setting), Transitional Living or Day Habilitation facility **shall be reported to the Plan by the waiver service provider immediately upon discovery.**

We review all reported SREs, PPCs, critical incidents, and non-behavioral health adverse incidents. We collect, document, evaluate, report, and monitor these incidents in a timely manner. We believe that the frequency of these events may be reduced by examining the settings in which they occur. We collaborate with providers to identify system changes to reduce the likelihood of similar occurrences in the future.

Medical Record Charting Standards

A medical record documents a member's medical care and treatment. The Plan encourages providers to maintain well organized and well documented medical records that represent the assessment of care and delivery of services.

Preventive care charting standards

In addition to the medical record charting standards outlined above, PCPs are required to document recommendations or examinations for the following:

- All services provided directly by the PCP
- All ancillary services and diagnostic tests ordered by the practitioner with results as noted in the charting section
- All diagnostic and therapeutic services for which a member was referred by a practitioner, including but not limited to home health nursing reports, specialty physician reports, hospital discharge reports and physical therapy reports as noted in the charting section

Preventive care services must include documentation of mammograms, Pap smears, adult and pediatric immunizations, risk screening, anticipatory guidance, and any other preventive health standards adopted by WellSense.

Pediatrics charting standards

In addition to the medical record charting standards for preventive care, pediatric charting must include the following:

- Flow sheet for immunizations
- Growth and development chart
- BMI percentile or BMI plotted on a percentile graph
- Anticipatory guidance documentation
- Appropriate physical and social/emotional developmental screenings and referrals as needed

Behavioral health services charting standards

We contract with Carelon Behavioral Health (Carelon Behavioral Health) to manage our behavioral health program. Please contact Carelon Behavioral Health at [carelonbehavioralhealth.com](https://www.carelonbehavioralhealth.com) or call Carelon Behavioral Health at 866-444-5155 for charting standards for behavioral health services.

Inpatient medical/surgical hospitalization charting standards

- Identification of the member
- Name of the member's physician
- Date of admission
- Plan of care required under 42 CFR 456, which must include diagnoses, symptoms, complaints and complications indicating the need for admission, a description of the functional level of the member, any orders for medications, treatments, restorative and rehabilitative services, activities, social services and diet; plans for continuing care and discharge, as appropriate, must be documented
- Initial and subsequent continued stay review dates described under 42 CFR 456.128 and 456.133
- Date of operating room reservation, if applicable
- Justification of emergency admission, if applicable
- Reason and plan for continued stay, if the attending physician believes continued stay is necessary
- Other supporting material that our Utilization Management staff believe appropriate to be included in the record

14.6 Provider Communication

Providers may freely communicate with members about their treatment options, including medication treatment options, regardless of benefit coverage limitations.

14.7 Clinical Practice Guidelines

We have endorsed several evidence-based preventive and disease management clinical guidelines, including those for asthma, diabetes, hypertension, pregnancy, Alzheimer's, and abuse and neglect identification. We encourage providers to refer to these guidelines to assist them in delivering quality care to our members. Links to the [Clinical Practice Guidelines](#) are available at wellsense.org. Printed copies may be obtained by calling our Provider Service Center at 888-566-0008.

14.8 Clinical Documentation and Medicare Risk Adjustment

Clinical Documentation Processes

Required Medical Record documentation

The Centers for Medicare & Medicaid Services (CMS) uses a risk adjustment system to account for medical expenses and care coordination costs for beneficiaries with special needs. As part of that system, CMS requires providers to maintain substantive documentation in their medical records on all relevant diagnoses for a member. CMS may audit providers at any point for compliance with documentation standards. The definition of "substantive documentation" is that each diagnosis billed must be supported by three items in the medical record:

- An evaluation for each diagnosis
- Assessment of relevant symptoms and physical examination findings at time of visit
- A status for each diagnosis; For example:
 - Stable, progressing or worsening, improving
 - Not responding to treatment or intervention
- A treatment plan for each diagnosis
- Observation or monitoring for exacerbation, responses to treatment, etc.
- Referrals to specialists or services (e.g., cardiologist or PT)
- Continuations or changes to any related medications

Coding Compliance

The Plan requires providers to code to the most appropriate level of specificity as a general standard of practice (CPT, ICD10). WellSense and/or CMS may audit the provider at any point for over-coding and/or similar billing practices related to fraud, waste, and abuse. In the event of an audit by CMS or any other regulatory body, WellSense may be required to provide medical record evidence of the submitted diagnoses. In the event that one or more of your patient's records are selected your practice will receive a Medical Record Request Letter for all applicable dates of service from WellSense or a designated vendor on WellSense's behalf. Timely production of the requested patient records is required. Please keep in mind that these regulatory bodies expect 100% participation from all providers. Providers' prompt attention and response to requests for chart information is critical and is greatly appreciated.

Educational Resources

Providers are encouraged to contact Provider Relations at -888-566-0008-to request education about coding and documentation compliance.

Medicare Risk Adjustment: General Guidelines and Recommendations

In order for the findings and coding of clinical encounters to be accepted by CMS for risk adjustment purposes, a clinical encounter must be in the form of a face-to-face visit by a physician or advanced practice clinician (such as an NP, PA, LICSW, OT, or PT). Moreover, all active diagnoses must be documented during a face-to-face encounter at least once per calendar year in order for the diagnoses to count for risk adjustment purposes. All diagnoses, meeting the "substantive documentation" standards listed above must be submitted on a claim for that date of service. Submission of all diagnoses on a claim is the best way to ensure an accurate risk adjustment calculation for each member.

Annual Assessment Process

The Plan encourages providers to adopt the practice of an annual comprehensive assessment to ensure that all active conditions are reviewed at least once during the calendar year. The process of reviewing active conditions may be tied to an annual wellness exam or an annual physical exam.

The documentation and coding compliance practices and general risk adjustment guidelines described above should be adhered to in documenting and coding the findings of an annual comprehensive assessment visit.

14.9 Star Ratings

The Centers for Medicare and Medicaid Services (CMS) uses the Five-Star Quality Rating System to determine compensation for Medicare Advantage plans and educate consumers on health plan quality. The Star Ratings system consists of over 50 measures from six different rating systems. The cumulative results of these measures make up the Star rating assigned to each health plan.

The Star measures are derived from six different measure groups:

- **HEDIS** (Healthcare Effectiveness Data and Information Set) is a set of performance measurements in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plan performance to other plans as well as to national or regional benchmarks. For example, this allows the health plan and CMS to determine how many members have been screened for high blood pressure.
- **CAHPS** (Consumer Assessment of Health Care Providers and Systems) is a patient/member survey rating health care experiences.
- **CMS** (Centers for Medicare and Medicaid Services) rates each plan on administrative type metrics, such as, beneficiary access, complaints, call center hold times, and percentage of customers choosing to leave a plan.
- **PDE** (Prescription Drug Events) is data collected on various medications related events, such as high-risk medications, medication adherence for chronic conditions (e.g., hypertension), and pricing.
- **HOS** (Health Outcomes Survey) is a survey that uses patient-reported outcomes over a 2.5-year time span to measure the health plan's performance. The goal of HOS is to gather valid, reliable, and clinically meaningful health status data in the Medicare Advantage (MA) program for use in quality improvement activities, pay for performance, program oversight, public reporting, and improving health. All managed care organizations with Medicare contracts must participate.
- **IRE** (Independent Review Entity) is an independent entity contracted by CMS to review Medicare health plans' adverse reconsiderations of organization determinations. Medicare Advantage plans are required to process enrollee appeals (reconsiderations) timely and submit all denied appeals to the IRE.

CMS awards quality-based bonus payments to high performing health plans based on their Star Ratings performance. For health plans with a four star (ratings 1-5 stars with 5 highest performing plans) or more rating, a bonus payment is paid in the form of a percentage (maximum of five percent) added to the county benchmark.

The Star Rating methodology was developed to:

- Help consumers choose plans on [medicare.gov](https://www.medicare.gov)

- Strengthen CMS' ability to distinguish stronger health plans for participation in Medicare Parts C and D
- Strengthen beneficiary protections

Addendum

Massachusetts Consumer Protections for Clarity Plan Products

As part of its compliance with Massachusetts laws and regulations, WellSense is required to distribute to providers the following provisions of certain Massachusetts managed care consumer protection requirements. These requirements apply only to our Clarity plan products (including QHP, ConnectorCare and Employer Choice Direct). They do not apply to WellSense Medicaid products.

1. According to M.G.L. c. 175 § 47U(b) (or M.G.L. c. 176G §5(b), M.G.L. c. 176A § 8U(b) and M.G.L. c. 176B § 4U(b)), carriers shall provide coverage for emergency services provided to insureds for emergency medical conditions. After an insured has been stabilized for discharge or transfer, a carrier may require a hospital emergency department to contact a physician on call designated by the carrier or its designee for authorization of post-stabilization services. The hospital emergency department shall take all reasonable steps to initiate contact with the carrier or its designee within 30 minutes of stabilization. However, such authorization shall be deemed granted if the carrier or its designee has not responded to the call within 30 minutes. In the event the attending physician and the on-call physician do not agree on what constitutes appropriate medical treatment, the opinion of the attending physician shall prevail and such treatment shall be considered appropriate treatment for an emergency medical condition, provided that such treatment is consistent with generally accepted principles of professional medical practice and is a covered benefit under the policy or contract.
2. According to M.G.L. c. 175 § 47U(c) (or M.G.L. c. 176G § 5(c), M.G.L. c. 176A § 8U(c) or M.G.L. c. 176B § 4U(c)), a carrier may require an insured to contact either the carrier or its designee or the primary care physician of the insured within 48 hours of receiving emergency services, but notification already given to the carrier, designee or primary care physician by the attending physician shall satisfy this requirement.
3. According to M.G.L. c. 176O § 10(c), “[a] carrier or utilization review organization shall conduct an annual survey of insureds to assess satisfaction with access to specialist services, ancillary services, hospitalization services, durable medical equipment and other covered services . . . [and c]arriers that utilize incentive plans shall establish mechanisms for monitoring the satisfaction, quality of care and actual utilization compared with projected utilization of health care services of insureds.”
4. According to M.G.L. c. 176O § 12(b), “[a] carrier or utilization review organization shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information . . . [and i]n the case of a determination to approve an admission, procedure or service, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall provide written or electronic

confirmation of the telephone notification to the insured and the provider within two working days thereafter. In the case of an adverse determination, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall provide written or electronic confirmation of the telephone notification to the insured and the provider within one working day thereafter.

5. According to M.G.L. c. 176O § 12(c), “[a] carrier or utilization review organization shall make a concurrent review determination within one working day of obtaining all necessary information. In the case of a determination to approve an extended stay or additional services, the carrier or utilization review organization shall notify by telephone the provider rendering the service within one working day, and shall provide written or electronic confirmation to the insured and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services. In the case of an adverse determination, the carrier or utilization review organization shall notify by telephone the provider rendering the service within 24 hours, and shall provide written or electronic notification to the insured and the provider within one working day thereafter. The service shall be continued without liability to the insured until the insured has been notified of the determination.”

6. According to 211 CMR 52.07(6), “[t]he written notification of an Adverse Determination shall include a substantive clinical justification therefor that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum: (a) include information about the claim including, if applicable, the date(s) of service, the Health Care Provider(s), the claim amount, any diagnosis, treatment, and denial code(s) and their corresponding meaning(s); (b) identify the specific information upon which the Adverse Determination was based; (c) discuss the Insured’s presenting symptoms or condition, diagnosis and treatment interventions; (d) explain in a reasonable level of detail the specific reasons such medical evidence fails to meet the relevant medical review criteria; (e) reference and include, or provide a website link(s) to the specifically applicable, clinical practice guidelines, medical review criteria, of other clinical basis for the Adverse Determination criteria; (f) a description of any additional material or information necessary for the Insured to perfect the claim and an explanation of why such material or information is necessary; (g) if the carrier specifies alternative treatment options which are Covered Benefits, include identification of providers who are currently accepting new patients; (h) prominently explain all appeal rights applicable to the denial, including a clear, concise and complete description of the Carrier’s formal internal Grievance process and the procedures for obtaining external review pursuant to 958 CMR 3.000: Health Insurance Consumer Protection, and a clear, prominent description of the process for seeking expedited internal review and concurrent expedited internal and external reviews, including applicable timelines, pursuant to 958 CMR 3.000; and a clear and prominent notice of a patient’s right to file a grievance with the Office of Patient Protection; and information on how to file a grievance with the Office of Patient Protection. (i) prominently notify the Insured of the availability of, and contact information for, the consumer assistance toll-free number maintained by the Office of Patient Protection, and if applicable, the Massachusetts

consumer assistance program; and (j) include a statement, prominently displayed in at least the languages identified by the Centers for Medicare & Medicaid Services as the top non-English languages in Massachusetts, that clearly indicates how the Insured can request oral interpretation and written translation services from the Carrier consistent with 958 CMR 3.000: Health Insurance Consumer Protection.

7. According to M.G.L. c. 176O § 12(e), "[a] carrier or utilization review organization shall give a provider treating an insured an opportunity to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. Said reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if said reviewer cannot be available within one working day. If the adverse determination is not reversed by the reconsideration process, the insured, or the provider on behalf of the insured, may pursue the grievance process established pursuant to [M.G.L. c. 176O, §§] 13 and 14. The reconsideration process allowed herein shall not be a prerequisite to the formal internal grievance process or an expedited appeal required by [M.G.L. c. 176O, §] 13."

8. According to M.G.L. 176O § 16(a) "[t]he physician treating an insured, shall, consistent with generally accepted principles of professional medical practice and in consultation with the insured, make all clinical decisions regarding medical treatment to be provided to the insured, including the provision of durable medical equipment and hospital lengths of stay. Nothing in this section shall be construed as altering, affecting or modifying either the obligations of any third party or the terms and conditions of any agreement or contract between either the treating physician or the insured and any third party."

9. According to M.G.L. 176O § 16(b) "[a] carrier shall be required to pay for health care services ordered by a treating physician if (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary.

A carrier may develop guidelines to be used in applying the standard of medical necessity, as defined herein. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed with input from practicing physicians in the carrier's or utilization review organization's service area; (ii) developed in accordance with the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured."

10. According to M.G.L. 176O § 16(c) "[w]ith respect to an insured enrolled in a health benefit plan under which the carrier or utilization review organization only provides administrative services, the obligations of a carrier or utilization review organization created by this section and related to payment shall be limited to recommending to the third party payor that coverage should be authorized."

11. According to 958 CMR 3.501, “[c]arriers shall allow any female insured who is in her second or third trimester of pregnancy and whose provider in connection with said pregnancy is involuntarily disenrolled for reasons other than those related to quality or fraud, to continue treatment with her provider, consistent with the carrier’s evidence of coverage, for a period up to and including the insured’s first postpartum visit.”
12. According to 958 CMR 3.502, “[c]arriers shall allow any insured who is terminally ill, and whose provider in connection with the treatment of the insured’s terminal illness is involuntarily disenrolled for reasons other than those related to quality or fraud, to continue treatment with the provider, consistent with the terms of the carrier’s evidence of coverage, until the insured’s death.”
13. According to 958 CMR 3.503(1), “[a] carrier shall provide coverage for health services to a newly insured provided by a provider who is not a participating provider in the carrier’s network for up to 30 days from the effective date of coverage if: (a) the insured’s employer only offers the insured a choice of carriers in which said provider is not a participating provider; and (b) said provider is providing the insured with an ongoing course of treatment or is the insured’s primary care provider.”
14. According to 958 CMR 3.503(2), “[w]ith respect to an insured pregnant individual who is in her second or third trimester, coverage pursuant to 958 CMR 3.503(1) shall apply to services rendered through the insured’s first postpartum visit.”
15. According to 958 CMR 3.503(3), “[w]ith respect to an insured with a terminal illness, coverage pursuant to 958 CMR 3.503(1) shall apply to services rendered until the insured’s death.”
16. According to 958 CMR 3.504(1), “[a] carrier may condition coverage of continued treatment by a provider under 958 CMR 3.500 through 3.502, upon the provider’s agreeing: (a) to accept reimbursement from the carrier at the rates applicable prior to the notice of disenrollment as payment in full; (b) to not impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; (c) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and, (d) to adhere to such carrier’s policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing treatment pursuant to a treatment plan, if any, approved by the carrier.”
17. According to 958 CMR 3.504(2), “[a] carrier may condition coverage of treatment by a provider under 958 CMR 3.503 upon the provider’s agreeing: (a) to accept reimbursement from the carrier at the rates applicable to participating providers as payment in full; (b) to not impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider participated in the carrier’s network; (c) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and (d) to adhere to the carrier’s policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing treatment pursuant to a treatment plan, if any, approved by the carrier.”

18. According to 958 3.504(3), "[n]othing in 958 CMR 3.500 through 3.502 or 3.504 shall be construed to require the coverage of benefits that would not have been covered if the provider involved had remained a participating provider. Nothing in 958 CMR 3.503 shall be construed to require coverage of benefits that would not have been covered if the provider involved was a participating provider."
19. According to 958 CMR 3.505(1), "[a] carrier that requires an insured to designate a primary care provider shall allow such a primary care provider to authorize a standing referral for specialty health care, including mental health care, provided by a health care provider participating in such carrier's network when:

(a) the primary care provider determines that such referrals are appropriate; (b) the provider of specialty health care agrees to a treatment plan for the insured and provides the primary care provider with all necessary clinical and administrative information on a regular basis; and (c) the health care services to be provided are consistent with the terms of the carrier's evidence of coverage."
20. According to 958 CMR 3.505(2), "[n]othing in 958 CMR 3.505 shall be construed to permit a provider of specialty health care who is the subject of a referral to authorize any further referral of an insured to any other provider without the approval of the insured's carrier."
21. According to 958 CMR 3.505(3), "[f]or purposes of 958 CMR 3.505, "specialty health care" means health care services rendered by a provider other than a primary care provider."
22. According to 958 CMR 3.506(1), "[n]o carrier that requires an insured to obtain referrals or prior authorizations from a primary care provider for specialty care shall require an insured to obtain a referral or prior authorization from a primary care provider for the following specialty care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in such carrier's health care provider network: (a) annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse midwife or family practitioner to be medically necessary as a result of such examination; (b) maternity care; and, (c) medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions."
23. According to 958 CMR 3.506(2), "[n]o carrier shall require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such insureds in the absence of a referral from a primary care provider."
24. According to 958 CMR 3.506(3), "[c]arriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse- midwives or family practitioners to communicate with an insured's primary care provider regarding the insured's condition, treatment and need for follow-up care."
25. According to 958 CMR 3.506(4), "[n]othing in 958 CMR 3.506 shall be construed to permit an obstetrician, gynecologist, certified nurse midwife or family practitioner to authorize any further referral of an insured to any other provider without the approval of the insured's carrier."

26. According to 958 CMR 3.506(5), "[f]or the purposes of 958 CMR 3.506, the term 'specialty care' is limited to those services that are medically necessary and consistent with the terms of the carrier's evidence of coverage."
27. According to 958 CMR 3.506(6), "[n]othing in 958 CMR 3.506 shall be construed to prohibit a carrier from applying all other applicable health plan requirements for preauthorization or other prior approval for admission to a facility or specific procedures for specialty care provided by an obstetrician, gynecologist, certified nurse-midwife or family practitioner."