WellSense Health Plan

Provider Manual

Massachusetts

2026 WellSense Health Plan
Effective Jan. 1, 2026

WellSense HEALTH PLAN

Table of Contents

Table of Contents **2**

Section 1: General Information **8**

1.1 About WellSense Health Plan 8

1.2 WellSense Provider Networks 8

1.3 Using this Provider Manual 9

1.4 Revisions to the Manual 10

1.5 Contacts Directory 10

1.6 Primary Care Team (PCT) 10

Section 2: Member Eligibility **13**

2.1 Primary Care Team (PCT) 13

2.2 Member ID cards 15

Section 3: Credentialing **17**

3.1 Overview 17

3.2 WellSense credentialing/recredentialing policies and procedures 17

3.3 Credentialing and re-credentialing process 18

3.4 Credentialing and Recredentialing criteria 20

3.5 Re-credentialing 24

3.6 Notice of Rights 25

3.7 Credentialing file review, determinations, notice, and reporting 25

3.8 Ongoing Monitoring and Off-Cycle Credentialing Reviews and Actions 26

3.9 Credentialing appeals process for practitioners 27

3.10 Role of the credentialed practitioner 29

3.11 Organizational providers 30

Section 4: Provider Responsibilities **34**

4.1 Overview 34

4.2 Provider Requests to Participate in Our Network or Join a New Product Line 34

4.3 Responsibilities by Provider Type 37

4.4 Fraud, Waste and Abuse 44

4.5 Provider Demographic Changes 46
4.6 Access to Care Standards 46
4.7 Physician Panel Closing 49
4.8 Requesting a Change in a Member's PCP Assignment 50
4.9 Member Transfer or Involuntary Termination 50
4.10 Second Opinion 53
4.11 Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program 53
4.12 Adult Health Screening 55
4.13 Advance Directives 55
4.14 Provider Preventable Conditions 56
4.15 ADA Guidelines 56
4.16 Cultural Competency & Health Equity 57
4.17 Members Held Harmless for Charges 60
4.18 Legal Notice 61
4.19 Members with Special Health Care Needs 61
4.20 Electronic Health Records (EHR) Attestation Requirement 62

Section 5: Provider Resources 64

5.1 Introduction 64
5.2 Secure Provider Portal 64
5.3 Additional Website Features 65
5.4 Provider Engagement Department 66
5.5 Provider Service Center 68
5.6 "Quick Reference" Charts and Code Lists 69
5.7 Provider Education and Communication 69
5.8 Positive Provider/Member Relationship 70
5.9 Special Programs and Items for WellSense Members 70
5.10 Provider Complaints 70

Section 6: Member Information 72

6.1 Member Information 72
6.2 Member Enrollment in WellSense 72

6.3 MassHealth Membership: Overview....73
6.4 MA Clarity plans (including ConnectorCare and Employer Choice Direct): Overview....74
6.5 MA Clarity plans (including ConnectorCare and Employer Choice Direct): Membership Overview....76
6.6 MA Clarity plans (including ConnectorCare and Employer Choice Direct): Membership Overview....76
6.7 Senior Care Options (SCO): Eligibility....77
6.8 Overview of WellSense Benefits....78
6.9 Member Eligibility....79
6.10 Primary Care Provider Selection and Assignment....79
6.11 Continuity of Care for New and Existing WellSense Members....81
6.13 Member Rights and Responsibilities....84
6.14 Member Outreach and Communication....86

Section 7: WellSense Product Information....91

7.1 MassHealth....91
7.3 Senior Care Options....94
7.4 Services Managed by Our Vendor Partners....94

Section 8: Utilization Management and Prior Authorization....96

8.1 General Information....96
8.2 Inpatient Utilization Management....99
8.3 SCO Care Transitions Program....102
8.4 Prior Authorization....102
8.5 WellSense Authorization Requirements....103
8.6 Authorization Requests: Requirements....104
8.7 Member Access to Emergent and Urgent Services....105
8.8 Utilization Management Timeframe Requirements....107
8.10 Services that Require Plan Notification....112
8.11 New Technology, Experimental Diagnostics, and Experimental Treatment....119

Section 9: Billing and Reimbursement....122

9.1 Overview....122
9.2 Provider Reimbursement....122
9.3 Member Eligibility....123

9.4 National Provider Identifier (NPI) and Tax ID Requirements 126
9.5 WellSense Specific Billing Guidelines by Service 127
9.6 Compliance: Deficit Reduction Act and HIPAA requirements 128
9.7 Remittance Advice 128
9.8 Other Party Liability 129
9.9 Claims Submission 131
9.10 Resubmitting a Claim 134
9.11 Submitting a Correct Claim - Any previously filed paid or denied claim a provider resubmits with changed or corrected information 136
9.12 Claims Payment 145
9.13 Clinical Audit 146
9.14 Special Investigations Unit 149
9.15 Credit Balance 150
9.16 Process to Address Negative Balances 152
9.17 Forms and Instructions 152

Section 10: Appeals, Inquiries, and Grievances 154

10.1 Overview 154
10.2 MassHealth Appeals: Related Definitions 154
10.3 MA Clarity plans (including ConnectorCare and Employer Choice Direct) Appeals: Related Definitions 156
10.4 Senior Care Options Appeals: Related Definitions 158
10.6 Clinical Right of a Provider to Discuss an Adverse Action/Determination 164
10.7 MassHealth Member Inquiries, Grievances, and Appeals 165
10.8 MA Clarity plans (including ConnectorCare and Employer Choice Direct) Member Inquiries, Grievances and Appeals 170
10.9 Senior Care Options Complaints, Grievances, and Appeals 179
10.10 Provider Reviews Related to Inquiries, Grievances, and Appeals 182

Section 11: Care Management 184

11.1 Important contact information 184
11.2 Overview of Care Management Services 184
11.3 Components of the Care Management Program 185
11.4 Care Management Levels of Intervention and Members Targeted 186

11.5 Care Management Process 189
11.6 Community Service Resource Support 189
11.7 Contacting the Care Management Staff 189
11.8 Care Transition Team 190
11.9 Senior Care Options—Care Management 190
11.10 Care Management Process 190

Section 12: Behavioral Health Management 191

12.1 Helpful contact information 191
12.2 Overview 191
12.3 Communication and Coordination of Member Treatment 193
12.5 Behavioral Health Crisis Services 196

Section 13: Pharmacy Services 198

13.1 Pharmacy contacts for providers 198
13.2 General Information 198
13.3 Controlled Substance Management Program 199
13.6 Pharmacy Benefits 200
13.7 Pharmacy Utilization Management Programs 201
13.8 Pharmacy Networks Affiliated with WellSense 203
13.9 Pharmacy Copayments 204

Section 14: Quality Management 207

14.1 General Information 207
14.2 Scope of the Quality Improvement Program 207
14.3 WellSense Quality Improvement Goals 208
14.4 Healthcare Effectiveness Data and Information Set Guidelines (HEDIS) 208
14.5 Provider Reporting of Serious Reportable Events (SREs), Provider Preventable Conditions (PPCs) and Adverse Incidents 210
14.6 Provider Communication 219
14.7 Clinical Practice Guidelines 219
14.8 Clinical Documentation and Medicare Risk Adjustment 219
14.9 Star Ratings 221

Section 15: Health-Related Social Needs (HRSN) Supplemental Services 223

15.1 Health-Related Social Needs (HRSN) Supplemental Services General Information 223

15.2 HRSN Supplemental Service Types 223

15.3 Member Eligibility for HRSN Supplemental Services 224

15.4 HRSN Provider Responsibilities 225

15.5 Delivery of HRSN Supplemental Services 225

15.6 HRSN Claims Submission and Reimbursement 227

Addendum 228

Massachusetts Consumer Protections for Clarity Plan Products 228

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 — 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) (herein ACO, referred to by MassHealth as ACPP)
- Managed Care Organization (MCO)

Massachusetts Clarity plans (MA ACA), including ConnectorCare and Employer Choice Direct: MA ACA plans were established as part of the Affordable Care Act. The Massachusetts qualified health plan program consists of the following health plans, which we offer through the Health Connector to individuals/families and small groups under the name WellSense Clarity plans:

- WellSense Clarity ConnectorCare (nongroup plans only)
- WellSense Clarity Platinum
- WellSense Clarity Gold
- WellSense Clarity Silver
- WellSense Clarity Bronze

Affordable Care Act: We offer WellSense Clarity plans directly through our off-exchange vendor. We also offer MA Clarity plans directly to certain small groups. These plans are referred to as Employer Choice Direct plans.

The WellSense Senior Care Options (SCO) plan is discontinued as of Jan. 1, 2026.

1.2 WellSense Provider Networks

WellSense has the following provider networks.

MassHealth ACO

We are contracted as a MassHealth Accountable Care Partnership Plan (ACPP) with eight 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, behavioral health, substance use disorder and other providers.

MA Clarity plans (including ConnectorCare and Employer Choice Direct)

Since 2024, we have contracted with one provider network for all MA Clarity plans called the Clarity network.

For all our health coverage programs, each member must select (or 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. If you are not in our network, please visit our online Provider Directory at wellsense.org to search for participating providers in the applicable provider network, or call the Provider Service Center at 888-566-0008 for more information.
- Verify if the service requires prior authorization by reviewing our Provider CPT Look-Up Tool and Prior Authorization Matrix. Please visit our website at wellsense.org for a list of services requiring prior authorization by product line.
- You should be aware that several of the above product lines have a high level of retroactive additions and terminations. Eligibility should be verified frequently. You 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. Your 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 WellSense. You are obligated to comply with the contract, this manual and

any policies and procedures referenced in this manual, such as WellSense Payment and Clinical Coverage policies, as part of your participation in our networks.

1.4 Revisions to the Manual

We will notify you of changes to this manual, including changes to policies and procedures, via Network Notifications and provider notices. These communications are emailed and posted at wellsense.org in advance of their effective dates. 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 with selecting a primary care provider (PCP). Information includes 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. 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 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. We 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 with scheduling an initial appointment with the PCP.

Request for a PCP change

Product	Time frame for requesting a
MassHealth (including CarePlus) members	Any time
MA Clarity plans (including ConnectorCare and Employer Choice Direct) members	Voluntary requests up to three times a year
The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.	

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 on the date the member signs the form.
- **Call WellSense directly**
  MassHealth and MA Clarity plan members may call the Member Service department 8 a.m. to 6 p.m., Monday through Friday (except holidays).
- MassHealth (including CarePlus) - 888-566-0010
- MA Clarity plans (including ConnectorCare and Employer Choice Direct) - 855-833-8120

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. You may assist members with PCP selection or PCP transfer.

We monitor members' voluntary changes in PCP selections to identify members with frequent changes. We will re-educate members regarding 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 Primary Care Team (PCT)

We offer you the convenience of checking member eligibility 24 hours a day, 7 days a week as outlined in the sections that follow. You should always check member eligibility before delivering services, on the date of service and daily during inpatient admissions. We require that you have a live representative reach out to us, so we are able to efficiently answer and resolve any issues.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

Verify member eligibility for MassHealth	
Step one	First 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. Verify eligibility for MassHealth in one of two ways: • Call MassHealth's automated voice response (AVR) at 800-554-0042. • Access MassHealth's WebEVS website at sso.hhs.state.ma.us/. You must use the member's identification number or certain personal attributes (gender, name and date of birth). To contact MassHealth Provider Service: • Call 800-841-2900, TTY at 800-497-4648 • Fax (617) 988-8974 • Email providersupport@mahealth.net
Step two	Once you confirm that an individual is enrolled in MassHealth, 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. • 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. Member panel reports are not an accurate method for verifying eligibility. These reports are only intended to inform you of the members' 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.

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

Access our online eligibility tool after logging in at our provider portal or call our provider line at 888-566-0008 during business hours (8 a.m. to 6 p.m., Mon.–Fri.).

Eligibility time frames	
MassHealth members	Eligibility may change daily.
MA Clarity plans (including 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.

Newborns only: Verify member eligibility for MA Clarity plans (including ConnectorCare and Employer Choice Direct)	
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	MA Clarity plan members (including 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 MA Clarity plan product as of the newborn's date of birth. Employer Choice Direct members must contact their group administrator to enroll the newborn in a WellSense plan, subject to group administrator and WellSense eligibility guidelines. If the mother remains a WellSense member, the newborn may be retroactively enrolled in our Employer Choice Direct Plan.

It is your responsibility to verify member eligibility at the time of service to ensure that services rendered are eligible for WellSense reimbursement. However, if you deliver emergency services, you may verify member eligibility after delivering the service. You 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

A live representative from your office contacts 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 the WellSense 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. You should bill MassHealth directly for 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 no later than 30 calendar days after the delivery. Please indicate birth weight and gestational age on this form.

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

See Maternity Program-related notification requirements for more maternity program guidelines and requirements.

Visit 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)	Each MassHealth member receives two (2) member identification (ID) cards, a MassHealth member ID card, and a WellSense member ID card. Our member ID cards include 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. 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.
MA Clarity plans (including ConnectorCare and Employer Choice Direct)	MA Clarity plan members are issued one WellSense member ID card. 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. Presentation of the member's ID card does not ensure member eligibility. For MA Clarity plan (including ConnectorCare and Employer Choice Direct) members, you will need to verify that the member is currently enrolled with WellSense on each date of service.
The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.	

Section 3: Credentialing

3.1 Overview

All credentialing information below applies to providers participating in all WellSense products, except when noted otherwise.

You must be credentialed by WellSense before joining our networks. You must then be recredentialed every two years to maintain your participation. 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.

You cannot be reimbursed for delivering care to our members until you are credentialed by WellSense. All Covering providers must also be credentialed by WellSense. This includes temporary and permanent coverage. Any change in coverage arrangements must be submitted to, and approved, by us prior to coverage occurring. See Section 4: Provider Responsibilities for our policy on the use of locum tenens providers.

3.2 WellSense credentialing/recredentialing policies and procedures

The following is a summary of our credentialing/recredentialing policies and procedures. A complete copy of these policies is available upon request by having a live representative from your office call our provider line at 888-566-0008.

Responsibility

Our Quality Improvement Committee (QIC) oversees our credentialing and recredentialing program, which includes but is not limited to oversight of the Credentialing Committee. Our Credentialing Committee, which is a peer-review committee, approves or denies provider participation based upon review of the application, supporting documents and results of the credentialing verification process.

Delegation

In certain instances, we delegate the credentialing function to another entity, such as a contracted hospital or an NCQA-certified credentialing verification organization. Notwithstanding any delegation, we retain the right to approve, suspend or terminate you from participating in our provider 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 you to submit information that HCAS-participating health plans use to verify your qualifications during the credentialing process. HCAS health plans partner with the Council for

Affordable Quality HealthCare (CAQH) to collect and store a provider'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	Please submit completed forms to WellSense through one of the following methods: • Email: Provider.ProcessingCenter@wellsense.org • Fax: 617-897-0818 • Mail: • Attn: Provider Processing Center WellSense Health Plan 100 City Square Suite 200 Charlestown, MA 02129

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:

- Addiction Medicine Specialists
- Alcohol and Drug Counselors
- Applied Behavioral Analysts
- Audiologists
- Chiropractors
- Certified Nurse midwives
- Marriage and Family Therapists
- Mental Health Counselors
- Nurse practitioners

- Nutritionists
- Occupational Therapists
- Optometrists
- Oral and maxillofacial surgeons (DDS)
- Physical Therapists
- Physicians (MD and DO), including locum tenens physicians
- Physician assistants
- Podiatrists
- Psychiatrists
- Psychologists
- Speech-language pathologists
- Acupuncturists

Hospital and facility-based physicians: We do not credential practitioners who practice exclusively within a hospital inpatient setting, community mental health centers and clinics or at freestanding facilities, 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 are not limited to Pathologists, Anesthesiologists, Radiologists and Emergency Department physicians.

Locum tenens physicians: Locum Tenens physicians who intend on providing services for 60 days or less require provisional credentialing. The provisional 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 complete and signed CAQH application that includes a signed attestation regarding the accuracy and completeness of all information provided.
- Current and unrestricted license to practice in the state where the locum will be providing care to Plan members
- 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. The provisional credentialing status for locum tenens is strictly limited to 60 calendar days from the date of approval and will not be renewed or extended. At the end of this 60-day period, we will automatically terminate the locum tenens' temporary network participation. Locum tenens who anticipates or needs to extend their network participation beyond 60 days must complete our full credentialing process To facilitate an extension beyond 60

days, notify us 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 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 that includes 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 their professional license, to the extent that we cover the identical services rendered by another Massachusetts-licensed provider of healthcare.

3.4 Credentialing and Recredentialing criteria

Practitioners are not entitled to be credentialed or recredentialed solely 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. At our sole discretion, we credential and recredential practitioners based on our credentialing criteria set forth in our credentialing policies and summarized in this manual. We are responsible for all final determinations regarding whether a practitioner is accepted or rejected as a WellSense-participating provider.

We use a standardized process to ensure we treat all applicants in a fair and nondiscriminatory manner. No WellSense credentialing or recredentialing decisions are based on a practitioner's race, ethnic/national identity, religion, gender, age, language, sexual orientation, patient type, or the types of procedures in which the practitioner specializes. We do 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, we do not exclude any practitioner from consideration based solely on the types of procedures they conduct or the types of patients they serve. We may include practitioners in our networks who meet certain demographic, specialty or cultural needs of members.

Applicants must meet the following criteria to participate in WellSense networks:

- **Contract**
  Providers must be participating with WellSense to provide services to our members without evidence that they are in breach of their contractual obligations to WellSense.
- **Credentialing application**
  Providers must have a current and complete Council for Affordable Quality Healthcare (CAQH)

credentialing application, which includes the Standard Authorization, Attestation and Release form.

- **Education and training (Initial credentialing only)**
  Providers 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 WellSense for up to 120 days pending the outcome of MassHealth's enrollment process.
- **License**
  Providers must have a current and unrestricted license in the state in which they provide care to WellSense members. Additional certifications may be required, as applicable to the provider's specialty. Hospitals with DMH-licensed beds must comply with the Department of Mental Health Inpatient Licensing Division Clinical Competencies and Operational Standards.
- **Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certification**
  Providers must possess a current and valid DEA or CDS certificate that is registered in each state where they provide care to our members. Providers with a pending DEA certificate may be credentialed if they submit documentation of their arrangement with a valid DEA certification holder who will write all required prescriptions until their pending certificate becomes active. For DEA or CDS eligible providers whose scope of practice includes prescribing controlled substances but who do not maintain an active certificate, the provider must sign a waiver and designate an alternate prescriber (individual or facility) who will prescribe on their behalf. Alternately, if a provider determines that their patient population does not require controlled substances based on their professional judgement, they may submit a written statement declaring this position along with their process for handling cases where such medications become necessary. This requirement applies to physicians (MDs and Dos), podiatrists, oral and maxillofacial surgeons, nurse practitioners and physician assistants only.)
- **Professional liability insurance**
  Providers must possess and maintain a current malpractice professional liability insurance policy with a minimum coverage of $1,000,000 per claim/$3,000,000 annual aggregate, unless a higher amount is 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 a higher amount is required by state or federal law.

The malpractice professional 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 and 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 only when necessary for us to maintain adequate member access. Waivers may require additional approval from 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 WellSense-contracted hospital. If the practitioner has any restrictions against their hospital privileges, they must provide a detailed description regarding the nature of the restrictions. All restrictions will be considered and evaluated by the credentialing committee in its discretion.
  Alternative admitting arrangements: If a practitioner does not have an active affiliation and admitting privileges at a WellSense-contracted hospital, they must provide an explanation of what arrangements are in place for their patients to be admitted to a WellSense-contracted hospital (e.g., covering physician who has current privileges at a WellSense-contracted hospital, or through the use of a hospitalist program at a WellSense-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 WellSense-participating, supervising-qualified healthcare professional at the time of initial credentialing if they have been licensed for less than two years. Physician Assistants must provide the name of their WellSense-participating supervising physician at the time of initial credentialing. Thereafter, the Physician Assistant is required to notify us of any change to this information.
- **Behavioral Health Provider Billing**
  Supervisory billing is permitted for qualified clinicians who have completed all educational requirements for an independent license, are actively pursuing clinical practice hours toward licensure and receive clinical supervision from a qualified clinical supervisor who is independently licensed and credentialed by WellSense.
- **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 healthcare programs.

- **Criminal proceedings**
  Practitioners must not have any felony convictions or been involved in 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**
  Providers can be reasonably expected to provide high-quality and cost-effective clinical care and service to our 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; and the 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, on 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.
- **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.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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, Gerontology Nurse Practitioner or Family Nurse Practitioner
- 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 oncological 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.

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 the WellSense 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. It may also include information from outside sources. References, recommendations, or other peer-review protected information will remain confidential.
- **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 there are 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, the WellSense 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 30 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 recredentialed 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.

If WellSense receives a direct notification from MassHealth, or other state or federal regulatory authorities to suspend or terminate a practitioner, we are required to suspend or terminate the practitioner from our MassHealth, 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 any Medicare 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, CMS, 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 Credentialing Policies, you are entitled to appeal the disciplinary action. A disciplinary action is an adverse action taken by our 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 a WellSense MassHealth, or MA Clarity plan (including ConnectorCare and Employer Choice Direct) programs.

Disciplinary notice

If the Credentialing Committee recommends 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 the WellSense Director of Credentialing postmarked no more than 30 calendar days following your receipt of notice of

disciplinary action from WellSense. 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 10 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 2 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.

Role of the credentialed behavioral health (BH) provider

Behavioral Health ACO partners must demonstrate joint decision-making across clinical integration; coordinating care; care needs screening; comprehensive assessments and care plans; wellness initiatives and disease management programs; and transitions of care.

For members under the age of 21, providers must ensure that enrollees have access to all medically necessary services under the Children's Behavioral Health Initiative (CBHI), including Intensive Care Coordination (ICC) Family Support and Training (FS&T), In-Home Therapy (IHT), Behavioral Health Services (IHBS), Therapeutic Mentoring; and youth mobile crisis services. Providers must use a family-centered approach in which caregivers or guardians are active participants in the member's care and coordination with school or early childhood supports, Community Based Care Management (CCM), Children's Behavioral Health Initiative (CBHI) and state agencies (e.g., DPH, DYS, DMH) . A release of information must be requested for all state agency behavioral health clients so they can be apprised of the member's current status.

CBHI providers must provide services in accordance with all EOHHS approved CBHI performance specifications and CBHI medical necessity criteria.

With member consent, all behavioral health providers must provide a member's clinical information to other providers to ensure proper coordination and behavioral health treatment of members who express suicidal or homicidal ideation or intent.

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 and has been reviewed and approved by an accrediting body if an organizational provider is 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
- Behavioral Health and Substance Use Disorder facilities and providers
- Skilled nursing facilities
- Medical/physical rehabilitation facilities
- Home health care providers
- Home infusion providers
- Hospice providers
- Free-standing surgical centers
- Free-standing psychiatric inpatient hospitals
- 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 the WellSense DMEPOS vendor, 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
- CBHI providers
- Community Behavioral Health Center (CBHC)/Mobile Crisis Intervention (MCI)

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 professional liability insurance policy with a minimum coverage amount of $1,000,000 per occurrence and $3,000,000 aggregate.
- Copy of current Clinical Laboratory Improvement Amendments (CLIA) certification, or waiver of a certificate of registration with a CLIA identification number (if applicable)
- 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)
- Council on Accreditation (COA)
- Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL)
- The Joint Commission (TJC)
- National Association of Childbearing Centers (NACC)
- In lieu of accreditation, 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. During the assessment, the Plan will use the appropriate form addressing the specific criteria for each provider. The assessment 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 recredentialed 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.

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:

- Provider.ProcessingCenter@wellsense.org
- Fax to 617-897-0818.

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, be responsive to persons experiencing homelessness, enrollees with special health care needs, by at a minimum having the capacity to communicate with members in languages other than English, communicate with deaf and hard of hearing, or deaf blind, have information available in alternate formats and adhere to our quality and utilization management programs. It is incumbent upon providers to inform members of available clinical care management options and all available care options, ensuring that members identified as requiring behavioral health services are offered referrals for behavioral health services when clinically appropriate. 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:

- Provider.ProcessingCenter@wellsense.org
- Fax to 617-897-0818.

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

Medical / Ancillary Providers

A medical or ancillary 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
100 City Square
Suite 200
Charlestown, MA 02129

You can email the documents to provider.info@wellsense.org or Provider.ProcessingCenter@wellsense.org.

Behavioral Health Providers

A behavioral health provider not affiliated with a WellSense contracted entity may request to participate in our provider network by requesting to contract through the Behavioral Health Network Strategy and Provider Engagement department at BHProviders@wellsense.org.

Your request must include the following:

- Behavioral health specialty
- Licensure
- Practice address/ locations
- Languages spoken and cultural competencies
- Applicable Provider, Group or Facility data form
- W-9, FDR and EFT authorization

You may also visit our website at wellsense.org, to access the forms required and obtain additional information go to Behavioral Health Insourcing and select the Join Our Network button

You may submit requests and documents to our BHProviders@wellsense.org or mail to:

WellSense Health Plan
Behavioral Health Network Strategy and Provider Engagement
100 City Square

Suite 200
Charlestown, MA 02129

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 provide WellSense with access to your CAQH information (for a new individual professional medical/surgical provider, behavioral health or substance use disorder provider, or for a new facility affiliated with a WellSense contracted facility).

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
  100 City Square
  Suite 200
  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, and provide WellSense access to your CAQH information (for a new individual professional medical/surgical provider, behavioral health or substance use provider, or for a new facility affiliated with a WellSense contracted facility).
- 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 or MA Clarity):

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
100 City Square
Suite 200
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.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026:

4.3 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 Engagement Consultant by having a live representative call 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, behavioral health (BH) providers, substance use disorder (SUD) providers, 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 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 or by calling WellSense at 855-834-5655 (TTY: 866-727-9441), or call, text or chat 988.
- 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 and substance use disorder services, as outlined in Section 8: Utilization Management and Prior Authorization.
- Ensure integrated care that is person centered and connects members to appropriate services and referrals and community organizations, coordinating with those providers to improve integration of care.
- Ensure members are screened for physical health, behavioral health, and health related social needs
- Providers of MOUD (medications for opioid use disorder) shall coordinate and integrate care with the member's PCP and other providers
- Ensure all members receive AMCI (adult mobile crisis intervention) or YMCI (youth mobile crisis intervention) provided by a CBHC (community behavioral health center) or crisis evaluation service in acute medical settings to ensure members are referred to the least restrictive appropriate treatment setting.
- 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; have a live representative 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, behavioral health or substance use disorder incident. See Section 14: Quality Management for a description of the adverse incidents including policy information and instructions on the appropriate notification process by incident category.
- Review Quality Management for a description of the adverse incidents, including policy information and instructions on the appropriate notification process by incident category.
- All Providers must comply with reporting requirements on Provider Preventable Conditions as described at 42 CFR 447.26(d) and as specified by EOHHS.
- 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 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. Behavioral health providers are required to measure and collect clinical outcomes data, incorporate that data into treatment planning and within medical records, and provide clinical outcomes data to WellSense upon request.
- For MassHealth 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

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 the WellSense 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. For MA Clarity plans, covering physicians are required to include modifier AG when submitting claims for primary care services rendered in any health care setting. 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:
- Have a live representative call our Member Service department to change their PCP assignment at another WellSense participating PCP.

Product	Member Service
MassHealth	888-566-0010
MA Clarity plans (including ConnectorCare and Employer Choice Direct)	855-833-8120
The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.	

- 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.
- Screen members for Health-Related Social Needs (HRSN) upon assignment and annually thereafter. Providers must screen members for the following domains: housing instability, food insecurity, utility difficulties, transportation needs, experience of violence, and school/education needs. While we expect screenings to be documented in the EMR, providers may use their discretion on documenting specific questions that may pose a safety risk to patients (e.g., experience of violence). HRSN screenings must include disclosures to the member about how information will be used and providers must have a process to describe and/or refer the member to potential resources that could meet identified needs. Providers should use culturally competent and trauma informed approaches to conduct HRSN screenings.

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 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 select behavioral health/substance use disorder services, 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.
- 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.

Behavioral Health / Substance Use Disorder Providers

Participating behavioral health and substance use disorder providers must comply with all applicable requirements in their WellSense contract, this manual and any specific requirements by specialty as outlined in the publicly available WellSense MassHealth Managed Care Organization and WellSense Accountable Care Organization Contracts. These requirements include but are not limited to Section 2.9.C. Behavioral Health Requirements.

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.

4.4 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
  100 City Square
  Suite 200
  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: Special Investigations Unit
  100 City Square

Suite 200
Charlestown, MA 02129

4.5 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 Requests to:

WellSense Health Plan
Provider Engagement Department
100 City Square
Suite 200
Charlestown, MA 02129

You can also email them to Provider.ProcessingCenter@wellsense.org.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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.

4.6 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.

Members may access behavioral health services provided by a Community Behavioral Health Center through self-referral, BH help line, WellSense toll-free telephone line or referral by family, guardian, individual practitioner, PCP, community agency or hospital ED

Network providers must offer hours of operation that are no less than the hours of operation offered to commercial members or MassHealth Fee-For-Service.

Behavioral Health providers must provide timely access to medically necessary services for members that are disproportionately boarded in an ED, including enrollees with Autism Spectrum Disorder, Intellectual Developmental Disabilities, dual diagnosis of mental health and SUD, co-morbid conditions, assaultive or combative presentation resulting in the need for special accommodation in an inpatient psychiatric hospital setting.

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: 24-hour answering service with option to page the physician, or Advice nurse with access to the PCP or on-call physician * see below for additional suggested after-hour office messaging
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 MA Clarity plans (including ConnectorCare and Employer Choice Direct)	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 MA Clarity plans (including	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

ConnectorCare and Employer Choice Direct)	Initial newborn care visit: 14 days of hospital discharge
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)	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.
Behavioral Health Services	Emergency Services – immediately, on a 24-hour basis, seven days a week, with unrestricted access for members who present at any qualified provider, whether a network provider of a non-network provider. Members may be referred to an appropriate emergency service provider. Behavioral health providers who do not maintain 24-hour coverage must maintain a system for referring members to a source of emergency assistance during non-business hours. Response time for face-to-face crisis evaluations by CBHCs does not exceed one hour from notification by telephone from the referring party or from the time of presentation by the member. AMCI/YMCI provided by CBHC or crisis evaluation services, including in acute medical settings emergency departments and in the community, immediately, 24 hours a day, seven days a week, with unrestricted access Urgent Care – within 48 hours for services that are not Emergency Services or routine services

	All other behavioral health services – within 14 calendar days Non-24-hour Diversionary Services – within 2 calendar days of discharge Medication management – within 14 calendar days of discharge Other outpatient services – within 7 calendar days of discharge Intensive Care Coordination Services – within the time frame directed by EOHHS Routine follow-up by a non-prescriber within 30 business days. Routine follow-up by a prescriber within 90 business days.

*Suggested After-Hour Messaging: For best practice, please include medical emergency guidance on your office recorded message, such as: "Hello, you have reached the answering service/centralized triage for (provider group). If this is a medical emergency, please hang up and dial 911 immediately or go to the nearest emergency room. Our office hours are xyz. If you wish to speak with an on-call provider, please stay on the line or dial xxx for assistance".

It is also required that the answering service or recorded message provide access, or offer guidance, on reaching a medical professional after hours.

4.7 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
  100 City Square
  Suite 200
  Charlestown, MA, 02129
- You can also email them 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.

4.8 Requesting a Change in a Member's PCP Assignment

Product	PCP change time frame
MassHealth MCO members	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.
MA Clarity plan members	MA Clarity plan members (including ConnectorCare and Employer Choice Direct) may request a PCP change only three times per year.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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 Engagement Consultant. The Plan will initiate the outreach and reassignment of the member to ensure there is no interruption in care or services.

4.9 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, 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.

4.10 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.

4.11 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 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 the WellSense contract with MassHealth, 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 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. 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
- Licensed behavioral health providers, including ESP (emergency service providers), CBHCs (community behavioral health clinics), AMCI/YMCI (Adult Mobile Crisis Intervention)

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.

4.12 Adult Health Screening

Physicians should perform adult health screenings 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.

4.13 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).

4.14 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.

4.15 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.

4.16 Cultural Competency & Health Equity

At WellSense, we are deeply committed to ensuring our provider network complies with all state and federal laws aimed at eliminating physical, communication, and other barriers that may prevent members from accessing essential services. This commitment reflects our dedication to fostering inclusiveness and delivering equitable care to every member.

To support this mission, WellSense requires all Plan providers to demonstrate cultural competency in their care delivery. If you or your staff have already completed Cultural Competency training, please inform us so we can provide a Cultural Competency for Providers Training Attestation form for documentation.

Health Equity-Related Training Topics Should Include:

- An overview of the provider's office health equity strategy, including the populations prioritized for intervention
- The role(s) trainees play in promoting and achieving health equity
- The importance of, and best practices for:
- Collecting self-reported social risk factor data, including race, ethnicity, language, disability, sexual orientation, and gender identity
- Addressing inequities experienced by patients with social risk factors, including but not limited to those listed above
- Adhering to Culturally and Linguistically Appropriate Services (CLAS) standards
- Applying trauma-informed practices when working with marginalized individuals
- Identifying and mitigating the impact of implicit biases on the delivery of high-quality, equitable health care
- Understanding and addressing anti-racism, including structural and institutional racism in health care
- A description of how the health equity training content aligns with the provider's office mission, values, and priorities—and how trainees have applied or are expected to apply the training in their work

Enhancing Cultural Competency and Communication Skills

Improving provider cultural competency and communication skills is essential to providing high-quality care to all patients, regardless of their race, ethnicity, language, religion, cultural background, sexual

orientation, or gender identity. To assist in this effort, WellSense offers several valuable training resources on our website under Provider Training and Support. Developed by the WellSense Health Equity and Learning & Development teams, these training courses include, but not limited to:

- Foundations of the Disability
  Competent Care Model: Focuses on care strategies that center on accessibility and participant needs.
- Cultural Responsiveness
  Teaches how to cultivate empathy, reduce bias, and improve communication with diverse populations.
- Provision of Language Services
  Covers protocols to ensure equitable access to care through effective language services.

In addition to these, providers can access the U.S. Department of Health and Human Services' Think Cultural Health platform. This resource offers online training modules accredited for continuing education credits across multiple disciplines, including physicians, nurses, social workers, and physician assistants. It also provides implementation guides developed by the Office of Minority Health.

Other important resources include:

- DPH/Fenway Health Training Initiative
  A collaboration between the Massachusetts Department of Public Health and Fenway Health aimed at improving healthcare professionals' capacity to serve the LGBTQIA+ community with culturally competent care.

Defining Key Concepts in Cultural Competency

- Cultural and Linguistic Competency refers to the set of behaviors, attitudes, and policies that enable effective work in cross-cultural situations.
- Cultural Competence is key to Diversity, Equity, Inclusion, and Accessibility (DEIA) efforts. It means using knowledge about various cultures to interact respectfully and effectively in diverse settings—not just recognizing differences but actively appreciating and embracing cultural diversity.
- Cultural Responsiveness builds on cultural competence by applying this knowledge in real-time care situations. It involves ongoing self-reflection, adaptation, and openness to learning about the cultural norms and needs of patients, tailoring care to meet their unique needs.
- Cultural Humility emphasizes a lifelong commitment to self-evaluation and self-critique. It involves recognizing that patients are the experts in their own lived experiences and encourages providers to build mutually respectful partnerships grounded in openness, empathy, and a willingness to learn from each individual.
- National CLAS (Culturally and Linguistically Appropriate Services) Standards focus on achieving health and racial equity, improving quality of care, and eliminating healthcare disparities. The

Office of Minority Health provides a comprehensive implementation guide to help healthcare organizations advance these standards.

- Intersectionality refers to how multiple identities—such as race, gender, disability, language, socioeconomic status, and sexual orientation—interact to shape each individual's experience of health care. Providers are encouraged to consider these overlapping social factors in delivering care that is truly person-centered and equitable.

Supporting Linguistic and Cultural Diversity in Our Network

WellSense serves a diverse membership with a wide range of linguistic, cultural, and ethnic backgrounds. To promote equitable access, we gather detailed linguistic, ethnic, and cultural data through health assessments and direct member contact via our Member Services department.

We recognize that not all practitioners have access to the language services their patients may need. As part of our efforts to support our members with language needs, we have partnered with Cyracom, a supplier that provides interpretation services for practitioners whose organizations do not provide them.

Cyracom offers interpretation services for nearly 300 languages. Practitioners can access these services by:

1. Dialing 844-945-4719
2. Entering your NPI and the member's 9-digit ID
3. Selecting the required language
4. Confirming the language selection
5. Following prompts to connect and press *8 once the interpreter joins
6. Documenting the interpreter ID number in the patient record

We can also translate any member communication upon request to our Provider Services team at 888-566-0008.

As part of our credentialing process, we evaluate each clinician's language capabilities and prioritize contracting with culturally diverse providers to better reflect and serve our communities. This approach helps ensure our provider network is both linguistically proficient and culturally responsive.

To help members connect with providers they feel comfortable with, we ask that you update your provider directory information on a quarterly basis to include:

- Languages spoken
- Race/ethnicity
- Other relevant demographic information

Providers can review and update their information anytime by submitting the provider enrollment form.

For access and availability assessments, a member's self-reported primary language serves as a key indicator of linguistic and cultural needs, while providers' self-reported language(s) serve as a proxy for cultural and linguistic alignment.

Provider Expectations for Equitable and Inclusive Care

To support our goals of equity and inclusion, Plan providers must ensure:

- Members are informed they have free access to qualified medical interpreters, sign language interpreters, and TDD/TTY services to support effective communication.
- Care is delivered with respect for each member's cultural background, language, abilities, and lived experiences, recognizing how these factors influence health and healthcare access.
- Staff who interact with members receive ongoing training in cultural humility, health equity, and inclusive communication.
  This includes not only clinical staff but also all patient-facing personnel in operational and administrative roles, such as receptionists, front desk staff, and security officers.
- Staff collecting demographic information make reasonable efforts to gather self-reported race, ethnicity, and language data, clearly explaining categories to support informed self-identification and documenting the information in the member's medical record.
- Clinical care and treatment planning incorporate an understanding of each member's cultural values, beliefs, and identity, including but not limited to race, country of origin, primary language, socioeconomic status, religion, physical or mental abilities, heritage, acculturation, age, gender identity, sexual orientation, and other lived experiences that shape care needs and preferences.
- Office sites provide printed and posted materials in English (using plain language), Spanish, and any additional languages required by state and federal regulators, ensuring accessibility for individuals with limited English proficiency.
- Providers should not rely on a member's child, family member, or friend to provide interpretation services, except when the member specifically requests it. In such cases, providers must ensure the interpreter is appropriate, and the members' choice is informed, voluntary, and documented.
- If a member declines the use of a qualified interpreter, the provider should respectfully explain potential risks, ensure the member understands their options, and document the informed declination.
- Members who speak languages other than English can access telephonic interpretation through WellSense by calling 877-957-1300 (option 1, Member Services).

4.17 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.

Non-contracted providers must sign a Waiver of Liability Statement, available at wellsense.org to appeal the WellSense denial.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

4.18 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.

4.19 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.

4.20 Electronic Health Records (EHR) Attestation Requirement

EHR-Eligible Clinicians are defined as: Clinicians who meet the eligibility criteria for using certified Electronic Health Records as defined by the ONC, which consists of Doctor's of Medicine (MDs), Doctors of Osteopathy (Dos), Nurse Practitioners (NPs), Physician Assistants (PAs), Certified Nurse-Midwives, Clinical Nurse Specialists (CNSs) and Chiropractors (DCs).

Electronic Health Record (EHR): A digital version of a patient's paper chart that provides real-time, patient-centered records that make information available instantly and securely to authorized users.

ONC Certification: Certification granted to EHR technologies that meet the criteria outlined by the Office of the National Coordinator for Health Information Technology. This ensures the system can support Meaningful Use criteria.

2015 Certification Edition: The standards and certification criteria established by the ONC in 2015, and subsequently updated, to ensure interoperability and support for the improved delivery of healthcare services.

21st Century Cures Act: Legislation passed in 2016 that advances the development and use of interoperable HER systems, with provisions for the prevention of information blocking.

Pursuant to the Plan's contract with EOHHS we are required to ensure that at least 75% of WellSense EHR-Eligible Clinicians adopt and integrate interoperable EHR certified by the Office of the National Coordinator (ONC). This adoption must align with the 2015 certification edition and any subsequent edits under the 21st Century Cures Act.

Interoperability Standards

All EHR systems adopted must support full interoperability, enabling the seamless exchange of health information across different healthcare platforms to ensure coordinated and continuous care.

Monitoring and Compliance

The Plan's Network Management Department will monitor compliance in the following manner:

- The total number of EHR-eligible clinicians within the organization.
- The number and percentage of clinicians who have adopted certified EHR systems.

- Details on the EHR system used (including ONC certification number and version).

Self-Reporting Mechanism

The Plan will use self-reported attestations through an online platform and/or a standardized form that providers are required to complete.

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 for 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 have a live representative contact your Provider Engagement 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
- Determine if a service requires prior authorization
- Submit a prior authorization request
- 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 Engagement 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, and commercial plan networks, including QHP. The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026. 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 Networks).

- 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 communication items 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 Engagement Consultant for more information.

- Other material available online: Our website provides links to WellSense 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 Engagement Consultant will provide you and your office with training and education regarding working with WellSense and our processes. Our goal is to develop and maintain a mutually beneficial relationship.

Our dedicated Provider Engagement staff members are assigned to assist you with any questions, such as inquiries about billing and payment policies and guidelines, claims, credentialing, care management, utilization management, etc. Your dedicated Provider Engagement Consultant is your contact for all things, including demographic changes, such as a change to group affiliation, tax identification number, address or phone change, navigating working with us, and provider trainings to include our provider portal.

Provider Engagement Consultants are experts in their field and value the importance of being available to our providers virtually and in person, to ensure satisfaction and to assist in all aspects of doing business with us.

Additionally, your dedicated Provider Engagement 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 providing 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 Engagement 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 Services Center, you may do that by having a live representative dial 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), and Commercial product benefit plans. The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.
- 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 Engagement Consultant
- Support with submission of prior authorization or WellSense notification of services (including medical/surgical services, and pharmacy services)

Provider Training

We are committed to offering 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
- Behavioral Health clinical topics
- CBHI Training (see below)

Licensed behavioral health providers must maintain current knowledge, ability and expertise in their practice by conforming with recognized managed care industry standards, such as those provided by

NCQA, and relevant state regulations, when obtaining Continuing Medical Education credits or Units and when participating in training activities.

- CBHI providers must participate in CBHI training, coaching and mentoring provided by the EOHHS CBHI training vendor and utilize their skills in service delivery.
- Staff of CSP-TPP (community support program - tenancy preservation program) and CSP-JI (justice involvement) must have demonstrated experience. CSP-HI (homeless individuals) must meet the following qualifications: a) specialized training or lived experience in behavioral health, treatment for co-occurring disorders, trauma-informed care and traumatic brain injuries; b) specialized training or experience in outreach and engagement strategies such as progressive engagement, motivational interviewing; c) knowledge of housing resources and dynamics of searching for housing.

If you have a change in office staff, please contact your dedicated Provider Engagement Consultant for medical or behavioral health, as they can schedule time to visit with your new staff to conduct a training session. 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 and Biling Managers, or provider, as well as with designated office staff.

Care Management Department phone line

- If you believe a member could benefit from our Care Management Services for medical and/or behavioral health reasons, please have a live representative 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.
- 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 Engagement Consultant to mail or fax copies to you.

Medical/Surgical and Behavioral Health Prior Authorization Reference Charts

- Our Medical/Surgical and Behavioral Health 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 PCP 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 Engagement 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 their member panel report, which is a list of assigned members. You can access this report via our secure provider portal at bmchp-wellsense.healthtrioconnect.com with a secure login and an arrangement by your Provider Engagement Consultant.

You should make your best efforts to schedule an initial appointment with every new member on your membership 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.

- **By phone**
  Please call your dedicated Provider Engagement Consultant who will document and escalate your complaint.

The main number for 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
  100 City Square, Suite 200
  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.

Provider complaints are tracked by Medical/Surgical (MS), Mental Health (MH) and Substance Use Disorder (SUD).

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	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. If the Commonwealth determines that an applicant is eligible, he or she becomes a WellSense member in one of the following ways: • 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).
MA Clarity plans (including ConnectorCare and Employer Choice Direct)	Eligibility is determined on an individual basis. Members will be eligible as of the first of the month after their confirmed plan 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).

	Eligible Massachusetts residents may enroll in one of our MA Clarity plans through one of the following ways: • 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 MA Clarity plans 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 3500 plans.
	WellSense Senior Care Options (SCO) plan is discontinued as of Jan. 1, 2026.

WellSense 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 MA Clarity plans (including ConnectorCare and Employer Choice Direct): Overview

WellSense Clarity plans, formerly called Qualified Health Plans, are available on and off the state-based exchange known as the Health Connector. Off-exchange plans are offered through our third-party vendor or by contacting WellSense directly.

Offered through the Health Connector only:

ConnectorCare plans

ConnectorCare plans are federal- and state-subsidized MA Clarity plans. There were three ConnectorCare plan types: 1, 2, and 3. As of January 1, 2026, ConnectorCare plan type 1 is no longer offered. ConnectorCare plan types 2 and 3 continue to be offered through the Health Connector to eligible individuals. ConnectorCare plans use our "Clarity Network." ConnectorCare ID cards will reference "ConnectorCare" and have both WellSense and the Health Connector logos.

Offered through the Health Connector and WellSense:

- Metallic plans
    - Platinum
    - High Gold
    - Low Gold
    - Silver A
    - Silver A II
    - Silver B
    - Low Silver Health Savings Account (HSA)-compatible
    - Bronze Health Savings Account (HSA)-compatible
- Offered through our third-party off-exchange vendor:
    - Silver 2000
    - Silver 3500

Each metallic MA 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 400% of the FPL. The maximum that a member may spend on health insurance is 8.5% of their income. All WellSense 2026 MA Clarity plans use our "MA Clarity Network." ID cards for these MA 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 the WellSense 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 MA 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 MA Clarity plans (including ConnectorCare and Employer Choice Direct): Membership Overview

ConnectorCare eligibility categories

We offer the following ConnectorCare benefit plan types:

- **ConnectorCare Plan 2**
  For individuals whose income is between 100.1% and 200% of the FPL
- **ConnectorCare Plan 3**
  For individuals whose income is between 200.1% and 400% 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 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 400% 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 MA Clarity plans (including ConnectorCare and Employer Choice Direct): Membership Overview

Massachusetts ACA plans offered by WellSense are called MA Clarity plans and individual plan names have been updated as noted below:

2025 Plan Name	2026 Plan Name
WellSense Clarity Platinum 0 Deductible	WellSense Clarity Platinum 0 Deductible
WellSense Clarity Gold 1000	WellSense Clarity Gold 1000
WellSense Clarity Silver 2000	WellSense Clarity Silver 2000
WellSense Clarity Bronze HSA 3600	WellSense Clarity Bronze HSA 3800
WellSense Clarity ConnectorCare 1	*Plan not offered in 2026*

WellSense Clarity ConnectorCare 2	WellSense Clarity ConnectorCare 2
WellSense Clarity ConnectorCare 3	WellSense Clarity ConnectorCare 3
WellSense Clarity Silver 3000	WellSense Clarity Silver 3500
WellSense Clarity Silver 2000 II	WellSense Clarity Silver 2000 II
WellSense Clarity Gold 1500	WellSense Clarity Gold 1750
WellSense Clarity Platinum 0 DeductibleSG	WellSense Clarity Platinum 0 DeductibleSG
WellSense Clarity Gold 1000SG	WellSense Clarity Gold 1000SG
WellSense Clarity Silver 2000SG	WellSense Clarity Silver 2000SG
WellSense Clarity Bronze HSA 3600SG	WellSense Clarity Bronze HSA 3800SG
WellSense Clarity Silver 3000SG	WellSense Clarity Silver 3500SG
WellSense Clarity Gold 1500SG	WellSense Clarity Gold 1750SG
WellSense Clarity Silver HSA 2000SG	WellSense Clarity Silver HSA 2500SG

Who is eligible for MA 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 MA 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 MA Clarity plans by enrolling though the Connector. Small businesses from 6–50 employees can also enroll in these MA Clarity plans directly with WellSense into our Employer Choice Direct plan.

6.7 Senior Care Options (SCO): Eligibility

WellSense Senior Care Options (SCO) plan is discontinued as of Jan. 1, 2026.

6.8 Overview of WellSense Benefits

MassHealth and MA Clarity Plan Benefits Overview

We offer comprehensive benefit packages for MassHealth, MA Clarity plans (including 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 MA Clarity plans (including 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 WellSense participating provider.

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 to answer members' questions
- Member newsletter
- Coordination of the MassHealth transportation benefit for qualified members
- Care management for special populations
- Health Related Social Needs (HRSN) Supplemental Services for qualified members in an ACO plan
- 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 MA Clarity plan members (including 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 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

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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. 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 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 and MA Clarity plans, 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 enrollment date with WellSense. Participating providers may assist members with a PCP selection or PCP transfer.
- **PCP Selection Form**
    - MassHealth and MA Clarity plan (including ConnectorCare and Employer Choice Direct) 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).

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.

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

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

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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)	• We cover services for up to 30 calendar days from the member's WellSense enrollment date if the member is receiving ongoing covered treatment, or management of a chronic condition. • We cover services for up to 30 calendar days from the member's WellSense enrollment date if the member: o Is hospitalized; o Is receiving treatment for behavioral health or substance use; o Are children in the care or custody of DCF and youth affiliated with DYS (either detained or committed) o 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. • For members with autism spectrum disorder, the continuity of care period for ABA Services is 90 days. • For members who are pregnant and in the second or third trimester, the continuity of care period is through the member's first postpartum visit. • For members who are terminally ill, the continuity of care period extends until the member's death.
MA Clarity plans (including ConnectorCare and Employer Choice Direct)	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: • 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. • 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. Additional conditions for coverage of continuity of care apply. Call us for further information.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026

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) MassHealth (including CarePlus) members	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.): • 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, for outpatient behavioral health or substance use disorder, ABA services for autism spectrum disorder, or Early Intensive Behavioral Intervention services. 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.
MA Clarity plans (including ConnectorCare and Employer MA Clarity plans (including ConnectorCare and Employer Choice Direct)Choice Direct)	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.): fraud or quality of care issues.): • We may allow affected members continued access to their terminated PCP for at least 60 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, or behavioral health or substance use disorder, 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 pregnant members 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.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026

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.

Providers are expected to comply with all applicable federal and state privacy, confidentiality and security regulations including HIPAA, the Health Information Technology for Economic and Clinical Health (HITECH) Act and 42 C.F.R. Part 2, Confidentiality of Substance Use Disorder Patient Records. In addition, Part 2 providers are responsible for obtaining a written consent from members to share substance use disorder treatment records, consistent with 42 C.F.R. Part 2.

In the event that WellSense receives a complaint or becomes aware of a potential violation of state or federal law, WellSense will, consistent with regulatory requirements, notify the provider and request that the provider respond to the allegation and implement corrective actions as appropriate.

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, MA ACA, our Covered Services, Network Providers, and your rights and responsibilities. The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.
- 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 a right to have personal information be private based on our policies and federal and state laws.
- 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, deciding with their provider, what is the best plan of care and having someone speak for them.

- 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 outlined above, the following rights are specific to MassHealth members:

- Members receive the information required per the WellSense 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 the WellSense 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: 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.
- Supply information about health complaints, health history, and other health information
- (to the extent possible) needed by WellSense and its network providers to arrange for and provide care.
- 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. 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 MA Clarity plans (including ConnectorCare and Employer Choice Direct)	Mon.–Fri. 8 a.m. to 6 p.m. (except holidays)

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026

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 Help Lines

Massachusetts' Community Behavioral Health Centers (CBHCs) are a statewide network of over 25 centers offering immediate, confidential care for mental health and substance use needs. These centers provide 24/7 crisis services, routine outpatient care, and community-based support, including mobile crisis intervention and stabilization. Services are available to all residents, regardless of their insurance or lack of insurance. For those seeking assistance, the Massachusetts Behavioral Health Help Line (BHHL) is a 24/7, confidential service that connects individuals to clinical support and treatment referrals. Staffed by trained clinicians and peer specialists, the BHHL offers real-time support via phone, text, and online chat in over 200 languages. They can help assess needs, provide immediate crisis support, and connect callers to the nearest CBHC or other appropriate services.

To access help, call or text 833-773-2445 or visit masshelpline.com.

To find your local CBHC, please visit mass.gov/find-a-cbhc/locations.

Behavioral Health Urgent Care

mass.gov/info-details/behavioral-health-urgent-care

Massachusetts Behavioral Health Access (MABHA) – service/provider search

mabhaccess.com/

Many CBHCs offer flexible in-person and telehealth options.

Members can contact Behavioral Health support 24 hours a day, seven days a week at:

Product	Behavioral Health Contact Info
MassHealth and CarePlus	888-217-3501
MA Clarity plans (including ConnectorCare and Employer Choice Direct)	877-957-5600

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026

Nurse Advice Line

Members may call our toll-free Nurse Advice Line to speak with a trained registered nurse about health and behavioral 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
MA Clarity plans (including ConnectorCare and Employer Choice Direct)	866-763-4695

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026

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 (SCO) product has been discontinued effective Jan. 1, 2026. 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 MA Clarity plan (including 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. The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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
- 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 MA ACA members to conduct Health Needs Assessments (HNAs). The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.
- 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, please refer to the Covered Services List and Member Handbook available in the Member sections of wellsense.org.

You will need to contact MassHealth to identify wraparound/non-MCO services; as well as to verify benefits and eligibility, and obtain pre-authorization for these 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.

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, including prescription drugs. Please note that as of April 1, 2024, there are no copayments for any covered service.
- 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.
- 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 the WellSense 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 plansWe offer MA ACA plans (WellSense Clarity Plans), which are available to eligible individuals and groups through the MA Health Connector and directly to individuals through our administrator, HSA Insurance . WellSense Clarity plans offered through the Health Connector are as follows:

- ConnectorCare Plans: ConnectorCare plans are federal and state-subsidized qualified health plans. 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 MA Clarity plan has different member cost-sharing obligations. Members purchasing these plans may be eligible for federal subsidies– depending on their income levels.

All of our WellSense Clarity Plans use providers in our MA Clarity Network.

ID cards: WellSense 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 WellSense Clarity plans offered through the Health Connector, we also directly offer WellSense 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 WellSense 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 MA Clarity Network. Except in an emergency or when authorized in advance by us, members enrolled in our WellSense Clarity plans must obtain all covered health care services from our MA Clarity network. If you have any questions about whether you participate in our MA Clarity network, please call your dedicated WellSense Provider Engagement Consultant. To identify your Provider Engagement 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 60 days of date of birth for us to cover any other medically necessary services rendered to the newborn.

Covered and excluded services: WellSense 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. Member cost sharing: Most WellSense 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, services rendered by a non-participating provider at an in-network facility, or air ambulance services. 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.

Cost-sharing terms and definitions applicable to MA 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. For some Health Savings Account (HSA)-compatible Clarity plans, the family deductible amount applies if there are two or more members enrolled on the Clarity plan. The family deductible is met when the full amount has been paid by one or more members on the Clarity plan. In such cases, the individual deductible is non-embedded and there is only a family deductible. 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. For all plans, including HSA-compatible Clarity plans, when family coverage is selected all amounts any members in a family pay toward their individual out-of-pocket maximum are applied toward the family out-of-pocket maximum. However, the most an individual can contribute toward the family out-of-pocket maximum per benefit year is equal to the individual out-of-pocket maximum amount. In such case, the individual out-of-pocket maximum is embedded. Out-of-pocket maximum amounts, if any, are in the member's Schedule of Benefits posted on our website.

7.3 Senior Care Options

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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
Retail Pharmacy Services	Express Scripts	Call 888-566-0008 To search covered drugs, search for an in-network pharmacy, or submit a prior authorization request, visit wellsense.org/providers/ma.
	Mail Order: Cornerstone Health Solutions	Mail Order: Cornerstone Health Solutions • Call: 844-319-7588 or TTY 711 • Fax: 781-805-8221 • Email: CornerstoneMailOrderPharmacy@bmc.org • Mail: • Cornerstone Health Solutions • 41 Teed Dr. Randolph, MA 02118
Medical Drug Management	Care Continuum	• Call: 877-512-5985

		• Fax: 833-812-0687 To search covered drugs, or submit a prior authorization request, visit wellsense.org/providers/ma.
Durable Medical Equipment (DME), medical Supplies and prosthetic/orthotics Includes management of prosthetics, orthotics, medical supplies, medical formulas, oxygen, respiratory equipment, and low protein foods	Northwood, Inc.	• 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 • Northwood claims submission address can be found in our Important Contact Information sheet, available on our website.
Optometry services	VSP Vision Care	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. Note: For MA Clarity members (including ConnectorCare and Employer Choice Direct) members, VSP will manage the WellSense discount program for vision hardware. Please note that VSP is not managing the vision medical benefit. The WellSense medical network will be used for the vision medical benefit. See the Contact Us page available on our website. Note: The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026. Please note that VSP is not managing the vision medical benefit. The WellSense medical network will be used for the vision medical benefit.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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 through the use of nationally recognized criteria such as InterQual® and our internal medical policies (available at wellsense.org). Criteria are applied with consideration to individual needs of the member, such as age, co-morbidities, progress of treatment and living environment. Availability of alternative levels of care, availability of local providers and assessment of the system of care delivery system are also considered. 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's Medical Policy Criteria or Pharmacy Policy Criteria used to render clinical review decisions at wellsense.org or by calling the provider line at 888-566-0008.

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 and behavioral health 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 the WellSense 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 medical/surgical and behavioral health 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 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
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

eviCore Healthcare	Non-emergent, outpatient radiology services (such as MRIs/MRAs, CT/CTA, PET scans, and nuclear cardiology studies)	Call Radiology/Cardiology: 888-693-3211 prompt #4, 844-725-4448 prompt #1 Genetic Testing (Lab Management): 844-725-4448 prompt #2 MSK-Spine, Joint, Pain: 844-725-4448 prompt #3 (Physical Medicine) Fax: Radiology/Cardiology: 888-693-3210 Genetic Testing (Lab Management): 844-545-9213 MSK-Spine, Joint, Pain: 855-774-1319 Visit evicore.com/pages/providerlogin.aspx to complete and process a web-based submission form
eviCore Healthcare	Interventional pain (spinal injections, spinal implants), joint surgery (large joint replacement, arthroscopy), 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: evicore.com/resources/healthplan/wellsense.
Express Scripts & WellSense	Prescription Drugs	Call 877-417-1822 (MassHealth); 877-417-0528 (MA ACA) Visit: wellsense.org Fax 833-951-1680 (MassHealth/MA ACA) or Visit wellsense.org/providers/ma/pharmacy/prior-authorizations to complete and process a web-based submission form
Care Continuum, Inc.	Medical drugs (Provider-administered)	Call 877-512-5985 Visit: wellsense.org Fax: 833-812-0687

		Visit Provider-Administered Drug Prior Authorizations to complete and process a web-based submission form
Advanced Medical Reviews (AMR)	Behavioral Health MD Initial Determinations and Peer to Peer Reviews	Advanced Medical Reviews (AMR)

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 . Emergent acute inpatient admissions and continued stay for emergent or elective admissions are reviewed for medical necessity, 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.
- Collaborates with state agencies, as appropriate, to manage and coordinate members' care across settings.
- 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.

MassHealth requires that Emergency Service Providers (ESPs) perform an emergency screening for all MassHealth enrollees requiring inpatient admission. For WellSense Clarity members an ESP does not have to complete an evaluation for members requiring inpatient admission.

Prior to admission for a mental health condition a behavioral health clinical assessment must be completed. The assessment must be completed by a qualified behavioral health professional and include a full biopsychosocial, medical necessity assessment and diversionary considerations. For youth under the age of 18 years old, the qualified behavioral health professional must have child-specific expertise or certification.

- Behavioral health clinical assessments must be in writing, dated and signed, and include, at a minimum: history of presenting problem; chief complaint and symptoms; strengths of enrollee and caregivers that will be used in treatment planning; past medical history; family, social, linguistic and

cultural background; current substance use; mental status examination; prescriptions and allergies; diagnosis; level of functioning; crisis assessment; and treatment plan.

- Inpatient mental health providers must submit a notice of admission (NOA) within 72 hours of admission, or the next business day on holiday weekends.
    - Substance use disorder ASAM level 4.0 and 3.7, and CSS (ASAM level 3.5) providers must submit an NOA. Per Massachusetts Chapter 258 of the Acts of 2014, a clinical review will not be conducted for the first 14 days of treatment

Acute Inpatient Hospital Review

The WellSense Inpatient Utilization Management (IUM) clinicians perform medical utilization management functions under the direction of the Plan's Chief Medical Officer or designee and licensed Clinical Manager. The staff work 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
- Supporting the discharge planning process to help ensure safe, appropriate, and timely discharge to the next level of care.
- Providing WellSense benefit information to assist with the planning of post-hospital services. Identifying members who may benefit from post-hospital care management services and making referrals, as appropriate, to the WellSense 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 stays, 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. Contracted SNFs 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 and ACO, 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)	Copy of completed Level I PASRR form must be submitted at time of request for approval to admit the member to the Nursing Facility 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. 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	Inpatient Utilization Management Fax: 617-897-0892 • 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

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 SCI 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 the WellSense 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.

Senior Care Options

Senior Care Options (SCO) plan is discontinued as of 1/1/26.

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

Senior Care Options (SCO) plan is discontinued as of 1/1/26.

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 the WellSense clinical documentation system to facilitate claims adjudication.
- Evaluation of medical necessity 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 internal medical policy criteria, internal pharmacy policy criteria, or EOHHS-approved pharmacy policy criteria.

- Secondary review by a Plan Physician Reviewer or other qualified, licensed clinician when the initial review fails to meet WellSense criteria.
- Communication of WellSense coverage determination to providers and 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 should submit an authorization request via The Provider Portal. See Section 13: Pharmacy Services for pharmacy prior authorization information.
- In the event of technical difficulty with the online provider portal, providers have the ability to submit prior authorization requests via fax, using the WellSense Medical Prior Authorization Request Form available at wellsense.org.
- Our Prior Authorization (PA) staff are available 8:30 a.m. to 5 p.m., Monday–Friday (except holidays).
- See Section 13: Pharmacy Services prior authorization information.

Even if a prior authorization has been obtained in advance of a planned service, 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 MA Clarity 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. The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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 section 8.8. MA Clarity 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

Prior (pre-service) authorization request

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

When prior authorization is required, WellSense will only accept a request for post service authorization if the request precedes a bill for services (no claim received by WellSense) and one of the extenuating circumstances detailed below applies. The review of a post service authorization request only guarantees consideration of the request against medical necessity criteria and is not a guarantee of authorization.

Extenuating Circumstances

WellSense Utilization Management Department will review requests for post service authorization when the below extenuating circumstances apply. The provider must indicate which of the circumstances apply.

- Unable to Know – The provider and/or facility is unable to identify from which health plan to request an authorization. The patient was not able to tell the provider about their insurance coverage, or the provider verified different or incorrect insurance coverage prior to rendering services. If different or incorrect coverage was verified, the provider must include details of the verification that was completed at the time of service.
- Not Enough Time – The patient requires immediate medical services, and the provider is unable to anticipate the need for a pre-authorization immediately before or while performing a service.
- An enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to the delivery of the service.

The extenuating circumstances must be detailed within the post service authorization request and providers are required to request the authorization as soon as they are able. Post service requests outside of the above will not be considered by WellSense.

When a post service authorization request is determined to meet any of the criteria above, UM staff will follow the workflow and timeframes applicable to the member's specific benefit plan.

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. Prior authorization is not required for in-network specialty care; it is required for out-of-network specialty care.

Authorization requests may be submitted by the PCP or by the specialist, using the Provider Portal.

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

Community Behavioral Health Centers (CBHC) do not have to obtain prior authorization for any service provided by the CBHCs.

Prior authorization or referral is not required for medications for opiate use disorder (MOUD) services or medication-assisted treatment, such as Methadone Maintenance, Suboxone, and Vivitrol administration. Outpatient therapy services for primary substance use disorder diagnosis do not require authorization.

MassHealth and Clarity Plans do not require prior authorization for routine behavioral health outpatient services.

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.

Emergency Services (including Post Stabilization services)	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. MassHealth: coverage is provided if the emergent care occurs in the United States and its territories MA ACA: coverage is worldwide SCO product has discontinued effective Jan. 1, 2026
Urgent Care Services	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.

	MassHealth: coverage is provided if the urgent care occurs in the United States and its territories MA ACA: coverage is worldwide SCO product has discontinued effective Jan. 1, 2026.
Out-of-Area Renal Dialysis	MA ACA: covered (limits apply; prior authorization required)

8.8 Utilization Management Timeframe Requirements

WellSense responds to members' needs as expeditiously as their medical and behavioral health conditions warrant and makes UM determinations in a timely manner to minimize any disruption in the provision of health care. WellSense complies with contractual, state, accreditation and federal regulatory timeframes. Where standards or requirements vary, WellSense adheres to the most stringent requirement. WellSense accepts authorization requests 24 hours a day, seven days per week (including holidays).

MA MassHealth ACO & MCO

For expedited requests, where the Practitioner indicates, or WellSense determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, WellSense will make a determination and provide notice as expeditiously as the member's health condition requires but no later than 72 hours after receipt of the request, with a possible extension not to exceed 14 additional calendar days. Such extension is allowed if:

- The Enrollee/Member or the Practitioner requests an extension; or
- WellSense justifies (to EOHHS 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 such information would lead to approval of the request, if received; and
- Such outstanding information is reasonably expected to be received within 14 calendar days.
- WellSense makes at least one attempt to obtain the necessary information and documents the attempt.

WellSense will notify the member and requesting Practitioner/Provider of its determination as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

ACO/MCO Urgent Concurrent Service Authorization Determinations

WellSense will give electronic and/or written notification of an urgent concurrent determination to the member and the requesting Practitioner/Provider within 72 hours of the request.

WellSense may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, or
- WellSense needs additional information, makes at least one attempt to obtain the necessary information, and documents the attempt.

WellSense will notify the member and the requesting Practitioner/Provider of the determination as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

ACO/MCO Standard Preservice Authorization Determinations

WellSense will provide notice for standard authorization determinations as expeditiously as the member's health condition requires, but no later than 7 calendar days after receipt of the request, with a possible extension not to exceed 14 additional calendar days.

Such extension is allowed if:

- The member or the Practitioner requests an extension, or
- WellSense can justify (to EOHHS 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 such Information would lead to approval of the request, if received; and
- Such outstanding information is reasonably expected to be received within 14 calendar days.
- WellSense documents that it made at least one attempt to obtain the necessary information.
- WellSense notifies the member and requesting Practitioner/Provider of its determination as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

ACO/MCO Post Service Authorization Determinations

Late notification post service authorization requests will only be considered when the Requestor has included information which meets criteria for extenuating circumstances.

For post service requests, WellSense will give electronic or written notification of the determination to the member and requesting Practitioner/Provider within 30 calendar days of the request.

If the request lacks clinical information, WellSense may extend the post service time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame, WellSense asks the Requestor for the information necessary to make the determination, and
- WellSense gives the Requestor at least 45 calendar days to provide the information.
- The extension period, within which a determination must be made, begins on the sooner of:

- The date when WellSense receives the Requestor's response (even if not all of the information is provided), or
- The last date of the time period given to the member to supply the information, even if no response is received from the Requestor.

WellSense may deny the request if information is not received within the time frame, and the member may Appeal the denial.

ACO/MCO Expedited and Standard Preservice Pharmacy Authorization Determinations

WellSense renders decision and provides notice to the Enrollee/Member and Provider for expedited or standard authorization determinations as expeditiously as the Enrollee/Member's health condition requires, but no later than 24 hours after receipt of request.

MA Clarity plans

MA Clarity Urgent Preservice Authorization Determinations

WellSense will make an initial determination regarding a proposed admission, procedure or service within two working days of obtaining all necessary information but will not exceed 72 hours from receipt of the request to provide written notification. "Necessary information" includes the results of any face-to-face clinical evaluation or Second Opinion that may be required.

In the case of a determination to approve an admission, procedure or service, WellSense will notify the Practitioner/Provider rendering the service by telephone within 24 hours of the determination and send electronic and/or written confirmation of the telephone notification to the member and the requesting Practitioner/Provider within two working days thereafter, with electronic/written notice not to exceed 72 hours from the receipt of request.

In the case of an adverse determination, WellSense will notify the Practitioner/Provider rendering the service by telephone within 24 hours of the determination and send electronic and/or written confirmation of the telephone notification to the member and the requesting Practitioner/Provider within one working day thereafter, with electronic/written notice not to exceed 72 hours from the receipt of request.

WellSense may extend the urgent preservice time frame once due to lack of information, for 48 hours, under the following conditions:

- Within 24 hours of receipt of the urgent preservice request, WellSense asks the Requestor for the information necessary to make the determination, and
- WellSense gives the Requestor at least 48 hours to provide the information, and
- The extension period, within which a determination must be made by WellSense, begins on the sooner of:
- The date when WellSense receives the Requestor's response (even if not all of the information is provided), or

- The last date of the time period given to the Requestor to provide the information, even if no response is received from the Requestor.

MA Clarity Urgent Concurrent Service Authorization Determinations

WellSense will make a concurrent review determination within 1 business day of receiving all necessary information but will not exceed 72 hours from receipt of request when providing written notification of the determination.

In the case of a determination to approve an extended stay or additional services, WellSense will notify the Practitioner/Provider rendering the service by telephone within 1 business day of the determination and send electronic and/or written confirmation to the member and the requesting Practitioner/Provider within 1 business day of the verbal notification, with electronic/written notice not to exceed 72 hours from the receipt of request. A written or electronic notification will 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 a determination to deny an extended stay or additional services, WellSense will notify the Practitioner/Provider rendering the service by telephone within 24 hours of the determination and send electronic and/or written confirmation to the member and the requesting Practitioner/Provider within 1 business day of the verbal notification, with electronic/written notice not to exceed 72 hours from the receipt of request. The service will be continued without liability to the member until the member has been notified of the determination.

Extensions will not be permitted for MA Clarity urgent concurrent requests.

MA Clarity Standard Preservice Authorization Determinations

WellSense will make an initial determination regarding a proposed admission, procedure or service within two working days of obtaining all necessary information but will not exceed 15 calendar days from the receipt of the request to provide written notification. "Necessary information" includes the results of any face-to-face clinical evaluation or Second Opinion that may be required.

In the case of a determination to approve an admission, procedure or service, WellSense will notify the Practitioner/Provider rendering the service by telephone within 24 hours of the determination and send electronic and/or confirmation of the telephone notification to the member and the requesting Practitioner/Provider within two working days thereafter, with electronic/written notice not to exceed 15 calendar days from the receipt of request.

In the case of an adverse determination, WellSense will notify the Practitioner/Provider rendering the service by telephone within 24 hours of the determination and send electronic and/or written confirmation of the telephone notification to the member and the requesting Practitioner/Provider within one working day thereafter, with electronic/written notice not to exceed 15 calendar days from the receipt of request.

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:

- Before the end of the time frame, WellSense asks the Requestor for the information necessary to make the determination, and
- WellSense gives the Requestor at least 45 calendar days to provide the information.
- The extension period, within which a determination must be made by WellSense, begins on the sooner of:
- The date when WellSense receives the Requestor's response (even if not all of the information is provided), or
- The last date of the time period given to the Requestor to supply the information, even if no response is received from the Requestor.

WellSense may deny the request if the information is not received within the time frame, and the member may Appeal the denial.

MA Clarity Post Service Authorization Determinations

Late notification post service authorization requests will only be considered when the Requestor has included information which meets criteria for extenuating circumstances.

WellSense will give electronic and/or written notification of the determination to the member and requesting Practitioner/Provider within 30 calendar days of the request.

If the request lacks clinical information, WellSense may extend the post service time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame, WellSense asks the Requestor for the information necessary to make the determination, and
- WellSense gives the Requestor at least 45 calendar days to provide the information.
- The extension period, within which a determination must be made, begins on the sooner of:
- The date when WellSense receives the Requestor's response (even if not all of the information is provided), or
- The last date of the time period given to the Requestor to supply the information, even if no response is received from the Requestor.

WellSense may deny the request if the information is not received within the time frame, and the member may Appeal the denial.

MA Clarity Standard Preservice Pharmacy Authorization Determinations

WellSense renders decisions and provides notice to the Enrollee/Member and Provider for standard authorization determinations as expeditiously as the Enrollee/Member's health condition requires, within 2 business days, but no later than 72 hours after receipt of request.

MA Clarity Expedited Preservice Pharmacy Authorization Determinations

WellSense renders decision and provides notice to the Enrollee/Member and Provider for standard authorization determinations as expeditiously as the Enrollee/Member's health condition requires, but no later than 24 hours after receipt of request.

Senior Care Options (SCO) plan is discontinued as of Jan. 1, 2026.

8.10 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 MA Clarity plan 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: 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.
- 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.
- Urgent/Emergent Admissions related notification requirements: Acute care facilities are required to notify the Plan within 1 business day following admission date.

Behavioral Health

Inpatient Services

Inpatient Services are 24-hour services that provide clinical intervention for acute mental health or substance abuse diagnosis.

Level of Care	Process	Criteria
Inpatient Mental Health	Admitting facilities are required to notify WellSense via portal or fax within 72 hours of admission (or the next business day on holiday weekends). The facility should contact their assigned concurrent reviewer for continued care and treatment/discharge planning	InterQual
Inpatient Substance Use Disorder (Level 4)	Submit Notification via Portal or Fax for both initial and continued stay request. Initial notification should be sent within 48 hours of admission. (Note: Clinical review will not be conducted for the first 14 days of treatment)	ASAM
Observation	Does not require Prior Authorization	InterQual

Administratively Necessary Days (AND)	Prior Authorization required. Facility should contact their assigned concurrent reviewer.	Internal Medical Policy
Specialing	Prior Authorization required. Facility should contact their assigned concurrent reviewer.	Internal Medical Policy
Acute Treatment Services (ACT 3.7)	Submit Notification via Portal or Fax for both initial and continued stay request. Initial notification should be sent within 48 hours of admission. (Note: Clinical review will not be conducted for the first 14 days of treatment)	ASAM
Adult Community Crisis Stabilization (ACCS)	Initial 5 days are authorization free. For continued care, submit Notification via Portal or Fax.	Internal Medical Policy
Community Based Acute Treatment (CBAT) and Intensive Community Based Acute Treatment (ICBAT)	Admitting facilities are required to notify WellSense via portal or fax within 72 hours of admission (or the next business day on holiday weekends). The facility should contact their assigned concurrent reviewer for continued care and treatment/discharge planning	Internal Medical Policy
Community Support Services (CSS) - ASAM 3.5	Submit Notification via Portal or Fax for both initial and continued stay request. Initial notification should be sent within 48 hours of admission. (Note: Clinical review will not be conducted for the first 14 days of treatment)	ASAM
Dual Diagnosis Acute Residential Treatment (DDART)/Enhanced Acute Treatment Services (E-ATS) – Medicaid Only	Submit Notification via Portal or Fax for both initial and continued stay request. Initial notification should be sent within 48 hours of admission. (Note: Clinical review will not be conducted for the first 14 days of treatment)	Internal Medical Policy
Individualized Treatment Stabilization (ITS) – Medicaid Only	Submit Notification via Portal or Fax for both initial and continued stay request. Initial notification should be sent within 48 hours of admission.	ASAM

	(Note: Clinical review will not be conducted for the first 14 days of treatment)	
Residential Rehabilitation Services (RRS) – Medicaid Only	Submit Notification via Portal or Fax for both initial and continued stay request. Initial notification should be sent within 48 hours of admission. (Note: Clinical review will not be conducted for the first 14 days of treatment)	ASAM
Residential Treatment Services – QHP Plans Only	Submit Notification via Portal or Fax for both initial and continued stay request.	InterQual
Transitional Care Unit (TCU) – Medicaid Only	Prior Authorization required. Facility should contact their assigned concurrent reviewer.	Internal Medical Policy
Youth Community Crisis Stabilization (YCCS)	Initial 5 days are authorization free. For continued stay, facility should contact their assigned concurrent reviewer for review and treatment/discharge planning.	Internal Medical Policy

Non-24 Hour Diversionary Services

Non-24 Hour Diversionary Services are non-24-hour mental health or substance use disorder services provided as an alternative to inpatient services, to support a Member returning to the community after a 24-hour acute placement or to provide intensive support to maintain functioning in the community.

Level of Care	Process	Criteria
Community Support Program (CSP)	Submit Notification via Portal or Fax for Initial and Continued Services. Up to 180 Units over 180 days is approved at a time.	Internal Medical Policy
CSP- Tenancy Preservation Program (TPP), CSP-Homeless Individuals (HI), and CSP-Justice Involved (JI)	Submit Notification via Portal or Fax for Initial and Continued Services. Up to 180 Units over 180 days is approved at a time.	Internal Medical Policy
Day Treatment	Does not require Prior Authorization	Day Treatment Performance Specifications
Intensive Outpatient Program (IOP)	Does not require Prior Authorization	InterQual

Program of Assertive Community Treatment (PACT) - Medicaid only	Submit Notification via Portal or Fax for Initial and Continued Services. Up to180 Units over 180 days is approved at a time.	Internal Medical Policy
Partial Hospitalization Program (PHP)	Submit Notification via Portal or Fax for both initial and continued stay request. 12 Units Over 21 a day period is approved at a time.	InterQual
Recovery Coach (RC)	Submit Notification via Portal or Fax for Initial and Continued Services. 180 Units over 180 days is approved at a time.	Internal Medical Policy
Recovery Support Navigator (RSN)	Submit Notification via Portal or Fax for Initial and Continued Services. 360 Units over 90 days is approved at a time.	Internal Medical Policy
Structured Outpatient Addiction Program (SOAP)	Does not require Prior Authorization	ASAM

Intensive Home and Community Based Services for Youth

Intensive Home and Community Based Services for Youth provide therapeutic interventions for children and families in their homes and community settings to improve youth and family functioning. These services are also known as wraparound services, Children's Behavioral Health Initiative (CBHI) services or Behavioral Health for Children & Adolescents (BHCA).

Level of Care	Process	Criteria
Applied Behavioral Analysis (ABA) for Autism	Prior Authorized required. Complete ABA Prior Auth form and return via fax or portal for both Initial and Continued Services.	Medicaid: Internal Medical Policy MA Clarity: InterQual
Applied Behavioral Analysis (ABA) for Down Syndrome	Prior Authorized required. Complete ABA Prior Auth form and return via fax or portal for both Initial and Continued Services.	Internal Medical Policy

Family Intensive Treatment (FIT) – Medicaid Only	Submit Notification via Portal or fax within 3 business days of initiating services for an initial 7 days. For continued Services submit treatment plan, call the assigned reviewer to complete a medical necessity review for up to an additional 14 days.	Internal Medical Policy
Family Stabilization Team (FST) – QHP Plans Only	Submit Notification via Portal or fax within 3 business days of initiating services for the initial 180 days. For Continued Services, call the assigned reviewer to complete a medical necessity review.	Internal Medical Policy
Family Support and Training (FS&T)	Does not require Prior Authorization	Internal Medical Policy
Intensive Care Coordination (ICC)	Submit Notification via Portal or fax within 3 business days of initiating services for an initial 45 days. For continued Services, call the assigned reviewer to complete a medical necessity review.	Internal Medical Policy
In-Home Behavioral Services (IHBS)	Submit Notification via Portal or fax within 3 business days of initiating services for the initial 180 days. For Continue Services, call the assigned reviewer to complete a medical necessity review.	Internal Medical Policy
In-Home Therapy (IHT)	Submit Notification via Portal or fax within 3 business days of initiating services for the initial 180 days. For Continued Services, call the assigned reviewer to complete a medical necessity review.	Internal Medical Policy
Youth Mobile Crisis	Does not require Prior Authorization	Community Behavioral Health Center (CBHC): Youth Community-Based Mobile Crisis Intervention Performance Specifications

Outpatient Behavioral Health Services

Outpatient Behavioral Health Services are services that provide clinical intervention for acute mental health or substance use diagnosis in an outpatient setting.

Level of Care	Process	Criteria
Acupuncture Treatment	Does not require Prior Authorization	Acupuncture Treatment Performance Specifications
Ambulatory Withdrawal Management	Does not require Prior Authorization	Ambulatory Withdrawal Management Performance Specifications
Assessment for Safety and Appropriate Placement (ASAP) – Medicaid Only	Does not require Prior Authorization	Assessment for Safety and Appropriate Placement Performance Specifications
Dialectical Behavioral Therapy (DBT)	Does not require Prior Authorization	Dialectical Behavioral Therapy Performance Specifications
Early Intensive Behavioral Intervention (EIBI)	Does not require Prior Authorization	Not Applicable
Electro-Convulsive Therapy (ECT)	Does not require Prior Authorization	Electro-Convulsive Therapy (ECT) Performance Specifications
Adult Mobile Crisis	Does not require Prior Authorization	Community Behavioral Health Center (CBHC): Adult Community-Based Mobile Crisis Intervention Performance Specifications
Opioid Replacement Therapy	Does not require Prior Authorization	Opioid Treatment Services Performance Specifications
Outpatient Therapy	Does not require Prior Authorization	Outpatient Performance Specifications
Psychiatric Consult on Inpatient Unit	Does not require Prior Authorization	Psychiatric Consult on Inpatient Unit Performance Specifications

Psychological and Neuropsychological Testing	Complete Psychological/ Neuropsychological form and return via fax or portal within 2 business days of initiating services. Note: This is only a Notification, a clinical review will not be conducted.	Psychological and Neuropsychological Testing/Assessment Performance Specifications
rTMS	Prior Authorization required. Complete rTMS request form and submit via fax or portal.	InterQual

Other Exemptions from Authorization

- Group Therapy, CPT code 90853 does not require authorization and does not count toward total number of outpatient visits
- Medication Evaluation and Management services do not require authorization
- Outpatient substance use disorder services do not require authorization
- Office visits for medication-assisted treatment (MAT) or medication for opioid use disorder (MOUD), Methadone maintenance, Suboxone and Vivitrol administration do not require authorization

8.11 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 MA Clarity plan (including 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.

Senior Care Options product has discontinued effective Jan. 1, 2026.

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.

Decision criteria

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/behavioral health 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 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 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 MA Clarity plans (including ConnectorCare and Employer Choice Direct). The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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: MA Clarity plan members are generally locked into 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. MA Clarity plan members (including ConnectorCare and Employer Choice Direct) receive only one WellSense 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:

- Please note that as of April 1, 2024, there are no copayments for any covered service.
- 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 MA Clarity plan (including 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 (SCO) plan is discontinued as of Jan. 1, 2026.

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.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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 MA Clarity plan (including 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. The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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 MA ACA. This interest penalty will accrue beginning 45 days after WellSense receives the clean claim for reimbursement. This interest penalty will not apply to claims that WellSense is investigating because of suspected fraud/abuse.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026. 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 MA Clarity plans (including ConnectorCare and Employer Choice Direct)

As required by the Affordable Care Act, MA Clarity plan members 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 "active" 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 may also process and pay claims for covered services rendered in the second and third months of the grace period– but reserves the right to pend claims during this time period. WellSense will provide 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.

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.

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.

Members enrolled without subsidies are entitled to a 31-day grace period under Massachusetts law. Members who fail to pay their premium by the end of this 31-day period will have their coverage retroactively terminated to the first day of the month when the grace period began. WellSense may process and pay claims for covered services rendered during the grace period but reserves the right to pend claims during this time period. WellSense will provide 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. The 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 WellSense will retract payment for all claims for services rendered during the grace period.

Pharmacy claims: Pharmacy claims with dates of service during a 31-day or 90-day 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 grace period, the member may seek reimbursement from the WellSense pharmacy benefit manager.

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 incorrect payments, delay in payments or claim denials. If billing 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.

Billing primary care services	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. For MA Clarity plans, covering providers must use a modifier when billing for primary care services, in any health care setting. 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. 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.

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. For MA Clarity plans, covering providers must use modifier AG when submitting claims for primary care services, in any health care setting.

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 the WellSense 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, and MA ACA (including ConnectorCare). The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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 Engagement 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 (the WellSense 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 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. For Behavioral Health Claims, WellSense may recoup claims paid for members not enrolled in WellSense on the applicable date of service for up to 12 months from the claim received date.

WellSense Other Party Liability Functions:

Other Party Liability work is conducted by the Third Party Liability Department (or TPL) consisting of Coordination of Benefits (COB) and Subrogation . The Third Party Liability Department 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.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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.

Providers 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 department at 617-748-6188 or by submitting a completed Coordination of Benefits Indicator Form for MassHealth, or Coordination of Benefits. —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 of 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 90 days for MA ACA (including ConnectorCare). We strongly suggest that providers submit Coordination of Benefits 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.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

Subrogation

Subrogation occurs when members are injured as a result of a liability accident/incident. In these instances another party may be liable for the payment of the member's medical claims. The most common types of Subrogation 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 members are entitled to $8,000 in Personal Injury Protection (PIP) benefits per automobile accident. MA Clarity plan (including ConnectorCare and Employer Choice Direct) recipients are entitled to $2,000.

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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

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

Providers are required to perform "due diligence" to:

- Contact us should you have any subrogation-related questions related to servicing our WellSense members at 617-748-6188.

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 Engagement 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 the WellSense 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 Coordination of Benefits, Subrogation, 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: The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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 (for dates of service through Jan. 1, 2026): Carelon Behavioral Health, LLC at carelonbehavioralhealth.com. For dates of service after Jan. 1, 2026, Behavioral Health claims should be submitted to WellSense.
- Durable Medical Equipment: Northwood, Inc. at northwoodinc.com

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026

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 MA Clarity plan (including 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 the WellSense Coordination of Benefits department regarding any repayment obligations.

Claims submitted for an administrative appeal must be received by the WellSense 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.

Timeframes for administrative appeal determination

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

For Senior Care Options claims:

Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026. This information has been intentionally left in for claims run-out periods

Providers must submit initial claims and encounters no later than 150 calendar days from the date of service, unless you are awaiting 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 WellSense, or previously denied for additional documentation such as medical records, invoice or itemized bill. For MassHealth claims and SCO claims, we must receive resubmitted claims no later than 300 days from the date of service. For MA Clarity plan claims (including ConnectorCare and Employer Choice Direct), we must receive resubmitted claims no later than 180 days from the date of service. Out-of-network provider or service, resubmitted claims must be received within 365 days from the date of service. COB claims: Claims must be resubmitted within the specified time frames above based on the process date of the primary EOB. The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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

Submitting a Resubmission claim

When submitting a resubmission claim electronically, submit through HealthTrio and use the Claim Review Form located on the WellSense website within Documents and Forms.

When submitting a resubmission claim via paper submission attach the Claim Review Form located on the WellSense website within Documents and Forms. Indicate at the top of the claim 'Resubmission' and enclose a copy of the remittance advice with the error highlighted and/or attach the documentation requested.

The claims submission address for resubmission paper claims is:

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

SCO Only: The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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

Providers may not resubmit a claim that was rejected for a missing NPI number as a corrected claim. Re-bill it 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. See "Submitting a Resubmission Claim"

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 "Provider administrative claims appeals."

If a provider disputes the payment amount of a claim and a discrepancy cannot be identified on the remittance, please contact WellSense Provider Service at 888-566-0008.

Payment retractions or adjustments are necessary when WellSense or the provider makes an error while processing a member's claim. WellSense follows industry-standard protocols related to payment retractions and adjustments. When such errors occur, providers should process the remittance advice and deposit the associated check as payment for those claims processed correctly.

For incorrectly processed claims, providers should submit the remittance to WellSense and highlight those claims that have been processed in error and note the incorrect payment on the remittance advice.

WellSense will adjust all incorrectly processed claims and retract the overpayments from future remittances. If a provider issues a refund check or returns the check issued by WellSense, payment will be delayed. If a provider believes WellSense has underpaid for covered services, they must notify WellSense or contact their dedicated Provider Engagement Consultant regarding a contract or fee schedule dispute.

See also, Section 9.3: Affordable Care Act (ACA) grace period for delinquent premium payments for MA Clarity plans, for Affordable Care Act standards related to retraction of payments for certain MA 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.

Corrected Claims

- A corrected claim is a claim where the provider has originally billed incorrectly.
- A corrected claim is related to one or more of the following:
- Incorrect provider name
- Incorrect member name or member ID number
- Incorrect Taxonomy Code
- Incorrect line-item details (e.g., procedures, modifier, units, or charges)
- Incorrect place of service

The corrected claims must:

- Include the original claim number
- Include an indication of the item(s) needing correction
- Not include handwritten changes
- Not include any correction fluid on the paper claim
- Be submitted within the following timeframes:
    - 150 calendar days of the original process remit date for SCO, MCO, ACO for all providers.
    - 90 calendar days from the original process date for MA Clarity for all providers.
- COB:
    - 150 calendar days of the prime EOB process date for SCO, MCO, ACO for all providers.
    - 90 calendar days from the prime EOB process date for MA Clarity for all providers
- Not include any correction fluid on a paper claim

9.11 Submitting a Correct Claim - Any previously filed paid or denied claim a provider resubmits with changed or corrected information

When submitting a corrected claim electronically submit via EDI using frequency code of 7, submit through HealthTrio using the Claim Review Form located on the WellSense website within Documents and Forms.

EDI can process corrected claims, which allow correction of most billing items. 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 the original WellSense claim number in specified locations as an electronic void or replacement request. Without this information, the claim will be rejected.

Changes to member (member name, member ID, etc.) and/ or provider information (provider name, NPI number, etc.) will require voided claims with a new submission.

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

- The claim is not at the finalized status. Finalized 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 "finalized." Claims identified with a status of "in process" or "adjudicated" are not considered finalized.
- 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 adjustment, (i.e., disputes regarding the original handling of the claim).

Questions should be directed to your assigned Provider Engagement Consultant or the WellSense EDI department.

Please refer to the EDI Guidelines or complete an online request, both available on our website at wellsense.org.

When submitting a corrected claim via paper submission attach the Claim Review Form located on the WellSense website within Documents and Forms.

- Include the word 'Corrected Claim' at the top of the HCFA/UB form when the claim is resubmitted.
- 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.

The claims submission address for corrected paper claims is:

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

SCO only: The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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

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 adjustments in Section 9.10 for information on submitting a corrected claim.

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

Claim is a 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 via the Plan's Provider Portal at wellsense.org or in writing to the WellSense Provider Service Center to the attention of the Provider Appeals department.	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.

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
- Third Party Liability (TPL):
- Subrogation (formerly Third Party Liability (TPL) and 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 Subrogation/Coordination of Benefits are not necessarily appeals involving Subrogation/Coordination of Benefits 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 Engagement Consultant 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 provider webpage.
- 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 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.
- 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 rational 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 claims(s) in question, the remittance advice, applicable Subrogation/Coordination of Benefits 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.
    - MA Clarity plans (including 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): The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026. This information intentionally left in for claims run-out periods. 150 calendar days from the original denial date and no later than 300 calendar days from the date of service.
- Timeframes for non-contracted provider appeals.
    - Senior Care Options – DSNP (Duals): The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026. This information intentionally left in for claims run-out periods.60 days from the original denial date. Appeal must be submitted with a Waiver of Liability or the appeal will be dismissed.
- 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 instances 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 must be included with all appeals and can be found at 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. Determinations for non-contracted provider appeals for will be rendered within 30 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 Advice- 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 the WellSense 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 Engagement 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 Engagement Consultant. After we receive the EFT-1, your Provider Engagement 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 Engagement Consultant.

Providers who enroll in the WellSense EFT program will continue to view their remittance advices via the WellSense 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

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

- Ensure the appropriateness and accuracy of provider billing practices, including but not limited to, charge accuracy, diagnosis and procedure coding, and DRG assignment.
- 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, unless otherwise specified below or in the specific

provider's contract. The guidelines were 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.

WellSense policies, including but not limited to clinical, authorization, eligibility, claims administration, and reimbursement, apply to all audits. In the event WellSense does 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, national health insurance carrier organizations, and/or recognized anti-fraud organizations.

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, including someone to receive audit results (via regular or electronic mail) at the conclusion of an audit.
- 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 (10) working days in advance if an on-site audit must be rescheduled or if documentation for a desk audit cannot be provided within the required 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 claim(s) at a mutually agreed-upon time and location for on-site 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 cost of 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), etc.
- Identify and present at the beginning of an on-site 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 copies of medical records, if requested,
- Receive audit results via regular or electronic mail at the conclusion of a desk audit.
- Respond to audit findings within thirty (30) days of the 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 the WellSense auditor within thirty (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.

WellSense kindly requests that providers please submit itemized bills with all facility claims. This helps us process claims more efficiently and accurately.

Role of the WellSense Clinical Audit Department

WellSense uses many different 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). If additional areas of concern are identified during the course of an audit, WellSense may expand the scope of the audit. WellSense reserves the right to extrapolate findings of an audit sample to a designated universe of claims. 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, WellSense will:

- Identify the audit sample using internal criteria.
- Select claims for audit with a final bill-paid date that is not more than two (2) years prior to the proposed audit date, 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 WellSense intent to audit not less than thirty (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 possess 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/altered medical records that are either unsigned, lacking credentials, and/or undated. We will not accept medical records or other documentation amended/altered more than thirty (30) days after the date of service.
- Provide written results at the conclusion of the audit for each claim reviewed, either as an individual initial Audit Summary Report for each claim reviewed or as a combined Audit Summary Report individually detailing the findings for all claims reviewed by desk audit.
- Allow providers a response period of thirty (30) days for all claims with audit discrepancies, unless otherwise agreed upon in writing at the time of audit. We may grant an extension period of fifteen (15) calendar days if requested in writing before the actual amendment due date.
- Accept late charge bills submitted within thirty (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.
- Adjust claim payments as indicated by the Final Audit Summary Report, at the conclusion of the thirty (30) day response period.

Note: WellSense 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.

If a provider disputes the audit findings on a Final Audit Summary Report, they 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 thirty (30) days of the date of the final written report. All clinical documentation related to the charge in question must be included, as well as any relevant policies as previously described, and any other supporting information. Clinical Audit will review your appeal, research the issue(s), and consult WellSense clinicians and other subject matter experts, as necessary.

WellSense will work to review the appeal and notify you in writing of the final determination within sixty (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 sixty (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 thirty (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 Engagement 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
  100 City Square
  Suite 200
  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
100 City Square
Suite 200
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 process to address negative balances is described below:

1. The WellSense 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:

- sssMember'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 Claim 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. MA Clarity plan (including ConnectorCare and Employer Choice Direct) members must pursue external appeals via the Office of Patient Protection. The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026. Member/consumer protections (inquiries, grievances, and appeals) differ between MassHealth and MA Clarity plans 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.
- The failure of WellSense to act within the required timeframes described in the utilization management section of this document.
- The failure of WellSense 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 the WellSense Member Service Department regarding an aspect of WellSense operations that does not express dissatisfaction about WellSense or invoke the WellSense 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 MA Clarity plans (including ConnectorCare and Employer Choice Direct) Appeals: Related Definitions

Below are definitions to be used for the MA Clarity plans (including 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- h o u r 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 MA Clarity plans (including 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 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 / MA ACA "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

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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 WellSense's SCO Contract with EOHHS 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 (no extensions allowed for Part B appeals).

- Note, as it applies to Medicare beneficiaries, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Section 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, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Section 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 temporary 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).

10.6 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 MA ACA products. The staff refers all provider requests that do not meet medical necessity review criteria,

level-of-care criteria, or medical policy to the WellSense 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 the WellSense 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.

10.7 MassHealth Member Inquiries, Grievances, and Appeals

We have an effective process to respond to member inquires 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 the WellSense internal appeal process and a final internal appeal decision has been rendered by WellSense. Medicaid Member internal appeals must be submitted to WellSense

within 60 calendar days of the date on the notice of Adverse Action sent to the member. We may reject as untimely any WellSense appeals submitted later than this timeframe.

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 to 617-897-0805 or by mail to:
  WellSense Health Plan
  Member Appeals and Grievances
  100 City Square
  Suite 200
  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 the WellSense 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.

10.8 MA Clarity plans (including 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 MA Clarity plans (including 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 (MA Clarity plan members, including 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
100 City Square
Suite 200
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 MA Clarity plan's Evidence of Coverage, 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 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 the possession of WellSense and under WellSense control.

Member or Authorized Representative MA Clarity plans (including 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 (MA Clarity plans, including 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 receipt by WellSense. 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
100 City Square
Suite 200
Charlestown, MA 02129

To submit an appeal in person, a member may visit the WellSense office 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 MA 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 MA ACA member only while the insured is 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 the 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 MA Clarity plan (including 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 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

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 the WellSense 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 (MA Clarity plans, including 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 the expense of WellSense 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 possession or under WellSense 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

10.9 Senior Care Options Complaints, Grievances, and Appeals

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026. This information has been intentionally left in for run-out periods.

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 Member Services Department at 888-566-0010. 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

100 City Square
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, Acentra, authorized by Medicare to review the aforementioned services. Members and/or Authorized Representatives are given instructions in their discharge notification about how to contact Acentra 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.
- For 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
- The member or Authorized Representative filed Standard or Expedited Appeal beyond the filing limit (65 days from the date on the notice in which 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.

10.10 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 Engagement 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 MA ACA 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.

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

The priority of WellSense 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 Engagement) 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

The WellSense 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, , Northwood staff, Provider referral, or member/ self or caregiver 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

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

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:

- Chronic conditions/disease management
- 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 members' 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 resources to alleviate food insecurity, 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 SNAP benefits, 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

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

11.10 Care Management Process

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

Section 12: Behavioral Health Management

12.1 Helpful contact information

Emergency Behavioral Health Services

Massachusetts' Community Behavioral Health Centers (CBHCs) are a statewide network of over 25 centers offering immediate, confidential care for mental health and substance use needs. These centers provide 24/7 crisis services, routine outpatient care, and community-based support, including mobile crisis intervention and stabilization. Services are available to all residents, regardless of insurance status, with many centers offering flexible in-person and telehealth options.

For those seeking assistance, the Massachusetts Behavioral Health Help Line (BHHL) is a 24/7, confidential service that connects individuals to clinical support and treatment referrals. Staffed by trained clinicians and peer specialists, the BHHL offers real-time support via phone, text, and online chat in over 200 languages. They can help assess needs, provide immediate crisis support, and connect callers to the nearest CBHC or other appropriate services.

- To access help
    - Call or text 833-773-2445
    - masshelpline.com
- To find your local CBHC, please visit mass.gov/find-a-cbhc/locations

Behavioral Health Urgent Care

- mass.gov/info-details/behavioral-health-urgent-care
- Massachusetts Behavioral Health Access (MABHA) – service/provider search
    - mabhaccess.com

12.2 Overview

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 substance use disorder 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.
- Using care management 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. WellSense does not provide financial or other types of incentives to providers, practitioners, employees or other individuals for issuing denials of coverage or services.

All inpatient and outpatient behavioral health services rendered by non-participating providers require prior authorization from WellSense, except for emergency services

WellSense requirements by categories of care

Behavioral Health providers must provide services in accordance with all EOHHS approved performance specifications and medical necessity criteria. See medical necessity guidelines.

WellSense notification, prior authorization, coordination of care, and discharge planning are essential elements of care management. 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 MA Clarity 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, including InterQual, ASAM (American Society for Addiction Medicine) and internal medical policies.

Inpatient admissions Discharge Planning

Discharge planning shall begin on the first day of the enrollees inpatient admission.

The hospital shall notify the enrollee's PCP to ensure that appropriate parties are included in discharge planning, including case managers, caregivers, and other critical supports. When the enrollees discharge includes DMH Community-Based Services, DMH case managers shall participate in each treatment team meeting.

The discharge summary shall be sent to the enrollees PCP, CP, ACO Care Management program, and/or Care Team within two business days of discharge. The discharge summary shall include a copy of the hospital's discharge instructions that were provided to the enrollee and include details on the enrollee's diagnosis and treatment.

Discharge/aftercare appointments must be scheduled in accordance with access and availability standards noted in Section 8.5 of this manual. Services contained in the enrollee's discharge plan must be offered and available with seven business days of discharge from an inpatient setting. Monitoring the availability of the next available aftercare appointment for the enrollee who has remained in the behavioral health inpatient and 24-hour Diversionary setting for non-medical reasons (e.g. the recommended aftercare resource is not yet available) is required.

Hospital providers must ensure that discharge planning staff are aware of and utilize available community resources to assist with discharge plan; make reasonable efforts to prevent discharge to emergency shelters unless enrollee is expected to remain in hospital for less than 14 days in which case hospital must contact emergency shelter to discuss housing options; and, if discharged to an emergency shelter or specific placement cannot be secured the hospital must provide additional supports and track discharges. For any enrollee whose behavioral health condition would impact the health and safety of individuals, the hospital must make all reasonable efforts to prevent discharges to emergency shelters.

For Enrollees experiencing homelessness or at risk of homelessness, the hospital must contact WellSense to collaborate on housing, incorporate housing into transitions of care and discharge planning upon admission and include DMH agencies as appropriate.

The hospital shall document in the enrollee's medical record all actions taken to satisfy discharge planning requirements.

Network providers of CSP-HI must employee staff with homelessness experience and expertise.

12.3 Communication and Coordination of Member Treatment

WellSense collaborates 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, the Behavioral Health providers would be part of the care team as described in Section 11: Care Management. With member informed consent, we require all providers to provide a member's clinical information to other providers, as necessary, to ensure proper coordination and behavioral health treatment of members who express suicidal or homicidal ideation or intent, consistent with

Massachusetts state law. For all state agency behavioral health clients, a release of information must be requested to inform the identified agency of the member's current status.

For MassHealth and MA ACA 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

Behavioral Health providers are required to obtain a release of information and notify the enrollee's PCP of an enrollees screening and emergency services treatment. Providers shall participate in or convene regular meetings and conduct ad hoc communication on clinical issues with CBHCs to enhance continuity of care for enrollees. Providers are also expected to comply with WellSense continuity of care policies and procedures as described in Section 6.11.

WellSense is committed to ensuring that all our members experience care that is integrated across providers, that is member-centered and connects members to the right care in the right settings.. For members under the age of 21 we expect providers to use a family-centered approach in which caregivers are active members of the member's care and coordination occurs, as appropriate, with schools, early childhood supports, Community Based Care Management (CCM), Children's Behavioral Health Initiative (CBHI), and state agency supports (e.g. DPH, DYS, DMH).

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 (4) 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 the WellSense Authorization for Behavioral Health Provider and PCP to Share Information Form and the Behavioral Health-PCP Communication Form for initial communication and subsequent updates, 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. Behavioral Health inpatient and 24-hour diversionary service providers are also required to coordinate with all contracted CBHCs including procedures to credential and grant admitting privileges to AMCI/YMCI provider psychiatrists, if necessary.

Acute care providers' communication requirements are addressed during continued stay and discharge reviews and documented in the WellSense 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 WellSense. 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 WellSense timeliness standards, and/or geographically accessible.

Additional Behavioral Health and substance use disorder provider responsibilities:

- For members under the age of 21 behavioral health clinical assessments must be completed by a certified CANS provider using the CANS tool and providers must ensure that members under the age of 21 have access to appropriate care.

CBHCs shall provide Crisis Assessment and Interventions, identify to the court clinician appropriate diversions from inpatient hospitalization and assist in plans to utilize diversionary services. CBHCs will conduct a search for an available bed, making best efforts to locate such a bed by 4:00 pm on the day commitment orders is issued. The CBHC may contact WellSense for assistance in securing an in-patient or 24-hour Diversionary service placement. CBHCs must utilize, as necessary, the statewide Massachusetts Behavioral Health Access website

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.

Massachusetts' Community Behavioral Health Centers (CBHCs) are a statewide network of over 25 centers offering immediate, confidential care for mental health and substance use needs. These centers provide 24/7 crisis services, routine outpatient care, and community-based support, including mobile crisis intervention and stabilization. Services are available to all residents, regardless of For

those seeking assistance, the Massachusetts Behavioral Health Help Line (BHHL) is a 24/7, confidential service that connects individuals to clinical support and treatment referrals. Staffed by trained clinicians and peer specialists, the BHHL offers real-time support via phone, text, and online chat in over 200 languages. They can help assess needs, provide immediate crisis support, and connect callers to the nearest CBHC or other appropriate services.

To access help, call or text 833-773-2445 or visit masshelpline.com.

To find your local CBHC, please visit mass.gov/find-a-cbhc/locations.

Behavioral Health Urgent Care

- mass.gov/info-details/behavioral-health-urgent-care
- Massachusetts Behavioral Health Access (MABHA) – service/provider search
    - mabhaccess.com
- Many CBHCs offer flexible in-person and telehealth options.

Section 13: Pharmacy Services

13.1 Pharmacy contacts for providers

In addition to the pharmacy information in this manual, we have a Pharmacy section on our website. It provides additional information and resources.

Information needed	Contact
Up-to-date medication coverage information, including over the counter (OTC) drugs	View the Pharmacy formulary at wellsense.org/providers/ma For MassHealth and MA Clarity plan members (formerly QHP): call WellSense at 888-566-0008. The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.
Prior authorization forms and clinical policy criteria	View Prior Authorization forms and clinical guidelines at wellsense.org/providers/ma. For MassHealth and MA Clarity plan members (formerly QHP): call WellSense at 888-566-0008. The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.
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 Controlled Substance Management Program

The Controlled Substance Management Program (CSMP) 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 CSMP 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.

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. In network opioid treatment providers (OTP) must follow the MassHealth Drug List for any drugs related to the provision of OTP.

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 the WellSense 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 MA Clarity plans (including ConnectorCare and Employer Choice Direct). 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.

Prior Authorizations may be submitted via the following options:

MassHealth

- Search the Formulary at Prior Authorization | Providers | WellSense Health Plan for prior authorization requirements
- Online through an ePA portal
- Surescripts
- CoverMyMeds
- ExpressPath

- Fax the completed prior authorization form to 833-951-1680
- Call 877-417-1822 to initiate a prior authorization by phone

MA Clarity

- Search the Formulary at Prior Authorization | Providers | WellSense Health Plan for prior authorization requirementsOnline through an ePA portal
- Surescripts
- CoverMyMeds
- ExpressPath
- Fax a prior authorization form to 833-951-1680
- Call 877-417-0528 to initiate a prior authorization by phone
- Medical Drug Management (Provider-Administered drugs)
- Search the HCPCS Code Lookup at Prior Authorization | Providers | WellSense Health Plan for prior authorization requirements
- Online through an ePA portal
- evicore.com
- Fax a prior authorization form to 833-812-0687
- Call 877-512-5985 to initiate a prior-authorization request by phone

Senior Care Options

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

Visit wellsense.org/providers/pharmacy/prior-authorizations for links and contact information.

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 the WellSense 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.

MA ACA Members may obtain up to 90-day supplies of eligible medications at the WellSense 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 not charged a copayment for medications, including 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

MA Clarity plan members (including 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. The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

See Section 6: Member Information for additional details regarding copayment amounts.

Monthly/Annual cost-sharing caps

As of April 1, 2024, there are no copayments for any covered service for MassHealth members.

MA Clarity plan members (including 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

The Senior Care Options (SCO) product has been discontinued effective Jan. 1, 2026.

Pharmacy copayment compliance

We expect all pharmacies to comply with the cost-sharing rules applicable to all plans.

- For MA Clarity plan members (including 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.
- 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. Please note that as of April 1, 2024, there are no copayments for any covered service for MassHealth members.

WellSense action with non-compliant pharmacies for MassHealth members

Our Pharmacy staff will immediately follow up with any pharmacy that denies 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 deliver quality services to members. Providers are required to participate in the program as part of their agreement with the Plan. Provider shall cooperate with Plan's quality improvement activities to improve the quality of care and services and Member experience, including the collection and evaluation of data related to quality improvement activities.

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 calendar 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, notify our Quality Department at 617-897-0899 to report the event.

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 that is 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. This internal program systematically assesses medical record documentation of patient care against standards as required in our Network Provider Medical Record Review Policy. The approach is designed to objectively assess the structure, content, and management of patient records at the time of the review while minimizing any impact of the review process on practitioner operations. The intent of the assessment is to give feedback to help providers continuously meet standards and to ensure continuity, efficiency and quality of care for WellSense members.

Medical records must be legible, documented accurately and comprehensively, and accessible to healthcare practitioners. This includes being required to transfer medical information when a member changes to another provider. Providers and WellSense must work together to ensure that member records are treated as confidential and in total compliance with state and federal laws and regulations.

Medical record charting standards for all providers

WellSense expects providers to maintain medical records according to industry standard practice and will periodically monitor charting practices. The following summarizes the components of required standards and charting practices that we evaluate during audits.

- Provider site has a central file where records are securely stored in an adequate filing space.
- Charts are available and retrievable.
- Charts are stored and accessed according to the Health Insurance Portability and Accountability Act (HIPAA). All staff train periodically on member confidentiality.
- Records are stored securely and accessible only to authorized personnel.
- There is a documented location of any and all WellSense member patient files retrieved from the filing system.
- Records consistently use standard formats and forms.
- All medical records are legible.
- All medical record entries are signed with name, title, and date.
- Provider site has physician counter-signature policies for all mid-level, physicians-in-training supervised by the physician.
- The office has an appropriate documentation system, including patient name and identification number on each page of the chart.
- Medical records are organized by individual patient in a logical manner that is current, detailed, and organized and that facilitates effective patient care, utilization, and quality review.
- Individual patient charts are organized in chronological order.

- Each file contains a data sheet with basic demographic and contact information, also including patient's race, ethnic background, preferred spoken and written language, and any disabilities.
- Medical records include documentation of problem list with status (new, stable, progressing or worsening, improving, not responding to treatment or intervention), medications, history (including serious accidents, operations and illnesses), physical exam, preventative services/age appropriate risk screening including, but not limited to cigarettes, alcohol and substance abuse, review of family history, documentation of clinical findings and evaluation at each visit.
- Working diagnoses are consistent with findings.
- All diagnoses, review of comorbidities, complications, and treatment plans, goals, and outcomes are documented; this includes radiology, laboratory work, and consultation results.
- All abnormal subjective and objective findings are appropriately addressed; unresolved problems from previous visits have documentation of a follow-up plan including return visits, telephone calls, or other medium with the timeframe designated.
- Review level of familial or other social/community supports and their involvement, as applicable
- Treatment plans are consistent with diagnoses.
- Laboratory, radiology, and consult notes are filed in the chart; reviewed, signed, and dated by the ordering provider at the time of receipt. Documentation exists of follow-up for abnormal findings.
- Provider sites have policies and procedures for consent.
- Records include prominent display of allergy and adverse reactions documentation or no known allergy.
- Review of current medications with dosages, dates of dosage changes, and documentation of compliance or non-compliance.
- Documentation of education regarding reasons for the medication, benefits, risks, side effects, and verbalization of understanding of education provided.
- Documentation, whether any member over age 18 has executed an advance directive.
- There is evidence that preventive screening and services are offered in accordance with the EPSDT Periodicity Schedule or for members over 21, the provider's own practice guidelines.
- There is no evidence that members are placed at inappropriate risk by a diagnostic or therapeutic procedure.
- There should be appropriate notation of under or over utilization of specialty services or pharmaceuticals.
- Records include prominent display of advance directives indicating patient wishes regarding treatment, where appropriate.
- All contacts with state agencies are documented or filed in the chart.
- All contacts with the member's family, guardians, or significant others are documented.
- Behavioral health screenings and referrals as appropriate

- Evidence that member clinical information is shared, with lawful member consent, to members, their authorized representative and to other providers, as necessary
- Documentation of continuity and coordination of care between providers as applicable such as specialists, PCPs, ancillary providers, DME providers, behavioral health providers, treatment programs/institutions, facilities (hospitals, LTSS), community organizations.
- Evidence of treatment being provided in a culturally competent manner (use of interpreter, translator services, as applicable).

Providers must retain medical records for the period of time specified in all applicable state and federal laws and regulations and in WellSense's contracts.

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
- Discussion of discharge planning and transition to next level as appropriate

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:

- All services provided directly by the Pediatrician
- Flow sheet for immunizations
- Growth and development chart
- BMI percentile or BMI plotted on a percentile graph
- Physical activity and nutritional counseling
- Anticipatory guidance documentation
- Appropriate physical and social/emotional developmental screenings and referrals as needed
- Behavioral health screenings and referrals as appropriate

Behavioral health services charting standards

In addition to the medical record charting standards outlined above, BH Provides are required to document recommendations or examinations for the following:

- All services provided directly by the Behavioral Health Provider
- Mental health exam
- Current and past suicide /danger risks
- Substance use and evidence of Medication Assisted Treatment or discussion
- Patient strengths, skills, abilities, motivation
- Relevant social environments, support systems, and family dynamics
- Use of Behavioral Health screening tools, PHQ-9, GAD-7
- Documented crisis plan
- Coordination of discharge planning and transition to next level as appropriate

Substance Use Disorder Treatment Providers are expected to submit to DPH/BSAS the data required by DPH and track, by referral source: 1) all referrals for services; 2) outcome of each referral; 3) if a provider refuses to accept a referral, the reason for the refusal and alternative referrals made.

All behavioral health providers must complete and document a behavioral health clinical assessment within 24 hours of admission to an inpatient setting or 24-hour diversionary service; by the end of the second visit for non-24-hour diversionary services; and, in accordance with DPH regulation 105 CMR 140.540 for outpatient services.

An individualized treatment plan must be documented for all members starting behavioral health treatment and for the behavioral health services to be provided upon discharge from any level of behavioral health care.

Behavioral Health Inpatient Treatment and discharge planning shall include:

- A comprehensive evaluation of members within 24 hours of admission, consisting of medical history and an assessment of the psychiatric and pharmacological status, and treatment needs.
- A physical examination/medical assessment within 24 hours of admission, completed by a physician, who is a psychiatrist or a non-psychiatrist physician.
- Timely treatment and discharge plan completed within 24 hours of admission.
- Assignment of multi-disciplinary treatment team within 24 hours of admission, consisting of a psychiatrist and one or more other discipline.
- Documentation that the multi-disciplinary treatment team meets to review the assessment and develop a treatment plan and discharge plan within 24 hours of admission.
- Documentation that the multi-disciplinary treatment team meets to review the assessment and develop a treatment plan and discharge plan within 24 hours of admission.
- The treatment and discharge plan are developed by a multidisciplinary team and must include a physician who is psychiatrist. (On weekends and holidays, the treatment plan may be developed

by an abbreviated treatment team, with a review by the full treatment team on the next business day.

- Participation in treatment and discharge planning meetings with state agency workers or parents and guardians as appropriate.
- Assignment of a facility-based case manager who will be involved in the implementation of treatment and discharge plans
- Identification of new acute clinical services, as well as supports, continuing care with established providers, identification of any new providers and the services that will be added
- Identification of state agency affiliation, release of information and coordination with any state agency case worker assigned to the member
- Identification of non-clinical supports and the role they serve in the member's treatment and after care plans
- Recommendation for the initial frequency of aftercare services and supports
- Identification of barriers to aftercare and timely discharge and strategies to address such barriers
- Access to medication monitoring within 14 business days of discharge from a behavioral health inpatient setting.
- A discharge plan to a more appropriate level of care
- Discharge plan includes a documented current and planned crisis prevention plan and or safety plan in place, and documentation that member was provided this plan.
- Documentation of post discharge appointment scheduling, occurring within 7-calendar days of discharge for an outpatient behavioral health follow up.
- Coordination of treatment and discharge plans with state agency staff
- A plan to ensure a smooth transition to the next service or to the community
- The member's participation in discharge planning.
- With member consent, documentation that written discharge summary is shared no later than 2 weeks of the member discharge to members, parents/guardian/caregivers, Primary Care Physician and current behavioral health providers. The discharge summary is documented in the health records and includes:
    - The course of treatment
    - Members' progress
    - Treatment intervention and behavior management techniques
    - Medication prescribed
    - For all youth under the age of twenty-one, completion of a Child and Adolescent Needs and Strengths (CANS) is completed by a certified clinician at the facility as part of the discharge planning process.
    - A copy of the CANS is maintained in the medical record.

Hospital responsibilities related to behavioral health services

Hospitals with DMH-licensed beds shall appropriately utilize the statewide Treatment Referral Portal (TRP) as required to indicate bed availability. DMH licensed hospitals must accept all referrals of members that meet established admission criteria of the inpatient unit. The hospital shall notify the member's PCP, CP, ACO Care Management program, and/or Care Team within one day of the member's inpatient admission.

All hospitals, including those who do not have DMH licensed beds, must treat all individuals admitted to any unit or bed within the hospital who present with co-occurring SUD, ASD, ID, DD and/or individuals who present with a high-level of psychiatric acuity, including severe behavior and assault risk.

All BH inpatient and 24-hour diversionary service providers must have a) human rights and restraint and seclusion protocols and regulations and include training of staff and education of enrollees regarding human rights and b) and human rights officer who shall provide written materials to enrollees regarding their human rights in accordance with DMH regulations and requirements

Inpatient and 24-hour diversionary providers must assign a facility based case manager for enrollees; identify new acute clinical services, as well as supports, that are required for treatment and discharge planning; identify any state agency affiliation and secure a Release of Information (ROI); identify non-clinical supports needed; schedule aftercare appointments in accordance with access and availability standards; recommend frequency of aftercare; identify barriers to aftercare and timely discharge and strategies to address those barriers; monitor aftercare resource availability to secure earliest available aftercare resource; provide a discharge plan to other providers, including PCP; coordinate with all contracted CBHCs; ensure family, guardians, outpatient, CP, ACO CM, Care Team and state agency staff participate in DC planning to the maximum extent practical, including treatment team meetings and developing the discharge plan with enrollee consent; ensure services offered and available to enrollees within 7 days of discharge; ensure enrollee has access to medication monitoring withing 14 days of discharge and document all activities including enrollees active participation in discharge planning.

The hospital shall notify the enrollee's PCP, CP, ACO Care Management program, and/or Care Team within one business day of the enrollee's presentation at a hospital emergency department.

MassHealth requires that Emergency Service Providers (ESPs) complete an emergency screening for all MassHealth members requiring inpatient admission. The ESP is responsible for locating a bed but may request WellSense assistance. WellSense may contact an out-of-network inpatient psychiatric placement when an appropriate treatment is not available in-network.

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

Medical record audits

Each provider site must participate in and cooperate with medical record audits. These audits are necessary to ensure compliance with the WellSense medical record standards and with criteria periodically developed and distributed. Providers are required to make medical records or copies of records available to WellSense, agents of CMS or other state or federal government agencies, and any authorized external quality review organization (e.g., NCQA) for purposes of assessing the quality of care rendered.

Medical record audits for PCPs

WellSense will conduct an annual audit of randomly selected medical records based on member population utilization and specialty service types for outpatient and or inpatient services. Primary Care Physicians (PCPs) such as General Medicine, Family Medicine, and Pediatrics, will be included in the audit universe regardless of utilization due to the essential role of the PCP in directing care.

The WellSense medical record audit process:

- The audit is performed using the basic charting standards outlined above and any medical care evaluation audit tools that might be relevant to a practice (for example, the audit tool might be used for evaluating the treatment of adult members with hypertension in an internal medicine practice). WellSense communicates the results of audits to the practitioner. A "Full Pass" is 100% for each selected record. A "Fail" is anything below 80% for each selected record. Providers scoring less than 80% in any individual record will be provided with an opportunity to submit or provide additional information specific to the record with deficiencies to close the identified gaps. Providers that do not respond within 30 days of notification to submit additional information will be put on a corrective action plan A corrective action plan is required for all medical record deficiencies and may include but not limited to

- One on one education on WellSense medical record documentation requirements
- Corrective action audit to review impact of recommendations/feedback and adherence to requirements
- Providers are required to provide access to the office or practice site and the members' medical records or to send copies of members' medical records to the clinical informatics department when requested by WellSense.

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

Considering the needs of our members WellSense has adopted several evidence-based preventive and disease management clinical guidelines consistent with nationally accepted standards of care and evidence-based practices. These guidelines conform to the standards of NCQA Health Plan Accreditation, are chosen based on an assessment of the local health care delivery system and consider the health needs of our members based on opportunities for improvement within the Plan's assessment of Quality Assurance and Performance Improvement. WellSense encourages providers to refer to these guidelines to assist in delivering clinically appropriate 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 the behalf of WellSense. 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 Engagement 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

- Strengthen CMS' ability to distinguish stronger health plans for participation in Medicare Parts C and D
- Strengthen beneficiary protections

Section 15: Health-Related Social Needs (HRSN) Supplemental Services

15.1 Health-Related Social Needs (HRSN) Supplemental Services General Information

Health-Related Social Needs (HRSN) Supplemental Services is a MassHealth program, available to certain eligible ACO members. HRSN Supplemental Services provides supplemental housing and nutrition resources with the goal of improving member health outcomes.

Members must meet specific criteria to receive HRSN Supplemental Services, and they must be delivered through a contracted HRSN provider.

15.2 HRSN Supplemental Service Types

HRSN Supplemental Services are offered under two service types, nutrition and housing. Each MassHealth ACO selects a subset of available services to offer to their members. This means that available services may differ between WellSense ACOs.

HRSN Supplemental Services offered by each ACO can be found in their respective Member Handbooks, found here Your Benefits | MassHealth | WellSense Health Plan.

HRSN Supplemental Nutrition Services:

HRSN Supplemental Nutrition Services are offered under two categories.

Nutrition Category 1 Services are services designed to provide food that is necessary to improve, stabilize, or prevent the deterioration of a member's health.

Examples of HRSN Category 1 Supplemental Nutrition Services include:

- Medically tailored home delivered meals
- Nutritionally appropriate home delivered meals
- Medically tailored food boxes
- Nutritionally appropriate food boxes
- Medically tailored food prescriptions and vouchers
- Nutritionally appropriate food prescriptions and vouchers

Nutrition Category 2 Services are services designed to enhance the effectiveness and impact of Nutrition Category 1 Services by providing additional education and services other than food.

Examples of HRSN Category 2 Supplemental Nutrition Services include:

- Nutrition education classes and skills development
- Nutrition counseling

- Kitchen supplies

HRSN Supplemental Housing Services:

HRSN Supplemental Housing services can help a member locate housing, get services to improve their living situation, or help them pay for certain things related to housing needs.

Examples of HRSN Housing Supplemental Services include:

- Healthy homes
- Housing search
- Housing navigation
- Transitional goods

15.3 Member Eligibility for HRSN Supplemental Services

For a member to be eligible for HRSN Supplemental Services, a member must:

1. Be an active MassHealth ACO-enrolled member
2. Meet Health-Needs Based Criteria (HBNC) for a service
    a. These vary by service type, but some examples include complex physical health need, pregnant with high-risk pregnancy or complications, assistance with one or more activities of daily living (ADLs), etc. For more information, please consult the MassHealth HRSN Supplemental Services Manuals linked below.
3. Meet a risk factor:
    a. These vary by service type, but some examples include, at risk for homelessness, experiencing food insecurity, etc. For more information, please consult the MassHealth HRSN Supplemental Services Manuals linked below.
4. Other programmatic criteria as required
    a. These vary by service type, but some examples include: if they are requesting Medically Tailored Home-Delivered Meals, they must be unable to prepare their own meals. For more information, please consult the MassHealth HRSN Supplemental Services Manuals linked below.

All HRSN Supplemental Services are a standard set of services developed by MassHealth, and each HRSN Supplemental Service has specific criteria.

A full list of HRSN Supplemental Services criteria can be found in the MassHealth HRSN Supplemental Services Manuals found at mass.gov/info-details/information-for-masshealth-acos-and-hrsn-providers.

Note: Members do not have appeal rights for HRSN Supplemental Services. If a member does not agree with WellSense Health Plan's or an HRSN provider's assessment of their eligibility for HRSN Services, they may file a grievance.

For more information and guidance on how a member may file a grievance, please refer to Section 10: Appeals, Inquiries, and Grievances.

15.4 HRSN Provider Responsibilities

To deliver HRSN Supplemental Services to eligible members, providers must be contracted with WellSense Health Plan, and only provide services discussed with WellSense Health Plan.

WellSense Health Plan contracts with several HRSN Providers, also known as Social Service Organizations (SSOs) to deliver HRSN services to our members. SSOs interested in providing HRSN supplemental services can contact our Provider Engagement department directly to inquire about participation. Please call 888-566-0008 and select the Provider Service option.

All HRSN Providers are required to establish, maintain, and implement written policies and procedures for

- Referrals and their disposition;
- Information exchange;
- Start and end dates of HRSN Supplemental Services;
- Timing and outcomes of determinations for whether an Enrollee meets the criteria to receive HRSN Supplemental Services; and
- Coordination with the ACO.

HRSN Providers shall ensure that:

- Receipt of HRSN Supplemental Services remains the choice of the Enrollee, and that the Enrollee may opt out at any time,
- Appropriate policies and procedures are in place to address potential conflicts of interest between service planning and service delivery.

15.5 Delivery of HRSN Supplemental Services

Screening Members for HRSN Supplemental Services

Members may be screened for HRSN Supplemental Services by multiple entities, such as SSOs, healthcare providers, and ACOs.

Contracted HRSN providers and ACO partners will have access to the HRSN platform and can screen members electronically.

Providers can screen members using our HRSN Screening Form found on our Provider webpage and can submit completed screenings to WellSense Health Plan for review.

Screening Criteria and Requirements

WellSense Health Plan will use an HRSN platform to document member screening activities, including responses and self-attestations, and serve as a repository for auditable and reportable requests.

Screenings should:

1. Verify that the member has an active and eligible ACO enrollment
    a. The member requesting HRSN services must be enrolled in an Accountable Care Organization
    b. The HRSN provider or other referring provider must check the member's eligibility through the Eligibility Verification System (EVS) or our provider portal
    c. Eligibility must be checked on each date of service to verify that the member is actively enrolled
2. Verify that the member meets the appropriate Risk Factor criteria for the service
    a. For nutrition services, this must include using a screening tool that can appropriately distinguish Very Low Food Security
    b. Verify that the member meets the appropriate Health Needs Based Criteria (HBNC)
3. HRSN provider may accept self-attestations by the member
    a. HRSN providers are not expected to have the appropriate clinical expertise to diagnose a medical or behavioral health condition
4. Verify that the member meets any other criteria for the service

Screening for Risk Factor criteria, Health-Needs Based Criteria (HBNC), and other criteria for HRSN Supplemental Services must be done in accordance with the MassHealth Service Manual can be found on our Provider webpage.

WellSense Health Plan will provide HRSN providers or other referring providers with the appropriate screening questions via paper form or the HRSN platform.

HRSN Service Registration

Once a member has been screened for HRSN Supplemental Services eligibility in the HRSN platform, the service registration will be sent to the ACO for review.

A Service Registration is a notification step that will enable ACOs and MassHealth to monitor utilization. Service Registrations are not Prior Authorizations, and do not require medical review. Once submitted, the HRSN provider will receive a response within seven business days.

HRSN providers are required to request and receive service registration prior to providing HRSN Supplemental Services.

Training for HRSN screening and the use of our HRSN platform can be requested through your provider engagement consultant, or through Provider Line 888-566-0008 and select the Provider Service option.

Service Plans

HRSN providers are required to develop and maintain a service plan for all Enrollees receiving HRSN Supplemental Services. Service Plans shall:

- Be person-centered;
- Identify the service(s) provided and responsible parties;
- Identify ways to support the Enrollee in mitigating barriers to accessing and utilizing services;
- Identify the Enrollee's needs and individualized strategies and interventions for meeting those needs;
- As appropriate, be developed in consultation with the Enrollee and Enrollee's chosen support network including family and other natural or community supports; and
- Subject to consent by the Enrollee and as appropriate, incorporate available records from referring and existing providers and agencies, including any bio-psychosocial assessment, reasons for referral, goal, and discharge recommendations.
- Service Plans should be reviewed and updated:
    - No less than every 12 months;
    - Whenever an Enrollee experiences a major change that may impact their HRSNs; and
    - Upon the request of the Enrollee.

15.6 HRSN Claims Submission and Reimbursement

HRSN providers should submit HRSN Supplemental Services claims in accordance with the requirements outlined in Section 9.9 Claims Submission and in accordance with the HRSN Supplemental Services Payment Policy which can be found on WellSense Health Plan's website. Claims that do not adhere to the applicable payment policies and the requirements outlined in the MassHealth HRSN Manual may be denied.

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 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.

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."

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.

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."

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.

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."

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."

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."

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."

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."

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."

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."

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."

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."

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."

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."

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."

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."

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."

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."

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."

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."

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."

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."

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."

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."

According to M.G.L. 176G § 4M (a) A health maintenance contract issued or renewed within or without the commonwealth shall provide mental health benefits on a nondiscriminatory basis to residents of the commonwealth and to all members or enrollees having a principal place of employment in the commonwealth for the diagnosis and treatment of the following biologically-based mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, referred to in this section as the DSM: (1) schizophrenia; (2) schizoaffective disorder; (3) major depressive disorder; (4) bipolar disorder; (5) paranoia and other psychotic disorders; (6) obsessive-compulsive disorder; (7) panic disorder; (8) delirium and dementia; (9) affective disorders; (10) eating disorders; (11) post traumatic stress disorder; (12) substance abuse disorders; and (13) autism.

(e) Any such health maintenance contract shall also provide benefits for the diagnosis and treatment of all other mental disorders not otherwise provided for in this section and which are described in the most recent edition of the DSM during each 12 month period for a minimum of 60 days of inpatient treatment and for a minimum of 24 outpatient visits