WellSense Health Plan

Provider Manual

New Hampshire



WellSense Health Plan

Effective January 1, 2027

WellSense HEALTH PLAN

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Section 1: General information

1.1 About WellSense Health Plan

WellSense Health Plan is a New Hampshire health plan that offers medical insurance to New Hampshire residents who qualify for Medicaid Marketplace plans. We administer plans to our members through an arrangement with the New Hampshire Department of Health and Human Services (NH DHHS) and the New Hampshire Insurance Department. This includes:

- The New Hampshire Department of Health and Human Services (NH DHHS) for our Medicaid plans
- The New Hampshire Division of Insurance for our Marketplace plans, also called individual and family plans that meet the Affordable Care Act (ACA) requirements.

WellSense Health Plan is the name under which Boston Medical Center Health Plan, Inc. (an affiliate of Boston Medical Center) does business in New Hampshire.

1.2 Who we serve

We are dedicated to providing coverage to New Hampshire Medicaid members , individuals enrolled in Medicare A and Band individuals and families eligible for Clarity plans. We offer an extensive network of acute care hospitals, primary care providers, specialists, and other providers. We have a physician advisory council (PAC) composed of a broad spectrum of providers. The membership of the PAC is drawn from representatives throughout the provider community. The PAC meets four times per year. If you are interested in hearing more about the PAC, email your questions to NHproviderinfo@wellsense.org.

Outlined below are the population types we serve:

Medicaid

The WellSense New Hampshire Medicaid plan is available to residents who qualify for the Medicaid Care Management program from NH DHHS. Services for all Medicaid members include, but are not limited to: inpatient, outpatient, behavioral health, laboratory and radiology, and long-term services and support for qualifying members. Our Medicaid members are divided into two groups based on their eligibility.

- **Standard Medicaid population**
  The standard Medicaid population is composed of individuals who qualify for Medicaid based on income, household size, disability, family status and other factors under NH DHHS.
- **Granite Advantage Health Care Program (GAHCP)**
  The Granite Advantage Health Care Program is the name of New Hampshire's expanded Medicaid program. It serves individuals ages 19–64 who are eligible based on income levels established under New Hampshire law (0-138% of the federal poverty level). New Hampshire Medicaid benefits are the same for all New Hampshire Medicaid members.

Clarity plans

WellSense Clarity plans are available to New Hampshire residents who meet Affordable Care Act eligibility requirements. We provide coverage to these individuals in exchange for a premium.

1.3 WellSense provider networks

We offer a separate provider network for each of our contracted plans. Our networks are structured so that a sufficient number of primary and specialty care providers are available to all members in our service areas within an acceptable distance. We contract statewide with physicians, health centers, hospital systems and other providers to care for our New Hampshire Medicaid and Clarity plan members.

1.4 Using the provider manual

We developed this manual to serve as a helpful reference tool for network providers. The manual is part of your provider contract with us. Therefore, providers are required to comply with and refer to the manual along with any policies and procedures referenced in the manual as part of their participation in our network.

1.5 Revisions to the manual

The information in this manual may change over time and will be updated at least annually. We notify providers of changes to this manual and/or policies or procedures via network notifications that are mailed, faxed or emailed and also posted at wellsense.org at least 60 days before becoming effective. Please note that information in the network notifications modifies, replaces or is in addition to information in this manual. The most current version of this manual is always available at wellsense.org.

1.6 Contacts directory

For a complete directory of WellSense contacts, visit wellsense.org/contact-us.

Section 2: Member Eligibility

2.1 Verifying eligibility

Verify an individual's enrollment and eligibility in Medicaid:

WellSense offers providers the convenience of checking member eligibility online or by phone (instructions are below). Medicaid eligibility must first be determined by DHHS, and then an eligible individual may enroll in WellSense. We update our system within 48 hours of any eligibility changes made by DHHS.

There are three ways to verify an individual's enrollment and eligibility in WellSense Medicaid:

- Visit the NH MMIS (Medicaid Management Information System) Health Enterprise Portal at nhmmis.nh.gov/portals.
- Visit our online eligibility verification system at wellsense.org.
- Call us at 877-957-1300, option 3, Provider Service. The NH DHHS maintains the NH MMIS eligibility lookup system. If there is a discrepancy in eligibility between the DHHS and our own systems, please notify us of the discrepancy. We will then either update our membership information to reflect the information provided by DHHS or report a discrepancy to DHHS for escalated resolution.

For inpatient admissions, providers should check eligibility daily, before delivering any care, since eligibility may change at any time. WellSense does not provide coverage for individuals who are not eligible for New Hampshire Medicaid and who are not enrolled with WellSense.

For emergency care, providers may verify eligibility after the individual's medical emergency has been assessed and his/her condition stabilized.

Primary care physicians should note that our eligibility system does not verify if a member is assigned to a physician's panel.

For instructions on how to obtain prior authorization, please see Section 8: Utilization Management and Prior Authorization, Section 12: Behavioral Health Management and Section 13.8: Pharmacy Utilization Management Programs.

For information on how providers may assist a member with changing the member's PCP assignment upon member request, please see Section 6: Member Information.

Please see Section 7: Member Benefit Information for a list of covered services for Medicaid members along with additional benefits covered directly by DHHS. Additional benefits, known also as "wraparound benefits," must be billed directly to DHHS.

Verify an individual's enrollment and eligibility in a WellSense Clarity plan:

Providers can verify a member's eligibility by accessing our online eligibility tool after logging into the provider portal at wellsense.org or calling the Provider Service line during business hours (8 a.m. to 6 p.m., Mon.–Fri.) at 855-833-8122,

Confirm member primary care provider (PCP) assignment

Our Provider Service Team can also confirm member PCP assignments and determine provider participation status before services are rendered. This information is available when providers complete our prior authorization process.

2.2 ID cards issued for Medicaid members

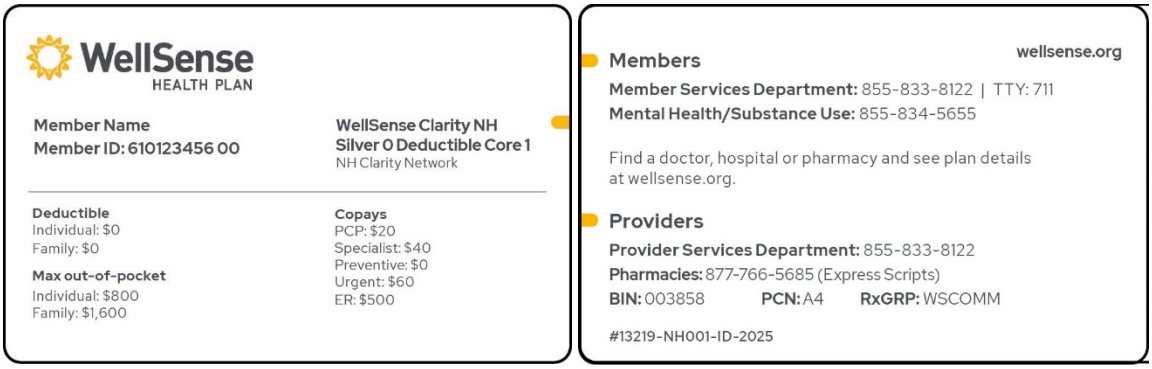
Each WellSense Medicaid member receives two identification cards: one from DHHS and one from WellSense.

Sample WellSense Medicaid member ID card:



Medicaid members should present both their ID cards to the treating provider at the time of service and contact their PCP before receiving care, unless it is an emergency. Providers should not deny care to a member who does not have ID cards. Please see section 2.1 Verifying Eligibility for methods to verify a member's eligibility.

Sample WellSense Clarity plan member ID card:



2.3 Newborn eligibility guidelines

Medicaid

Any newborn whose mother is a WellSense Medicaid member is automatically covered under the mother's benefits. To ensure continuity of care and enrollment of the newborn into WellSense, the admitting hospital or hospital where the delivery occurred must notify us at 877-957-1300 within 24 hours of each new birth. See Section 4: Provider Responsibilities for a summary of notification guidelines for newborn deliveries and newborn care.

Please fax a completed Notification of Birth form available at wellsense.org to the Enrollment Department at 866-335-9317.

WellSense automatically assigns the newborn to the newborn's admitting doctor, or, if the admitting doctor is a neonatologist, to:

- A sibling's PCP

- The mother's primary care site if the PCP specialty is appropriate for the newborn (such as a family medicine site)
- A randomly assigned primary care pediatric or family medicine site (within access guideline) unless the mother requests another PCP assignment

The mother may request a PCP assignment or change a PCP assignment at any time by calling our Member Service Team at 877-957-1300, or by faxing a completed Member PCP Transfer Request form, found at wellsense.org, to our Enrollment Department at 866-335-9317.

Follow the guidelines below to verify newborn eligibility and to notify WellSense of a newborn birth.

Step	Process
1: Verify mother's eligibility and enrollment.	Check the mother's eligibility in WellSense on the newborn's date of birth using one of the options below: • Visit our online eligibility verification system via the secure Provider Portal at wellsense.org • Call WellSense at 877-957-1300, Provider Service.
2: Hospital notifies WellSense of the birth.	If the mother is enrolled in WellSense on the newborn's date of birth, the hospital or treating provider must submit a completed Birth Event Notification form within 24-48 hours after a vaginal birth and 96 hours after a C-Section birth to our Enrollment Department by faxing it to 866-335-9317.
3: WellSense issues newborn member ID number.	We generate a temporary ID number for the newborn within one business day of the notification. Hospitals must include the newborn's temporary ID number on the claim form when billing for newborn services.
4: DHHS issues newborn member ID number.	DHHS generates an ID number after it receives or confirms the newborn's birth certificate. If the mother is a WellSense member, the newborn will be retroactively enrolled in WellSense from the newborn's date of birth. Please contact us at 877-957-1300, o, Provider Service, if you have questions or need clarification on newborn member eligibility.

Clarity

Step	Process
1	Check the mother's eligibility for WellSense on the date of birth of the newborn.
2	If the mother is enrolled in WellSense on the newborn's date of birth, the hospital or treating provider must bill newborn charges under the mother's ID number for the first 31 days following birth.

3	Clarity plan members must enroll newborns within 60 days of the newborn's date of birth via Healthcare.gov. The newborn may be retroactively enrolled in our Clarity plan product as of the newborn's date of birth.

2.4 Affordable Care Act grace period for delinquent premium payments for NH ACA APTC vs Non APTC.

Providers should understand these federal requirements because they directly affect your payments from us for covered services. Under the Affordable Care Act (ACA), health plans are permitted to pend and later deny claims rather than pay and later retract payment for claims for services rendered during the grace periods as described below. We reserve our right to pend such claims.

NH ACA APTC Claims

Medical Claims

As required by the ACA, New Hampshire ACA members who receive a federal tax credit (APTC) to lower their monthly premium 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 and must show as "eligible" on our systems. We will process and pay claims for covered services rendered during the first month of the grace period. We will then pend claims for covered services rendered in the second and third months of the grace period. In this circumstance, providers may bill the member for covered services rendered during the last two months of the grace period.

If a member fails to pay their required premium at the end of this 90-day period, both the Health Insurance Marketplace and WellSense will retroactively terminate the member as of the first day of the second month of the 90-day grace period. We will then deny any claims for services delivered during the second or third month of the grace period.

We cannot retroactively terminate a delinquent member until the Health Insurance Marketplace approves the action. If the Health Insurance Marketplace 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.

If the member pays their premiums sometime during the second or before the end of the third month, we will release claims and process them towards the member's benefits. We will include notice in the Remittance Advice and the Electronic Remittance Advice (835).

Pharmacy claims

Pharmacy claims with dates of service during the second and third months of the grace period will be processed in accordance with all our pharmacy rules, but not covered by WellSense. During this time period, members will be responsible for 100% of prescription costs. If the member pays their premium in full by the end of the 90-day grace period, the member may seek reimbursement from our pharmacy benefit manager.

NH ACA Non-APTC Claims

Medical claims

Members who do not receive APTC benefits are asked to make premium payments that are due in advance, on a calendar month basis. These members are given a 31-day grace period to submit their premium payments. We will pend claims during the 31-day period to see if the member submits their premium payment. We will notify HHS, as necessary, of the non-payment of premiums, the member, as well as providers of the possibility of denied claims when the member is in the grace period. At the end of the 31 days, we will retroactively terminate the member if the premium is not paid. We will then deny any claims held due to eligibility.

Pharmacy claims

Pharmacy claims with dates of service during the 31-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 31-day grace period, the member may seek reimbursement from WellSense's pharmacy benefit manager

Section 3: Credentialing

3.1 General information

All credentialing information below applies to providers participating in WellSense networks, except when noted otherwise. All physicians and other allied health practitioners must achieve credentialed status with us before becoming participating providers. You must renew your credentialed status every two years to maintain participation. Our government contracts mandate the requirements for credentialing, which are also consistent with National Committee for Quality Assurance (NCQA) standards and applicable New Hampshire professional licensing board regulations.

We cannot reimburse providers for delivering care to our members until they achieve credentialed status. All covering practitioners also achieve credentialed status. This includes temporary and permanent coverage. We must approve any change in coverage arrangements prior to coverage occurring. See Section 4: Provider Responsibilities for our policy on the use of covering physicians. Providers must notify us of changes in the status of any items that are submitted as part of the credentialing process.

3.2 WellSense credentialing/recredentialing policies and procedures

The following is a summary of our credentialing/recredentialing policies and procedures. You can request a complete copy of these policies by calling our provider line at 877-957-1300 (Provider Service).

Responsibility

Our Quality Improvement Committee (QIC) oversees our credentialing and recredentialing processes. Our Credentialing Committee approves or denies practitioner participation based upon peer review of the application, supporting documents and results of the credentialing verification process.

Delegation

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

WellSense and HealthCare Administrative Solutions, Inc. (HCAS)

We are a member of HCAS. HCAS offers a single point-of-entry for practitioners to submit information that HCAS-participating health plans use to verify a practitioner's qualifications prior to network participation. HCAS health plans partner with DataSpring, (formerly the Council for Affordable Quality HealthCare [CAQH]) to collect and store a practitioner's credentialing information. For more information about HCAS, please visit their website hcasma.org.

Steps to become credentialed and enrolled with WellSense:

1. Complete an HCAS Enrollment Form.
2. Complete a Provider Data Form.

3. Ensure that you have a complete and recently attested DataSpring application, and that permission to access your DataSpring account has been granted to Boston Medical Center HealthNet Plan/WellSense Health Plan.
4. Submit completed forms to one of the following:
    - Email: NHProvider.Enrollment@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

We credential practitioners who have an independent relationship with us and are permitted to practice independently under New Hampshire law and provide care to members under the organizations medical benefits, including but not limited to the following types of practitioners:

- Addiction medicine specialists
- Alcohol and drug counselors
- Applied behavioral analysts
- Audiologists
- Certified nurse midwives
- Marriage and family therapists
- Mental health counselors
- Nurse practitioners
- Nutritionists
- Occupational therapists
- Oral and maxillofacial surgeons (DDS)
- Physical therapists
- Physicians (MD and DO)
- Physician associates
- Podiatrists
- Psychiatrists
- Psychologists
- Speech-language pathologists

Hospital and facility-based physicians

WellSense does not fully credential practitioners who practice exclusively within a hospital inpatient settings, community mental Health centers and clinics, or freestanding facilities. Hospital- and facility-based practitioners include, for example, pathologists, anesthesiologists, radiologists and emergency room physicians.

Locum tenens physicians

Locum tenens intended to provide services for fewer than 60 calendar days require only a provisional credentialing process for that 60-day period. The provisional credentialing requirements include, but are not limited to:

- An HCAS Enrollment Form and Provider Data Form with an indication that the provider requests locum tenens status
- A Locum Tenens Credentialing Form
- A complete and signed DataSpring application that includes a signed attestation regarding the accuracy and completeness of all information provided.
- A current and unrestricted license to practice in the state where the locum will provide care to Plan members.
- Hospital admitting privileges (If no privileges, include coverage arrangements)

All contracted providers using locum tenens 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 fewer than 60 calendar days from the date of approval and will not be renewed or extended. At the end of this period, we will automatically terminate the locum tenens's temporary network participation. Locum tenens who anticipate or need to participate for 60 calendar days or more must complete our full credentialing process. To facilitate this extended timeframe, please 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 their services according to the guidelines established in Section 9.2: Provider 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, intermediate and inpatient care, including care provided in a network hospital, clinic, professional office, home care setting, long-term care setting or any other setting, when rendered by a participating nurse practitioner practicing within the scope of the nurse practitioner's professional license to the extent that WellSense covers the identical services rendered by another New Hampshire-licensed provider of health care.

3.4 Credentialing/re-credentialing criteria

Practitioners are not entitled to be credentialed or re-credentialed on the basis that they are licensed by the state to practice a particular health profession or that they are certified by any clinical board or have clinical privileges in a WellSense-contracted entity. WellSense, in our sole discretion, credential and re-credential 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 that we treat all applicants in a fair and non-discriminatory manner. No WellSense credentialing or re-credentialing decisions are based on a practitioner's race, ethnic/national identity, religion, gender, age, 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 his/her 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 type of patients they serve.

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

- **Contract**
  Practitioners must be participating with WellSense to provide services to our members without evidence that they are in breach of their contractual obligations to us.
- **Credentialing application**
  Practitioners must have a current and complete DataSpring (formerly the *Council for Affordable Quality Healthcare [CAQH])* credentialing application, which includes the Standard Authorization, Attestation and Release form.
- **Education and training** *(Initial credentialing only)*
  Practitioners must successfully complete all education and/or professional training relevant to their contracted specialty and as applicable to their scope of practice and licensure. This includes graduate and post-graduate education, professional school, residency training, fellowship training and/or other accredited training programs as applicable.
- **Medicaid certification**
  All WellSense Medicaid providers are required to be enrolled with the State of New Hampshire as a New Hampshire Medicaid provider. In order to expedite the enrollment process, we may concurrently credential a provider while they are in the process of obtaining their New Hampshire Medicaid ID. Exceptions may be made for enrolling non-NH Medicaid approved providers, pending the outcome of screening and enrollment in New Hampshire Medicaid of up to 120 calendar days' duration. We will terminate a participating provider immediately and will contact affected members upon notification from DHHS that the participating provider cannot be enrolled with NH Medicaid or the expiration of the 120-day period.
- **Medicare participation**
  All providers enrolled in the WellSense Medicare Advantage HMO and PPO networks must be eligible to participate in the federal Medicare program.
- **National Practitioner Identifier (NPI)**
  All provider types that may obtain an NPI must have one in accordance with 45 CFR Part 162, Subpart D.
- **License**
  Practitioners must have a current, valid and unrestricted license to practice in the state in which they provide care to our members, unless otherwise permitted under a state-established licensure pathway approved by the Plan. Additional certifications may be required as applicable to the practitioner's specialty.
- **Drug Enforcement Agency (DEA) or controlled dangerous substance (CDS) certification**
  Practitioners must possess a current and valid DEA or CDS certificate that is registered in each state where they provide care to our members. Practitioners 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 practitioners whose scope of practice includes prescribing controlled substances but who do not maintain an active certificate, the practitioner must sign a waiver and designate an alternate prescriber (individual or practitioner) who will prescribe on their behalf. Alternately, if a practitioner

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 maxillo-facial surgeons, nurse practitioners, and physician associates only.

- **Professional liability insurance**
  Practitioners 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 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 maxillo-facial surgeons, nurse practitioners and physician associates 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.

  We may consider waiving these requirements only when necessary for us to maintain adequate member access.
- **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 restriction(s). All restrictions will be considered and evaluated by the Credentialing Committee in its discretion.
- **Alternative admitting arrangements**
  If the practitioner does not have an active affiliation and admitting privileges at a 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 thorough the use of a hospitalist program at a WellSense-contracted hospital).
- **Physician collaboration**
  Physician associates must comply with applicable New Hampshire requirements regarding collaboration, consultation, and practice arrangements, including maintaining a written collaboration agreement when required under RSA 328-D3-b.
- **Federal/state program sanctions and exclusions**
  Practitioners must not be currently debarred, suspended sanctioned, precluded or otherwise excluded from participation in Medicare, Medicaid or any other federal or state health care programs.
- **Criminal proceedings**
  Practitioners must not have been involved in any felony convictions or criminal proceedings that may be grounds for suspension or termination of the practitioner's license to practice.

- **Compliance with legal standards**
  Practitioners must be in compliance with all applicable legal requirements relating to the practice of their profession, including meeting all required continuing education requirements.
- **Quality care and service**
  Practitioners can be reasonably expected to provide quality and cost-effective clinical care and service to WellSense 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 ten years preceding the credentialing decision date for physicians, or five (5) years for non-physician practitioners. If the physician has fewer than ten (10) years of work history, or the non-physician practitioner has fewer than five (5) years of work history, the time frame starts at the date of initial licensure. (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 WellSense 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 experience surveys (applies to re-credentialing applicants only)
- Note: The Credentialing Committee may, in its discretion, look back further than 10 years if necessary to appropriately inform its decision making.
- **Practitioner behavior**
- Practitioners must not have engaged in behaviors that may adversely impact member care or service, including behaviors that:
  - 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 the practitioner's interactions with WellSense, our provider network or our members
  - Reflect a lack of commitment to managed care principles or a repeated failure to comply with our managed care policies and procedures
  - Indicate a lack of cooperation with our Quality Improvement or Utilization Management programs
  - Constitute unlawful discrimination against a member under any state or federal law or regulation
- Practitioners have not engaged in any behaviors that could harm other health care professionals, patients or WellSense employees. Such behavior includes acts of violence committed within or outside the practitioner's practice, whether or not directed towards other health care professionals, patients or WellSense employees, and must be judged by the Credentialing Committee to create a significant risk to other health care professionals, patients or WellSense employees.
- **Primary Care Practitioners (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 only)
- A Nurse Practitioner (NP) that is board certified as an Adult Nurse Practitioner, Pediatric Nurse Practitioner, Gerontology Nurse Practitioner or Family Nurse Practitioner
- A Physician Associate (PA)

- Exceptions: WellSense may authorize a specialist physician to serve as a member's PCP if the member has a life-threatening, degenerative or disabling condition or disease that requires prolonged specialized care (e.g., HIV, end-stage renal disease or an oncology diagnosis), and WellSense believes it will be in the best interests of the member to make this exception. Specialists acting in the capacity of a PCP must be or must become a plan-participating PCP and are required to adhere to all WellSense standards applicable to PCPs.
- **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 that is not required by contract, statute, regulation or accreditation standard when, in its discretion, to do so will advance patient care or service and WellSense's objectives.

3.5 Re-credentialing

WellSense re-credentials all practitioners who have a current contractual arrangement with us to provide services to our 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 WellSense's Credentialing Verification Organization (CVO) vendor and without notice to the practitioner.

Practitioners must continue to satisfy WellSense's credentialing criteria to be re-credentialed by us. They must ensure that DataSpring contains up-to-date information and must re-attest periodically or as needed so their DataSpring application remains current. If a practitioner does not keep their DataSpring application 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, we will notify you in writing of the discrepancy. (**Note:** we are 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, WellSense's Medical Director and/or the Credentialing Committee will review the applications to determine if the practitioner meets our credentialing criteria outlined in this section. Based on this review, practitioners may be fully approved and credentialed, approved with conditions, denied initial credentials or terminated.
- **Notice to practitioners**
  All applicants granted initial credentials are notified in writing of the approval. The effective date for a practitioner is the credentialing date or contract effective date, whichever is later. WellSense will complete initial credentialing of all providers applying for network participation within 30 calendar days for primary care providers and 45 days for specialty care providers. The start time begins when WellSense has received a provider's clean and complete application (including an active NH Medicaid ID if applicable) and ends on the date of the provider's written notice of network status.
- **Approved with conditions or terminated**
  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 within 10 calendar days from the Committee's decision. Practitioners who are re-credentialed in the ordinary course do not receive written notice.
- **Notice to members**
  If a practitioner is terminated for any reason, we are required to notify members who have been obtaining services from these practitioners that the practitioner is no longer affiliated with WellSense.
- **Reporting**
  WellSense complies with all regulatory and government reporting requirements. All denials, conditional approvals or terminations that constitute disciplinary actions under state law and/or adverse professional review actions under federal law will be reported as required.

3.8 Ongoing monitoring and off-cycle credentialing reviews and actions

Between re-credentialing cycles, WellSense conducts ongoing information monitoring from external sources, such as sanctions from state licensing boards (e.g., Board of Medicine); Medicare/Medicaid or the 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 NH DHHS or other state or federal regulatory authorities to suspend or terminate a practitioner, we are required to suspend or terminate the practitioner from our WellSense network. In such a case, we will notify the practitioner in writing with the reasons no later than seven calendar 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 DHHS or other regulatory authority.

3.9 Credentialing appeals process for practitioners

Right of appeal

If the Credentialing Committee denies your initial credentials, credentials you with conditions, or terminates your credentials and such action constitutes a "disciplinary action" as defined in WellSense's Credentialing Policies, you are entitled to appeal the disciplinary action. A disciplinary action is an adverse action taken by WellSense's Credentialing Committee, up to and including termination from WellSense, on the basis of a Committee determination that the practitioner does not meet WellSense's 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 NH DHHS, CMS, or other regulatory authority to terminate or suspend a practitioner who participates in the WellSense networks.

Disciplinary notice

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

Practitioner request for appeal

The practitioner may request an appeal in writing by sending a letter to WellSense's Director of Credentialing postmarked no more than 60 calendar days following their receipt of WellSense's notice of disciplinary action. We will not accept provider appeals after the 60 calendar day period. Providers should include in their appeal a statement indicating the foundation of the appeal and any supporting

documentation they wish to submit, including any new or relevant information that they believe may not have been originally considered by the Credentialing Committee. When we receive a timely appeal, we will send the practitioner an acknowledgement letter. The Director of Credentialing will arrange for the 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 overturns its original decision, we will notify you in writing. 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 that an independent review appeals panel will be assembled to review the appeal, request your availability for a hearing and provide you with the timeframe in which you may submit additional evidence for the panel's consideration. Additional evidence will be due approximately 2 weeks prior to the scheduled appeal hearing.

Appeals panel hearing and notice

The appeals panel is a medical peer review committee appointed by the WellSense Chief Clinical Officer (CCO), Chief Medical Officer (CMO) or designee to hear the appeal. The hearing will occur between 30 and 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 a review of the written submissions by WellSense and the practitioner. You have a right to be represented in an appeal by another person of your choice (including an attorney). The panel is empowered to uphold, modify or overturn 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 no later than 3 business days from the date of the hearing. If the disciplinary action is reversed during the appeal process, WellSense shall take all steps to reverse the disciplinary action within three calendar days.

Re-application following denial or termination

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

3.10 Role of the credentialed practitioner

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 3.3 Credentialing and re-credentialing process for our policy on the use of locum tenens physicians.

Role of the credentialed primary care practitioner (PCP)

A 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, 7-

days-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.

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 or another Plan-recognized board. 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. We must credential all covering providers.

Credentialed Behavioral Health specialists are licensed clinicians specializing in mental health and substance use disorder services. Behavioral Health specialists are responsible for providing mental health and substance use disorder services that are clinically and developmentally appropriate, member-centered, aligned with principles of system of care, recovery and resiliency and that considers parents, caregivers, and other networks of support the Member may rely on. These providers deliver behavioral health services consistent with trauma-informed models of care, as defined by Substance Abuse and Mental Health Services Administration (SAMHSA). Credentialed providers who supply services for substance use disorder must be compliant with the Covered Services provisions in He-W 513.0 applicable to their provider type, to Opioid Treatment Programs, other Substance Use Disorder Treatment, and Recovery Services providers.

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 DHHS survey against WellSense standards. We will conduct an onsite assessment if the facility is not accredited and has not had a recent DHHS survey.

Behavioral Health credentialed facilities are responsible for credentialing and overseeing its clinical staff. Master's-level behavioral health counselors are approved to function in all contracted hospital-based, agency/clinic-based and other facility sites. State-certified SUD outpatient and SUD comprehensive programs are the only facilities allowed to utilize Licensed Alcohol and Drug Counselors (LADCs) to provider SUD services under the supervision of an MLADC

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

- Acute care hospitals
- Acute rehabilitation hospitals
- Skilled nursing facilities
- Medical/physical rehabilitation facilities

- Home health care providers
- Home infusion providers
- Community Mental Health Providers
- Community Mental Health Programs (CMHCs)
- Certified Community Behavioral Health Clinics (CCBHC)
- Substance Use Disorder providers
- Opioid Treatment Providers (OTPs)
- Hospice providers
- Free-standing surgical centers
- Sleep centers
- Family planning clinics
- Free-standing urgent care facilities
- Minute clinics (e.g., limited services clinics)
- Durable medical equipment, prosthetic, orthotic suppliers (please refer to WellSense's 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

Standards for participation

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

- Providers must submit a current and complete credentialing application
- Medicaid Participation: All providers that are applying to be enrolled in the Wellsense Medicaid network must first obtain a New Hampshire DHHS Medicaid ID. To expedite enrollment, Wellsense may concurrently credential a provider while it's in the process of obtaining their Medicaid ID with DHHS. As an exception, providers may be provisionally enrolled with Wellsense for up to 120 days pending the outcome of the DHHS enrollment process.
- Medicare Participation: All providers that are enrolled in the WellSense Medicare Advantage networks must be eligible to participate in the federal Medicare program.
- Copy of current state license issued by the Department of Health and Human Services or appropriate state agency. If license is not current, the provider must provide a letter from the Department of Health and Human Services indicating the licensure status.
- Providers must not be currently debarred, suspended or otherwise excluded from participation in Medicare, Medicaid, or any other federal or state health care programs.
- Providers must have a current 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 (applies to providers with laboratories only).

- Accreditation, Site-Survey, or Plan On-Site Quality Assessment: Providers must be accredited by a nationally recognized accrediting body or must meet equivalent quality standards as verified through on-site or governmental review.
    - WellSense-recognized accreditation agencies:
        - Accreditation Association for Ambulatory Health Care (AAAHC)
        - Accreditation by the American College of Radiology (ACR)
        - Accreditation Commission for Health Care (ACHC)
        - Association for the Advancement of Blood & Biotherapies (AABB)
        - Center for Improvement in Healthcare Quality (CIHQ)College of American Pathologists (CAP)
        - Commission for the Accreditation of Birth Centers (CABC)
        - Commission on Accreditation of Rehabilitation Facilities (CARF)
        - Commission on Office Laboratory Accreditation (COLA)
        - Community Health Accreditation Program (CHAP)
        - Continuing Care Accreditation Commission (CCAC)
        - Council on Accreditation (COA)
        - DNV Healthcare
        - Intersocietal Accreditation Commission of Vascular Testing (IAC)
        - Joint Commission f(TJC)
        - National Association of Childbearing Centers (NACC)
        - Quad A
        - Urgent Care Association (UCA)
- 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 DHHS within the past 36 months. WellSense 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, we must receive a letter showing that the plan of correction has been accepted by CMS or DHHS.
- 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 our standards, we will complete an on-site quality assessment. During the assessment, we will use the appropriate form addressing the specific criteria for each provider type. 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. We will also review the provider's process for credentialing the practitioners employed at the organization.
- A provider may be considered exempt from having to meet this requirement if it is located within a rural area as defined by the US Census Bureau.

Re-credentialing

All contracted organizational providers are re-credentialed at least three years 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 10 business days of any actions by a state agency that might impact their credentialing status with us, including 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.

Section 4: Provider Responsibilities

4.1 New provider request to participate in our network or request to join a new product line

Both new providers and providers contracted under a different WellSense plan type may request participation in any of our provider networks by submitting a letter of interest (LOI) to the WellSense Provider Engagement department. The letter should include provider's:

- Name
- Specialty
- NPI(s)
- Statement of interest in participating in WellSense's network
- Practice location(s)
- Hospital affiliation(s), if applicable
- Language(s) spoken and other cultural competencies
- W9 form
- NH Medicaid ID if joining the WellSense NH Medicaid Provider Network

LOIs can be sent to:

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

LOIs may also be emailed to NHproviderinfo@wellsense.org.

4.2 Responsibilities by provider type

General requirements for all providers

WellSense works with New Hampshire Medicaid, New Hampshire Insurance Department to serve eligible individuals. We encourage providers to work with members to promote self-care, independent living and the minimization of secondary disabilities. To provide care management for high-risk members, WellSense contracts with PCPs, behavioral health and substance use disorder and other specialists experienced in working in multidisciplinary teams.

Providers participating with us must comply with the obligations specified in their provider agreement, this Provider Manual and network notifications that we post to our website. We will take appropriate action with respect to providers not in compliance with our requirements. Providers are expected to work cooperatively on corrective actions, as appropriate. We notify providers in writing of any material changes to plan policies and procedures at least 60 calendar days prior to the effective date of the change unless regulatory requirements or directives require a different time frame.

Providers are trained in Trauma-informed models of care, suicide assessment, prevention and intervention, person-centered care management, health related social needs, quality, privacy and confidentiality of certain conditions.

For questions or to request provider training, contact your Provider Relations Consultant at NHProviderinfo@wellsense.org or call the WellSense Provider Service team at 877-957-1300 option 3 (for NH Medicaid), 855-833-8122 option 3 (for Clarity plans).

All providers are expected to comply with the accessibility standards of the ADA, including physical access, reasonable accommodations, and accessible equipment for all members including those with physical or cognitive disabilities [42 CFR 436.206(c)(3)]

To assure participating providers meet Substance Abuse and Mental Health Services Administration (SAMHSA) Levels of Integrated Healthcare, physical and behavioral health providers should provide co-located or integrated care to the maximum extent feasible.

Contract requirements for all providers

Below are some of the most important contractual obligations for participating PCPs, specialty physicians, health centers, ancillary providers, hospitals and affiliated vendors.

Care coordination requirements for all providers

- Supervise, coordinate and provide medically necessary WellSense-covered services, along with associated covered services according to accepted standards of clinical practice by provider type.
- Be mindful of the member's need for dignity and respect and treat members promptly and courteously in a clean, comfortable environment.
- Maintain confidentiality and security of member information and records at all time
    - If a member is receiving a prior authorized ongoing course of treatment with a provider who becomes unavailable to continue to provide services, the provider should notify WellSense within one day of unavailability so that WellSense may develop a transition plan for the member. Accept and treat members without regard to race, age, gender, sexual preference, national origin, religion, health status, economic status, or physical disabilities including children with special health care (CSHC) needs (those who have an increased risk for, chronic physical, developmental, behavioral, or emotional conditions, or who require health and related services of a type beyond that required by children generally). No provider may engage in any practice with respect to any WellSense member that constitutes unlawful discrimination under any state or federal law or regulation.
- Freely communicate with members about their treatment options, including medication treatment options, regardless of any benefit coverage limitations.
- Collaborate and provide consultation to New Hampshire Division for Children, Youth, and Families (DCYF) regarding medical and psychiatric matters for members who are children in State custody/guardianship to ensure continuity and coordination of physical health and behavioral health services.
- Providers cannot refuse to provide services to members who have missed appointments or who have an outstanding debt from a time prior to when the individual became a WellSense member.
- Providers must work with the member and WellSense to help members keep appointments.
- Maintain complete medical records consistent with all statutory and regulatory requirements and WellSense policies. Medical records must be available to WellSense to fulfill quality management

responsibilities. See medical record charting standards in 14.7 - Medical record charting standards for participating physicians.

- 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, providers must have protocols in place to document good faith efforts, including reasons for why the check was not conducted, and document and address contradictory information in the PDMP from information received by patients
- Comply with WellSense prior authorization and notification requirements by service type:
  - Medical/surgical services, behavioral health and substance use disorder services as specified in Section 8: Utilization Management and Prior Authorization
  - Section 13: Pharmacy Services
- Adhere to all WellSense reimbursement and clinical coverage guidelines.
- Report immediately to WellSense any adverse medical incident(s). Refer to sections 4.19 and 14.6 for more specific details and definitions.
- Providers who are discharging members from an ED or a medical unit following hospitalization for an overdose or substance use disorder an appointment for treatment, within seven calendar days of discharge, with a substance use disorder provider must be scheduled prior to discharge whenever possible]; discharging providers must provide the final discharge instruction sheet to the member and/or the member's authorized representative prior to discharge or the next business day for at least 98% of members discharged. They must ensure that the discharge progress note is provided to any continuing care treatment provider within seven calendar days of member discharge for at least 98% of members discharged. For discharge progress notes containing information about mental health or substance use disorder treatment, applicable privacy laws may apply.
- For NH Medicaid members, all providers shall utilize, leverage and partner with the NH closed-loop referral service to ensure appropriate communication among and between providers and WellSense, appropriate follow-up care in the most integrated and cost-effective delivery setting and warm transfers
- Transitional Health Care shall be available from a primary care, behavioral health or specialty provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.
- Transitional Home Care shall be available with a home care nurse, licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the PCP or Specialty Care Provider or as part of the discharge plan.
- Eligible NH Medicaid members with SPMI, SMI, or SED shall be provided with coordinated care when entering and leaving a designated receiving facility DRF).
- Provide integrated care coordination, assessment, diagnostic evaluation and the appropriate level of care for all NH Medicaid members referred from a court order or a request from NH Department of Health and Human Services (DHHS).

Relevant only to primary care physicians (NH Medicaid product)

Upon initial contact with a member, and ongoing thereafter or after the onset of a condition requiring mental health and/or substance use disorder treatment complete a behavioral health assessment to

identify a member's need for behavioral health treatment. We require all PCPs and behavioral health Providers to incorporate the following domains into their screening and assessment process: Demographic, Medical, SUD, Housing, Family and support services, Education, Employment and entitlement, Legal, Risk assessment including suicide risk and functional status (ADL, IADL, cognitive function). PCPs must collaborate with behavioral health providers to ensure continuity and coordination of physical health and behavioral health services for members. They must furnish member clinical information, subject to the member's consent, to other providers as necessary to ensure timely and appropriate coordination of care. To increase the frequency and quality of information shared between behavioral health clinicians and PCPs, WellSense developed a referral process to be used by participating providers, including what information shall be exchanged and when to share this information, as well as notification to the member's care manager. Please see the Behavioral Health Notification Form, available at the WellSense website. For members who are discharging from an ED or from a medical unit following hospitalization for an overdose or substance use disorder, the provider should collaborate with WellSense care management to assist in the development of the written discharge plan, ensure a seamless transition of care back to the community and coordinate aftercare with the applicable provider. Following discharge, WellSense care management will call the member within three business days of discharge. If we cannot reach the member, we may reach out to the member's PCP or behavioral health provider with a request to make contact with the member within 24 hours.

If a member requires behavioral health services, including services for or substance use disorder treatment, promptly direct the member to secure a behavioral health provider or have the member call 877-957-1300 for assistance.

Relevant only to behavioral health providers

- Report immediately any behavioral health reportable adverse incident related to a WellSense member. See Section 14: Quality Management for a description of the behavioral health and reportable adverse incidents, including policy information and instructions on the appropriate notification process by incident category.
- See section 4.5 Access to Care standards. All NH Medicaid providers must comply with time and distance and wait standards.
- Members may access outpatient behavioral health and substance use disorder services by self-referring to a network provider, by calling WellSense care management, through acute or emergency room encounters, or through their PCP. A PCP referral is never required for behavioral health services.
- Subject to a member's consent, furnish the member's clinical information to other providers as necessary to ensure proper coordination and behavioral health treatment of members who express suicidal or homicidal ideation or intent.
- Request written consent from the member to release personally identifiable or protected health information to coordinate care regarding behavioral health services and primary care. If the member's consent is not given, the provider should notify WellSense in writing within two business days of the consent request and include, if possible, the reason that consent was not given.
- Prior to discharge of a NH Medicaid member from an inpatient psychiatric facility, providers shall ensure that the behavioral health discharge instruction sheet is provided to the member and the member's authorized representative prior to discharge, or the next business day, for at least 98% of members discharged. for at least 98% of members discharged.

- The discharge progress note for NH Medicaid members shall be provided to the aftercare provider(s) within seven (7) calendar days of member discharge for at least 98% of members discharged for at least 98% of members discharged.
- An appointment with a CMH Program or Provider, or other appropriate mental health clinician shall be scheduled and transportation arranged for the appointment prior to discharging NH Medicaid members from an inpatient psychiatric facility.
- NH Medicaid members shall have an appointment with a CMH provider or program within seven (7) calendar days of discharge from a State-owned Hospital, inpatient psychiatric facility or other State determined IMD.
- NH Medicaid members discharged from a psychiatric facility who are not currently attributed to a CMH program will have an intake appointment scheduled with the CMH program within seven (7) calendar days of discharge.
- Eligible Members shall be provided with coordinated care when entering and leaving a designated receiving facility.
- Aftercare providers are required to conduct medication reconciliation within 48 business hours of discharge for any member discharged from an acute care setting, including psychiatric hospitalization and residential treatment.
- Child and adolescent behavioral health providers shall collaborate with the adult mental health service delivery system in the transition of members through these systems by communicating treatment plans and exchanging information.

Relevant only to community mental health (CMH) programs and providers

- CMH providers must comply with NH Department of Health and Human Services (DHHS) Medicaid Care Management (MCM) Agreement, Medicaid State Plan and He-M 401.02, He-M 403.02 and He-M 426 and all applicable State and federal laws, rules and regulations.
- All CMH services provided by a CMH provider must ensure that all members receiving CMH services are currently eligible and that there is a method for collaborative service planning and service delivery with the regional CMH Program including joint development and approval of an Individual Service Plan (ISP) for each member.
- An evidence-based assessment tool, such as the NH version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA) will be used to complete a Comprehensive Assessment. If a CMH Program elects to use an evidenced-based assessment tool other than CANS or ANSA, the CMH Program shall notify and receive approval of the specific tool from the NH DHHS.
- Clinicians using CANS and ANSA, or alternative evidenced-based assessment tool approved by DHHS, shall be certified in the use of the assessment tool within one hundred and twenty calendar days of training,
- Newly evaluated NH Medicaid members and existing members shall be assessed using the CANS, ANSA or approved alternative assessment tool no later than the member's first eligibility renewal determination for CMH Program services.
- The CANS and ANSA assessment shall be completed at least every 90 calendar days to document progress towards goals and objectives and any continued need for CMH Program services. Documentation of the review shall fulfill the quarterly review requirements as defined in He-M 408 and He-M 401.

- Initial and updated person-centered treatment/care plans for NH Medicaid members shall be based on the Comprehensive Assessment completed by the CMH Program and include measurable outcomes to drive the individualized service plan (ISP).
- All members eligible for CMH services shall be offered the provisions of supports for illness self-management and recovery
- Care coordination shall include communication and coordination with WellSense and other providers serving the member.
- Community Mental Health Programs, and Certified Community Behavioral Health Clinics, must ensure coordinated care and connection between the providers, or at minimum confirm that the connection has been made between the providers.
- NH Medicaid members receiving ACT team services shall be seen within twenty-four (24) hours of discharge from an inpatient psychiatric facility by the applicable CMH program or provider.
- CMH Programs and Providers will review cases of members that New Hampshire Hospital and other State determined IMDs for mental illness have indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community.
- Community Mental Health Programs must comply with the Prior Authorization requirements of NH RSA 126-A:5, XIX(g) for behavioral health drugs for behavioral health drugs, including use of the universal online Prior Authorization form provided by DHHS for drugs used to treat mental illness
- CMH Programs must comply with quality monitoring or audits of performance of the CMH Program and will meet with CMH Program at least quarterly to coordinate data collection, ensure data sharing and quality assurance activities conducted by WellSense and review quality improvement plan, data reports, care coordination activities, and outstanding needs.
- CMH Program Emergency Service teams employ clinicians and certified Peer Support Specialists who are trained to manage crisis intervention and have access to a clinician who can evaluate members in-person in the community to address crisis and evaluate the need for hospitalization.

Relevant only to substance use disorder providers

- For members being transferred from or otherwise referred by another provider, the provider shall use the clinical evaluation completed by the licensed behavioral health specialist from the referring agency, which may be amended by the receiving provider.
- The SUD Provider shall complete individualized treatment plans for all Members based on clinical evaluation data within three (3) business days of the clinical evaluation (or three (3) sessions, if the Member is meeting with an outpatient treatment provider no more than once per week), that addresses problems in all ASAM 2013 domains which justify the Member's admittance to a given level of care and that include individualized treatment plan goals, objectives, and interventions written in terms that are specific, measurable, attainable, realistic, and time relevant (SMART).
- The treatment plan shall include the member in identifying, developing and prioritizing goals, objectives and intervention and shall be updated based on any changes in any ASAM domain and at minimal intervals as described by ASAM for each level of care
- Treatment plan updates shall include: documentation of the degree to which the member is meeting treatment plan goals and objectives; modification of existing goals or addition of new goals based on changes in the member's functioning relative to ASAM domains and treatment goals and objectives; the providers assessment of whether or not the member needs to move to a different level of care based on ASAM continuing care, transfer and discharge criteria; and the signature of the member and

the provider agreeing to the updated treatment plan or if applicable, documentation of the members refusal to sign the treatment plan.

- SUD Providers ensure that members are provided with coordinated care with the provider(s) to whom the Member is being referred for ongoing treatment and services when entering or leaving a treatment program and that PRSS is provided.
- Ensure an aftercare appointment is scheduled prior to discharge and that transportation has been arranged for the appointment. Aftercare appointments shall occur within seven (7) calendar days after discharge and include recovery support services.
- The final discharge instruction sheet shall be provided to the member and the member's authorized representative prior to discharge, or the next business day, for at least 98% of members discharged.
- The discharge progress note shall be provided to any treatment provider within seven (7) calendar days of member discharge for at least ninety-eight percent (98%) of members discharged.
- Substance use disorder providers shall comply with monitoring of service performance through quality metrics and oversight procedures specified by the DHHS. WellSense will conduct reviews and audits of clinical records and claims for members receiving substance use disorder services provided by substance use disorder programs and Medication Assisted Treatment (MAT) services provided by Opioid Treatment Programs (OTPs)
- Substance use disorder program and/or providers shall have naloxone kits available on-site. Education on naloxone administration and emergency response procedures can be found at the U.S. Centers for Disease Control and Prevention here.

Relevant only to emergency services providers

- Emergency medical and behavioral health care shall be available twenty-four (24) hours a day, seven (7) days a week
- Notify WellSense no later than the next business day following provision of emergency services.
- For any member with behavioral health needs being discharged from an emergency department to homelessness, please contact WellSense Care Management within twenty-four (24) hours of discharge contact WellSense care management 8:30 a.m.–5 p.m., Monday–Friday at 855-833-8119 Emergency departments can also refer to New Hampshire Care Path at 866-634-9412 or New Hampshire Coalition to End Homelessness at 866-444-4211.
- Providers who are discharging members from an ED or from a medical unit following hospitalization for an overdose or substance use disorder must provide the final discharge instruction sheet to the member and the member's authorized representative prior to discharge or the next business day for at least 98% of members discharged. Providers must also ensure that the discharge progress note is provided to any continuing care treatment provider within seven calendar days of member discharge for at least 98% of members discharged. For discharge progress notes containing information about mental health or substance use disorder treatment, applicable privacy laws may apply.

Relevant only to notification of pregnancy

- Notify WellSense as soon as possible, but no later than three business days after confirming a member's pregnancy. Notice should be given by contacting the Prior Authorization Department by calling WellSense at 877-957-1300 Option 3 and selecting the medical prior authorization option. This requirement does not apply to ancillary providers.

Primary care office responsibilities

PCPs must provide comprehensive primary care services to WellSense members:

- Tracking, scheduling, and following up on missed health screening appointments, including the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
- Scheduling members timely in accordance with Access to Care standards outlined in 4.5 Access to Care standards
- Scheduling and authorizing member follow-up care with other providers
- Tracking and reporting the information required, as outlined in the EPSDT and Adult Health Screening sections of this chapter

WellSense Medicaid Primary Care Provider responsibilities

The responsibilities listed below are specific to PCPs who render services to members and are in addition to the responsibilities listed in this section for all physicians. This list is a supplement to the Provider Agreement.

- All PCPs shall conduct wellness visits at least annually. Wellness visits are PCP visits that include health risk and social determinants of health risk assessments and an evaluation of the member's physical and behavioral health, including screening for depression, mood, suicidality, and substance use disorder, for the purpose of determining a member's health wellness and developing of a plan of care.
    - The health risk assessment must incorporate the following domains: demographic; medical, including chronic and acute needs and chronic pain; substance use disorder (SUD); mental health (PHQ-2 or 9); housing, education, family supports, employment, and other social needs; risk assessment including suicide risk and functional status (ADL, IADL, cognitive functioning); tobacco cessation; unique needs of children with developmental delays, such as special healthcare needs; and unique needs of children involved with juvenile justice or DCYF.
- PCPs must offer preventive screenings in accordance with the Practice Guidelines and Standards (Section 4.8.2), including the recommendations of the United States Preventive Services Task Force for the provision of primary and secondary care for adult, adolescent and pediatric populations rated Level A or B and other preventive screening and services as required by the NH Department of Health and Human Services
- Pediatric PCPs must ensure that all children receive standardized, validated developmental screening, such as the Ages and Stages Questionnaire and/or Ages and Stages Questionnaires: Social Emotional at 24/30-month pediatric visits and at ages 9 and 18 and use a screening system developed by the American Academy of Pediatrics (AAP) or other nationally recognized developmental and behavioral. The assessment shall minimally include universal screening via full adoption and integration of the following two evidenced-based screening practices: Depression screening (PHQ2 &9) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care.
- PCPs must complete comprehensive medication reviews for adult members prescribed five or more medications and for children prescribed four or more medications as described in further detail in Section 13.10.
- PCPs must coordinate, monitor and supervise the delivery of primary care services to each member.
- PCPs must participate in transition of care activities including Medication Reconciliation following a transition in level of care.

- PCPs serve as the primary entity responsible for assessing each member's needs and creating the member care plan. The member care plan is a document prepared and updated by a member's PCP and interdisciplinary care team with input from the member which summarizes the member's health conditions, specific care needs and current treatments. The member care plan outlines what is needed to manage the member's care needs and helps organize and prioritize care and treatment, including referrals relative to health-related social needs as defined in this manual.
- Coordinating care among and between providers serving a member, including primary care physicians, specialists, behavioral health providers and social service resources. Including related documentation in the member care plan and assisting Plan staff with exchanging this information on activities for members.
- Initiating the coordination of closed-loop referrals for clinical and non-clinical services the Member needs. This will include, but not be limited to, Behavioral Health Services and health-related social needs, with the Provider remaining engaged with clinical and non- clinical Provider(s) throughout the course of treatment for the referred service(s).
    - For services that the PCP is unable to coordinate, they are encouraged to refer to WellSense care management.
    - As stated in the New Hampshire Medicaid contract, the PCP is encouraged to utilize the closed–loop referral system that has been adopted by NH DHHS.
- Collaborating with behavioral health providers as well as entities including the New Hampshire Division for Children, Youth, and Families (DCYF) to ensure continuity and coordination of physical health and behavioral health services for members.
- Ensuring that the need for behavioral health services is systematically identified by and addressed at the earliest possible time and ongoing thereafter or after the onset of a condition requiring mental health and/or substance use disorder treatment.
- Maintaining continuity of each member's health care and medical records to include documentation of all services provided by the PCP as well as any specialty service.
- Ensuring the availability of physician services to members in accordance with appointment scheduling as outlined in this section.
- Arranging for on-call and after-hours coverage in accordance with the after-hours service as outlined in this section.
- Ensuring NH Medicaid members are aware of the availability of public transportation, where available, and non-emergency medical transportation (NEMT) availability by calling WellSense Member Service at: 877-957-1300, Option 1, for NH Medicaid, or the WellSense transportation line at 844-909-RIDE (844-909-7433).
- Providing access to WellSense or its designee to thoroughly examine the primary care offices' books, records, and operations of any related organization or entity. A related organization or entity is defined as: having influence, ownership, or control and either a financial relationship or a relationship for rendering services to the primary care office.
- Submitting an encounter for each visit where the provider sees the member and submits encounter data according to HEDIS guidelines as outlined in Section 14: Quality Management
- Following the guidelines as outlined in Section 9: Billing and Reimbursement.
- Ensuring members utilize Plan providers. If unable to locate a participating provider for required services, contact WellSense for assistance. Our Provider Service team is available at 877-957-1300 option 3 (for NH Medicaid), 855-833-8122 option 3 (for Clarity plans)

Covering Physicians

If a physician is temporarily unavailable to furnish care or referral services to Plan members, the physician should make arrangements with another Plan-contracted and credentialed physician to furnish services on the physician's behalf, unless there is an emergency. In non-emergency cases, if a covering physician is not contracted and credentialed with WellSense, providers should contact WellSense for prior authorization. The physician should be credentialed by WellSense, sign an agreement accepting the negotiated rate and agree not to balance-bill Plan members.

For additional information, please contact your Provider Relations Consultant or call the Provider Service team at 877-957-1300 option 3 (for NH Medicaid), 855-833-8122 option 3 (for Clarity plans)

Responsibilities of contracted hospitals

Contracted hospitals are required to comply with all relevant requirements in their WellSense contract and with this manual. Additional requirements include:

- Medical/surgical hospital services for WellSense members require prior authorization.
- Hospitals are required to notify us of any emergency admissions of our members.
- Hospitals must update us on maternity or newborn services used by our members.
- Hospitals must collaborate with our hospital care coordinators on concurrent review and discharge planning activities for medical or surgical services for our members.
- Hospitals must coordinate a WellSense member's behavioral healthcare services with our behavioral health care managers. If a member is experiencing a behavioral health crisis, immediately contact NH Rapid Response at 988 or by calling 833-710-6477. Hospitals must coordinate with providers and members after non-fatal overdoses including sharing discharge information with treatment providers within seven calendar days of discharge and with the member and the member's authorized representative prior to discharge or the next business day for 98% of our members.
- Hospitals are required to notify us of any member discharging against medical advice after being admitted to an emergency department for a non-fatal overdose.

Out-of-network/non-participating providers*

Providers and practitioners who have contracts with WellSense are considered network" or plan participating providers. Those who do not have contracts with WellSense are considered out-of-network or non-participating providers.

Except in the case of urgent/emergency services and family planning services, a WellSense member is not covered for services provided by an out-of-network provider unless the rendering provider has received prior authorization from us in advance of services being rendered. Any non-participating providers, including Indian health care providers, may refer an American Indian/Alaskan Native member to a WellSense participating provider.

WellSense Medicaid members are not covered for any medical care, including emergency or urgent care, outside of the United States or its territories.

For assistance with arranging services for out-of-network providers, please contact the Prior Authorization department by calling 877-957-1300 Option 3 and selecting the prior authorization option.

4.3 Fraud, waste and abuse

WellSense Health Plan is committed to preventing, detecting and correcting fraud, waste and abuse (FWA) across all of its products. Providers, their staff and their subcontractors share this responsibility and must comply with all applicable federal and state program integrity requirements.

Definitions

- **Fraud**
  An intentional deception or misrepresentation made by a person who knows it is false, or does not believe it is true, and knows the deception could result in an unauthorized benefit to themselves or another person. It includes any act that constitutes fraud under applicable federal or state law.
- **Waste**
  The overuse of services, or other practices that directly or indirectly result in unnecessary costs to the health care system. Waste is generally not caused by criminal or intentional actions, but by the misuse of resources.
- **Abuse**
  Provider practices that are inconsistent with sound fiscal, business or medical practices and that result in unnecessary cost, in payment for services that are not medically necessary, or in services that fail to meet professionally recognized standards of care. It also includes member practices that result in unnecessary cost.

Claim submission representations

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, were medically necessary in the provider's reasonable judgment; were performed by the provider or under appropriate clinical supervision; were billed accurately using appropriate coding; and are properly documented in the member's medical record. Submission of a claim also constitutes the provider's representation that the claim is not false or misleading.

If the medical record does not support the provision of a service, the service is considered not to have been documented or provided, and payment is subject to recovery by WellSense.

Audits and investigations

WellSense Health Plan ("WellSense" or "the Plan"), and/or authorized vendors, conducts routine and investigative audits of claims, encounters, and medical/business records submitted by network and non-network providers. These cover all audit and investigation types and lines of business, including, without limitation, coding, billing, medical necessity, documentation, coverage, quality, durable medical equipment ("DME"), and fraud, waste, and abuse ("FWA") audits and investigations, to verify compliance with applicable requirements and to identify overpayments, underpayments, and noncompliance. WellSense reserves the right, at its election, to expand the scope of any audit, and perform extrapolation of audit results to the defined audit population. If extrapolation methodology is selected, the process shall be performed in accordance with generally accepted sampling principles.

Provider cooperation and records requests

Providers must cooperate fully with WellSense, its authorized vendors, and state and federal agencies in any audit, review or investigation. This includes:

- Producing complete medical, billing and business records, in the specific format detailed in the SIU request letter, within [30] calendar days of the request unless WellSense sets a different timeframe.
- Allowing onsite reviews of facilities and records with or without advance notice, as permitted by law.
- Making staff available for interviews
- Retaining records per state and federal guidelines on retention

If a provider does not produce requested records by the due date, WellSense may deny or recover payment for the claims under review, and may take the actions in 4.3.5.

Administrative actions

Based on the nature and severity of the findings, WellSense may take one or more of the following actions:

- Provider education and written warnings
- Prepayment review of some or all claims
- Recovery of overpayments, including by offset against future payments
- Corrective action plans, with follow-up monitoring
- Payment suspension when there is a credible allegation of fraud, in accordance with 42 CFR 455.23 and state requirements
- Termination from the WellSense network
- Referral to state and federal regulators and law enforcement

When WellSense places a provider on prepayment review and identifies that the billing behavior extends to earlier dates of service, WellSense reserves the right to apply prepayment review to unadjudicated claims with dates of service up to six (6) months before the review start date. Previously adjudicated claims will not be impacted by this provision.

Overpayments and member billing

Any amount billed by a provider in violation of this policy, if paid by WellSense, constitutes an overpayment and is subject to recovery. Any amounts billed to and paid by members in violation of this policy must be immediately refunded to the member.

Providers must report and return known WellSense overpayments within 60 calendar days of identification, with a written explanation of the reason for the overpayment. Providers are required to maintain an internal process for identifying and refunding overpayments.

When WellSense notifies a provider of an overpayment identified through an audit, review or investigation, the provider must, within thirty (30) calendar days of the date of notification, either (a) refund the overpayment amount to WellSense, or (b) submit a written dispute of the findings, including supporting documentation. A provider may refund the undisputed portion of an overpayment and dispute the remainder within the same timeframe. If the provider does not refund or dispute the findings within thirty (30) calendar days, WellSense may recover the overpayment by offset against future payments and may take additional administrative actions as described in Section 4.3.5.

Exclusion screening

WellSense does not pay for items or services furnished, ordered or prescribed by an excluded individual or entity. Providers must screen all employees, contractors and owners before hire or engagement and at least monthly thereafter against:

- The HHS-OIG List of Excluded Individuals and Entities (LEIE)

- The System for Award Management (SAM)
- The MassHealth and New Hampshire Medicaid exclusion and sanction lists, as applicable

Providers must notify WellSense within [5] business days of learning that they, or anyone they employ or contract with, has been excluded, suspended or debarred. Payments made for services involving an excluded party are subject to recovery.

Examples of fraud, waste and abuse

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

- Billing for services or supplies that were not provided
- Misrepresenting the service provided, the date of service, the provider or the member
- Upcoding, or billing a higher level of service than documented
- Unbundling services that should be billed together
- Billing duplicate claims
- Performing or ordering services that are not medically necessary
- Charging in excess of usual, customary and reasonable fees
- Billing for DME or supplies that were not delivered, not ordered by a qualified practitioner, or not needed by the member
- Altering, falsifying or back-dating medical records
- Offering, paying, soliciting or receiving anything of value in exchange for referrals
- Using another person's member ID, or allowing members to share IDs
- Collecting money from a member except for appropriate cost-sharing (deductibles, coinsurance, copayments) and payments for non-covered items
- Repeatedly or intentionally waiving members' deductibles, coinsurance or copayments
- Failing to refund known WellSense overpayments within 60 calendar days

Applicable laws

Providers must comply with all federal and state laws that address fraud, waste and abuse, including:

- The federal False Claims Act and applicable state false claims acts, including whistleblower protections
- The federal Anti-Kickback Statute
- The Physician Self-Referral Law (Stark Law)
- The Civil Monetary Penalties Law
- The Social Security Act's exclusion provisions

Providers that receive $5 million or more per year in Medicaid payments must meet the employee education requirements of the Deficit Reduction Act of 2005.

Reporting suspected fraud, waste and abuse

Providers must maintain an environment in which employees can report any suspicion of fraud, waste or abuse without fear of retaliation. Providers should also report any such concerns to WellSense. WellSense does not retaliate against anyone who makes a report in good faith.

Complaints or allegations of suspected provider or member fraud, waste or abuse, from an internal or external source, are investigated by the WellSense Special Investigations Unit (SIU). WellSense refers suspected fraud to state and federal agencies as required. Concerns involving a provider or WellSense member should be reported by:

- Calling the anonymous, independent Compliance Hotline, available 24 hours a day, seven days a week, at 888-411-4959
- Emailing the SIU at DG-SIU@wellsense.org
- Faxing the SIU at 866-750-0947
- Mailing: WellSense Health Plan, Attn: Special Investigations Unit, 100 City Square, Suite 200, Charlestown, MA 02129

Complaints or allegations of suspected fraud, waste or abuse by a WellSense employee are investigated by the Compliance Officer. These concerns should be reported by:

- Calling the anonymous, independent Compliance Hotline at 888-411-4959
- Mailing: Compliance Officer, WellSense Health Plan, 100 City Square, Suite 200, Charlestown, MA 02129

4.4 Provider demographic changes

For provider demographic changes, please complete and submit the Provider Change Form and submit by email to NHprovider.enrollment@wellsense.org or fax to 866-779-5948.

4.5 Access to Care Standards

In an effort to ensure members have timely access to care, providers are required to comply with the following standards: Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency.

Service	Access standard
Hours of operations	Must be no less than hours offered to commercial enrollees. Hours must be comparable to those offered to Medicaid fee-for-service members if provider serves only Medicaid members
Office/service waiting time	30 minutes or less
After-hours services	Provide one of the following: • 24-hour answering service with option to page the physician (see below for suggested messaging) • Advice nurse with access to the PCP or on-call physician
Make emergency and psychiatric services available	Immediately upon entrance to delivery site, including out-of-network facilities, 24 hours a day, 365 days a year
Other healthcare services	• In accordance with New Hampshire Medicaid standards and guidelines at dhhs.nh.gov/programs-services/medicaid

As a 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 for assistance.

Medical health services appointment type for NH Clarity	
Primary care routine	15 business days
Specialty care (non-urgent)	30 business days

Medical health services appointment type	Primary care and specialty care
Non-urgent, symptomatic (routine care)	10 calendar days - Medicaid
Non-symptomatic (preventive care)	45 calendar days - Medicaid
Obstetrics and gynecological	15 Calendar Days – Medicaid
Urgent care	48 hours (applies to all Plans)
Emergency services	24 hours a day/7 days a week (applies to all Plans)
Transitional healthcare	2 business days of member discharge from inpatient or institutional care
Transitional home care	2 business days of member discharge from inpatient or institutional care

Behavioral health services appointment type	Appointment must be offered
Emergency Services	Immediately; 24 hours a day, seven days a week
Non-life-threatening emergency	Within 6 hours
Urgent Care	Within 48 hours
Routine Office Visits	Within 10 business days

Aftercare Appointment Standards

Inpatient service must schedule an aftercare appointment prior to a member's discharge. For NH Medicaid members, aftercare appointments following discharge from NH Hospital must be scheduled within 7 days of discharge.

Type of Appointment	Appointment Must be Offered
Crisis Intervention	Services must be available 24 hours a day, 7 days per week. Outpatient facilities, physicians, and practitioners are expected to provide these services during operating hours.

	After hours, providers must have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency, crisis team, or hospital emergency room.
Transitional Health Care	Within 2 calendar days
Medication Management	Within 7 calendar days
Outpatient services	Within 7 calendar days Outpatient providers should have services available Monday through Friday, from 9 a.m. to 5 p.m. Evening and weekend hours should also be available at least two days per week.
On-call	24-hour on call services for members in treatment

Substance Use Disorder Services (SUD)

Type of Appointment	Appointment Must be Offered
Response Time for Contracted Agencies	SUD outpatient programs and SUD Comprehensive programs respond to inquiries for SUD services from members or referring agencies as soon as possible and no later than two (2) business days following the day the call was first received.
Initial Eligibility Screening for SUD Services	Conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (direct communication by phone or in-person) with the member or the referring agency, but no later than two (2) business days following the date of first contact.
Members Screening Positive for SUD Servies	Members who have screened positive for SUD services receive an ASAM level of care assessment within two (2) business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM LOC assessment and no later than three (3) business days after admission.
Withdrawal Management, Outpatient and Intensive Outpatient Services	Initiation of services within seven (7) business days from the date the ASAM LOC was completed and until such time as the member starts receiving services by the receiving provider.4.7.5.12.6
Partial Hospitalization & Residential Services	Interim Services or the identified level of services are provided within seven (7) business days from the date the initial assessment was completed and identified services are provided no later than fourteen (14) business days from the date the ASAM LOC assessment was completed.
Services Not Available Within Required Time Frames	If the type of service identified in the ASAM Level of Care Assessment is not available from the Provider that conducted the initial assessment within

	forty-eight (48) hours provide interim substance use disorder services until such a time that the Member starts receiving the identified level of care. If the type of service is not provided by the ordering provider, and the ordering provider does not make a referral for the Covered Service within three (3) business days from initial contact, then the provider must contact WellSense Care Management and make a closed loop referral for the identified level of care, and to the applicable Doorway Program location within three (3) business days thereafter. 4.7.5.12.7 WellSense care management can assist with the closed loop referral and arrange interim SUD services until such time that the member starts receiving services by the receiving provider. When the level of care identified by the initial assessment becomes available by the receiving provider, that provider will reassess the member for ASAM level of care. 4.7.5.12.9
Pregnant Women	Pregnant women shall be admitted to the identified level of care within twenty-four (24) hours of the ASAM Level of Care Assessment. If the provider is unable to admit a pregnant woman for the needed level of care within 24 hours, then the provider shall either assist the pregnant women with identifying alternate providers and accessing those services or shall call WellSense Care Management for assistance .4.7.5.12.9.1. Interim services shall be provided until the appropriate level of care becomes available, or an alternate provider can supply interim services. Interim services include at least one sixty (60) minute individual or group outpatient session per week, or recovery support services as needed by the member with daily calls to the member to assess and respond to any emergent needs. 4.7.5.12.10 Pregnant women seeking treatment shall be provided access to childcare and transportation to aid in treatment participation.
Prior to Admission	Prior to admission, as part of interim services or within 3 business days following admission, a biopsychosocial evaluation is completed in accordance with SAMHSA Technical Assistance Publication (TAP) 21: Addiction Counseling Competencies including DSM 5 diagnostic

	information and a recommendation for a level of care based on ASAM criteria. [4.12.27.3]

4.6 Physician panel closing

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

- 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 their provider contract) to NHproviderinfo@wellsense.org or:
  WellSense Health Plan
  Provider Engagement
  100 City Square Suite 200
  Charlestown, MA 02129
- Keep the panel open to all WellSense members who were provided services prior to the panel closing
- Submit written notice to WellSense of the re-opening of the panel, including a specific effective date

4.7 Member transfer or termination

Providers may not seek or request to terminate their relationship with a member or transfer a member to another provider based on the member's medical condition, volume or types of care required, or the cost of covered services required.

Providers must accept all individuals without restrictions and not discriminate against individuals on the basis of religion, gender, race, color or national origin. Additionally, they cannot use any policy or practice that has the effect of discriminating on the basis of religion, gender, race, color or national origin or on the basis of health, health status, behavioral health history, pre-existing conditions or need for health care services.

Reasonable efforts should be made to establish a satisfactory provider and member relationship. The provider should include adequate documentation in the member's medical record to support the provider's efforts to develop and maintain a satisfactory relationship.

You must give WellSense 60 calendar days' notice in the event you must terminate or transfer a member from your panel. Submit a completed Member PCP Transfer Request form via fax to our Enrollment department at 617-897-0838 or at 866-335-9317. You may also contact your Provider Engagement team and request assistance reassigning the member with 60 calendar days' notice. Providers must continue to render medical care to the member until written notice is received from WellSense stating that the member has been transferred from the provider's practice.

4.8 Out-of-area network transfer

There may be occasions when a member requires services that are not available in WellSense's network. When this happens, we will work with the member's PCP to determine medical necessity and develop a plan for the member to be seen by an out-of-network provider (either inside or outside of our service area). Plan providers should help WellSense in arranging the member's transfer to an out-of-network provider. WellSense care management will assist members who have chronic or acute medical or behavioral health conditions, and member who are pregnant, in transitioning to a participating provider

when there are changes within the participating provider network. With the exception of members in their second or third trimester of pregnancy, WellSense will provide for the continuation of the terminating provider's services for up to ninety (90) calendar days or until the member can be reasonably transferred to participating provider without disruption of care. For members in their second or third trimester of pregnancy, WellSense permits continued access to the member's prenatal care provider and any provider currently treating the member's chronic or acute medical, behavioral health, or substance use disorder condition, or currently providing LTSS through the postpartum period.

4.9 Second opinion

A second medical opinion may be requested at no cost to members in any situation where there is a concern about diagnosis, surgery options or other treatment of a health condition.

The second opinion must be provided by a qualified health care professional within the member's available provider network based on their plan type. In the event there is no WellSense network provider with expertise in the medical condition, a non-network provider can provide the second opinion but must obtain prior authorization from WellSense.

4.10 Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Medicaid program

WellSense has implemented a variety of initiatives, targeted at both providers and members, to support compliance with EPSDT requirements for Medicaid members under age 21 and has ensured those members receive all elements of preventative health screenings recommended by the AAP Bright Futures periodicity schedule including all recommended, age appropriate, screening tools. WellSense endorses nationally recognized clinical practice guidelines which reflect the requirements of the EPSDT Medical Protocol and Periodicity Schedule. The American Academy of Pediatrics Bright Futures Periodicity schedule is recognized by most state Medicaid agencies as a component of meeting federal EPSDT requirements. Providers can access this schedule and related EPSDT materials through WellSense's website at wellsense.org.

Primary care providers are responsible for furnishing EPSDT services and ensuring follow-up care identified during a well visit is obtained by the member. This includes following up on missed appointments, including missed referral appointments identified through screenings, and follow up on any abnormal screening results.

EPSDT program services, including the full range of preventive, screening, diagnostic and treatment services, and all medically necessary services that correct or ameliorate physical and mental illnesses and conditions must be provided for all WellSense members from birth to age 21. These services must include a comprehensive health screening and developmental history, an unclothed physical exam, appropriate immunizations, laboratory tests and health education at DHHS recommended intervals.

Screenings must include:

- A comprehensive health and developmental history that assesses both physical and mental health as well as substance use disorders

- Social emotional developmental screenings at 24/30 month pediatric visits and at ages 9 and 18 using an AAP or other nationally validated developmental and behavioral screening tool. Assessments must include universal screening via full adoption and integration of at least two specific, evidenced-based screening practices such as:
    - Depression screening (e.g., PHQ2 & 9)
    - Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care
- Screening for developmental delay at each visit through the fifth year using an AAP or nationally validated screening tool
- Screening for autism spectrum disorders per AAP guidelines
- Measurements, such as height, weight and head circumference
- A comprehensive, unclothed physical exam
- All appropriate immunizations, in accordance with the schedule for pediatric vaccines, laboratory testing (including blood lead screening appropriate for age and risk factors)
- Health education and anticipatory guidance for both the child and caregiver
- Vision screening
- Hearing screening
- Nutritional services
- Oral health screening and referral to a dental health provider
- All necessary referrals and follow up appointments based on history and exam

Health education services must include:

- Informing members of the availability of EPSDT health screenings without cost
- Nutritional services
- Importance of preventative care, including vaccinations
- Periodicity schedule and depth and breadth of services
- How and where to access services
- Services provided without cost
- Availability of assistance with transportation and scheduling on request

Periodically, WellSense will send all PCPs a mailing of their well child visit rates, including a listing of their members by age category, and a list of which members will be due for a well visit in the upcoming months. The listing will also include members who are not in compliance with the periodicity schedule. PCPs are required to contact the members or guardians by telephone or mail to schedule an appointment.

Providers should have the following equipment available to adequately perform EPSDT screening exams:

- Weight scale for infants
- Weight scale for children and adolescents
- Measuring board or device for measuring length or height in the recumbent position for infants and children up to age 2
- Measuring board or device for measuring height in the vertical position for children aged 2 or older
- Blood pressure apparatus with infant, child and adult size cuffs
- Screening audiometer
- Device for measuring hematocrit or hemoglobin
- Age-appropriate eye charts
- Developmental and behavioral screening tools
- Ophthalmoscope and otoscope

WellSense will perform the following compliance monitoring regarding the above requirements:

- WellSense will conduct random audits to ensure follow-up visits are occurring and that full EPSDT visits are being performed.
- WellSense will work with provider sites to schedule on-site visits to review medical records or coordinate faxing or mailing of the needed information to a secure location. Electronic submission of medical records should be transmitted via a secure method and encrypted or password protected.
- While WellSense strives to make these reviews as easy as possible for practices. We rely on the cooperation of providers to make these reviews successful. Providers' prompt attention and response to requests for chart information is critical and is appreciated.
- WellSense uses a variety of tools to monitor EPSDT compliance including medical record audits and several HEDIS Effectiveness of Care measures, including Well Child Visit Encounter Rates, Childhood Immunization Status, Immunizations for Adolescents and Lead Screening in Children.

4.11 Observation status

Observation does not require plan notification. Plan must be notified if the Observation stay converts to an In-Patient level of care. All in-patient level of care stays require authorization. Please refer to WellSense Policy "Inpatient Short Stay "(0-1 Midnight Length of Stay).

4.12 Adult health screening

Physicians should perform an adult health screening for members age 21 or older in accordance with federal preventative care regulations. The adult member should receive an appropriate assessment and intervention as indicated or upon request including assessment of behavioral health or substance use disorders and timely referral to a provider if co-located care is not available. Appropriate screening tools are available at wellsense.org.

4.13 Neonatal abstinence syndrome screening tool

Primary care, obstetrics/gynecology, pediatrics and neonatologists are encouraged to follow their institutions' clinical guidelines for screening and treatment for neonatal abstinence syndrome (NAS) for all infants born in New Hampshire. In the absence of local clinical protocols, we recommend using the Minnesota Hospital Association's Neonatal Abstinence Syndrome Toolkit.

Providers are also encouraged to reference Boston Medical Center's Grayken Institute, which has been studying screening and treatment protocols for NAS since at least 2013.

For NH Medicaid members with a diagnosis of substance use disorder and all infants with a diagnosis of NAS, or that otherwise known to have been exposed prenatally to opioids, alcohol, or other drugs, providers shall refer those members to WellSense care management. Substance use disorder care management includes outreaching to members, ensuring members have the appropriate level of substance use disorder services, scheduling appointments and following up to ensure appointments are attending, coordinating care and coordinating care management services supplied by the treating provider. WellSense care managers work with the Division of Child, Youth and Families (DCYF), as needed, including follow-up after thirty (30) calendar days and implementing a Plan of Safe Care in collaboration with the treating provider, the infants family/caregiver.

4.14 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:

- A living will is a legal document that outlines specific information on which life-prolonging measures one does and does not want to be taken if the individual becomes terminally ill or incapacitated. Many measures can be considered, including 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.
- A health care proxy is a legal document in which one names another trusted individual as their Durable Power of Attorney for Health Care. This individual is then responsible for making decisions on the patient's behalf, if the patient is unable to do so.

PCPs should ask members whether they have made an advance directive and ask for a copy of the advance directive to include in the member's medical 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 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 when coming under the care of a home health, hospice or personal care agency.

4.15 Members with chronic or life-threatening conditions

Members with chronic conditions are defined as adults and children who have a physical or mental impairment or ailment of indefinite duration or frequent recurrence, including:

- A mental health condition, asthma, diabetes or heart disease
- Obesity, as evidenced by a body mass index as follows
  - 25–30 = overweight
  - 30 or higher = obese
- An ongoing physical, behavioral, or cognitive disorder, including chronic illnesses, impairments, and disabilities
- A functional limitation, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) that require services beyond what is normally considered routine

Physicians rendering services to members with chronic or life-threatening conditions should:

- Apply a "whole person approach that incorporates the member and/or care givers into the development of the care plan and addresses the member's physical, behavioral, developmental and psychosocial needs."
- Allow members who need a treatment course or regular care monitoring to have direct access through standing authorization or approved visits as appropriate for the member's condition or needs.

- Coordinate with WellSense to ensure the member has access to ongoing primary care support appropriate to the member's needs.
- Ensure members have access to specialty centers in or outside of New Hampshire for diagnosis and treatment of rare disorders and for care over a prolonged period of time.

4.16 Smoking cessation program

WellSense covers individual and group counseling services and related prescription drugs for members who smoke or use tobacco products. Members in need of services can contact Quit Works at quitworksnh.org or call the NH Tobacco Helpline at 800-QUIT-NOW or 800-784-8669.

4.17 Non-emergent transportation services

WellSense provides non-emergent transportation services to our New Hampshire Medicaid members and will coordinate transportation services for members within its network of transportation providers in New Hampshire. Transportation is available to members for all Medicaid-covered medical, behavioral health and dental appointments for members under the age of 21.

Providers and members can call 844-909-RIDE (844-909-7433) for transportation to outpatient appointments. Contact information is also available on the member's ID card for NH Medicaid members.

4.18 Telemedicine

WellSense covers telemedicine as a means of healthcare delivery. Coverage of this service is also contingent on the use of an interactive audio and/or video telecommunications system that permits two-way, real-time, secure, HIPAA-compliant communication between the member and provider or between two providers. In addition, the provider performing telemedicine services must have an active unrestricted NH medical license. When billing for telemedicine services, providers must use applicable modifiers listed in the telemedicine policy, available in the Policies section of wellsense.org. Telecommunications systems must be HIPAA compliant, with an encrypted secure transmission portal.

4.19 Provider-Preventable Conditions (PPC)

Consistent with applicable state and federal guidelines, WellSense does not reimburse providers for the cost of services that are attributable to those events and/or conditions identified as provider-preventable conditions (PPCs). In addition, members cannot be billed for these services. Refer to Section 14: Quality Management for more detailed information.

PPCs are categorized as follows:

- Health care acquired conditions (HCACs) – any condition identified on Medicare's list of hospital-acquired conditions (HACs).
- Other provider-preventable conditions (OPPCs) – conditions that could apply in any health care setting, as follows
  - Incorrect or incorrectly performed surgical or other invasive procedure performed
  - Surgical or other invasive procedure performed on incorrect location on the body

- Surgical or other invasive procedure on the wrong patient
- Events identified by the National Quality Forum (NQF) as serious reportable events (SREs)

For a complete list of PPCs and detailed reporting, billing and coding guidelines, please refer to the Reimbursement Policy titled Provider Preventable Conditions and Serious Reportable Events in the policies section of our website.

4.20 ADA guidelines

People living with disabilities

Health services provided through Medicaid managed care must be accessible to all people living with disabilities who qualify for the program. Providers must offer a level of service that allows Medicaid members with disabilities full and equal enjoyment of services and access to facilities that are offered to its other customers. New and altered areas or facilities must be as accessible as possible to all customers. In the event that provider sites are not readily accessible, the provider must provide reasonable alternative methods for making the services accessible and usable. Providers must ensure appropriate and timely health care to all members, 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.

4.21 Cultural competency

WellSense requires providers to be culturally competent in their delivery of care to members. Please let us know if you are trained on the topic of cultural competency, and we will send you a Cultural Competency for Providers Training Attestation document for completion.

Enhancing your communication skills helps you to provide quality care to all of your patients regardless of race, ethnicity or religious beliefs. The resources below can help you assess and improve your cultural competency.

- A Physician's Practical Guide to Culturally Competent Care: A free, online educational program accredited for physicians, physician associates and nurse practitioners. A training program is also available for nurses and social workers.
- National CLAS Standards: Information from the Office of Minority Health to help you advance health equity and quality for all cultures within your practice or healthcare organization.

Cultural and linguistic competency is defined as a set of congruent behaviors, attitudes and policies present among members and professionals that enable effective work in cross-cultural situations.

"Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups, including American Sign Language-using deaf, hard-of-hearing, and deaf-blind persons.

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

WellSense has a diverse membership with many linguistic abilities and cultural and ethnic backgrounds. To promote access to providers who have the ability to communicate with members in a linguistically appropriate and culturally sensitive manner, WellSense uses a number of methods to capture detailed linguistic, ethnic and cultural data on our members, including health assessment tools and querying members through contact with the Member Service department. As part of the credentialing process for individual clinicians, WellSense assesses providers' linguistic capabilities.

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

Plan providers must ensure that:

- Members know they have access to medical interpreters, signers and TDD/TTY services to facilitate communication without cost to them.
- Care is provided with consideration for the member's race/ethnicity, disability and language and how it impacts the member's health or illness.
- Staff members with routine access to patients have cultural competency training and development.
- Staff responsible for data collection make reasonable attempts to collect race and language-specific member information. Staff members explain ethnicity categories so members can identify themselves and their children.
- Treatment plans and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.
- Office sites have posted and printed materials in English suitable for those with limited English proficiency and in Spanish. If required by New Hampshire Medicaid, they also post and print materials in any other required non-English language.
- A provider cannot rely on a member's child to provide interpretive services. A provider cannot rely on the member's family and/or friends to interpret.
- If a member refuses an interpreter, the provider should document the member's declination in the member's medical record.
- If the member speaks a language other than English, WellSense will provide telephonic language assistance services at the member's request. The provider or member may call WellSense at 877-957-1300, Member Service, to be connected telephonically to the appropriate interpreter.

4.22 Members held harmless for charges

Except for the collection from members of any copayments, coinsurance or deductibles, contracted providers must look solely to WellSense for payment of covered services rendered to members. Contracted providers agree that in no event, including non-payment by WellSense, will the contracted provider bill; charge; collect a deposit, seek compensation, remuneration, or reimbursement from; or have any recourse against the member for a WellSense-covered service.

In the case of a non-contracted provider), the member may be responsible for all charges and fees.

4.23 WellSense Medicaid Health risk assessments

WellSense encourages participating primary care providers to conduct and review a health risk needs assessment (HRA) screening for each member at least annually or whenever the member's circumstances or needs change significantly to identify members with unmet health care needs. The HRA screening may be conducted in-person or through HIPAA-compliant electronic platforms, telephonically, or through completion of the written form by the member. For members working with community mental health services, providers are encouraged to coordinate completion of the HRA screening with the member's applicable community mental health program or provider, who may provide support for effective completion of the HRA screening by the PCP and member.

Upon completion of an HRA Screening either completed by the primary Care provider or completed by CMHC and shared with the PCP, the provider shall review the results and make the appropriate referrals for clinical and non-clinical services, including closed-loop referrals to specialists, not limited to behavioral health services providers and community resources.

PCPs may use WellSense's HRA screening tool or their own HRA screening tool provided the following required domains are within the assessment:

- Recommended core components of a HRA screening tool are:
- Activities of Daily Living
- Money/Resources
- Sleep
- Alcohol Use
- Nutrition/Eating Patterns
- Social/Emotional Support
- Anxiety
- Pain
- Stress
- Depression
- Patient Priorities
- Substance Use
- Family and Home
- Personal Safety
- Tobacco/Nicotine Use
- General Health
- Physical Activity
- Medication Adherence
- Sexual Activity
- Providers conducting HRA screenings shall share HRA results with WellSense upon request.

WellSense allows for professional services billing of completed and reviewed HRAs in accordance with section 4.10.2.2 of the Medicaid Care Management Services contract.

Section 5: Provider Resources

5.1 General information

WellSense is committed to partnering with and supporting our network providers so that we can ensure the highest quality of care for members enrolled in our New Hampshire Medicaid, and New Hampshire Clarity plans.

Our website offers a variety of resources and tools to help you meet the medical and behavioral health needs of your patients and our members. For additional information or if you have questions, please contact medical Provider Engagement at NHProviderInfo@wellsense.org, or behavioral health provider engagement at BHProviders@Wellsense.org, visit our website at HYPERLINK "https://www.wellsense.org/providers/nh/policies"wellsense.org, or call WellSense Provider Service at 877-957-1300 option 3 (for NH Medicaid), 855-833-8122 option 3 (for Clarity plans) or).

PCP offices participating in WellSense's network can access the following services:

- Support from the various departments at WellSense, including Provider Engagement, Customer Service, Care Management, and Community and Member Outreach teams
- Information on providers related to the management of referrals and discharge planning

5.2 Secure provider portal Health Trio

Providers can visit wellsense.org and register for our provider portal to securely:

- Check the status of a claim
- Check member eligibility
- Request online authorization for medical and behavioral health services and procedures requiring authorization
- View remittance history
- Request customized reports including inpatient census and admit, discharge and transfer reports
- View member rosters that identify those with completed health risk assessments (HRAs), copies of which are available upon request to NHProviderInfo@WellSense.org

5.3 Provider Engagement department

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

Your Provider Relations Consultant can assist you with any questions on billing, claims, credentialing, care management and our pharmacy formulary. Your Provider Relations Consultant can provide updated PCP panels/rosters of members. Each PCP report is refreshed daily and indicates members who have completed health risk assessment (HRAs), copies of which provider offices may request. Please be aware that completed member HRAs are available to providers upon request to your Provider Relations Consultant or to NHProviderInfo@wellsense.org. The Consultant is the person you contact when you have questions about working with WellSense. Our Provider Engagement team is composed of experts in their

field who understand how important it is to be available to our providers and to ensure satisfaction by assisting in any way they can.

WellSense is committed to offering an in-service training within 30 days of your contract being executed. This training will include:

- Member eligibility
- Provider responsibilities
- Care management
- Provider portal
- Billing and claims submission
- Cultural competency
- Administrative, clinical and reimbursement policies and procedures
- Fraud and abuse reporting

If you have a change in office staff, please contact your Provider Relations Consultant to ensure all appropriate staff receive timely notification of WellSense policies and other updates. Your consultant can schedule a time to visit with your new staff and do a training session for them. Our Provider Engagement team will visit your office on a routine basis. These meetings are designed to proactively identify and provide any additional training or assistance your office may require. Preferably, these meetings will take place with the office manager or provider, as well as new staff.

WellSense is committed to communicating efficiently and effectively with our provider network.

5.4 WellSense Provider Service

- NH Medicaid: Call 877-957-1300, option 3
- WellSense Clarity: 855-833-8122, option 3
- Hours:
  Monday–Friday, 8 a.m.– p.m., except holidays
  Saturday, 9 a.m.–12 p.m., except designated holidays

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

5.5 Automated system to check member eligibility and claims status

For NH Medicaid and Clarity plans: Call 877-957-1300 24 hours a day, 365 days a year to verify member eligibility and check the status of a claim as follows:

- Verify member eligibility by visiting the NH MMIS (Medicaid Management Information System) Health Enterprise Portal at nhmmis.nh.gov/portals.
- Visit our online eligibility verification system at wellsense.org.
- Call WellSense at 877-957-1300for NH Medicaid
- Call WellSense at 855-833-8122, for Clarity plans.
- We also have an automated provider line for Medicaid. By calling our automated provider line, you can verify member eligibility, claims status, provider enrollment status, etc. Dial our provider line at 888-566-0008

When checking member eligibility, providers will be asked for their phone, NPI, or tax ID number, along with the member's ID number.

When checking the status of a claim, providers will be asked for their phone, NPI, or tax ID number, as well as the member's ID number and dates of service.

5.6 Additional resources

The following resources are available at wellsense.org:

- Behavioral Health Integration Toolkit
- Contacts Directory
- Provider Engagement directory
- Network notifications, news and updates
- Policies (clinical and reimbursement)
- Documents and forms
- Community resources
- Provider directory
- Prior Authorization lookup Tool
- Pharmacy resources including formularies
- Quality and risk adjustment resources
- Provider orientation and product training
- Claims resources

Section 6: Member Information

6.1 General information

Health plans from WellSense

WellSense offers two types of health plans to meet different needs:

- Medicaid: For New Hampshire residents who qualify for Medicaid.
- Marketplace (ACA): For individuals and families who qualify for coverage through the Affordable Care Act.

6.2 Member enrollment in WellSense Health Plan

Enrolling in WellSense's Medicaid plan

1. Apply
   - Fill out the NH Easy Form at nheasy.nh.gov.
   - Mail it to:
     NH DHHS – Central Processing Unit
     129 Pleasant Street, Concord, NH 03301-9846
   - Or get help applying online through local hospitals, health centers, or community groups.
2. Provide Information
   - Income and employment
   - Disability/illness details (if any)
   - Family members
   - Proof of citizenship/ID/immigration status
3. Wait for DHHS Decision
   - DHHS reviews your application and lets you know if you qualify.
4. Become a Member
   - You choose WellSense,
   - DHHS assigns you, or
   - You are transferred from another plan.

Enrolling in a WellSense New Hampshire Clarity plan (ACA plan)

- To become a member of a WellSense Clarity plan, a New Hampshire resident may purchase insurance through the Federal Marketplace or any entity authorized to offer those plans. Individuals may purchase plans at healthcare.gov, through a licensed broker or directly from WellSense.

6.3 Overview of health plan benefits

WellSense offers a comprehensive benefits package for WellSense members. For additional information, please see Section 7: Member Benefit Information and visit wellsense.org for a complete list of covered services.

Member self-referral services

WellSense does not require referrals. Nevertheless, in an effort to support communication between providers and members, WellSense asks each member to contact the member's PCP before seeking non-emergent healthcare services.

However, please note that certain services require prior authorization. For more information, please refer to Section 8: Utilization Management and Prior Authorization in this manual.

All WellSense members have access to the following supports

- Member and Provider Service toll-free member line to answer questions
- Coordination of WellSense's transportation benefit for qualified members
- Care management
- Access to WellSense's 24-hour Nurse Advice line

Special programs and supplemental benefits for members

In addition to the clinical programs available to our members, WellSense Medicaid offers several special programs, like incentives for healthy behaviors and certain doctor visits. Members can earn over-the-counter (OTC) rewards when they complete healthy actions that can be used to buy common drugstore items. Members are also eligible for replacement eyeglasses every 12 months and replacement batters for hearing aids.

For full details, please visit wellsense.org/nhextras.

Language and interpretive services

- WellSense provides free help for members who do not speak English:
- Translation by phone
- Website access in 54 languages
- TTY/TDD (711) services for members with hearing or speech difficulties

Member Handbook

WellSense's Member Handbook is available:

- In English and Spanish (Spanish is available for the WellSense Medicaid Handbook only)
- Through oral translations in any language by calling the WellSense Member Service department at 877-957-1300, for WellSense Clarity plans call 855-833-8122.In Braille, large font or American Sign Language video clips upon request

As part of ADA guidelines, WellSense encourages providers to have a list of available interpreters for patients.

6.4 Member identification cards and member eligibility

WellSense members may have up to two (2) identification cards: a WellSense-distributed member ID card and an ID card from the agency overseeing their insurance product, such as DHHS.

Members should present all cards to the treating provider at the time of service and should contact their PCP before receiving care, unless it is an emergency. Providers should not deny care if the member does not have his/her ID cards.

Please call the WellSense Provider Service team to check member eligibility, benefits, and PCP assignment at 877-957-1300 for Medicaid or 855-833-8122 for WellSense Clarity plans.

All WellSense ID cards include:

- Plan name and logo.
- Special program designations if applicable, such as Granite Advantage.
- 11-digit WellSense-issued member ID number.
- When submitting claims to WellSense, use the member's ID number from the WellSense-issued ID card.
- Telephone numbers for the WellSense Member and Provider Service departments.
- Pharmacy benefits manager and phone number.
- WellSense non-emergent transportation line for Providers and Members: 844-909-7433 (844-909-RIDE) on the Medicaid ID cards only.

6.5 Member eligibility

Please remember to always check member eligibility before delivering services, on the date of service, and daily during inpatient admissions. See Section 2: Member Eligibility in this manual for instructions on verifying member eligibility in WellSense.

6.6 Primary care provider selection and assignment

WellSense proactively assists and encourages each member to select his/her own PCP and other health care professionals. WellSense provides each member with information about selecting a provider (e.g., physician specialty, geographic location, and experience with special populations). Our Member Service department provides interpreter services for members when they call, if necessary, and/or if requested by the member. If the member or the member's designee does not select a PCP, we will assign an appropriate PCP no later than fifteen (15) calendar days after the member's enrollment date with us.

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).
- For NH Medicaid products, if the member has not been enrolled in WellSense before, we will consider the following criteria when assigning a PCP to the member:
  - Member's health needs
  - PCP's training and expertise with demographic or special populations similar to the member's
  - Geographic proximity of the PCP's site to the member's residence on file
  - PCP site's ability to accommodate the member's disability, if applicable
  - Capabilities of the PCP to practice in the member's preferred language
  - PCP's access to medical interpreters for the member's preferred language
- The member's age:
  - Pediatrics – birth to age 21
  - Internal Medicine – age 18 or older
  - Family Medicine – all age categories

- An obstetrician/gynecologist (OB/GYN) may serve as a PCP if selected by a female member, but WellSense will not assign a member to an OB/GYN practice for primary care services without the member's request.

Request for PCP change

WellSense members may change their PCP for any reason. The change can be made in any of the following ways:

- Members can call WellSense at 877-957-1300, for our Medicaid plan, and 855-833-8122 for WellSense Clarity plans. Enrollment in the new PCP's panel will be effective the next business day. WellSense will transfer the member to the new PCP's panel the same day if the member clearly states that he or she is in the PCP's office and wants the transfer to be effective immediately.
- Members log in 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 us. Participating providers may assist members with a PCP selection or PCP transfer.

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

6.7 Continuity of care for new and existing plan members

When medically necessary, we will arrange for a new member to continue receiving treatment from his/her current, non-network provider under certain circumstances; prior authorization by WellSense is required. This may occur as follows:

- For up to ninety (90) calendar days or until we complete a medical necessity review of the service, whichever comes first, from the member's enrollment date, or
- If the member is in her second or third trimester of pregnancy when she enrolls in WellSense—through her pregnancy and up to sixty (60) calendar days after delivery; or
- If the member is determined to be terminally ill at the time of enrollment

Continuing treatment when a provider has been terminated from WellSense:

For existing WellSense members undergoing active treatment for a chronic or acute medical condition, whose provider has been terminated from the network for any reason other than fraud, abuse, or quality of care issues, WellSense may provide coverage for services delivered by the provider. Affected members may be allowed continued access to their terminated practitioner for up to ninety (90) calendar days after the provider's effective termination date from WellSense when prior approval is granted by WellSense.

Continuing coverage of prescribed medications:

For new WellSense members with an ongoing special condition with currently prescribed medications, WellSense will cover such medications for ninety (90) calendar days from the member's enrollment date, or until completion of a medical necessity review, whichever occurs first.

6.8 Confidentiality and provider access to member information

WellSense complies with all applicable state and federal laws and regulations pertaining to confidentiality of member medical and personal records, and confidentiality of the business, proprietary, and security information of network providers. Plan staff will verify the identity of the provider or his/her designee seeking information that is considered protected health information (PHI) under HIPAA, or personal information that is otherwise protected by law. Before WellSense will release any PHI, the provider or his/her designee must provide to WellSense one of the following: tax identification number (TIN), National Provider Identifier (NPI), or the WellSense-assigned provider number.

6.9 Member rights and responsibilities

Plan members have rights concerning health care and certain responsibilities to their treating providers. WellSense shares this information with members and providers on an annual basis, or sooner, if policy changes occur.

Providers are responsible for complying with applicable state and federal requirements concerning member rights.

Member rights

All members have the right to:

- Receive information about WellSense, its services, network providers, and member rights and responsibilities.
- Be treated with respect and recognition of their dignity and right to privacy.
- Voice complaints or appeals about WellSense or the care arranged for by WellSense.
- Receive information about any illnesses he or she has, presented in a manner appropriate to the member's condition and ability to understand.
- Have an open and honest discussion with the provider 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 his/her coverage type.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Participate in decisions regarding the member's health care, including the right to refuse treatment as far as the law allows, and to know what the outcomes may be.
- Request a change to the member's care manager.
- Be told where, when, and how to get services they need from their plan (standard and Long-Term Services and Supports [LTSS] services), including how they can obtain covered benefits from out-of-network providers if they are not available in the network.
- Be free from any form of restraint or seclusion, used as a means of coercion, discipline, convenience, or retaliation.
- Freely exercise the member's rights without adversely affecting the way WellSense and its providers treat the member.
- Request and receive a copy of the member's medical records and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526, which describes patient access rights.

- Be furnished with Plan-covered services.
- Request an interpreter when he or she receives medical care.
- Request an interpreter when he or she calls or visits WellSense offices (the Member Service department assists with providing an interpreter).
- Have any printed materials from WellSense translated into his/her primary language, and/or have these materials read aloud to him/her if the member has trouble seeing or reading.
- WellSense Medicaid members may choose his/her PCP and change the PCP assignment up to three (3) times per year by calling WellSense's Member Service department at 877-957-1300, ,
- Receive medical care within the timeframes as outlined in the Access to Care Standards described in Section 4: Provider Responsibilities of this manual, and to file an internal appeal if he or she does not receive care within those timeframes.
- Ask for a second opinion about any medical care the member's PCP advised to the member.
- Receive emergency care 24 hours a day, 365 days a year.
- Change the member's health plan (subject to certain DHHS limitations, as applicable).
- Receive medical treatment from Plan providers without regard to race, age, gender, sexual preference, national origin, religion, health status, economic status, or physical disabilities. No provider should engage in any practice, with respect to any Plan member, that constitutes unlawful discrimination under any state or federal law or regulation.
- Expect healthcare providers to keep member records private, as well as anything members discuss with them. No information will be released to anyone without the member's consent, unless permitted or required by law.
- Voice a complaint and file a grievance with WellSense's Member Service Department about services received from WellSense or from a medical provider. The member also has the right to appeal certain decisions made by WellSense. Please see Section 10: Member Appeals, Inquiries, and Grievances for more detailed information.
- Make recommendations about WellSense's member rights and member responsibilities.

Member responsibilities

Plan members are responsible to:

- Supply information (to the extent possible) needed by WellSense and its network providers to arrange for and provide care.
- Follow plans and instructions for care they have agreed to with their network providers.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, as they are capable.
- Discuss with the member's PCP when a specialist's services may be required or before he or she goes to the hospital (except in cases of emergencies or when he or she may self-refer for certain covered services). **If a member self-refers to certain specialists, prior authorization may be required.**
- Keep appointments, be on time, and call in advance if he or she is going to be late or have to cancel.
- Notify WellSense's Member Service department when he or she believes that someone has purposely misused Plan benefits or services.
- Notify WellSense's Care Manager and Member Service department when the member has a change of address or phone number.
    - WellSense Medicaid members should also notify the New Hampshire Medicaid customer service center.
- Pay for services not covered by their WellSense Medicaid or Clarity plans.

- Describe health complaints clearly and provide as much information as possible to the treating provider.
- Inform the member's PCP and/or treating provider about the member and/or the member's medical history.
- Treat the member's PCP with dignity and respect.
- Learn about any recommended treatment and consider it before receiving it.
- Understand that refusing treatment recommended by the member's PCP might harm the member's health.
- Authorize the member's PCP to obtain copies of all the member's medical records.
- Receive all of the member's health care from WellSense providers, except emergency services.
    - For our Medicaid members: For services not covered by New Hampshire Medicaid, but covered directly by WellSense, which a member receives using his/her WellSense member ID card, the member may receive the care from any WellSense participating provider.
- Not allow anyone else to use the member's Plan ID card to obtain healthcare services.
- Learn and understand each right they have under their program.
- Know the name of their PCP and their care manager.
- Know when they should go to the emergency room.
- Follow their care manager's advice or talk to their care manager if they are unable or unwilling to follow their care plan.

6.10 Member outreach and communication

Member Service department

The WellSense Member Service department is available to assist members during regular business hours, except on recognized holidays. If needed, a Member Service representative can arrange for another staff member to communicate with a Plan member in their primary language at no cost through interpreter services. Representatives can also coordinate TTY/TDD services for members who are deaf or hard of hearing, or utilize other language assistance tools to ensure members can effectively communicate their needs and receive appropriate support

Plan type	Hours of operation	Telephone number
WellSense Medicaid	Monday–Wednesday, 8 a.m.–8 p.m., Thursday–Friday, 8 a.m.–6 p.m.	877-957-1300
WellSense Clarity	Monday-Friday 8 a.m.-6 p.m.	855-833-8122

Nurse advice line

Members may call the WellSense toll-free nurse advice line at 866-763-4829 (NH Medicaid), , or 855-537-3463 (NH Clarity) to speak with a trained registered nurse about health-related issues 24 hours a day, 365 days a year. 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 his/her treating provider or PCP, administer self-treatment, and/or seek immediate help in an emergency

department. WellSense educates members that the Nurse Advice Line does not replace the member's PCP.

New member materials

The WellSense new-member packet includes a notice on how to access a Member Handbook, and all members receive information on accessing WellSense's online Provider Directory. In addition, a paper copy of the Health Risk Assessment (HRA) form is sent to all members with their Plan ID cards, along with a QR code to complete it online.

The Member Handbook, available at wellsense.org, provides a description of WellSense's covered services, how to use the Plan, and any member cost-sharing (e.g., copayments).

WellSense provides members with user-friendly benefit literature in English and, upon request, will provide literature in the member's preferred language. At the time of enrollment, WellSense also informs members of their right to terminate their Plan membership.

Member orientation

WellSense attempts to contact each new member by mail or telephone to welcome the member to WellSense and orient the member to our administrative guidelines, covered benefits, role of the PCP, network composition, and methods of communicating with WellSense. We urge new members to complete a Health Risk Assessment (HRA). HRAs enable WellSense and the provider to follow up with members identified as high-risk or who may have a chronic medical condition. WellSense will refer those members to our care management staff to perform a comprehensive assessment, if applicable.

Communication with high-risk members may include:

- 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 the member's diagnosis, condition, or symptom(s)

Member marketing

WellSense requires that Plan network providers abide by the following guidelines regarding marketing to individuals eligible for WellSense.

- Do not make unsolicited personal contact with non-Plan members about WellSense to influence them to enroll in WellSense.
- Providers may answer questions about WellSense, if patients ask.
- Providers may post approved Plan brochures and posters in their facility.
- If a patient wants to join WellSense, refer the patient to Member Service Department. The patient may use your phone, but please do not make the call for the member.
- Providers may help any patients with their New Hampshire Medicaid eligibility and application.
- In the course of treating a patient, providers may talk to the member about benefits or services available, if the benefit or service relates to the patient's treatment needs.

- Providers may talk with New Hampshire members about anything to do with their Plan membership, including extra items and services, choosing a primary care provider, how to get a new ID card, or other member questions.
- Providers shall not engage in marketing to members except when coordinated with and approved by WellSense.

WellSense Health Plan approval

If a communication is determined to be marketing material, it must comply with our state contract content requirements and be approved by WellSense thirty (30) days prior to distribution. WellSense is responsible for obtaining approvals from DHHS.

Section 7: Member Benefit Information

WellSense Medicaid

Any New Hampshire Medicaid enrollee who is eligible to enroll in a managed care organization may enroll in the WellSense Medicaid plan. Medicaid enrollees are offered a wide range of healthcare services under both New Hampshire Medicaid (fee for service) and WellSense programs.

WellSense New Hampshire ACA

Eligible New Hampshire residents may enroll in a WellSense Clarity plan WellSense offers several plan options available based on a member's eligibility with a variety of cost-sharing and premium options.

7.1 Services covered and managed by WellSense

WellSense Medicaid

When members are enrolled in WellSense Medicaid, most of their New Hampshire Medicaid benefits are managed and paid for by WellSense. The benefits that are managed and covered by WellSense are outlined in the WellSense NH Medicaid Member Handbook. . The Member Handbook also indicates whether a Prior Authorization from WellSense may be required before the covered service will be eligible for coverage. All covered services must be medically necessary, and members must receive all their healthcare services from WellSense network providers, with the following exceptions: with the following exceptions:

- Emergency Care
- Urgent Care
- Family Planning Services
- If WellSense gives an authorization in advance for the member to get care from an out-of-network provider

Note: WellSense Medicaid members are not covered for any medical care, including emergency or urgent care, outside of the United States or its territories.

WellSense New Hampshire ACA

When members are enrolled in WellSense NH ACA, their benefits are managed and paid for by WellSense. The benefits that are managed and covered by WellSense are outlined in the WellSense NH Clarity Evidence of Coverage. . The Evidence of Coverage also indicates whether a Prior Authorization from WellSense may be required before the covered service will be eligible for coverage. All covered services must be medically necessary and members must receive all their healthcare services from WellSense's network providers with the following exceptions:

- Emergency Care
- Urgent Care
- In the event the member receives covered services from a non-network provider such as an anesthesiologist or radiologist
- Specific circumstances requiring continuity of care
- Out-of-network services at an Indian health facility without prior authorization only for members who are American Indian or Alaska Native (AI/AN) from a federally recognized tribe

- If WellSense gives an authorization in advance for the member to get care from an out-of-network provider

Note: WellSense NH ACA members are covered for emergency services received outside the United States and its territories, but coverage does not include transportation back to the service area once their emergency or urgent condition is stabilized.

All information regarding services that are covered and not covered by WellSense for the plans we offer are available at wellsense.org.

7.2 Medicaid services covered by New Hampshire Medicaid (not WellSense Health Plan)

The services listed below are managed and paid directly by New Hampshire Medicaid (fee-for-service program), not by WellSense Health Plan. Services covered directly by New Hampshire Medicaid are known as "wrap-around" or "non-managed care organization (MCO)" benefits.

- Comprehensive Dental Services, including routine, non-routine, emergency, orthodontia, and oral surgery for members under age 21 years.
- Dental services limited to the treatment of acute pain or infections for members aged 21 years and over
- Early supports and services (early intervention services) for infants and children aged birth to 3 years.
- Nursing home or nursing facility services (sometimes called long-term care nursing facility services), including:
  - Skilled nursing facility services
  - Long-term care nursing facility services
  - Intermediate care facility services (nursing homes and acute care swing beds)
  - Glencliff Home services
- Long Term Acute Care (LTAC) facilities
- Medicaid-to-school services
- Home and Community-Based Waivered Services (HCBS). (See the chart in 7.3 below for full description of these programs and services.)
- Crisis intervention mental health services and supports in the home, as well as in assisted living facilities, community residences and residential care homes.
- Division of Child, Youth, and Family Program services for Medicaid eligible children and youth referred by the courts or juvenile parole board, including:
  - Home-based therapy
  - Child support services (also known as Child Health Support Services)
  - Intensive Home and Community Services
  - Placement services
  - Private Non-medical Institutional Care for Children
  - Crisis intervention

For information on services covered by the MCOs, as well as the wrap-around benefits covered directly by New Hampshire Medicaid, please visit wellsense.org.

You may also contact the New Hampshire Medicaid customer service center at 1-844-ASK-DHHS ext. 4344 or for TTY/TDD, call 800-735-2964.

7.3 Medicaid Home and Community-Based Services (HCBS) waivered programs (managed by New Hampshire Medicaid)

As mentioned under Section 7.2 above, NH Medicaid is also responsible for the management and funding of the HCBS waivered program services. The 1915(c) home and community-based waiver is an option that allows states flexibility in providing long-term care services in home and community-based settings (HCBS), rather than institutional settings. States must apply and be approved for a waiver.

- The benefit of a HCBS Waiver program is that states can offer a variety of services through the waiver that may not be available in the standard Medicaid plan.
- When a member is eligible for a waivered program, they are eligible for a combination of standard Medicaid benefits as well as any services afforded to them under their waivered service program.

WellSense works with NH Medicaid to assist in the coordination of these services.

The waivered programs included under the Home and Community-Based Waiver programs are outlined below:

HCBS waivered program	Eligibility requirements	Description of covered services
Acquired Brain Disorder (HCBC-ABD) Waiver	Provides a system of services and supports to individuals age 22 years and older with traumatic brain injuries or neurological disorders who are financially eligible for Medicaid and medically qualify for institutional level of care provided with a need for specialized nursing care or specialized rehabilitation services.	• Assistive Technology • Community Support Services • Crisis Response Services • Environmental and Vehicle Modification Services Community Participation Services • Respite • Service Coordination • Supported Employment • Wellness Coaching • Residential Habilitation • Specialty Services
Choices for Independence (CFI) Program Waiver	Serves individuals who are age 18 years or older, financially eligible for Medicaid coverage, and clinically eligible for long term care services, and who choose to receive care in their home or another community setting instead of in an institutional setting. Adults participating in the CFI program must be age 18 or older and meet certain financial and	• Adult Family Services • Adult Medical Day Services • Community Transition Services (managed through the Community Passport program)

	clinical eligibility requirements.	• Environmental Modifications / Accessibility Adaptations • Home-Delivered Meals • Home Health Aide Services • Homemaker Services • Non-Medical Transportation • Nursing Services (skilled) • Personal Care Services • Personal Emergency Response Services (PERS) • Residential Care Services • Respite • Specialized Medical Equipment and Supplies Services • In-home support services • Supported employment • Financial management services • •
Developmental Disabilities (HCBC-DD) Waiver	Provides a system of long-term care services and supports in non-institutional settings to individuals of any age with mental retardation and/or developmental disabilities who are financially eligible for Medicaid and medically qualify for institutional level of care provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).	• Community Participation Services • Assistive Technology • Community Support Services • Crisis Response Services • Environmental and Vehicle Modification Services • Residential Habilitation

		• Respite • Service Coordination • Specialty Services • Supported Employment • Wellness Coaching
In-Home Supports for Children with Developmental Disabilities (HCBC-IHS) Waiver	In-Home Supports for Children with Developmental Disabilities (HCBC-IHS) Waiver is the home and community-based care 1915(c) waiver program that provides a system of long-term care services and supports to families with children diagnosed with autism and other developmental disabilities through age 21 living at home with their families who require services to avoid institutionalization.	• • Environmental and Vehicle Modification Services • Respite • Service Coordination • In Home Residential Habilitation • Assistive Technology • Community Integration Services • Consultations • Individual Goods and Services • Non-Medical Transportation • Personal Emergency Response Services (PERS) • Wellness Coaching

7.4 Plan-covered services managed by our partners

Note: Please refer to Section 8: Utilization Management and Prior Authorization for important authorization details. For questions on the WellSense Medicaid plan, contact WellSense at 877-957-1300, option 1. For questions on WellSense Medicare Advantage plans, contact WellSense at 866-808-3833. For questions on WellSense New Hampshire ACA plans, contact WellSense at 855-833-8122.

Type of service	Partner	Contact information – WellSense Medicaid plan	Contact information – New Hampshire ACA
Prescription Pharmacy Services	Express Scripts	• Call: WellSense at 877-957-1300. • Visit: WellSense's Pharmacy section at wellsense.org. • Submit PA: • Call: 877-417-1839 • Fax: 833-951-1680	Call: WellSense at 855-833-8122. Visit: WellSense's Pharmacy section at wellsense.org Submit PA: Call: 877-573-1929 Fax: 833-951-1680

Medical Drug Management Services (Outpatient buy & bill)	Care Continuum	Call: 877-817-4042 Visit: WellSense's Pharmacy section at wellsense.org. Submit PA: • Call: 877-817-4042 Fax: 833-812-0687	Call: 855-833-8122 Visit: WellSense Pharmacy section at wellsense.org Submit PA: • Call: 866-716-8338 Fax: 833-812-0687
Accredo	Specialty Pharmacy Services	Call: 844-516-3319 Fax: 800-391-9707	Call: 844-516-3319 Fax: 800-391-9707
Cornerstone Health Solutions	Mail-Order Pharmacy services	844-319-7588 Fax: 781-805-8245 • Write: 40 Teed Dr. Randolph, MA 02368	Call: 844-319-7588 Fax: 781-805-8245 Write: 40 Teed Dr. Randolph, MA 02368
Durable Medical Equipment and Prosthetics/Orthotics (DMEPOS)	Northwood, Inc. (NW)	• DMEPOS Providers Only • Call: 866-802-6471 (urgent requests only) • Fax: 877-552-6551 • Provider Portal: providerportal.northwoodinc.com • Visit: northwoodinc.com • Email: provideraffairs@northwoodinc.com • Write: P.O. Box 510 • Warren, MI, 48090	• DMEPOS Providers Only • Call: 866-802-6471 (urgent requests only) • Fax: 877-552-6551 • Provider Portal: providerportal.northwoodinc.com • Visit: northwoodinc.com • Email: provideraffairs@northwoodinc.com • Write: P.O. Box 510 • Warren, MI, 48090
Advanced Elective Radiology, Musculoskeletal Services and Genetic Testing	eviCore Healthcare	• Call: 888-693-3211 • Visit: https://www.evicore.com/	• Call: 888-693-3211 • Visit: https://www.evicore.com/ •
Vision Benefits	Vision Services Plan (VSP)	• Call: 800-877-7195 • Call: TTY/TDD line at 800-428-4833 • Visit: vsp.com	N/A

		• Mail to: Vision Service Plan Out-of-Network Claims • Attention: Claim Services PO Box 495918 Cincinnati, OH 45249-5918 • Mail to: Vision Service Plan In-Network Claims • Attention: Claim Services PO Box 495907 Cincinnati, OH 45249-5918	
Non-Emergent Medical Transportation Services	MTM Health	Call: 844-909-RIDE (844-909-7433)	N/A
Meals at Home Program	Mom's Meals	• N/A	N/A
Preventive Dental and Comprehensive Dental Services	Northeast Delta Dental (NEDD)	• N/A	N/A
OTC items	InComm	N/A	N/A
	TruHearing	N/A	N/A

Section 8: Utilization Management and Prior Authorization

8.1 General information

The Utilization Management (UM) program evaluates requests for covered services, where required. The program determines medical necessity through the use of nationally recognized criteria such InterQual® and WellSense's internal medical policies and pharmacy policies available at wellsense.org. These internal policies are:

- Developed in accordance with the standards created and adopted by nationally accredited organizations;
- Developed with input from Plan practicing physicians, actively practicing pharmacists, external specialty consultants, and advisory boards, as needed;
- Developed in accordance with applicable contractual obligations and regulatory requirements;
- Evidence-based and scientifically derived if practicable;
- Used as a guideline for making medical necessity decisions but are not a substitute for professional clinical judgment;
- Reviewed on an annual basis with input from appropriate actively practicing physicians, pharmacists and other specialists and updated as new treatments, applications, and technologies are adopted as generally accepted professional medical practice; and
- Approved for implementation by the Utilization Management Committee or Pharmacy & Therapeutics Committee

Providers can access WellSense's medical or pharmacy policy criteria used to render decisions by visiting the Policies page of our website at wellsense.org, or calling WellSense NH Medicaid at 877-957-1300, NH Clarity at 855-833-8122. WellSense's Utilization Management staff is available 8:30 a.m. to 5 p.m., Monday–Friday (except holidays). WellSense provides medical necessity criteria for medical necessity determinations for covered benefits, including mental health or SUD benefits, to any member, potential member, or participating provider upon request at no cost.

Secure provider portal

For information on accessing member information and online provider functions, please view WellSense's secure Provider Portal at wellsense.org.

Clinical review decisions

WellSense requires that qualified licensed health care professionals render or supervise all clinical review decisions. All utilization review decisions involving a denial of coverage are made by qualified, licensed physicians, or other licensed clinicians with the appropriate clinical expertise, as allowed by law. For example, pharmacy denial decisions are rendered by WellSense's licensed pharmacists.

WellSense conducts annual testing for all licensed clinical decision makers to ensure that criteria are applied in a consistent manner.

Medical necessity for substance use disorder services is based on American Society of Addiction Medicine (ASAM) criteria. WellSense may require prior authorization for covered substance use disorder services, except Medication assisted treatment (MAT) and methadone received at a methadone clinic. If prior authorization is required, a medical clinician or licensed alcohol and drug counselor will be available on a

24-hour hotline to make the medical necessity determination and assist with placement at the appropriate level of care. In those cases, a prior authorization decision will be made as soon as practicable after receipt of the clinical rationale consistent with ASAM criteria, and in no event more than 6 hours of receiving such information.

WellSense's Physician Reviewers or Clinical Pharmacists are available to providers by phone to discuss coverage denial determinations that were based on medical necessity.

Utilization Management decision making is based only on appropriateness of care and service and existence of coverage. WellSense does not reward practitioners, providers, or employees who perform utilization reviews, including delegated entities, for not authorizing health care services. No one is compensated or provided incentives to encourage denials or limit authorizations that would result in the underutilization of a service or to discontinue medically necessary covered services. Denials are based on lack of medical necessity, because a service is not a covered service, or because of the lack of existence of coverage.

8.2 Utilization Management vendors

WellSense contracts with the following vendors to perform authorization and utilization management for certain services:

Northwood, Inc. (Northwood) is delegated to manage requests for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for WellSense members,

eviCore healthcare (eviCore) is delegated to manage requests for high end radiology/cardiology services, genetic testing /, and musculoskeletal and pain management services.

Care Continuum (CCUM) is delegated to manage requests for outpatient medical drug services.

Vendor	Service	Contact Information
Northwood, Inc.	Durable medical equipment and prosthetics/orthotics (DMEPOS)	DMEPOS Providers Only Call: 866-802-6471 (urgent requests only) Fax: 877-552-6551 Provider Portal: providerportal.northwoodinc.com Visit: northwoodinc.com Email:provideraffairs@northwoodinc.com Write: 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

	Genetic Testing (lab management) MSK-Spine, Joint, Pain Interventional pain (spinal injections, spinal implants), joint surgery (large joint replacement, arthroscopy), and spine surgery (spinal implants, cervical/thoracic/lumbar),	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
Express Scripts	Prescription pharmacy services	Call: WellSense at • NH Medicaid: 877-957-1300 • NH Clarity: 855-833-8122 • Visit WellSense's Pharmacy webpages NH Medicaid. • NH Clarity Fax: 833-951-1680
Care Continuum	Medical Drug Management services	Call: WellSense at • NH Medicaid: 877-957-1300 • NH Clarity: 855-833-8122 • Visit WellSense's Pharmacy webpages NH Medicaid. • NH Clarity Fax: 833-812-0687
Northeast Delta Dental (NEDD)	Preventive/comprehensive Dental Services	Call: 833-884-1360 (WellSense Medicare Advantage only)
Mom's Meals	Meals at Home program	Call: 855-833-8128 (WellSense Medicare Advantage only)

8.3 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 in the hospital.

Through acute care coordination, WellSense:

- Makes medical necessity determinations using nationally recognized criteria such as InterQual® clinical criteria, or WellSense's internal medical policy criteria. Emergent acute inpatient admissions and

continued stay for emergent or elective admissions, as well as preadmission and continued stay in the acute rehabilitation and LTAC levels of care are reviewed for medical appropriateness. For skilled nursing facility care for WellSense Medicaid members, please follow DHHS's current process, available at dhhs.nh.gov. Coordinates inpatient clinical services in the setting that is best for the member's needs.

- Evaluates care to ensure that providers use resources appropriately and offer high quality of care.
- Develops and implements alternative and innovative services that enhance high-quality, cost-effective care.
- Collaborates with state agencies to manage affected members, as appropriate.

Acute inpatient hospital review

WellSense's Inpatient Utilization Management (IUM) clinicians perform medical utilization management functions under the direction of a Plan medical director and licensed clinical manager. WellSense 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 timely and appropriate transitions between levels of care, through the following:

- Performing admission reviews
- Performing concurrent reviews
- Reviewing the appropriateness of discharge plans
- Providing Plan benefit information to help facilitate post-hospital services
- Identifying members who may benefit from post-hospital care management services and making referrals, as appropriate, to WellSense's care management staff

Behavioral health

Prior to admissions to a State-Owned Hospital, inpatient psychiatric facility, or other State determined Institute for Mental Disease (IMD) a face-to-face evaluation by a mandatory pre-screening agent must be completed to assess eligibility for emergency involuntary admission and to determine whether all available less restrictive alternative services and supports are unsuitable.

If a member has been evaluated by a licensed physician or psychologist for admission to a State-Owned Hospital or other State determined IMD, a crisis team consultation must be completed prior to admission.

All inpatient mental health admissions require a notice of admission.

All substance use disorder services utilize ASAM criteria for medical necessity determinations.

Acute rehabilitation and long-term acute care review

Clinicians evaluate the medical necessity of admissions and continued stay in acute rehabilitation and LTAC facilities using nationally recognized criteria such as InterQual® clinical criteria. The clinician identifies the purpose, goals, and expected duration of the stay. For inpatient medical rehabilitation programs, the member must be able to actively participate in the treatment program. Staff are responsible for:

- Evaluating the proposed transfer from the acute care setting to the acute rehabilitation setting and validating that the level of care is appropriate for the member's needs and condition(s)
- Notifying the facility of the member's available 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

For skilled nursing facility admissions for WellSense Medicaid members, please follow DHHS's current process, available at dhhs.nh.gov.

8.5 WellSense's Prior Authorization department

To ensure members receive medically necessary care at the appropriate level and in the appropriate setting, the Prior Authorization department reviews coverage requests for certain services and products. Through the review process, staff:

- Verify member eligibility, benefits, and servicing provider's participation in our network.
- Document service requests and supporting information.
- Evaluate the medical necessity of the requested services using nationally recognized criteria such as InterQual® clinical criteria, Wellsense's internal medical and pharmacy policy criteria, Provide alternative coverage options when clinically appropriate.
- Communicate coverage determinations to members and providers.
- Identify cases that could benefit from a WellSense's care management staff evaluation for care coordination.

8.6 Plan Authorization requirements

Below is an outline of Plan requirements for authorization. You can view the list of covered services and specific benefit exclusions or limitations located on the member page of wellsense.org.

To request prior authorization:

Submit medical service requests for prior authorization online through our secure Provider Portal, which is the most efficient way to submit a prior authorization request. There are also medical prior authorization forms available on the "Prior Auth " page of our website at wellsense.org that can be submitted. . Even if prior authorization has been obtained, providers must check member eligibility on the date of service prior to delivering services. See Section 2: Member Eligibility for guidelines and step-by-step instructions on how to determine member eligibility in WellSense. A provider may contact Member Service by calling 877-957-1300, or the TTY/TTDD 711 at any time to determine member benefits and eligibility, PCP assignment, and provider participation. To submit a medical drug prior authorization request or a prescription pharmacy prior authorization request, see prior authorization resources page of our website at wellsense.org. When WellSense receives a prior authorization request, providers are given a reference number online, by return fax, or telephone, in accordance with the timeframes listed. The reference number, which does not guarantee approval or payment, is assigned for tracking purposes and to confirm for you that we have received your request. Payment is contingent upon the member's eligibility on the date(s) of service and on whether the service is a covered service and is medically necessary.

A provider's submission of cost and pricing information on a prior authorization request does not guarantee payment at the submitted rate. See Section 9: Billing and Reimbursement for provider reimbursement guidelines.

8.7 Authorization requests: requirements and timeframes

A prior (pre-service) authorization request

A prior authorization request is a request for services or items that require Plan determination in advance of the service being rendered or the item being furnished. 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.

Planned inpatient stays associated with services or procedures requiring prior authorization must have a prior authorization request initiated for the service or procedure prior to the inpatient admission and in accordance with all other prior authorization guidance. For a procedure that does not require prior authorization for outpatient, but the provider is now requesting inpatient hospitalization, pertinent clinical information would need to be submitted for an inpatient level of care determination, at the time of inpatient admission.

Authorizations are to be obtained prior to the date of service or elective admission. In order to allow sufficient time for a thorough medical review of the request, the expectation is that authorization requests for scheduled services will be received as soon as scheduling is contemplated and will include required medical necessity documentation.

A retrospective (post-service) authorization request

- WellSense requires that Providers request authorization prior to rendering services to Enrollees/Members. WellSense will only accept a request for retroactive 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 retro-authorization 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 retroactive authorization when the below extenuating circumstances apply. The provider must indicate which of the circumstances apply.

1. 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.
2. 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.
3. 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 retroactive authorization request and providers are required to request the authorization as soon as they are able. Retroactive requests outside of the above will not be considered by WellSense.

Please see instructions for filing a provider Administrative Appeal and on how to request reconsideration of an adverse determination/action in Section 10: Member Appeals, Inquiries, and Grievances.

Note: WellSense authorizes ancillary services and therapies, such as diagnostic tests, laboratory services, radiology services, occupational therapy, physical therapy, and speech therapy during inpatient admissions, if the admission is authorized. However, non-covered services, such as infertility services, provided in conjunction with an inpatient admission, are not automatically authorized even if the admission is authorized. If providers have any doubt whether an inpatient admission has been authorized, or that a service is authorized in conjunction with an inpatient admission, please contact WellSense Provider Line, for Medicaid and Clarity plans, at 877-957-1300

Requirements by service types

Note: This list does not contain all requirements. Please visit wellsense.org for a complete list of requirements by service type.

Type of service	Services that require authorization	Request instructions	Timeframe requirements and responsible party
Select outpatient medical/surgical services and items	For a complete list, view the Prior Authorization matrix on our website at wellsense.org. Examples: • Home health care, including prenatal visits and certain post-partum visits • Outpatient rehabilitation therapies • Select ambulatory surgeries	To complete an online request visit the Provider Portal. Our provider portal, also known as HealthTrio, will be the primary method for all inpatient and outpatient authorization requests submitted directly to WellSense* The following Fax numbers are available . Please note: Utilizing the Health Trio Portal is the preferred method when making requests. Outpatient service fax to: 603-218-6634. Submitting initial or additional clinical information for pending decisions:, fax to: 603-218-6667. To inquire if a specific service or product	A minimum of 7 calendar days before the requested date of service. PCP or servicing provider.

		requires prior authorization : Please visit wellsense.org for a complete list of requirements by service type or call the provider line at 877-957-1300, option 3.	
Elective inpatient admissions	Elective inpatient	To complete an online request visit the Provider Portal. Our provider portal, also known as HealthTrio, will be the primary method for all inpatient and outpatient authorization requests submitted directly to WellSense* The following Fax numbers are available. Please note: Utilizing the Health Trio Portal is the preferred method when making requests. Elective inpatient service fax to: 603-218-6634. Submitting initial or additional clinical information for pending decisions, fax to: 603-218-6667.	A minimum of 7 calendar days before the requested date of service. Servicing facility.
Acute rehabilitation facility or long-term acute care hospital	Acute rehabilitation or long-term acute care hospitals	To complete an online request visit the Provider Portal. Our provider portal, also known as HealthTrio, will be the primary method for all inpatient and	Acute rehabilitation facility or long-term acute care hospital / admission requests must be submitted prior to admission.

		outpatient authorization requests submitted directly to WellSense* The following Fax numbers are available. Please note: Utilizing the Health Trio Portal is the preferred method when making requests. Initial requests, fax to: 866-813-8607. Submitting initial or additional clinical information for a pending or continued stay decisions, fax to: 866-837-5725.	
Emergent or urgent inpatient admissions	Emergent or urgent inpatient admissions for initial and ongoing care	To complete an online request visit the Provider Portal. Our provider portal, also known as HealthTrio, will be the primary method for all inpatient and outpatient authorization requests submitted directly to WellSense* The following Fax numbers are available. Please note: Utilizing the Health Trio Portal is the preferred method when making requests. Initial requests, fax to: 866-813-8607. Submitting or initial or additional clinical information for a	Within 1 business day following the admission date. Servicing facility.

		pending or continued stay decisions, fax to: 866-837-5725.	
Maternity-related admission	Routine delivery or scheduled or emergency C sections	To complete an online request visit the Provider Portal. Our provider portal, also known as HealthTrio, will be the primary method for all inpatient and outpatient authorization requests submitted directly to WellSense* The following Fax numbers are available. Please note: Utilizing the Health Trio Portal is the preferred method when making requests. Initial requests, fax to: 866-813-8607. Submitting initial or additional clinical information for a pending or continued stay decisions, fax to: 866-837-5725.	Servicing facility.
Newborn-related admission/care	Newborn admission or later transfer to NICU or Level 2 nursery Newborn hospitalization following mother's discharge	To complete an online request visit the Provider Portal. Our provider portal, also known as HealthTrio, will be the primary method for all inpatient and outpatient authorization requests submitted directly to WellSense* The following Fax numbers are available. Please note: Utilizing the	NICU/level 2 nursery: 1 business day following admission. Continuing care: prior to the mother's discharge. Servicing facility.

		Health Trio Portal is the preferred method when making requests. Initial requests, fax to: 866-813-8607. Submitting initial or additional clinical information for a pending or continued stay decisions, fax to: 866-837-5725.	
Non-elective observation services	WellSense covers medically necessary observation services. Refer to Short Stay (<0-1 Midnight Length of Stay) Policy on provider website	Authorization is not required for non-elective observation services.	Observation stays do not need to be notified to the plan. Any observation stay that converts to an inpatient stay must be notified for inpatient level of care authorization.
Non-covered services	Requests for coverage of otherwise non-covered services For a list of services we do not cover, visit wellsense.org/plans.	To complete an online request visit the Provider Portal. Our provider portal, also known as HealthTrio, will be the primary method for all inpatient and outpatient authorization requests submitted directly to WellSense* The following Fax numbers are available. Please note: Utilizing the Health Trio Portal is the preferred method when making requests. Initial outpatient service fax to: 603-218-6634.	Requests are required to be submitted at least 7 calendar days before the requested date of service. PCP or servicing provider.

		Submitting initial or additional clinical information for pending decisions requests, fax to: 603-218-6667. To inquire if a specific service or product requires prior authorization: Please visit wellsense.org for a complete list of requirements by service type or call the provider line at 877-957-1300, option 3.

*If for any reason providers cannot submit via the Portal, please contact your Provider Engagement representative.

Authorizations for out-of-network care

Contracted providers listed in the Plan's New Hampshire Provider Directory (for Medicaid), , and New Hampshire Provider Directory for Clarity (ACA) are considered part of the applicable WellSense New Hampshire network that may include some surrounding state border hospitals and affiliated physicians. Any facility or provider not listed in the applicable Provider Directory is considered out-of-network for that product. A Prior Authorization from WellSense is necessary for the member to get care from an out-of-network provider.

Members are only covered for out-of-network services if it is medically necessary due to one of the exceptions below*:

- Emergency services.
- Urgent care .
- If WellSense gives an authorization in advance for the member to get care from an out-of-network provider.
- If WellSense does not have a participating specialty provider with the same level of specialty provider expertise required or cannot provide necessary medical, behavioral health or other services in a timely manner. This must be approved in advance through our prior authorization process.
- Second opinions, as long as the provider receives a prior authorization from us.
- For Medicaid members seeking family planning services, a member may choose any NH Medicaid participating doctor, clinic, community health center, hospital, pharmacy, or family planning office.
- If the member needs care that is a covered service and is medically necessary and our network providers cannot provide this care, members may be able to get this care from an out-of-network provider. We must approve this in advance through our prior authorization process.
- The member has been authorized to see an out-of-network provider under our Continuity of Care policy described in Section 5.3 (Continuity of Care).

- *Please note out-of-network coverage varies by Plan type.

Medicaid and Clarity Plan Members are covered for out-of-network services only if services are medically necessary due to one of the exceptions below:

- All emergency care or urgently needed services
- If we do not have providers in our network that can provide the care a member needs and timely. The plan must approve out-of-network service(s) before the member can have them (except for the exceptions noted above).
- Kidney dialysis if a member is temporarily outside the plan's service area.

WellSense considers several important factors when evaluating a prior authorization request for care at an out-of-network provider. These factors include: the member's specific medical needs; the medical necessity of the requested covered service or provider; the cost-effectiveness of the out-of-network options; quality; and access. If the member chooses to go to an out-of-network provider without prior authorization from WellSense, we will not cover the cost of the care—and the member will be responsible for the cost.

Second opinions

Second opinions are not mandated for any service or procedure, even though all Plan 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, WellSense will provide coverage for a consult with the second opinion physician. The member makes the final decision about the course of treatment. WellSense provides coverage for a second opinion from a qualified healthcare professional within WellSense's provider network, or arranges for the member to obtain a second opinion outside the provider network at no cost to the member if one is not available within the network. Prior authorization is required for a member to obtain an out-of-network second opinion.

8.8 Service denial for failure to obtain a prior authorization

In the event that a service is not authorized by WellSense due to a provider's failure to seek authorization, all claims will deny, including those associated with the service rendered on the same date by any provider supporting the services provided. For example, if an outpatient surgery has been scheduled and performed, which includes facility services, surgical service, and anesthesia services, claims for all of these services will be denied in the absence of an authorization for the surgical services rendered.

8.9 Member access to care without prior authorization

Services that *do not* require prior authorization

- Emergency and urgent services
- WellSense covers emergency care for all members. Determination of medical necessity for emergency services is based on 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, Plan 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, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairments to bodily functions; 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 provided outside of the Plan's service area. Members may have medical emergencies or require urgent care when they travel outside WellSense's service area.
    - Emergency services, including medications or procedures deemed necessary during the course of the emergency treatment, including post stabilization services: These are covered when the definition of emergency medical condition is met.
    - Urgent care services are covered when the definition of urgent care is met and the member cannot safely wait to obtain services from an in-network provider.
    - Community Mental Health covered services are not subject to any prior authorization or prior approval

Services that *do* require prior authorization

- Out-of-area non-emergent or non-urgent services, medications, or items.
- Transcranial Magnetic Stimulation
- ABA services
- Inpatient elective/planned admission, readmissions, and select outpatient surgeries, procedures, and other services,

Other special circumstances never requiring prior authorization

Plan members can receive any of the following services without prior authorization when the treating provider is a Plan provider:

- Maternity care
- Routine annual gynecologic exam, including any follow-up obstetric or gynecological services determined to be medically necessary as a result of such exam
- Medically necessary evaluations and related healthcare services for acute or emergency gynecological conditions
- Mammograms

8.10 Plan's Utilization Management timeframe requirements

The WellSense Timeliness of Utilization Management Decisions and Notification policy includes decision and notification timeframes that:

- Meet applicable regulatory requirements and accreditation standards;
- Are established for standard and urgent/expedited preservice requests, concurrent standard and urgent/expedited requests, and postservice requests for initial authorizations, extensions, limited authorizations, and denials of service requests;

- Apply to all authorization requests received and processed by WellSense or its designee;
- Provide the necessary guidance for timely processing of requests within Utilization Management departments; and
- Are intended to provide notice as expeditiously as the member's health condition requires.

Timeliness of utilization review decisions and notifications

WellSense makes and communicates utilization management authorization decisions to providers and members, when applicable, within the timeframes below.

Review type & priority	Turnaround time
Medical & Behavioral Pre-Service Non-Urgent/Standard	Medicaid Written notification to the member and provider within 7 calendar days of the receipt of request NH Clarity Written notification to the member and provider within 7 calendar days of obtaining all information necessary to make the determination, not to exceed 15 calendar days of the receipt of request
Medical & Behavioral Pre-Service Urgent/Expedited	Medicaid and NH Clarity Written notification to the member and provider within 72 hours of receipt of request
Medical & Behavioral Continued/Extended Services (i.e., Concurrent Urgent)	Medicaid and NH Clarity Written notification to the member and provider within 72 hours of the receipt of request
Pharmacy Pre-Service Non-urgent/Standard	Medicaid: Written notification to provider within 24 hours of receipt of request NH Clarity: Written notification within 7 calendar days of receipt of request
Pharmacy Pre-Service Urgent	Medicaid: Written notification to provider within 24 hours of receipt of request NH Clarity: Written notification within 72 hours of receipt of request

PCPs are notified of a Medicaid member's hospital admission.

Receipt of Request (ROR) is considered the:

- Submission date and time stamp on an online request.

- Date and time a fax is received,
- Date and time call received, or
- Received date stamp on a letter of medical necessity, 8.11 Services that require plan notification

WellSense must be informed, as described below, about certain services a member has already received or of specific changes in a member's health status. This notification assists care managers in identifying those members who might benefit from care management involvement. Notification also allows WellSense to monitor utilization and to initiate actions to improve service.

Maternity program notification requirements

WellSense's maternity program focuses on identifying high-risk pregnancies early and implementing appropriate interventions.

Type of Service	Notification Instructions	Notification Timeline	Party Responsible for Notification
Newborn Birth	Fax all newborn statistical information to the Enrollment Department at 866-335-9317. Note: See Newborn Eligibility in Section 2: Member Eligibility for additional information related to notification of birth.	1 business day after delivery	Servicing facility
Confirmed Pregnancy	Online, telephone or fax notification of confirmed pregnancy to the Prior Authorization department: Complete an online request visit wellsense.org Fax: 603-218-6634 Call: 877-957-1300	3 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 reimburse pediatric clinicians who provide this service. This service does not require Plan authorization.

Out-of-network exceptions for pregnant members

A Plan member who is pregnant must receive care from a Plan provider. However, WellSense will consider exceptions to this policy if one of the following applies:

- The woman is in her second or third trimester of pregnancy when she becomes a Plan member and she has an established relationship with a non-Plan obstetrical provider;
- Her Plan-participating provider becomes non-participating while the WellSense 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 60 driving minutes or45 driving miles away from any network obstetrician.

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

Postpartum home care visits

For Medicaid members, prior authorization is not required for an initial postpartum/newborn home care visit when mother and baby are discharged at the same time. For Clarity members, prior authorization is not required for the initial two postpartum/newborn home care visits. This initial visit(s) include services for both the mother and newborn(s). Additional home care services for either the mother or the newborn(s) rendered beyond the initial follow-up home visit(s) require prior authorization.

If during the postpartum visit, it is determined that a newborn or mother requires urgent or emergent services, additional services are provided through our Care Management program. See Section 11: Care Management Services for detailed information about the program.

8.11 New technology, experimental diagnostics, and experimental treatment

WellSense's Utilization Management Committee (UMC) regularly reviews information from clinically appropriate sources, including peer-reviewed medical literature, professional societies, and regulatory agencies.

The UMC also obtains expert opinions from specialist providers to determine whether new or emerging technologies or new uses for existing technologies, such as devices or pharmaceuticals, are experimental or investigational, or whether they constitute an accepted standard of practice. The results of these reviews determine whether the technologies reviewed should constitute a covered service or item. WellSense does not cover experimental or investigational services except when required by law.

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

The UMC uses all the following five (5) criteria to evaluate gathered information and to reach a decision on coverage:

- The service, treatment, or item must have final approval from the appropriate governmental regulatory bodies (e.g., the U.S. Food and Drug Administration) or any other federal governmental body with authority to regulate the technology. This applies to drugs, biological products, devices, and other products that must have final approval to market the technology.
- 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 or treatment on health outcomes.
- The service or treatment must improve the net health outcome and should outweigh any harmful effect.

- The service or treatment must be as beneficial as any established alternative for the specified indication, including interventions considered the standard of care.
- The documented, favorable health outcomes must be attainable outside the investigational settings.

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

8.12 Clinical right of provider to discuss an action

WellSense Medicaid & Clarity providers may request to speak with a Plan Physician Reviewer when a service has been denied or limited. Any additional clinical information that was not previously provided or used in WellSense's decision may be faxed to the appropriate department with a specific request that a provider speak with a Plan Physician Reviewer. The Physician Reviewer will need to receive the information prior to the discussion. Call WellSense at 877-957-1300, Provider Service, and select the appropriate department based on the type of service to be discussed (i.e., Medical Prior Authorization department, Care Management department, or Pharmacy department). An adverse action includes a denial or limited authorization of requested services, or the reduction, suspension, or termination of a previous authorization for a service. See guidelines available at wellsense.org that outline a provider's clinical right to discuss an action.

WellSense's Medical/Surgical Prior Authorization staff is responsible for processing preauthorization and concurrent requests. Requests, including pharmacy prior authorization, that do not meet medical necessity review criteria, level-of-care criteria, or medical policy criteria are referred to a Plan physician reviewer or licensed clinical pharmacist for review and determination.

Section 9: Billing and Reimbursement

WellSense is committed to reimbursing providers timely and efficiently for covered services rendered to Plan members. This guide will help ensure prompt payment, which relies on both WellSense and successful provider submissions. All necessary claim form samples are available in the Provider Forms section of our website at wellsense.org. Please remember the importance of verifying member eligibility. See Section 2: Member Eligibility for additional information. All payment policies are available at wellsense.org.

9.1 Covered services

WellSense Medicaid WellSense is responsible for most, but not all, New Hampshire Medicaid benefits available to the New Hampshire Medicaid population. For a summary of member benefits, visit wellsense.org/plans which outlines those benefits covered by WellSense and those paid for directly by New Hampshire Medicaid.

Providers must also adhere to the reimbursement and clinical coverage policies available at wellsense.org. Adhering to these requirements is necessary to avoid service denials, which become a provider liability and cannot be billed to a member, including provision of services that have been excluded according to the Benefit Exclusions Policy available at wellsense.org.

When billing for a service covered directly by New Hampshire Medicaid, please obtain the required authorization form from DHHS available at dhhs.nh.gov and bill New Hampshire Medicaid directly for prompt payment.

9.2 Provider reimbursement

Reimbursement rates are based on a provider's individual contract with WellSense.

Clean claims late payment

If clean claims, described in detail in Section 9.7 Claims Submission are not paid within thirty (30) days following receipt, WellSense will pay interest at the Medicare interest rate published in the Federal Register in January of each year.

The only New Hampshire Medicaid service requiring copayment collection is pharmacy services. See Section 6: Member Information for more information.

Providers may not bill or balance-bill New Hampshire Medicaid members for any covered service. Please see guidelines when providers may bill a New Hampshire Medicaid member for a non-covered service. See Section 4: Provider Responsibilities for administrative, coverage, and notification requirements for contracted providers and locum tenens physician services.

Contractual terms

This Provider Manual is incorporated by reference into your provider agreement with the Plan and includes all policies in this manual, as well all Plan policies which are referenced in this manual.

WellSense reimburses providers for covered services and supplies provided to members according to the contractual terms in individual provider agreements.

General conditions of payment:

Submitting cost and pricing information does not guarantee payment at the submitted rate. Rates are based on:

- Established reimbursement rates in your provider agreement
- Compliance with WellSense's administrative guidelines, including prior authorization and claim submission guidelines
- Verification of medical necessity
- Verification that the service is a covered service
- Eligibility of the member on date of service
- Adherence to proper Current Procedural Terminology and Healthcare Common Procedure Coding System (CPT/HCPCS) and other national coding guidelines
- Reimbursement Policy terms, which may reduce or deny payment based on standard editing rules (such as National Correct Coding Initiative claim edits)

See Section 8: Utilization Management and Prior Authorization for medical/surgical and Section 9: Billing and Reimbursement for payment and notification guidelines.

Prior authorization and retrospective review prior to claim payment

Prior authorization is required for certain services, products, and inpatient admissions. Since certain circumstances may prevent prior authorization, in some cases WellSense handles requests as a retrospective authorization request. See Section 8: Utilization Management and Prior Authorization for more detailed information.

Billing WellSense members for non-reimbursable plan services

Plan providers may not bill a WellSense member for missed appointments, and may not balance-bill a member for the difference between WellSense's reimbursement rate and provider charges for covered services when the provider is contracted . Providers may only charge New Hampshire members for applicable cost shares. In the case of non-contracted providers, or a provider who does not accept Medicare Assignment, a WellSense Medicare Advantage member may be responsible for all charges and fees. Examples of some scenarios:

Situation	Action by provider	Action by plan
A member seeks or requires a Medicaid benefit that is managed directly by New Hampshire Medicaid (a "wrap-around" benefit).	Submit the claim directly to New Hampshire Medicaid.	Continue to coordinate member's care with treating provider.
A member under age 21 seeks or requires a non-covered service required to treat a medical or behavioral condition found during the course of EPSDT services.	Provider may request special approval of the non-covered service through WellSense's Prior Authorization department or Care Management department (if the member's care is being coordinated by a Plan-affiliated care manager.)	Reimburse for the service after Plan review and approval.

Providers may bill a member for a service that is not medically necessary and not covered by WellSense or New Hampshire Medicaid only under the following conditions before non-covered services are rendered:

- Provider has informed the member, in writing and in advance, that neither WellSense nor New Hampshire Medicaid covers payment for the service. In addition, the provider must clearly describe the service for the member.
- The member decides to both receive and pay for that service, and the provider informs the member that they are responsible for payment.
- The member acknowledges in writing by signing a waiver stating that he or she is financially responsible for the non-covered service.
- Provider has the member's signed waiver on file before the service is rendered, which must outline the service to be rendered as well as the cost to the member. The cost to the member must be no more than what WellSense would have paid for the service.

Cost-sharing (deductibles, coinsurance, and copayments)

For Clarity plans, some 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.

Member eligibility

Member eligibility must be checked—before delivering a service—on the date of service, and daily for an inpatient admission. For New Hampshire Medicaid members, eligibility may change.

Two ID cards will be issued to New Hampshire Medicaid members, which they receive upon enrollment. Each member receives a New Hampshire Medicaid ID card and a Plan member ID card.

National provider identifier (NPI) and tax ID requirements

Providers must confirm that all NPI and tax ID numbers on all electronic 837 formatted claims are valid and correct.

The Provider's NPI number must match (have been registered with) an existing tax identification number (TIN) record on file with WellSense. Even if the NPI number is valid, WellSense will have to reject any claim where these numbers do not match. 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 thirty (30) calendar days prior to the effective date of the change. This will allow WellSense to complete any necessary system changes and safeguard against payment disruption.

The NPI requirements described above are federally mandated. Please submit questions regarding NPI or claims payments in writing to NHproviderinfo@wellsense.org.

Taxonomy Codes

Providers must submit their billing and rendering taxonomy codes for claims processing. Absence of the taxonomy codes will result in a claim denial. Providers must have a National Plan and Provider Enumeration System (NPPES) primary taxonomy that is a Medicare approved taxonomy.

9.3 Billing guidelines by service

Please see WellSense's reimbursement policies available at wellsense.org for detailed information on coding and billing requirements.

Service	Billing Guidelines
Newborn care billing	NH Medicaid The mother and newborn care must be billed separately, using a unique member ID number for each Plan member. WellSense creates a temporary ID number for the newborn so the billing process is not delayed. Treating providers, including hospitals and pediatric practices, must bill medical care for newborns under the child's unique ID number. If claims are not submitted correctly, payment can be delayed for clinical edit reasons. Please see Section 8: Utilization Management and Prior Authorization for Plan notification guidelines for maternity admissions. WellSense will provide the child's temporary member ID number via fax to the provider who gave the birth notification. The treating provider may bill WellSense for the inpatient stay and all services for a newborn child in one of two ways: • Bill with WellSense-assigned temporary member ID number for the newborn; or • Wait for the New Hampshire Medicaid- assigned member ID number and use that number for billing. It may take 6 to 8 weeks for DHHS to issue a newborn's ID number. See Section 2: Member Eligibility for a description of how to check member eligibility for newborns. Clarity: Claims for newborn care should be billed separately with the mother's ID number for the first 31 days following birth.
Primary care billing	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. WellSense must approve and credential physicians with dual specialties in both specialties. A member can change his/her PCP assignment at the time of care. See Section 6: Member Information for guidelines on PCP transfers and new assignments.

Modifiers

WellSense complies with HIPAA billing guidelines, and, therefore, mandates the use of HIPAA-standardized modifiers. Please see WellSense's reimbursement policies available at wellsense.org for detailed information on coding and billing requirements.

Revenue codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain codes that require CPT/HCPCS codes to be billed. Please see WellSense's reimbursement policies available at wellsense.org for detailed information on coding and billing requirements.

9.4 Compliance: Deficit Reduction Act and HIPAA requirements

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

To ensure compliance with the DRA, WellSense provides all its employees, provider network, contractors, and agents with information about the False Claims Acts and publishes WellSense Fraud and Abuse Policy internally as well as on the Providers page of WellSense's website.

Plan employees, contractors, and providers are expected to immediately report any potential false, inaccurate, or questionable claims or any other type of suspected fraud and/or abuse to WellSense's Fraud and Abuse Coordinator, the Compliance Officer or to the Compliance hotline at 888-411-4959 in accordance with WellSense's 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, or abuse issue. Please review and adhere to the complete Plan Fraud and Abuse policy at wellsense.org.

WellSense has 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. See wellsense.org for the most up-to-date reimbursement policies and guidelines.

9.5 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.

See sample remittance advice and explanation codes at wellsense.org.

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)
- Plan-derived DRG
- Claim number
- Date(s) of service rendered
- Billed amount
- Allowed amount (WellSense's allowed fee)
- Adjustment or other insurance amount (amount for which other insurance is primary)
- Member cost sharing amount
- Amount paid (with the remittance)
- Disallow remarks (will provide brief descriptions of disallowable payments and the reasons for the reduction from charges or the line item denial)

9.6 Third Party Liability (TPL)

Provider's role in Coordination of Benefits (COB)

Members may have other primary insurance coverage. When WellSense has established that other insurance coverage is the primary payer, providers should:

- Pursue payment from all other liable parties prior to submitting claims to WellSense. This includes resubmitting claims to the primary carrier when WellSense notifies the provider of other active coverage. Providers are expected to follow standard COB protocols, including submission of the primary Explanation of Benefits (EOB) when applicable.
- Submit a claim for any secondary balance due when the primary coverage pays or denies a payment. When submitting the claim to WellSense, include the other carrier's payment and denial details, including the reason for denial, for each line of the claim.
- Providers have one hundred twenty (120) days and ninety (90) days for NH Clarity to bill WellSense after receiving the primary payer's determination. We strongly suggest that you file COB claims electronically as it is the fastest and most accurate submission method

Subrogation

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

Providers should notify WellSense of all instances of other party coverage by calling WellSense at 877-957-1300 or submitting a completed Subrogation indicator form available at wellsense.org.

When a provider notifies WellSense, or when WellSense identifies through independent sources that Subrogation exists, WellSense will deny any claims related to the incident where liability has been accepted and the liability carrier is actively paying claims as the primary carrier.

9.7 Claims submission

Guidelines

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

Please remember to obtain any necessary 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.

Clean claims

Clean claims are required to avoid a claim denial. A "clean claim" is a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment. A computer-generated claim is when all required data fields are completed alphanumerically. An altered claim is a computer-generated claim that has been altered with some data fields in pen or pencil or crossed out, and is not considered a clean claim. WellSense is required to deny any claims submitted with partial handwritten or crossed-out information.

Electronic claims

WellSense receives most claims electronically and accepts and processes them in the standard HIPAA-compliant claims format using electronic data interchange (EDI). Compared to paper claims, there are many benefits to submitting electronic claims:

- Faster claim turnaround
- Faster payments
- Reduced administrative costs for mailings
- Faster notification of rejected claims

Including provider NPI numbers on electronic claims will help expedite the process, as WellSense will reject claims submitted without this information.

Ways to submit claims electronically:

Providers can submit claims directly to WellSense or via a third party. WellSense accepts and processes claims electronically from five (5) major clearinghouse entities:

- Capario (formerly MedAvant/MedUnite)
- Emdeon (formerly WebMD/Envoy)
- RelayHealth (McKesson, Per-Se)
- The SSI Group
- NEHEN (New England Healthcare EDI Network)

If a provider or a provider's billing agency uses one of these clearinghouses, providers can begin sending electronic claims simply by contacting the clearinghouse representative or customer support line. Providers can also submit claims directly to WellSense using the 837 format. Plan staff will work with providers to coordinate electronic claims submission and testing before EDI implementation. For questions regarding electronic claims submission, please contact WellSense at 877-957-1300 option 3 (for NH Medicaid), 855-833-8122 option 3 (for Clarity plans) or 866-808-3833 (for Medicare Advantage). For

additional information about electronic claims submission and detailed instructions for electronic data interchange (EDI), see WellSense's EDI Claims Companion Guide at wellsense.org.

Paper claims

When a paper claim must be filed:

- Claim requires an attachment, for example, invoices or operative reports.
- Provider is filing a clinical and Administrative Appeal, even if the claim was originally submitted electronically.

Send paper claims for covered services rendered to Plan members to:

WellSense Health Plan
P.O. Box 55049
Boston, MA 02205-5049

Please note that sending claims via certified mail will not expedite payment.

Required forms:

- Professional services: use CMS-1500 form to submit paper claims.
- Facility services: use UB-04 form to submit paper claims.
- Provider's statements on claims forms

All provider claims forms must be imprinted in **boldface** type with the following statements, or with alternate wording that is approved by the Regional CMS Administrator:

- "This is to certify that the foregoing information is true, accurate, and complete."
- "I understand that payment of this claim will be from federal and state funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws."

The statements may be printed above the claimant's signature or, if they are printed on the reverse of the form, a reference to the statements must appear immediately preceding the claimant's signature.

Time limits

Initial Claims and Encounters		
WellSense Medicare Advantage	WellSense Medicaid	NH Clarity
Claims must be submitted within 120 calendar days of the date of service	Claims must be submitted within 120 calendar days of the date of service	Claims must be submitted within 90 calendar days of the date of service

The above filing limits may be extended when a provider is awaiting payment and remittance advice (Explanation of Payment) from a primary insurer due to coordination of benefits (COB).

For Certified Community Behavioral Health Clinics (CCBHCs), claims for NH Medicaid services must be submitted within 6 months of the date of service.

For paper claims, the receipt date is defined as the date the claim is received by WellSense.

Coordination of benefits (COB) with other Insurers

If providers receive payment or documentation from another insurer more 120 calendar days for Medicaid or Medicare Advantage, and 90 days for NH Clarity, after the date of service, they should send the claim/encounter form and the primary insurer's remittance advice to WellSense within 120 calendar days of receiving the remittance advice from the other insurer or Medicaid or Medicare Advantage, and 90 days for NH Clarity. Include the Explanation of Benefits or remittance with any claims submitted to WellSense If a provider receives payment from both WellSense and another payer, providers are required to contact WellSense's Coordination of Benefits department regarding any repayment obligations.

For Clarity plan claims

Initial claims and encounters must be submitted within 90 calendar days from the date of service, unless payment and remittance advice (or explanation of payment) from a primary insurer are pending as part of Coordination of Benefits (COB). For paper claims, the receipt date is the date the claim is received by WellSense.

When payment or supporting documentation from another insurer is received more than 90 calendar days after the date of service, the claim or encounter form, along with the primary insurer's remittance advice or Explanation of Benefits (EOB), must be submitted to WellSense within 90 calendar days of receipt of the remittance advice. The remittance advice or EOB must accompany the claim submission.

If payment is received from both WellSense and another payer for the same service, providers must contact WellSense's Coordination of Benefits Department regarding any repayment obligations.

Claims submitted for an administrative appeal must be received by WellSense's Provider Appeals

Unit within the timeframe specified in Section 10.2, Administrative Appeals. A completed Request for Claim Review form is required for all appeals and is available at WellSense.org.

Corrected claim

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 have handwritten changes
- Be submitted within the following timeframes:
  - 120 calendar days of the original process paid date for Medicaid and Medicare Advantage
  - 90 calendar days for NH Clarity of the original process paid date.

COB

    - 120 days from primary payer's final payment determination date for Medicaid and Medicare Advantage
    - 90 days from primary payer's final payment determination date for NH Clarity.
- Not include any correction fluid on the paper claim

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).
- The claim is not the same subtype.

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 Relations Consultant or the WellSense EDI department.

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

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

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
P.O. Box 55049
Boston, MA 02205-5049

Rejected or denied claims

WellSense only accepts standard transaction codes (CPT, HCPCS, place of service, diagnosis codes, etc.) in compliance with HIPAA transaction code set standards. Claims containing old codes that have been replaced or deleted will be denied 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 denies any outpatient facility claim submitted with a revenue code if there is no corresponding HCPCS code where required.

The reference number generated during WellSense prior authorization process is not a guarantee of payment. See claims submission guidelines in Section 9: Billing and Reimbursement

Common claim scenarios and troubleshooting recommendations

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 National provider identifier (NPI) and tax ID requirements.
- WellSense member ID number 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.

Possible solution/process

- See payment retraction or adjustment information in Section 9: Billing and Reimbursement for information on submitting a corrected claim.

Denied claims: After processing properly submitted claims, a claim may be denied for many reasons

Possible reasons

- Is not a clean claim.
- Duplicate claim.
- Claim is filed after the claims submission time limits.
- Member is ineligible for Plan 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 as specified in the CMS-1500 Required Claim Data Elements
- 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 in Section 9: Billing and Reimbursement
- Claim does not meet clinical editing guidelines.

Possible solution/process

- Determine the cause of the denial and fix.

Administrative appeals of denied claims

Submit a provider Administrative Appeal in writing to WellSense to the attention of the Provider Appeals department.

- For questions about Administrative Appeals, please call WellSense at:
  NH Medicaid: 877-957-1300, Monday–Friday 8 a.m. to 6 p.m. and Saturday 9 a.m.–12 p.m.
- Clarity plans: 855-833-8122

To learn more, visit Section 10: Member Appeals, Inquiries, and Grievances

Electronic claims are processed automatically.

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

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

- The claim is not at the finished status. Finished claims are those printed on a remittance advice with an assigned claim number, or those claims in the claims status section in the Secure Provider Portal at the portals.bmchp-wellsense.org with a status of "finished". Claims identified with a status of "in process" or "adjudicated" are not considered finished.
- The claim is "split" (e.g., a request for a claim that crosses a calendar year span).
- EDI void or replacement transactions do not apply to clinical appeals, Administrative Appeals, or requests for a claim adjustments (i.e., disputes regarding the original handling of the claim. Questions should be directed to your assigned Provider Engagement team or WellSense's EDI department.

Please refer to the EDI Guidelines at or complete an online request at wellsense.org for specific instructions.

Resubmitting a Rejected Claim A resubmission applies when a claim fails the front-end validation edits and is rejected before entering WellSense's claims processing system. Because the claim does not pass initial intake validation, it is not considered received, accepted for processing, adjudicated, or denied by WellSense.

Claims rejected through front-end validation edits must be corrected and submitted as a new original claim. These submissions are not considered corrected claims, reconsiderations, or appeals.

Providers have 240 calendar days from the date of service to resubmit a claim that was rejected through front-end validation editing.

For claims involving Coordination of Benefits (COB), where another payer is primary, the claim must be received by WellSense within 240 calendar days of the primary payer's final payment determination date. A copy of the primary payer's remittance advice or Explanation of Benefits (EOB) must accompany the claim submission.

Common reasons for front-end claim rejection include, but are not limited to:

- **Subscriber id error:** The member identification number or member name does not match eligibility records.
- **Invalid provider information:** Required provider information, such as the National Provider Identifier (NPI) or tax identification number, is missing, incomplete, or invalid.
- **Missing required data:** Required claim elements, such as dates of service, diagnosis codes, procedure codes, modifiers, or other mandatory fields, are missing.
- **Incorrect payer id:** The electronic claim was submitted using an incorrect payer identification number or routing destination.

Because these claims are rejected before entering WellSense's claims adjudication system, they are not considered received or processed by WellSense. The identified error(s) must be corrected and the claim resubmitted as a new original claim within the applicable filing timeframe.

Distinction Between Resubmissions and Appeals

A resubmission is appropriate only when a claim is rejected before entering WellSense's claims processing system. Claims that have been accepted into the claims processing system and subsequently adjudicated must follow the applicable claim adjustment, reconsideration, or administrative appeal processes described elsewhere in this Provider Manual.

Submitting a resubmission claim

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.

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

Follow guidelines within Corrected Claims and Resubmission claims to prevent a delay in reprocessing.

The preferred option for resubmitting claims is to submit through HealthTrio using the Claim Review Form.

Paper resubmissions require the use of the Claim Review Form. The paper claims submission address is:

WellSense
P.O. Box 55049
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 9.15.

If a provider disputes the payment amount of a claim and a discrepancy cannot be identified on the remittance, please contact WellSense at 877-957-1300. Contract-related issues should be directed to your designated Provider Engagement team.

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 the provider's Provider Engagement team regarding a contract or fee schedule dispute.

9.9 Claims payment

Inquiring about a claim

WellSense is available to assist with payment issues. A team of highly trained professionals work with providers to resolve claims-related questions from the provider's first contact through the adjustment process. The WellSense Provider Service team provides information by telephone on the status of a claim for a maximum of three (3) claims per request. Providers with claim-related questions or payment issues may call the WellSense Provider Service team and select the claims status inquiry option. They can be reached at 877-957-1300 (for NH Medicaid), 855-833-8122 (for Clarity plans)
Online claims status inquiry and remittance advice

Providers may check the status of a claim at wellsense.org which has important information on individual claims:

- **Claims status inquiry**
  A printer-friendly version of a claims status inquiry. Once providers have entered the claim number and received results on that claim, they can print out a properly formatted document with complete information about the specific claim.
- **Remittance advices**
  An image of the remittance advice. The payment reference ID number will be shown as a link where the remittance advice can be viewed. Claim payment remittance images are on file for three hundred sixty-five (365) days. Specific claims can be searched by claim number.

To access this information online, a provider must have a Plan-assigned login ID number and password to ensure that HIPAA privacy standards are maintained for Plan members.

Clean claims

WellSense seeks to process clean claims and reimburse providers within thirty (30) calendar days of receiving the claim. WellSense mails a check to the treating provider or issues an electronic funds transfer (EFT) if the provider is enrolled in WellSense's EFT program.

A clean claim must meet the following criteria:

- No defects or improprieties
- Includes all required substantiating documentation from contracted or non-contracted providers and suppliers
- Does not involve particular circumstances that require special treatment that would prevent timely payment
- Includes all documentation substantiating and supporting any special treatment and/or complex procedures, including operative reports or use of an assistant surgeon
- Follows all prior authorization policies and procedures
- Is not under investigation for fraud, waste, or abuse
- Involves covered benefits
- Is properly submitted in the required format with all of the necessary data
- Meets WellSense's adjudication clinical editing guidelines
- Is submitted ready for processing, without the need to investigate information related to the claim

Electronic funds transfer (EFT)

EFT is an optional service that permits direct electronic deposit of a Plan claims payment. The program is easy, free, and saves time and money. WellSense automatically issues 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 payments are deposited electronically with EFT, there are no deposit slips for providers 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
- No standing in line at the bank
- Simplified record keeping
- Reduced paperwork

Request payment by EFT

For EFT payment, fill out the Electronic Funds Transfer Authorization form available on our website or contact WellSense at 877-957- (for NH Medicaid), 855-833-8122 (for Clarity plans) or 866-808-3833 (for Medicare Advantage), for a form to be sent to you. Forms should be submitted with one of the following forms of documentation from the account in which you wish to receive Plan payments:

- Voided check
- Letter from your practice's bank confirming the ABA transit number and account number

- Letter from you on your practice 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.

Once the EFT is received, a Provider Engagement team member will contact the provider to verify that the information is complete and correct and payment will be received via EFT approximately seven (7) to ten (10) calendar days after the verification has been completed. If payments are not received within fourteen (14) calendar days or two (2) check cycles, whichever is later, contact your Provider Relations Consultant.

Providers who enroll in WellSense's EFT program will continue to receive a paper-based remittance advice indicating member names, dates of service, services rendered, and amounts of Plan payments. The bank statement will continue to reflect deposited amounts and dates of deposit.

9.10 Claims audit

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

- Ensure appropriateness and accuracy of provider billing practices, including, but not limited to charge accuracy, diagnosis and procedure code, and DRG assignment.
- Evaluate Plan and provider compliance with contract rights and obligations related to claims, including rates of payment.
- Verify the financial accuracy of claims payment.

In performing these audits, WellSense subscribes to the third-party payer billing audit guidelines outlined in the National Health Care Billing Audit Guidelines, unless otherwise specified below or in a 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's 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, WellSense reserves the right to utilize policies promulgated by The Centers for Medicare and Medicaid Services (national or local), the NH DHHS, American Medical Association, and/or national health insurance carrier organizations.

Provider's role

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

- Designate someone with relevant knowledge and experience to coordinate audit activities, including someone to attend an exit conference at the conclusion of an on-site audit, or per mutual agreement, or to receive audit results (via regular or electronic mail) at the conclusion of a desk audit.
- Respond to the notification and provide the information and/or documentation requested within the designated time period.
- Notify WellSense 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.
- Provide clinical records and any additional documentation that supports the claim(s) in question 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; policies developed, adopted, and periodically reviewed by clinical staff, as evidenced by dates of implementation, 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.
- Provide a suitable work area for on-site audits and provide such additional information and/or documentation as is necessary to allow Plan auditors to understand the exact nature of specific charges, if required.
- Provide copies of medical records, if requested.
- Respond to audit findings within thirty (30) days of the Audit Summary Report date, unless otherwise agreed upon.
- Submit late charge type claims for any agreed upon previously unbilled or under-billed charges to WellSense auditor within thirty (30) days of the Audit Summary Report date.

Role of WellSense's Audit department

WellSense uses many different criteria to identify claims for review and 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. WellSense does not pay a fee to conduct an audit under any circumstance.

In the performance of these audits, WellSense will:

- Identify claims using internal criteria.
- Select claims for audit that are 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 WellSense's intent to audit e providing sufficient information regarding the nature of the audit and the specific claims to be audited.
- Employ auditors with reasonable expertise, integrity, and professionalism.
- Verify service descriptions against the appropriate charge description master.
- Accept all documentation containing sufficient information to identify the individual completing the documentation and the provider's credentials as evidence those specific services were 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 to providers—at the conclusion of the audit—for each claim reviewed, either an individual Audit Summary Report for each claim reviewed on-site or a combined Audit Summary Report detailing the findings for each claim reviewed by a desk audit.
- Allow providers a response period of thirty (30) days for all claims with audit discrepancies, unless otherwise agreed upon at the time of the audit.

- Accept late charge bills submitted within thirty (30) days of the initial Audit Summary Report for any previously agreed upon unbilled or under-billed services/items you identified at the beginning of an on-site audit or submitted with the documentation packet for a desk audit.
- Provide a Final Audit Summary Report, one for each claim for which an Audit Summary Report was presented at the conclusion of an on-site audit or a combined Final Audit Summary Report for all claims for which a combined Audit Summary Report was presented at the conclusion of a desk audit.
- Adjust claim payments as indicated by the Final Audit Summary Report, at the conclusion of the thirty (30) day response period.
- Identify audit-related retractions and/or claim adjustments on the remittance advice.

If a provider disputes the audit findings on a Final Audit Summary Report, they may submit a letter of appeal to the Provider Audit department within thirty (30) days of the date of the Final Audit Summary 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. The Provider Audit director will review the appeal, research the issue(s), and consult Plan 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 thirty (30) days of receipt of the appeal. Any claim adjustments resulting from the final determination of an appeal will be processed by WellSense within thirty (30) days of the final appeal determination.

9.11 Special Investigations Unit

To combat fraud, waste, and abuse (FWA), our 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. Neither SIU investigations nor the final determinations of such investigations are subject to look-back periods or other processes or procedures described elsewhere in this Provider Manual, with the exception of section 4.3 detailing fraud, waste, and abuse.

Providers will be required to adhere to any reasonable requests made by WellSense for supporting documentation. In all cases, providers agree to cooperate with any SIU investigation including, but not limited to, providing medical records and other documentation, or access to them, as requested. For any provider under review, WellSense has the right to evaluate through inspection, evaluation, review or request, or other means, including desk reviews or 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. 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. 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. Failure to provide medical records for services under review will result in recovery of claims payments related to those services.

Review Period and Record Retention

WellSense Health Plan's Special Investigations Unit (SIU) generally conducts investigations, audits, and claim reviews utilizing a lookback period of up to six (6) years from the date of service. However,

WellSense reserves the right, in its sole discretion, to review claims, provider records, encounters, payments, and related documentation for a longer period, including up to ten (10) years or as otherwise permitted by applicable law, regulation, contract, or where circumstances warrant an expanded review. Providers must maintain and make available all records and documentation necessary to support services billed to WellSense in accordance with applicable federal and state record-retention requirements.

Claim submission representations

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, were medically necessary in the provider's reasonable judgment; were performed by the provider or under appropriate clinical supervision; were billed accurately using appropriate coding; and are properly documented in the member's medical record. Submission of a claim also constitutes the provider's representation that the claim is not false or misleading.

If the medical record does not support the provision of a service, the service is considered not to have been documented or provided, and payment is subject to recovery by WellSense.

Audits and investigations

WellSense Health Plan ("WellSense" or "the Plan"), and/or authorized vendors, conducts routine and investigative audits of claims, encounters, and medical/business records submitted by network and non-network providers. These cover all audit and investigation types and lines of business, including, without limitation, coding, billing, medical necessity, documentation, coverage, quality, durable medical equipment ("DME"), and fraud, waste, and abuse ("FWA") audits and investigations, to verify compliance with applicable requirements and to identify overpayments, underpayments, and noncompliance. WellSense reserves the right, at its election, to expand the scope of any audit, and perform extrapolation of audit results to the defined audit population. If extrapolation methodology is selected, the process shall be performed in accordance with generally accepted sampling principles.

Provider cooperation and records requests

Providers must cooperate fully with WellSense, its authorized vendors, and state and federal agencies in any audit, review or investigation. This includes:

Producing complete medical, billing and business records, in the specific format detailed in the SIU request letter, within [30] calendar days of the request unless WellSense sets a different timeframe. Failure to provide the records in the requested format may result in delayed processing and/or review.

Allowing onsite reviews of facilities and records with or without advance notice, as permitted by law.

- Making staff available for interviews with SIU representatives/investigators.
- Retaining records per state and federal guidelines on retention

If a provider does not produce requested records by the due date, WellSense may deny or recover payment for the claims under review, and may take action.

Administrative actions

Based on the nature and severity of the findings, WellSense may take one or more of the following actions:

- Provider education and written warnings
- Prepayment review of some or all claims

- Recovery of overpayments, including by offset against future payments
- Corrective action plans, with follow-up monitoring
- Payment suspension when there is a credible allegation of fraud, in accordance with 42 CFR 455.23 and state requirements
- Termination from the WellSense network
- Referral to state and federal regulators and law enforcement
- When WellSense places a provider on prepayment review and identifies that the billing behavior extends to earlier dates of service, WellSense reserves the right to apply prepayment review to unadjudicated claims with dates of service up to six (6) months before the review start date. Previously adjudicated claims will not be impacted by this provision.

Overpayments and member billing

Any amount billed by a provider in violation of this policy, if paid by WellSense, constitutes an overpayment and is subject to recovery. Any amounts billed to and paid by members in violation of this policy must be immediately refunded to the member.

Providers must report and return known WellSense overpayments within 60 calendar days of identification, with a written explanation of the reason for the overpayment. Providers are encouraged to maintain an internal process for identifying and refunding overpayments.

When WellSense notifies a provider of an overpayment identified through an audit, review or investigation, the provider must, within thirty (30) calendar days of the date of notification, either (a) refund the overpayment amount to WellSense, or (b) submit a written dispute of the findings, including supporting documentation. A provider may refund the undisputed portion of an overpayment and dispute the remainder within the same timeframe. If the provider does not refund or dispute the findings within thirty (30) calendar days, WellSense may recover the overpayment by offset against future payments and may take additional administrative actions.

Appeals - New Hampshire Medicaid members only

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 sixty (60) days, as follows:

- Your appeal must be submitted in writing;
- Any claims a provider wishes to appeal, together with the rationale for the appeal and all supporting documentation, must be submitted as a single, consolidated appeal package in response to the final written report. Claims, issues, arguments, or supporting documentation not included in the initial appeal package may be deemed waived and may not be considered during the appeal review process or in any subsequent appeal request.
- 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 thirty (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 thirty (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 sixty (60) 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 a reviewer not a party to the initial appeal.

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.

Appeals - New Hampshire ACA/Medicare members only

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 thirty (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 thirty (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 thirty (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 (30) 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 a reviewer not a party to the initial appeal.

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.

DHHS State Fair Hearing - New Hampshire Medicaid members only

A State Fair Hearing through the New Hampshire DHHS is an independent review by the state of a provider's request for coverage of denied or partially approved services through WellSense. A provider may be eligible for a State Fair Hearing appeal *only after they have exhausted WellSense's internal appeal process and have received a denial or partial approval*. If a provider wishes to request a State Fair Hearing, they must do so within thirty (30) calendar days of the date of WellSense's appeal denial or partial approval letter.

The provider can refer to the DHHS website for full Administrative Appeals rights dhhs.nh.gov/doing-business-dhhs/legal-services/administrative-appeals. Information on requesting a State Fair Hearing is included WellSense Provider Appeal denial or partial approval notices.

Providers may file a request for a State Fair Hearing Appeal in writing to:

New Hampshire Administrative Appeals Unit
105 Pleasant Street
Main Building
Concord, NH 03301

Information on the DHHS State Fair Hearing process and how to request a hearing can be found on the DHHS website at dhhs.nh.gov/doing-business-dhhs/legal-services/administrative-appeals.

For questions relating to DHHS AAU State Fair Hearings, providers may call (603) 271-4292.

9.12 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

It is the provider's responsibility to perform "due diligence" to identify and refund overpayments to WellSense within sixty (60) days of receipt of the overpayment. 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.

Providers may either:

- Upload the request to the Provider Portal. If you haven't signed up for the portal, please contact your Provider Relations Consultants. Please upload Claim Review Form, Credit Balance Refund Data Sheet, and any necessary supporting documents. Both forms are downloadable from our website; or
- Submit the Credit Balance Refund Data Sheet, and any necessary supporting documents, using one of the traditional methods below. Again, please do not send us refund checks.
  - Fax: 617-897-0811
  - Mail:

    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 cannot submit a retraction request, please mail the refund check along with Credit Balance Refund Data Sheet and any necessary supporting documents to us by mail. 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

The Credit Balance Specialist team monitors the requests from the Health Trio portal, fax and mail on a daily basis. It takes approximately thirty (30) to forty-five (45) days from the date of receipt for us to complete the requests.

If you have any questions please call WellSense's Credit Balance Department at 617-748-6229.

Role of WellSense's Credit Balance department

When a provider notifies WellSense of an overpayment, the claim will be adjusted to reflect the correct payment. The reason for the adjustment will be identified on the remittance advice.

9.13 Process to address Negative Balances

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

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

1. WellSense's Finance Department runs weekly reports to identify any negative balances and reviews and validates the content of the reports.
2. In order to recoup negative balances, WellSense will take the following actions related to negative balances created greater than sixty (60) days from the week of the report:
    - 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
    - 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.
3. 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.

9.14 Forms and instructions

WellSense requires that CMS-1500 and UB-04 paper claim forms, or the electronic equivalent, be submitted using proper coding according to the HIPAA transaction code set guidelines. Please see WellSense's reimbursement policies available at wellsense.org for detailed information on coding and

billing requirements.

Service	Form	Instructions
Ambulatory surgery center (freestanding)	CMS 1500/ UB-04	Freestanding ambulatory surgery centers must bill only those procedures identified in their contractual fee schedule.
Ambulance transportation	CMS-1500	WellSense is responsible for the payment of covered emergency transportation. Non-emergent transportation services are administered by WellSense's transportation vendor.
Anesthesia services	CMS-1500	Anesthesiologists must bill using the appropriate anesthesia CPT-4 or HCPCS codes and an anesthesia modifier. For anesthesia services, providers should bill using the total number of minutes for the service(s) performed (base units should not be reported); the minutes should be indicated in the units field of the CMS-1500 Form. Surgeons performing anesthesiology services should bill using CPT-4 codes for anesthesia services.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	CMS-1500	To identify EPSDT services, providers should bill according to WellSense's EPSDT Reimbursement Policy at wellsense.org. For behavioral health screenings, use code 96110 with the identified modifiers.
Emergency services	CMS-1500/ UB-04	The Plan covers and pays for emergency services at rates that are no less than the equivalent DHHS fee-for-service rates if the provider that furnishes the services has an agreement with the Plan.
Family planning services	CMS-1500	For billing procedures for family planning, please see WellSense's Family Planning, Sterilization, and Abortion reimbursement policy available at wellsense.org.
Home health and home infusion services	CMS1500/UB-04	Home health care on a UB-04 Form: If home health services are billed on a UB-04 Form, the provider must include the appropriate bill type. See the Home Health reimbursement policy.
Inpatient facility services	CMS-1500 UB-04	Appropriate ICD procedure, diagnosis, and current bill type codes are required for proper processing for all inpatient billing. All inpatient and outpatient services billed on a UB-04 form must include a valid revenue code. Most but not all outpatient services must include a corresponding CPT-

		4/HCPCS code as required by National Uniform Billing Committee rules and specifications.
Laboratory services (free-standing)	CMS-1500	Modifiers are required when billing for the technical or professional component of laboratory services unless billing the service globally.
Observation stays	UB-04	See WellSense's Hospital reimbursement policy for guidelines related to observation stays at wellsense.org.
Occupational therapy	CMS-1500	See WellSense's Physical, Occupational and Speech Rehabilitation Modalities And Therapeutic Procedures reimbursement policy available at wellsense.org to access billing procedures for occupational therapy.
Optometry services	CMS-1500	VSP Vision Care manages vision benefits for WellSense. Please forward all claims and find reimbursement information directly from VSP at vsp.com or call 800-877-7195.
Physical therapy	CMS-1500	See WellSense's Physical, Occupational and Speech Rehabilitation Modalities And Therapeutic Procedures reimbursement policy available at wellsense.org for billing procedures for physical therapy.
Primary care services	CMS-1500	Primary care providers must follow industry standard coding for new and established patient billing, as specified by CPT. Refer to WellSense's General Billing and Coding Guidelines and General Clinical Editing and Payment Accuracy Review Guidelines reimbursement policies for further billing guidance.
Radiology services (free-standing)	CMS-1500	A modifier is required when billing separately for the technical or professional component of radiology services. Refer to WellSense's CPT and HCPCS Level II Modifiers Reported on CMS-1500 Claims reimbursement policy for additional details.
Speech, language, and hearing services	CMS-1500	See WellSense's Physical, Occupational and Speech Rehabilitation Modalities and Therapeutic Procedures reimbursement policy, and the Hearing Aid Services reimbursement policy available at wellsense.org.
Unlisted codes	UB-04/ CMS-1500	For procedures with an unlisted code, providers are required to provide an operative note upon billing WellSense for review, in order for the claim to be paid.

Vaccine and immunization administration	CMS-1500	All claims for reimbursement of immunization administration must include the specific antigen code in order for payment to be made. If the antigen is state supplied (SL), use the SL modifier. When billing for multiple vaccine administrations, a provider must use the appropriate administration codes and number of units. WellSense cannot reimburse higher for a state-supplied vaccine administration than is permitted under federal regulations. See the Immunization Services Reimbursement Policy for billing and reimbursement guidelines for immunizations and vaccines both available at wellsense.org.

Required Claim Data Elements

Professional claims			
Box	**Field Name**	**Submission Requirements**	
		Paper CMS-1500	**Electronic 837P**
1	Type of Coverage	Optional	Optional
1a	Insured's ID Number	Required	Required
2	Patient's Name	Required	Required
3	Patient's Date of Birth	Required	Required
4	Insured's Name	Required	Required
5	Patient's Address	Required	Required
6	Patient Relationship to Insured	Required	Required
7	Insured's Address	Required	Required
8	Reserved for NUCC use	N/A	N/A
9	Other Insurance Information	Required, if applicable	Required, if applicable
9a	Other Insured's Policy or Group Number	Required, if applicable	Required, if applicable
9b	Reserved for NUCC use	N/A	N/A
9c	Reserved for NUCC use	N/A	N/A
9d	Insurance Plan	Required	Required
10a-c	Is Patient's Condition Related To	Situational	Situational
10d	Reserved for NUCC use	N/A	N/A
11	Insured's Policy Group or FECA Number	Situational	Situational
11a	Insured's Date of Birth and Sex	Situational	Situational

11b	Other Claim ID	Situational	Situational
11c	Insurance Plan Name or Program Name	Situational	Situational
11d	Another Health Benefit Plan	Required, if applicable	Required, if applicable
12	Patient's or Authorized Person's Signature	Situational	Situational
13	Insured's or Authorized Person's Signature	Situational	Situational
14	Date of Current Illness/Injury/Pregnancy	Required	Required
15	Other Date	Situational	Situational
16	Dates Patient unable to Work In Current Occupation	Situational	Situational
17	Name of Referring Provider or Other Source	Required	Required
17b	ID Number of Rendering Provider	Required	Required
18	Hospitalization Dates Related to Current Services	Situational	Situational
19	Additional Claim Information	Situational	Situational
20	Outside Lab	Required, if applicable	Required, if applicable
21	Diagnosis or Nature of Illness/Injury	Required	Required
22	Resubmission Code	N/A	N/A
23	Prior Authorization Number	Required, if applicable	Required, if applicable
24A	Date of Service From/To	Required	Required
24B	Place of Service	Required	Required
24C	EMG	Situational	Situational
24D	Procedure Codes/Modifiers	Required, if applicable	Required, if applicable
24E	DIAGNOSIS CODE	Required	Required
24F	Total Charge	Required	Required
24G	Days or Units	Required	Required
24H	EPSDT Family Plan	Required, if applicable	Required, if applicable
24I	ID Qualifier	N/A	N/A
24J	Rendering Provider ID/Taxonomy code	Required	Required
25	Federal Tax ID Number	Required	Required

26	Patient's Account No.	Required	Required
27	Accept Assignment	Required	Required
28	Total Charges	Required	Required
29	Amount Paid	Required, if applicable	Required, if applicable
30	Balance Due	N/A	N/A
31	Signature of Provider	Required	Required
32, 32a-b	Name and Address of Facility	Required, if applicable	Required, if applicable
33	Provider/Supplier's Billing Number and Address	Required	Required
33a	Billing Provider/Group NPI	Required	Required

Required Claim Data Elements for Institutional Claims

Institutional Claims				
Form Locator	**Field Name**	**Submission Requirements**		
		Inpatient Paper UB-04	**Outpatient Paper UB-04**	**Electronic - 837I**
1	Provider Name and Address	Required	Required	Required
2	Pay-To Name and Address	Situational	Situational	Required, if applicable
3a	Patient Control Number	Required	Required	Required
3b	Medical Record Number	Situational	Situational	Situational
4	Type of Bill	Required	Required	Required
5	Federal Tax Number	Required	Required	Required
6	Statement Covers Period	Required	Required	Required
7	Future Use	N/A	N/A	N/A
8a-b	Patient ID, Patient Name	Required	Required	Required
9	Patient Address	Required	Required	Required
10	Patient Date of Birth	Required	Required	Required
11	Patient Sex	Required	Required	Required
12	Admission Date	Required	Required, if applicable	Required, if applicable

13	Admission Hour	Required	Required, if applicable	Required, if applicable
14	Type of Admission/Visit	Required	Required	Required
15	Source of Admission	Required	Required	Required
16	Discharge Hour	Required	Required, if applicable	Required, if applicable
17	Patient Discharge Status	Required	Required	Required
18-28	Condition Codes	Required, if applicable	Required, if applicable	Required, if applicable
29	Accident State	Situational	Situational	Situational
30	Future Use	N/A	N/A	N/A
31-34	Occurrence Codes and Dates	Required, if applicable	Required, if applicable	Required, if applicable
35-36	Occurrence Span Codes and Dates	Required, if applicable	Required, if applicable	Required, if applicable
37	Future Use	N/A	N/A	N/A
38	Responsible Party Name and Address	Required, if applicable	Required, if applicable	Required, if applicable
39-41	Value Codes and Amounts	Required, if applicable	Required, if applicable	Required, if applicable
42	Revenue Code	Required	Required	Required
43	Revenue Description/IDE Number/Medicaid Drug Rebate	Required	Required	Required
44	HCPCS/Rates	Required, if applicable	Required, if applicable	Required
45	Service Date	N/A	Required	Required
46	Service Units	Required	Required	Required
47	Total Charges (by rev code)	Required	Required	Required
48	Non Covered Charges	Required, if applicable	Required, if applicable	Required, if applicable
49	Future Use	N/A	N/A	N/A
50	Payer Identification	Required	Required	Required

51	Health Plan Identification Number	Required	Required	Required
52	Release of Information	Required	Required	N/A
53	Assignment of Benefits	N/A	N/A	N/A
54	Prior Payments	Required, if applicable	Required, if applicable	Situational
55	Estimated Amount Due	N/A	N/A	Situational
56	NPI	Required	Required	Required
57	Other Provider ID	Optional	Optional	Optional
58	Insured's Name	Required	Required	Required
59	Patient Relationship	Required	Required	Required
60	Insured's Unique ID	Required	Required	Required
61	Insured Group Name	Situational	Situational	Situational
62	Insured Group Number	Situational	Situational	Situational
63	Treatment Authorization Number	Situational	Situational	Situational
64	Document Control Number	Situational	Situational	Situational
65	Employer Name	Situational	Situational	Situational
66	Diagnosis/Procedure Code Qualifier (ICD Version Indicator)	Required	Required	N/A
67	Principal Diagnosis Code/Other Diagnoses	Required	Required	Required
67	Principal Diagnosis Code/Other Diagnoses	Situational	Situational	Situational
68	Reserved	N/A	N/A	N/A
69	Admitting Diagnosis Code	Required	Required, if applicable	Required, if applicable
70	Patient's Reason For Visit	N/A	Required, if applicable	Required, if applicable

71	Prospective Payment System (PPS) Code	Optional	Optional	Optional
72	External Cause of Injury (ECI) Codes	Situational	Situational	Situational
73	Reserved	N/A	N/A	N/A
74	Principal Procedure Code	Required, if applicable	N/A	Required, if applicable
75	Reserved	N/A	N/A	N/A
76	Attending Provider and Identifiers	Situational	Situational	Situational
77	Operating Provider Name and Identifiers	Situational	Situational	Situational
78-79	Other Provider Name and Identifiers	Situational	Situational	Situational
80	Remarks	Situational	Situational	Situational
81	Code-Code Field Qualifiers (TAXONOMY)	Required	Required	Required

9.15 Provider administrative claims appeals

If a provider needs to appeal a claim denied by WellSense, he/she will need to submit a Request for Claim Review form. The Request for Claim Review form is available at wellsense.org or by calling WellSense at 877-957-1300, , Provider Service. For questions about an administrative claims appeal, call WellSense at 877-957-1300 to speak with a Provider Service Center representative. Staff is available from 8:00 a.m. to 6 p.m. Monday–Friday

Administrative claims appeals may be submitted if a provider is requesting that a previously denied claim be overturned due to circumstances outlined below. Providers may request that WellSense review a claim that was denied for an administrative reason rather than for medical necessity of services. The administrative claims appeal process is only applicable to claims that have already been processed and denied and cannot be considered for services rendered to an individual not eligible on the date(s) of service, or for benefits not administered or covered by WellSense.

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

- Level of Compensation/Reimbursement
- Timely Filing of Claims
- Retroactive Member Eligibility
- Lack of Prior Authorization/Inpatient Notification Denials
- Non-Covered and/or Unlisted Code Denials
- Other Party Liability (OPL)/Subrogation/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: Member 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.*
- *Note: Claims issues involving OPL/Subrogation/COB are not necessarily appeals involving OPL/subrogation/COB claims. Providers are responsible for sending their requests to the appropriate address via the required method(s).

Internal Appeal

Send administrative claims appeals to:

WellSense Health Plan
Provider Appeals
P.O. Box 55049
Boston, MA 02205

WellSense offers one level of internal administrative claims appeals to providers. Administrative claims appeals must be filed within sixty (60) calendar days from the original denial date. An administrative claim appeal filed after this timeframe will be denied, and the provider has no further right to appeal.

WellSense may extend the appeal decision timeframe by up to 60 calendar days to obtain additional information from the Provider or for other reasonable circumstances.

If an internal administrative claims appeal is denied, participating providers may be eligible for an external appeal with DHHS. Providers that are eligible for this process will receive an explanation of their external appeal rights in their WellSense internal appeal denial letter. Participating providers may submit an external appeal request to the DHHS Administrative Appeals Unit (AAU) *only after exhausting* WellSense's internal appeal process. If WellSense does not meet the required notice or appeal decision timeframes, the Provider may consider the appeal process complete and may request a State fair hearing.

An overview of the DHHS external appeals process is outlined below.

DHHS State Fair Hearing

A State Fair Hearing through the New Hampshire DHHS is an independent review by the State of a participating provider's request for coverage of denied or partially approved services through WellSense. A provider may be eligible for a State Fair Hearing appeal *only after they have exhausted WellSense's internal appeal process and have received a denial or partial approval*. If a provider wishes to request a State Fair Hearing, they must do so within thirty (30) calendar days of the date of WellSense's appeal denial or partial approval letter.

Upon request, WellSense will provide the Department and the Participating Provider with all Plan-held records related to the Provider Appeal within three (3) business days. Records may include transcripts, case files, supporting documentation, and written appeal decisions.

WellSense will work with the Department throughout the State fair hearing process and will provide the documentation, affidavits, and staff support necessary to explain and support its appeal determination, including participation by the Medical Director or other appropriate personnel when required.

WellSense will comply with the final State fair hearing decision. If the hearing overturns the Plans decision, WellSense will reverse the adverse action and implement the hearing outcome within 10 calendar days.

The provider can refer to the DHHS website for full Administrative Appeals rights: https://www.dhhs.nh.gov/doing-business-dhhs/legal-services/administrative-appeals. Information on requesting a State Fair Hearing is included in WellSense's provider appeal denial or partial approval notices.

Participating providers may file a request for a State Fair Hearing Appeal in writing to:

New Hampshire Administrative Appeals Unit
105 Pleasant Street
Main Building
Concord, NH 03301-6521

Information on the DHHS State Fair Hearing process and how to request a hearing can be found on the DHHS website at dhhs.nh.gov/doing-business-dhhs/legal-services/administrative-appeals.

For questions relating to DHHS AAU State Fair Hearings, providers may contact the AAU at:

- Email Address: dhhs.aau@dhhs.nh.gov
- Phone: (800) 852-3345
- Alternate Phone: (603) 271-4292
- Fax: (603) 271-8422

Information required for administrative claims appeals

Required documentation:

General Rules for Submission of Provider Administrative Claims Appeals

- Provider administrative claims appeals may be submitted via the WellSense provider portal, which can be found via the Provider Login on the WellSense Health Plan website.
- Provider administrative claims appeals may also be submitted via paper and mail through the United States Postal Service. If submitted via this option, the appeal must include a completed* Request for Claim Review Form.

*A completed Request for Claim Review Form is a form submitted with all required information, including but not limited to completion of all fields denoted with an asterisk (*) and the correct Review Type box. If using "Other" on the Form, providers must document specific information pertaining to their request.

- Appeals with incomplete Forms will be dismissed. A dismissal letter will inform the submitting provider that they may resubmit their appeal with the completed Form. The provider's request will not be processed unless/until a completed Form is received with the original appeal within the original appeal timely filing timeframes. Once the appeal is received with a completed 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 denied by the Plan as untimely.

- Forms submitted must be legible. Appeals that contain a Request for Claim Review Form that cannot be interpreted or are illegible will be dismissed as unable to process.
- All appeals must be accompanied by a written narrative explaining in full detail the discrepancy or the rationale for the appeal of the denial.
- Appeals that do not contain a written narrative detailing the request and rationale will be dismissed as unable to process.
- All appeals must include a copy of the claims(s) in question, the remittance advice, applicable OPT/Subrogation/COB documents (example: EOB from another carrier, PIP letter, etc.) and any Plan-issued correspondence.
- All appeals must include all necessary information the provider wishes to have considered during the review.
- The Plan will not accept additional information for review after an appeal decision has been rendered by the Plan.
- Providers must complete the 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.

Required data elements for administrative claims appeals

The following data elements must be present on the Request for Claim Review Form and must be legible:

- Provider name
- WellSense-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 claim appeal. Additionally, each claim denial being appealed 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 notification to an incorrect insurance company
- Proof of timely claims submission
- Notes showing verification date of valid insurance
- 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 claim appeal

Reimbursement appeal:

- Include a written narrative (explanation) of the requested change(s). Include the remittance advice and identify the claim we should review.
- Include all supporting documentation in the form of invoices, operative notes, office notes, or any necessary medical record information.
- Include a completed 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 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. Include all pertinent information including all necessary clinical documentation.
- Include a copy of the claim and the remittance advice.
- 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).

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

- The member was added retrospectively to WellSense after the service was rendered.
- The member was added retrospectively 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. WellSense will send written notification to providers of all denials of administrative claims appeals.

In the event WellSense approves an administrative denial and the appeal requires clinical review, the appeal will be sent to a Plan Physician Reviewer (MD) for review and determination. If an appeal is approved because the service(s) met the clinical criteria for coverage, the claim will be adjusted accordingly. If an appeal is denied on the basis that the service was not medically necessary due to not meeting clinical criteria for coverage, the claim denial will be upheld.

Claim denied for submission over the filing limit

An appeal submitted due to a claim denial for violating the filing limit must include at least one of the following: If the initial claim submission is after the filing limit and the circumstance for the late submission

was beyond the provider's control, providers may appeal by sending a letter documenting the reasons why the claim could not be submitted within the contracted filing limit. Include the original claim form and send the appeal within the appeal timeframe specified, as outlined in filing an Administrative Appeal.

If the member did not identify him/herself as a Plan member, supply proof to WellSense that the member or another payer had been billed within WellSense's timely filing limit.

If submitting an appeal via mail, include a completed Request for Claim Review form available at wellsense.org

When paper claims are submitted, the following are examples of acceptable proof of prior timely submission and applicable documents must be attached :

- 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 WellSense did not reject the claim.

WellSense Health Plan (WellSense) partners with TriZetto Provider Solutions (TPS) to manage its electronic data interchange (EDI) transactions exclusively. Clearinghouse service organizations and billing agencies that submit EDI transactions must send through TPS. Please utilize this Trizetto Provider Solutions New User Request link where your organization can enroll if your provider entity does NOT use one of the billing agencies listed below.

ADS DATA SYSTEMS	MIRRUS
• Affiliated Professional Services	• Nthrive / XactiMed
• APEX EDI	• Numeric
• Ascentria	• People Care Inc.
• Athena Health	• Physician's Computer Company
• Emergency Medicine Solutions	• PV Kent & Associate
• eSolutions / Claim Remedi	• Quest Diagnostics
• Experian Health / Passport Health	• ServiceNet
• Hill Associates	• Tempus Unlimited INC
• IDX/GE Healthcare / WV Holdings	• Viatrack Systems
• Logix Health	• XIFIN

For more information Providers can email us at ItOpsSupport@wellsense.org for any EDI related questions.

Claim denied because the member was ineligible on the date of service

- If a member becomes retroactively eligible or loses plan eligibility and is later determined to be eligible, the thirty (30) calendar day timely filing deadline begins on the date the member is enrolled into 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 a New Hampshire eligibility verification system or another agency or organization approved to provide eligibility information can serve as written evidence of eligibility.
- Include a completed Request for Claim Review Form for appeals sent via mail. The Form can be found at wellsense.org.

Claim denied for coding and clinical editing

Appeals must include all pertinent information, including the remittance advice 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 must support the levels billed. If billing for two (2) separate services or procedures, the documentation for each service must be able to stand alone and support that charge. This includes:

- Clearly stated 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.
- A copy of the claim and the remittance advice must be attached.

A completed Request for Claim Review Form must be included for appeals sent via mail.

Timeframes for administrative claims appeal determinations

An appeals coordinator ensures all necessary information is included with the appeal. All incoming appeals are date stamped and assigned a document control number. The appeal is sent to a third-party vendor for imaging and the vendor returns the image to WellSense via an electronic file. Providers can call WellSense at 877-957-1300 and speak with a representative to confirm receipt or to verify the status of an appeal. All provider administrative claims appeals are decided by an administrative or clinical professional with expertise in the subject matter of the appeal. Once a decision has been reached, WellSense will make all necessary attempts to adjust a claim(s) accordingly for approvals within ten (10) calendar days of the decision. An Administrative Appeal decision is based on the information available at the time of the review and is rendered within thirty (30) calendar days from WellSense's receipt of the appeal.

Section 10: Member Appeals, Inquiries, and Grievances

10.1 General information

WellSense strives to promptly resolve member inquiries, grievances, and appeals as defined in this section. It also addresses provider requests for clinical reconsiderations of denials of member and provider appeals. For information on provider Administrative Appeals, see Section 9: Billing and Reimbursement.

The member appeals process includes the right of a member or authorized representative to use WellSense's member appeals and grievances processes. For information on member appeals and grievances, see page 140.

10.2 Medicaid appeals-related definitions

For purposes of this section, the following definitions apply:

Action
An action is an occurrence that falls into one of the following categories:

- A Plan denial or limited authorization of a requested service, including the type or level of service.
- WellSense reduction, suspension, or termination of a previously authorization for a service.
- WellSense denial, in whole or in part, of payment for a service.
- WellSense's failure to provide services in a timely manner.
- WellSense's failure to act within the required timeframes for reviewing service authorization requests and issuing a decision.
- WellSense's failure to act within the required timeframes for reviewing an internal appeal and issuing a decision.
- WellSense's denial of a Medicaid enrollee request, for a resident of a rural area with only one MCO, to exercise the individual's right to obtain services outside the network.

Administrative appeal
A written request made by a provider for reconsideration of a denied claim or retrospective review for authorization after services have been rendered. These reviews include, but are not limited to, evaluating a claim denial for clinical editing, late submission, or unauthorized services (e.g., failure to request Plan prior authorization). Administrative Appeals do not include corrected claims, adjustments or claim resubmissions. See Section 9: Billing and Reimbursement for information on provider Administrative Appeals.

Appeal
A review of an action. There are appeals related to benefits and to determining medical necessity.

Appeals and Grievances Specialist
WellSense staff member responsible for coordinating, investigating, documenting, and resolving all member appeals and grievances. For member appeals, this specialist serves as a liaison between WellSense and the NH DHHS.

Continuation of benefits
Covered services previously authorized by WellSense that become the subject of an internal appeal or DHHS State Fair Hearing appeal involving a decision by WellSense to terminate, suspend, or reduce the

previous authorization for those services. A provider acting as an authorized representative cannot request a member's continuation of benefits pending appeal even with the member's written consent. WellSense provides continuing services pending the resolution of the internal appeal or a DHHS State Fair Hearing appeal. Continuation of benefits will occur if:

- The request is made within ten (10) calendar days from the later of: the date of the notice of action, or the intended effective date of WellSense's proposed action.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The authorization period has not expired.
- The member requests extension of benefits.

If the final resolution of the appeal is to uphold the action, the member may be responsible for paying for the continuation of benefits.

Date of action
The effective date of an action.

Expedited Internal Appeal
An internal appeal is expedited when 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.

Grievance
Any expression of dissatisfaction by a member or an authorized representative about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care of services provided, any aspects of interpersonal relationships such as rudeness of a provider, office staff or Plan employee, or failure to respect the member's rights.

Inquiry
Any oral or written question by a member to WellSense's Member Service department regarding an aspect of WellSense's operations that does not express dissatisfaction about WellSense.

NH Department of Health and Human Services (DHHS) State Fair Hearing Appeal
An external appeal that is available to members who have exhausted WellSense's internal appeals process. This appeal requires a written request to DHHS by a member or authorized representative to review a final, internal appeal decision made by WellSense.

Provider
An individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

Standard internal appeal
The internal review of a request by a member or authorized representative for review of an action.

10.3 Medicare appeals-related definitions

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). Part B Medical Drug appeals fall under Part C. These procedures include reconsideration by WellSense, and if necessary, an independent review entity (IRE), 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), Administrative Law Judge (ALJ) hearings, reviews by the Medicare Appeals Council (MAC), and judicial reviews.

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 his/her 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. When a minor is able, under law, to consent to a medical procedure, that minor can request an Appeal of the denial of such treatment without parental/guardian consent and appoint an Appeal Representative without the consent of a parent or guardian. 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.

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.

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 seventy-two (72) hours from the time it is received at WellSense, unless an extension of up to fourteen (14) calendar days is necessary. Note that Part D Appeals and Part B Appeals cannot be extended.

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 seventy-two (72) hours from receipt at WellSense.

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, including a provider on behalf of a member, about any action or inaction by the Plan other than an Organization Determination. 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. A member or their Authorized Representative, including a provider on behalf of a member, may make the complaint or dispute, either orally or in writing, to WellSense, provider, or 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 services (Part D grievance)
A Part D grievance is any expression of dissatisfaction by a member or Appeal Representative, including a provider on behalf of a member, about any action or inaction by the Plan other than a coverage determination or a late determination penalty (LEP) determination. 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 member's right to dispute a Part D sponsor refusing to expedite a Coverage Determination or redetermination.

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. 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.

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.

Organization determination
An Organization Determination is any determination made by WellSense with respect to the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
- Payment for any other health services furnished by a provider other than WellSense that the member believes are covered under Medicare, or if not covered under Medicare, should have been furnished, arranged for, or reimbursed by WellSense.
- WellSense's refusal to provide or pay for services, in whole or in part, including the level of services, that the member believes should be furnished or arranged for by WellSense.
- Reduction or premature discontinuation of a previously authorized ongoing course of treatment.
- Failure of WellSense to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.

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 SNFs, HHAs, and CORFs.

Reconsideration
Reconsideration is a member's first step in the Part C (and Part B) appeal process after an adverse Organization Determination; WellSense or Independent Review Entity may revaluate an adverse Organization Determination, the findings upon which it was based, and 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 to a pre-service part C or D appeal is anywhere from seven (7) to thirty (30) calendar days from date of receipt at WellSense. Extensions are only allowed for Part C Reconsiderations. No extensions are allowed for Part B reconsiderations. Note that the turnaround time for post-service reconsiderations is 60 calendar days.

10.4 Medicaid Member grievances and appeals

General information

WellSense has an efficient process in place to resolve member grievances and address member appeals in a timely manner. If a member is inquiring about medical necessity or a service coverage issue, WellSense offers assistance and informs the member of the appeals process. Providers may assist in the appeals process by furnishing documentation and other information WellSense requests and may be appointed as an authorized representative by the member to act on their behalf regarding an internal appeal or a DHHS State Fair Hearing appeal. The member must give written permission for a provider to act as their representative for standard internal appeals and DHHS State Fair Hearing appeals.

A member or authorized representative may submit three (3) types of appeals for actions related to medical/surgical and/or pharmacy services:

- Standard internal appeal
- Expedited internal appeal
- DHHS State Fair Hearing appeal (external)

An appeal of an action is a standard internal appeal or an expedited internal appeal filed with WellSense by a member or member's authorized representative. Member *internal* appeals must be submitted to WellSense within sixty (60) calendar days of the date of the notice of action. WellSense may reject as untimely any internal appeals received later than sixty (60) calendar days after the date of the notice of an action. An *external* appeal may be submitted to DHHS only after the internal appeal process is completed.

How a member submits a grievance

When a member has a question or is dissatisfied about the care, service, or access to service provided by WellSense or a participating provider, the member or authorized representative, including a provider on behalf of a member, may inquire about that care and/or may file a grievance in any of the following ways:

- Make oral inquiries by calling the Member Service Department at 877-957-1300, option 1.
- File an oral grievance by calling WellSense's Member Service department at 877-957-1300, option 1 or 711 for TTY/TDD services.
- File an oral grievance in person at a Plan office location during regular business hours, Monday–Wednesday, 8 a.m. to 8 p.m. and Thursday and Friday 8 a.m. to 6 p.m. (except holidays)
- Send written grievances to:

WellSense Health Plan
Member Grievances
100 City Square, Suite 200
Charlestown, MA 02129

WellSense provides instructive materials and forms to assist members submitting a grievance. Upon a member's request, WellSense will provide reasonable assistance in completing the forms and following procedures applicable to the grievance process. This includes, but is not limited to, providing free interpreter services and toll-free numbers with TTY/TDD and interpreter capability. Members are entitled to free access to and copies of any information related to their grievance that is in WellSense Health Plan's possession and under WellSense control.

WellSense provides written acknowledgement for any grievance it receives to members and/or authorized representatives.

Upon completion of the resolution of a grievance, written notice is sent to affected parties no more than forty-five (45) calendar days from the date WellSense received the grievance, unless the timeframe is extended by mutual agreement between the member or authorized representative and WellSense. In some cases, grievances may be extended for up to fourteen (14) calendar days.

Grievance process

Grievances are categorized as follows:

- **Administrative grievances**
  Grievances related to billing issues, provider office condition or staff, attitude or service of a provider, or a member's dissatisfaction with Plan staff, policies, processes, or procedures.
- **Clinical grievances (quality of care grievances)**
  Grievances related to the health care and/or services a member has received or is trying to receive from a participating Plan provider.
- **Expedited clinical grievances (expedited quality of care grievances)**
  Grievances relating to clinical issues such 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.

If a grievance is filed orally, a Plan Appeals and Grievances Specialist will write a summary of their understanding of the grievance in an acknowledgment letter and send a copy to the member or authorized representative. This summary will serve as both a written record of the grievance as well as an acknowledgment of receipt of the grievance.

Written grievances should include:	Fax or mail to:	WellSense's response
• Name • Address • Plan ID number	WellSense Health Plan Member Grievances Fax to: 617-897-0805 Or	• Once the grievance is received, WellSense sends a letter to the member or authorized representative

• Description of grievance, including relevant dates and provider names. • Applicable documents that relate to the grievance (Ex: billing statements)	Mail to: 100 City Square, Suite 200Charlestown, MA 02129	acknowledging receipt of the grievance. • The grievance is processed by an Appeals and Grievances Specialist with reviews by appropriate healthcare professionals. • A written response is sent to the member or authorized representative within 45 calendar days of receipt of the grievance unless the grievance is extended. WellSense may extend the timeframe up to 14 calendar days, if necessary.

How a member submits an appeal

When a member wishes to dispute an adverse action, the member or authorized representative may inquire about that adverse action and/or file an appeal in any of the following ways:

- File an oral appeal by calling WellSense's Member Service department at 877-957-1300, or 711 for TTY/TDD services.
- If a minor is able, under law, to consent to a medical procedure, that minor can request an appeal of the denial of such treatment without parental/guardian consent.
- File an oral appeal in person at a Plan office location during regular business hours, Monday–Wednesday, 8 a.m. to 8 p.m. and Thursday and Friday 8 a.m. to 6 p.m. (except holidays)
- Send written appeals to:
  WellSense Health Plan
  Member Appeals
  100 City Square, Suite 200
  Charlestown, MA 02129

WellSense provides written acknowledgement to members and/or authorized representatives for any standard internal appeal it receives. See Standard internal appeal, Expedited internal appeal, and DHHS State Fair Hearing for notice of resolution for appeals.

WellSense provides instructive materials and forms to assist members submitting an appeal. Upon a member's request, WellSense will provide reasonable assistance in completing the forms and following procedures applicable to the internal appeals process. This includes, but is not limited to, providing free interpreter services and toll-free numbers with TTY/TDD and interpreter capability. Members are entitled to free access to and copies of any of their medical information related to their appeal that is in WellSense Health Plan's possession and under WellSense control.

Monitoring member appeals

WellSense maintains reports of all member appeals (including external appeals submitted to DHHS), that include the following information:

- Type and nature of the appeal
- Member name
- Date appeal was filed and date of resolution
- How each appeal was addressed
- What, if any, corrective action was taken related to the appeal
- The name of the provider involved in the appeal
- If the service was denied or approved after review of the appeal

On an annual basis, WellSense reviews the data and its appeals policies and makes any necessary modifications or improvements.

Standard internal appeal

WellSense offers one internal review for standard appeals. The review is performed by healthcare professionals with appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the action. Authorized representatives, including providers, may file standard appeals on behalf of members; however, the member must provide written consent to WellSense. The healthcare professional who decides the internal appeal will be someone who has not been involved in any prior review or determination of the particular requests at issue nor is the subordinate of someone who was involved. During the appeal review process, WellSense will consult, if appropriate, with same or similar actively practicing specialty providers who typically treat the medical condition, perform the procedure, or provide the treatment involved in the appeal. Information regarding the internal appeal process and the DHHS external appeal process is included in any notice following an action or denied internal appeal. Internal appeals must be filed by the member or authorized representative within sixty (60) calendar days of the date of the notice of the action regarding WellSense's service authorization decision. WellSense will not take punitive action against providers who support a member's internal appeal.

WellSense's standard internal appeal process and written notice to affected parties will conclude no more than thirty (30) calendar days from the date the request for a standard internal appeal is received (unless the timeframe is extended).

WellSense allows a member or 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. Additionally, WellSense allows 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.

The standard appeal timeframe may be extended up to fourteen (14) calendar days if the member or member's authorized representative requests the extension, or if WellSense can justify that:

- There is a need for additional information; and
- The extension is in the member's best interest

WellSense will continue to provide benefits to the member, pending a resolution, as long as the request for an internal appeal:

- Is submitted within ten (10) calendar days of the action;
- Involves the termination, suspension, or reduction of a previously authorized course of treatment;
- Is for a service ordered by an authorized provider;

- Is within the authorization period;
- The member requests the standard appeal within sixty (60) calendar days following the date of the initial denial letter, and
- The member requests continuation of benefits, either orally or in writing.
- Note that a provider acting as an authorized representative cannot request a member's continuation of benefits pending appeal even with the member's written consent.

Expedited internal appeal

A member or authorized representative may request an expedited internal appeal after receiving notification of an action for urgent or time-sensitive care. WellSense does not require written permission from the member for providers to file expedited appeals on the member's behalf. WellSense will not take punitive action against providers who request an expedited resolution on behalf of a member.

An expedited internal appeal is conducted by a healthcare professional with the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the action. During the expedited appeal review process, WellSense will consult, if appropriate, with same or similar actively practicing specialty providers who typically treat the medical condition, perform the procedure, or provide the treatment involved in the appeal. A determination is made within seventy-two (72) hours of receiving the expedited internal appeal.

The expedited appeal timeframe may be extended up to fourteen (14) calendar days if the member or member's authorized representative requests the extension, or if WellSense can justify that:

- There is a need for additional information; and
- The extension is in the member's best interest.

WellSense allows reasonable opportunity for a member or authorized representative to present evidence and allegations of fact or law in person as well as in writing. WellSense also reminds a member or authorized representative of the limited time available for this opportunity in the case of an expedited internal appeal.

WellSense may reject a member or authorized representative's request for an expedited appeal. In the event the request is rejected, WellSense will:

- Convert the requested expedited internal appeal to the timeframe for standard internal appeal resolution, and
- Make reasonable efforts to give the member or authorized representative oral notice of the denial for expedited review, and will send written notice within two (2) calendar days.

WellSense may only reject a provider's request on behalf of a member for an expedited internal appeal if WellSense determines the request is unrelated to the member's health condition.

The member has the right to file a grievance regarding the denial of an expedited internal appeal request.

WellSense will continue to provide benefits to the member, pending a resolution, as long as the request for an internal appeal:

- Is received within ten (10) calendar days of the date of the Plan's notice, or the intended effective date of the Plan's proposed action;
- Involves the termination, suspension, or reduction of a previously authorized course of treatment;
- Is for a service ordered by an authorized provider;

- Is within the authorization period;
- The member requests the appeal within sixty (60) calendar days following the date of the initial denial letter, and
- The member requests extension of benefits, orally or in writing.
- Note that a provider acting as an authorized representative cannot request a member's continuation of benefits pending appeal even with the member's written consent.

The member may be required to pay the cost of services received pending an internal appeal if the appeal results in a decision to uphold WellSense's initial denial or partial approval. Members are notified of this in the Member Handbook and the Notice of Rights for Standard, Expedited, and State Fair Hearing Appeals insert which accompanies action and appeal correspondence from WellSense.

WellSense notifies the member and/or authorized representative and treating provider of the decision on an expedited appeal by telephone and in writing. After the resolution of the expedited internal appeal with WellSense, a member or authorized representative may submit an external appeal request to the DHHS if the request is still denied or partially approved.

Members and/or authorized representatives may submit an external appeal request to the DHHS only *after exhausting* WellSense's internal appeal process. An overview of the DHHS external appeals process is outlined below.

DHHS State Fair Hearing

A State Fair Hearing through the New Hampshire DHHS is an independent review by the State of a member's request for coverage of denied or partially approved services through WellSense. A member may be eligible for a State Fair Hearing appeal *only after they have exhausted WellSense's internal standard or expedited appeals process and have received a denial or partial approval*. If a member or authorized representative wishes to request a State Fair Hearing through DHHS, they must do so within one hundred twenty (120) calendar days of the date of WellSense's internal appeal denial or partial approval letter.

A member may be eligible to receive continuation of benefits throughout the State Fair Hearing process if:

- The member or authorized representative requests a hearing within ten (10) calendar days of the date of the Plan's internal appeal denial/partial approval notice;
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The service was ordered by an authorized provider;
- The authorization period has not expired;
- The Member files the request for a State Fair Hearing appeal within sixty (60) calendar days following the date of the initial denial letter; and
- The Member requests extension of benefits, orally or in writing, says, either orally or in writing that they do not want to continue benefits.
- Note that a provider acting as an authorized representative cannot request a member's continuation of benefits pending appeal even with the member's written consent.

The member may be required to pay the cost of services received pending a State Fair Hearing if the State Fair Hearing results in a decision to uphold WellSense's denial or partial approval. Members are notified of this in the Member Handbook and the Notice of Rights for Standard, Expedited, and State Fair Hearing Appeals insert which accompanies action and appeal correspondence from WellSense.

Members or authorized representatives may file a request for a State Fair Hearing Appeal in writing to:

New Hampshire Administrative Appeals Unit
105 Pleasant Street
Main Building
Concord, NH 03301-6521

State Health Insurance Assistance Program (SHIP)

If WellSense determines that a dual-eligible member's appeal is solely related to a Medicare service, WellSense will refer the member or authorized representative to New Hampshire's SHIP.

The State Health Insurance Assistance Program, or SHIP, is a federal grant program that helps states enhance and support a network of local programs, staff, and volunteers. Through one-on-one personalized counseling, education, and outreach, this network of resources provides accurate and objective information and assistance to Medicare beneficiaries and their families. This allows the recipients to better understand and utilize Medicare benefits. SHIP is currently administered by ServiceLink Aging and Disability Resource Center. Members or authorized representatives will be informed that they may contact the SHIP program at 866-634-9412 or by accessing their website at www.servicelink.nh.gov.

Medicare complaints, grievances, and appeals

We have an effective process to respond in a timely manner to member complaints, grievances, and appeals. If the complaint deals with medical necessity or a coverage issue, we offer the member assistance and inform him/her of the appeals process. You may assist in resolving a member issue by furnishing documentation and other information that we request, and may be appointed as an Authorized Representative by the member to act on a 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, including a provider on behalf of a member, to file a grievance is to put it in writing and send it to us by mail or fax. A grievance also may submitted orally by calling the WellSense Member Service Department at 877-957-1300.

Written grievances should include name, address, WellSense Medicare Advantage 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 postal mailed to:

WellSense Medicare Advantage
Member Grievances Department
100 City Square, Suite 200
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:

1. An Appeals and Grievance Specialist acknowledges the receipt of the grievance in writing.
2. Grievances are reviewed within thirty (30) calendar days (or within twenty-four (24) hours if the grievance is expedited). Under certain circumstances, grievance reviews may be extended up to fourteen (14) calendar days.
3. Reviews will be performed by appropriate healthcare professionals who are knowledgeable about the type of issues involved in the grievance.
4. 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 (2) or more similar Grievances within three (3) months or three (3) or more Grievances within six (6) months of the Grievance receipt date.

It is the expectation of WellSense that you kindly respond in a timely manner to our requests for information relating to grievances.

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 Acentrato initiate the fast-track appeal process.

When a member files a fast-track appeal, the QIO will notify WellSense and 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, in conjunction with the provider, will fax to the QIO the applicable notices and the complete 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 Pre-Service Reconsideration Process consists of one level of appeal and the process may not exceed more than thirty (30) calendar days from the date WellSense receives the member's or Authorized Representative's request for Appeal, unless the timeframe is extended. Post-Service Reconsiderations consists of one level of appeal and the process may not exceed more than sixty (60) calendar days from the date WellSense receives the member's or Authorized Representative's request for Appeal, and the timeframe cannot be extended A Standard Appeal will be considered a final level of internal review. Members or their Authorized Representative may request Standard Appeals. A treating provider may also file a Standard Appeal on behalf of the member. WellSense 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.

WellSense's Expedited Reconsideration Process consists of one level of review and will conclude no more than seventy-two (72) hours from the time WellSense received the member's or Authorized Representative's request for expedited appeal, unless the timeframe is extended. Part B Appeals cannot be extended. An Expedited Appeal will be considered a final level of internal review.

Timeframes for Standard and Expedited Reconsideration (non-Part B) may be extended for up to fourteen (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.

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 will dismiss a Level 1 Standard or Expedited Reconsideration if:

- The member or Authorized Representative filed a Standard or Expedited Appeal beyond the sixty-five (65) calendar day filing limit from when WellSense provided the Member notice of the adverse Organization Determination), unless the member shows good cause. A request to file a level 1 appeal after the timeframe must be in writing and state why the request for a level 1 appeal was not filed on time.
- The individual or entity making the request is not a proper party to the appeal under the applicable regulation. This includes the following situations: If an individual requests a reconsideration on behalf of an enrollee, but a properly executed appointment of representative form has not been filed (and there is no other documentation to show that the individual is legally authorized to act on the enrollee's behalf), the MA plan is obligated to make attempts to secure the missing documentation 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
- If a non-contracted provider requests a reconsideration of a denied claim (i.e., post-service appeal) but fails to provide a waiver of liability statement indicating that it will not bill the enrollee regardless of the outcome of the appeal, the MA plan should make attempts to secure the missing documentation prior to dismissing the request. Please note: a pre-service reconsideration request by a physician who is providing treatment to an enrollee, upon providing notice to the enrollee, is considered a valid request.
- When the plan determines the party failed to make a valid request for an appeal that substantially complies with the applicable regulation for making a valid request for a level 1 appeal. For example, when the party fails to file the level 1 appeal within the proper filing timeframe in accordance with the applicable regulation. A valid request as contemplated in §§ 422.582(a) and 423.582(a) includes

sufficient information to identify the enrollee to allow the plan to adjudicate the request (or, at a minimum, make contact with the enrollee to clarify the request), including a full name or member ID number or at least one means of contact (e.g., address, telephone number, email).

- When the enrollee dies while the appeal is pending and the enrollee's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the level 1 appeal. Financial interest means having financial liability for the item(s) or service(s) underlying the coverage request.
- When the individual or entity that requested the reconsideration submits a timely written request to withdraw their request for a level 1 appeal. When the dismissal is the result of a timely withdrawal request, the plan is required to mail or otherwise transmit a dismissal notice in order to preserve the rights of other proper parties to the decision who may wish to request review of the dismissal. The dismissal notice will explain that the withdrawal request is the reason for dismissal in section 50.9.1 in order to preserve the rights of other proper parties to the decision who may wish to request review of the dismissal. The dismissal notice will explain that the withdrawal request is the reason for dismissal.in order to preserve the rights of other proper parties to the decision who may wish to request review of the dismissal. The dismissal notice will explain that the withdrawal request is the reason for dismissal in section 50.9.1 in order to preserve the rights of other proper parties to the decision who may wish to request review of the dismissal. The dismissal notice will explain that the withdrawal request is the reason for dismissal.

Standard and expedited redetermination (appeal) for Part D drugs

- WellSense's Standard Redetermination Process consists of one level of appeal, and the process may not exceed more than seven (7) 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 and may not be extended.
- WellSense's Expedited Redetermination Process consists of one level of review and will conclude no more than seventy-two (72) hours from the time WellSense received the member's or Authorized Representative's request for expedited appeal. An Expedited Appeal will be considered a final level of internal review and may not be extended.

Standard and expedited reconsideration (appeal) for Part B drugs

- WellSense's Standard Reconsideration Process consists of one level of appeal, and the process may not exceed more than seven (7) 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 and may not be extended.
- WellSense's Expedited Reconsideration Process consists of one level of review and will conclude no more than seventy-two (72) hours from the time WellSense received the member's or Authorized Representative's request for expedited appeal. An Expedited Appeal will be considered a final level of internal review and may not be extended.

Depending upon plan type and service(s) requested, members may be eligible for certain external appeal options through the CMS IRE. The member's reconsideration and redetermination letters will provide specific instructions on next steps and their options on how to proceed if members and/or their Authorized Representative wish to file an external appeal.

10.5 Clarity plans appeals

Definitions

Below are definitions to be used for the Clarity plans sections of this manual.

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 171 Section 10: Appeals, Inquiries, and Grievances 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.

Appeal
A member appeal is a formal complaint by a member or member's Authorized Representative about a denial of coverage. There are two types of denials which may be appealed:

- Benefit denial: A WellSense decision, made before or after the member has obtained services, to deny coverage for a service, supply, or drug that is specifically limited or excluded from coverage in the Clarity plans member's applicable Evidence of Coverage (EOC).
- Adverse determination: A WellSense decision, based on a review of information provided, to deny, reduce, modify or terminate an admission, continued inpatient stay or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care or effectiveness. These are often known as medical necessity denials because in these cases WellSense has determined that the service is not medically necessary for the member.

Grievance
A grievance is any formal complaint, oral or written, submitted by a member or member's Authorized Representative including a provider on behalf of a member, regarding dissatisfaction with:

- WellSense administration (how WellSense is operated): Any action taken by a WellSense employee(s), any aspect of WellSense's services, policies or procedures, or a billing issue.
- Aspects of interpersonal relationships such as rudeness of a provider or a provider staff member.
- Quality of care: The quality of care a member received from one of our participating providers. • A Commercial "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.

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.

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."

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 855-833-8122 for Clarity plan 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 or is trying to receive from a WellSense participating provider.

- 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 855-833-8122.

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.

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.

If the grievance requires us to review medical records, a signed Consent Form for the Release of Medical Information, available at wellsense.org must be submitted to us. When signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided. If a Consent Form for the Release of Medical Information is not included with the grievance, we will promptly send a blank form to the member or member's Authorized Representative. If we do not receive this form within 30 calendar days of the date of the grievance, we may respond to the grievance without having reviewed relevant medical information. In addition, if we receive the form but a provider does not give us the medical records in a timely fashion, we will ask the member or Authorized Representative to agree to extend the time limit for us to respond to the grievance. If we cannot reach agreement on a timeline extension, we may respond to the grievance without having reviewed relevant medical information.

All grievances will be processed by an Appeals and Grievances Specialist. Reviews will be performed by appropriate healthcare professionals who are knowledgeable about the type of issues involved in the

grievance. Responses will be based on the terms of the Clarity plan's Evidence of Coverage, the WellSense clinical policies and guidelines, the opinions of the treating providers, the opinions of WellSense professional reviewers, applicable records provided by providers, and any other relevant information available to WellSense.

We will send a written response to the member or member's Authorized Representative within 30 calendar days of receipt of the grievance. The 30 calendar day period begins as follows:

- If the grievance requires WellSense's review of medical records, the 30 calendar day period begins from the date of receipt but we cannot truly review all necessary documents until WellSense receives a signed consent.
- If the grievance does not require a WellSense review of medical records, the 30 calendar day period begins on the next working day following the end of the three-working-day period for processing inquiries through the internal inquiry process, if the inquiry was not addressed within that time period, or on the day WellSense was notified of the member's lack of satisfaction with the response to the inquiry.

These time limits may be extended by mutual written agreement between the member or member's Authorized Representative and WellSense. Any extension will not exceed 30 calendar days from the date of the mutual agreement. If WellSense does not respond to a grievance that involves benefits within the timeframes described in this section, including any mutually agreed upon written extension, the grievance will be deemed decided in the member's favor. Our written response to a grievance will describe other options, if any, for further WellSense review of a grievance.

We will not consider a grievance received until it is actually received by us at the appropriate address, fax or telephone number listed. Members are entitled to free access to and copies of any of their medical information related to their grievance that is in WellSense's possession and under WellSense's control.

10.6 Provider reviews related to inquiries, grievances, and appeals

Monitoring provider performance

WellSense monitors the performance of physicians, hospitals, and other participating healthcare providers related to member inquiries, grievances, and appeals by:

- Reviewing utilization patterns
- Analyzing results of member experience surveys
- Compiling information from member inquiries, grievances, and appeals

Provider quality issues

WellSense routinely provides feedback to providers on a case-by-case basis relevant to quality issues. If it is determined that a quality issue exists, the following procedure applies:

- WellSense's quality manager or medical director notifies the provider of the issue.
  The provider must respond to WellSense either orally or in writing within thirty (30) calendar days of the notification. A provider's response is reflected in WellSense's final determination of the severity level. Levels range from "no quality of care issue was identified" to "a quality of care issue with confirmed significant adverse impact to the member."

- Upon receiving a provider's response, the medical director, and/or the clinician reviewer, in conjunction with the provider, determines if a corrective action plan is required. The decision is based on the severity level of the issue and on the provider's response.
- The medical director and/or clinician reviewer works collaboratively with providers to develop, implement, and evaluate the corrective action plan. Modifications to WellSense are made as appropriate. If a provider does 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 the provider's practice.

WellSense maintains documentation of performance monitoring in providers' credentialing files, which is reviewed at the time of re-credentialing. For additional details, review Section 14: Quality Management or contact the Provider Engagement team by visiting at wellsense.org

Section 11: Care Management Services

11.1 General information

WellSense knows that a fragmented approach to members' health needs does not allow for the best level of care. That's why WellSense's Care Management Model integrates physical, social, behavioral health services, pharmacy management, and wellness programs, enabling us to fully respond to our members' needs.

This integrative and collaborative approach includes assessing the member's overall health status, facilitating coverage for medically necessary services, social and community-based services, and advocating for the member as he or she navigates the healthcare system.

Program goals

WellSense's priority is to help members with all their health-related needs, including members with special health care needs who may have developmental delays and co-occurring disorders and members receiving services through waiver programs. The goal is for members to regain optimum health or improved functional capability. WellSense aims to proactively identify and engage our members, their families, and significant supports in a way that integrates care management with medical, social, environmental, behavioral health, medication management, wellness, and community support. We focus on what matters to members, the provider's care and coordination of services, other Plan resources and departments (e.g., UM, Pharmacy, Member Service, and Provider Engagement). We maximize value through the most efficient use of available resources and technology, resulting in better health, better experience, and better health outcomes.

Our 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, this approach ensures the provision of necessary services by a member's primary care physician, licensed professionals, agencies, and caregivers.

11.2 Components of the care management program

WellSense's Care Management program consists of the following components:

- Care coordination and care navigation for medical, behavioral health, and social needs
- Transition of Care
- Non-emergency medical transportation
- Wellness and prevention programs
- Chronic care management programs
- High-cost/high-risk member management programs, including the following Priority Populations:
  - Individuals who have required an inpatient admission for a behavioral health diagnosis within the previous twelve (12) months;
  - Infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children Youth and Families (DCYF), including those in foster care, and/or those who have elected voluntary supportive services;
  - Infants diagnosed with low birth weight and/or neonatal abstinence syndrome (NAS); and

    - Individuals with behavioral health needs (e.g., substance use disorder, mental health) who are incarcerated in the State's prisons and eligible for participation in the Department's Community Reentry demonstration waiver pending CMS approval.
- Children with special health care (CSHC) needs (those who have an increased risk for, chronic physical, developmental, behavioral, or emotional conditions, who require health and related services of a type beyond that, required by children generally)
- Coordination and integration with social services and community care
- Coordination of long term services and supports

Identifying members for enrollment in care management

WellSense 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 (HRA) or referrals from providers. Members are also identified by WellSense staff (e.g., Inpatient Utilization Management clinicians, Prior Authorization clinicians), , Northwood staff, and, as applicable, state agencies. Also, members can make a self-referral into care management. Your Provider Relations Consultant can provide you with a membership roster, refreshed daily on the provider portal, identifying members who have completed a health risk assessment (HRA). Please be aware that completed member HRAs are available to providers upon request to your Provider Relations Consultant or to NHProviderInfo@wellsense.org.

Assessing member's medical, social, behavioral health needs

Members who agree to participate in care management are assigned a care manager and a comprehensive assessment is conducted with the member either telephonically or in-person.

Individual and comprehensive person-centered care plans include the identification of problems, interventions, and goals unique to the individual to meet his/her health needs, with interventions identified through available benefits to the member and community based services. Providers collaborate in the development of the care plan along with the member, primary caregivers and member's identified care team such as; case managers from Area Agencies, CFI waivers, Community Mental Health Programs, Special medical services, and 1915(j) case managers including the medical equipment and specific services provided, with members consent as applicable

11.3 Care Management levels of intervention and targeted members

The program includes three levels of intervention:

- Care Management Education and Wellness
- Low to Moderate Risk Care Management and Chronic Condition Management
- Complex Care Management

Care Management Education and Wellness

This level offers information and coaching so members can successfully manage illness and stay healthy. We coach the members and share culturally and linguistically appropriate materials, tools, and resources that promote wellness and disease prevention. These include:

Educational initiatives:

- 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 any of the population conditions described above, 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, to accomplish their health-related goals. WellSense emphasizes 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 member's care.

Low to moderate risk care management and chronic condition management

This is 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 and their care team, either by telephone or in person. They assess a member's condition, coordinate care, and review available benefits. The care manager, with assistance from the care team, 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.

Targeted conditions are those with comorbid chronic conditions.

Maternity care management: Sunny Start

Care Managers with expertise in Maternal and Child Health, in collaboration with the WellSense behavioral health team, provide an integrated, high-touch approach to care management for infants with NAS and their mothers. Use of evidence-based protocols determines the specific interventions employed. Care managers develop strategies to address immediate care needs that impact continued substance use on mother and child. Care Managers ensure follow up with the specialty pediatrician to monitor the infant's withdrawal symptoms and ability to meet developmental milestones, and consider referral to early intervention for the infant. Care managers also provide referrals to the mother for SUD treatment, including Peer Recovery, self-help groups, and Recovery Housing. Additional services and supports, for both infant and mother, include care manager home visits to offer support, coordination, as applicable, with the NH Division for Children, Youth and Families (DCYF) and, if the mother receives treatment at a Community Mental Health (CMH) Program, integrated care management in the CMH Program setting.

Providers are required to notify WellSense's Prior Authorization department of every confirmed member pregnancy. This will allow for members to benefit from participating in the pregnancy/postpartum program.

Complex care management

This complex level of intervention addresses the needs of the highest risk members, who are the most complex members of WellSense's care management program. They typically have comorbidities, psychosocial and socioeconomic needs, and high emergency department and inpatient admission utilization that can significantly diminish their quality of life. They may also be unable to adhere to treatment plans designed by their providers. Care management staff uses a multidisciplinary approach to comprehensively assess members' conditions. They conduct face-to-face meetings if appropriate. With the member's cooperation, they coordinate care through the health care continuum, which helps determine benefits and needed resources, including family and community resources, working with the member's Primary Care Provider and local care team.

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. WellSense 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.

Conditions that may be appropriate for a care management referral include Priority Populations and chronic comorbidity conditions.

Indications that a member may benefit from a referral to complex care management for any medical condition (including one managed through the Priority Populations) 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 homeless
- An illness or event that has caused a change or decline in ability to self-manage
- Multiple admissions/readmissions

11.4 Transitional care management

All NH Medicaid participating providers must comply with WellSense and State policies related to transition of care policies set forth by the DHHS and included in the WellSense Member Handbook.

WellSense understands that proactive and timely discharge planning is a critical element of transitions of care—from EDs and inpatient facilities back to the community or to another facility. We proactively begin discharge planning prior to, or at the time of admission. Our clinicians provide member- and provider-oriented interventions for members moving from one clinical setting to another with a goal to prevent unplanned or unnecessary readmissions, ED visits, or adverse health outcomes. The program aims to help the member remain in the least restrictive, most cost-effective setting possible, avoiding unnecessary use of the ED and/or inpatient settings. Interventions of the transitional care management team include, but are not limited to:

- Completing a comprehensive assessment with the member and updating his/her care plan when the member has been hospitalized
- Participating and assisting State-Owned Hospitals and other State determined IMDs staff in the development of a written discharge plan within twenty-four (24) hours of admission.
- Coordinating with inpatient discharge planners for members referred for sub-acute treatment in a nursing facility and facilitating clinical hand-offs
- Communicating with the member's PCP about discharge plans and any changes to the care plan
- Coordinating inpatient and community services related to the hospitalization, involving the outpatient provider
- Conducting a post-hospitalization discharge assessment to include medication reconciliation and supporting members to keep outpatient appointments following discharge from one clinical setting to another
- Ensuring there is a member-specific discharge plan for State-owned hospitals and State determined IMDs, psychiatric hospital and residential treatment facility discharges that includes: immediate access to an appropriate living situation rather than a homeless shelter; collaboration with the CMH program or provider or other qualified behavioral health aftercare clinician; an aftercare appointment within seven (7) days of discharge; and transportation to the aftercare appointment
- Completing an assessment for any social services needs to include housing and other necessary supports that young adults need to assist in their stability in their community
- Ensuring continuity of care regarding medication
- Evaluating for continued mental health and SUD services and involving the outpatient provider in discharge planning
- Coordinating with providers and members who have had an ED visit or hospitalized for an overdose or Substance Use Disorder. This includes outreaching to hospitals to share information as well as actively participating and assisting hospital staff in development of the discharge plan to ensure that members are not released to the community without referrals for evaluation and treatment. This also includes ensuring that the final discharge instruction sheet is provided to the Member and the Member's authorized representative prior to discharge, or the next business day, for at least ninety-eight percent (98%) of Members discharged; and, the hospital discharge progress note is provided to any treatment provider within seven (7) calendar days of Member discharge for at least ninety-eight percent (98%) of Members discharged
- Providing the discharge instruction sheet for NH Medicaid members discharged from a State-Owned hospital or State determined IMD to the member and the member's authorized representative prior to discharge, or the next business day, for 98% of members discharged.
- Ensuring the discharge progress note for NH Medicaid members is provided to the aftercare provider with seven (7) days of member discharge for 98% of members discharged and for Assertive Community Treatment (ACT) members the discharge progress note is provided to the CMH Program or CMH provider within 24 hours of member discharge. and for Assertive Community Treatment (ACT) members the discharge progress note is provided to the CMH Program or CMH provider within 24 hours of member discharge.

11.5 Care management process

WellSense uses the care management process with clinical, social, and behavioral health care managers, care navigators, community wellness advocates, and a housing coordinator who handle:

- Assessment
- Planning
- Intervention
- Evaluation

11.6 Community service resource support

WellSense makes community social support resources available to our members through our website and our social care management program.

11.7 Contacting the care management staff

WellSense encourages providers to contact WellSense's Care Management department at 855-833-8119 if you feel a member could benefit from care management services Referrals can also be sent through secure email to: NHCare.management@wellsense.org

Section 12: Behavioral Health

12.1 General information

WellSense is responsible for contracting with Behavioral Health (BH) providers to ensure our members have access to all levels of care for mental health conditions and substance use disorders, including inpatient and residential care, psychotherapy, psychological evaluation and testing, community mental health (CMH) programs and providers, certified community behavioral health clinics (CCBHCs), opioid treatment providers (OTPs), substance use disorders, crisis services including mobile crisis and CMH emergency services. WellSense covers all NH Medicaid State Plan services that are within the Managed Care Management program including, but not limited to, assessment and diagnostic evaluations, for our members as ordered by any court within New Hampshire. All behavioral health services are delivered at the appropriate level of care consistent with medical necessity for the service.

Our behavioral health programs and services aim to enhance clinical integration between medical and BH providers, offer our members superior quality of care and improve member and provider satisfaction. Through our provider network we ensure that BH services are delivered in a manner that is both clinically and developmentally appropriate, align with principles of system of care, recovery and resiliency and that considers the member, parent, caregiver, and other networks of support the member may rely upon.

12.2 Behavioral health department activities

A range of emotional, social, and behavioral issues can pose a major threat to the overall health and quality of life for some members. Therefore, WellSense's Behavioral Health Program plays a central role in overseeing and managing the delivery of behavioral health and substance use disorder services for WellSense members, as well as coordinating these needs with medical services. Our clinical and operating standards and procedures are consistent with trauma-informed models of care, as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) and reflect a focus on recovery and resiliency. Behavioral Health Program activities focus on:

- Evaluating behavioral health services based on clinical criteria.
- Request written consent from members to release information to coordinate care regarding mental health services, or substance use services, or both, and primary care.
- Coordinating effective and efficient care through a continual review process, when additional behavioral health services are required beyond those given prior authorization using WellSense care management programs 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.
- Closely monitoring members whose level of acuity and/or utilization patterns suggest a need for additional assistance and care coordination.
- Developing and maintaining contractual agreements with available community resources and providers that represent a full continuum of behavioral health care through network development activities.
- Ensuring participating providers meet SAMHSA Standard Framework for Levels of Integrated Healthcare.

- Assuring timely access to a PCP for behavioral health screening to facilitate early identification of behavioral health needs and appropriateness of the diagnosis, treatment and referral of behavioral health disorders commonly seen by PCPs.
- Ensuring PCPs have access to a broad array of behavioral health assessment tools, clinical practice guidelines, WellSense behavioral health care managers and appropriate resources.
- Working collaboratively to coordinate members' care and providing timely and accurate information in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 CFR Part 2.

Utilization management decision-making is based on the appropriateness of care and service and the terms of WellSense coverage. WellSense does not provide financial or other types of incentives to providers, practitioners, employees, or other individuals for issuing denials of coverage or services.

Note: All inpatient and outpatient behavioral health services rendered by out-of-network providers require prior authorization , except for emergency services.

12.3 Communication and coordination of member treatment

WellSense collaborates with providers to manage members' care and ensure that WellSense meets individual needs in the most clinically appropriate setting, considering both behavioral and physical health needs. WellSense is committed to improving the quality of care delivered to members. To that end, we have developed a joint Behavioral Health Notification Form to increase the frequency and quality of information shared between behavioral health clinicians and primary care providers (PCPs). With informed member consent, this form can be used by PCPs and behavioral health providers to communicate with one another. Advantages to using 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. We support communication and coordination between mental health and substance use disorder service Providers and PCPs by providing access to data and information when Member consent has been documented in accordance with State and Federal law.

12.4 Psychiatric emergency and crisis services

WellSense ensures that all types of behavioral health crisis response services are included in our program, such as mobile crisis and office-based crisis services. Emergency behavioral health care and crisis services are available to WellSense members twenty-four (24) hours a day seven (7) days a week:

- Mobile crisis services may be provided by a CMH Program in any CMH Region to ensure accessibility to members in crisis
- CMH Program delivered emergency services that are not delivered by mobile crisis teams are provided within the CMH Program's designated region

New Hampshire's CMH Programs are a network of 10 nonprofit agencies providing comprehensive, community-based behavioral health services across the state. They offer 24/7 crisis support, psychiatric evaluations, therapy, case management, and specialized programs for children, families, older adults, and those with substance use disorders. Operated regionally and guided by the state's Department of Health and Human Services, CMH Programs serve individuals regardless of insurance status, often using sliding fee scales. CMH Program emergency services teams employ clinicians and Peer Support Specialists who are trained to manage crisis intervention and who have access to a clinician to evaluate members in-person in the community to address the crisis and evaluate the need for hospitalization.

NH Rapid Response is available to anyone in New Hampshire to talk to members about emotional distress, mental health, substance use and suicidality. They provide mobile crisis services, connect members to follow-up appointments or crisis intervention services and refer members to treatment options. Rapid Response is confidential and provided at no cost.

For immediate help, New Hampshire offers a 24/7 crisis line at (phone) 833-710-6477 (text) 988 or visit nh988.com.

The NH Doorways can connect members to substance use and recovery supports and services including screening and evaluation, treatment, prevention including naloxone, resources and Peer Recovery Support services. To reach a Doorway call 211 or visit www.thedoorway.nh.govTo reach a Doorway call 211 or visit www.thedoorway.nh.gov.

Additional Resources:

- NH Community Behavioral Health Association:
- NH DHHS mental health landing page for providers
- NH Children's Behavioral Health Resource Center

12.5 Mental health parity assurance

Federal and state laws require WellSense to provide coverage for mental health and substance use disorder treatments as favorably as it provides coverage for other medical health services. This is referred to as parity. Parity laws require that coverage for mental health and/or substance use disorders be no more restrictive than coverage for other medical conditions, such as diabetes or heart disease. For example, if WellSense provides unlimited coverage for physician visits for diabetes, it must do the same for depression or schizophrenia.

Parity means that:

- We must provide the same level of benefits for any mental health and/or substance use disorder as we would for other medical conditions our members may have.
- We must not impose stricter prior authorization requirements and treatment limitations for mental health and substance use disorder benefits as we do for other medical benefits.
- We must provide our members and their providers with the medical necessity criteria used by us for prior authorization upon either the member's or provider's request at no cost.
- We must not impose aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits.
- Within a reasonable time frame, we must provide the member the reason for any denial of authorization for mental health and/or substance use disorder services.

- Within a reasonable timeframe, if we provide out-of-network coverage for other medical benefits, we must provide comparable out-of-network coverage for mental health and/or substance use disorder benefits.

The parity requirement applies to:

- Drug copayments
- Limitations on service coverage (such as limits on the number of covered outpatient visits)
- Use of care management tools (such as prescription drug rules and restrictions)
- Criteria for determining medical necessity and prior authorizations
- Prescription drug list structure

If you think that we are not providing parity as explained above, you or a member have the right to file an appeal or file a grievance (complaint) with us. For more information, refer to Section 10: Member Appeals, Inquiries, and Grievances

With respect to our Medicaid Members: If you think we did not cover behavioral health services (mental health and/or substance use disorder services) in the same way as medical services, you or a member may also file a grievance or complaint with the New Hampshire Department of Insurance Consumer Services Hotline at 1-800-852-3416 (TDD Access Relay: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:30 p.m. ET, or online at nh.gov/insurance/complaints/index.htm.

Community mental health programs (also known as community mental health centers)

In case of a mental health and/or substance use crisis or emergency call the toll-free NH Rapid Response Access Point (1-833-710- 6477) anytime day or night.

Connect with the Ten Community Mental Health Centers in New Hampshire

Community Mental Health Center	Contact Information
Center for Life Management	10 Tsienneto Road Derry, NH 03038 Phone: 603-434-1577 centerforlifemanagement.org
Community Partners	113 Crosby Road, Suite 1 Dover, NH 03820 Phone: 603-516-9300 communitypartnersnh.org
Greater Nashua Mental Health Center at Community Council	7 Prospect Street Nashua, NH 03060-3990 Phone: (603) 889-6147 Emergency Services: (800) 762-8191 gnmhc.org
Lakes Region Mental Health Center	40 Beacon Street East Laconia, MH 03246 Phone: 603-528-0305 lrmhc.org
Mental Health Center of Greater Manchester	401 Cypress Street

	Manchester, NH 03103 Phone: 603-668-4111 Mobile Crisis Response (24/7) (800) 688-3544 mhcgm.org
Monadnock Family Services	40 Avon Street1 Keene, NH 03431 Phone: 603-357-4400 Emergency Services (603)357-4400 mfs.org
Northern Human Services	25 West Main Street Conway, NH 03818 Phone: (603) 447-2111 Daytime # and Emergency Services # by location • Berlin (603) 752-7404 • Colebrook (603) 237-4955 • Conway (603) 447-2111 • Littleton (603) 444-5358 • Wolfeboro (603) 569-1884 / northernhs.org
Riverbend Community Mental Health Center	40 Pleasant Street Concord, NH 03302-2032 Phone: (603) 228-1600 Emergency Services (844) 743-5748 riverbendcmhc.org
Seacoast Mental Health Center, Inc.	1145 Sagamore Avenue Portsmouth, NH 03060 Phone: 603-431-6703 Emergency Services • Exeter (603) 772-2710 • Portsmouth (603) 431-6703 smhc-nh.org

West Central Behavioral Health	Rivermill Commercial Center 85 Mechanic Street, Suite 360 Lebanon, NH 03766 Phone: (603) 448-5610 Emergency Services (800) 564-2578 wcbh.org

Section 13: Pharmacy Services

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

Information Needed	Contact
Up-to-date medication coverage information	View the pharmacy formulary. Call our Pharmacy department at 877-957-1300.
Prior authorization forms and clinical guidelines	View the drug coverage section of the prior authorization page. page.
Mail Order Pharmacy Program	View the Mail Order Pharmacy Program. Call WellSense at 877-957-1300.
To verify which medications are available or excluded from the Maintenance Drug program	View the Pharmacy formulary.
Office administered drugs (i.e., injectables) that require prior authorization	View the CPT and HCPCS Code lookup View the drug coverage section of the prior authorization page.
List of covered medications	View the Pharmacy formulary.

13.1 General information

WellSense's Pharmacy Services division helps contribute to the organization's broad goal of keeping members healthy. To ensure that members receive quality, affordable healthcare, WellSense contracts with a pharmacy benefits manager (PBM) to provide a pharmacy network and manage the pharmacy benefits offered to members. In addition, the pharmacy program offers comprehensive utilization management.

13.2 Pharmacy and Therapeutics (P&T) committee

WellSense maintains a Pharmacy and Therapeutics (P&T) committee that is comprised of actively practicing physicians, pharmacists, and other practitioners, both internally and externally. The committee develops and manages WellSense's drug formulary to reflect current evidence-based clinical practice. It also helps to maintain compliance with all applicable legal, regulatory, and accreditation standards.

In addition, the committee evaluates the most current medical literature and consults with appropriate practitioners to develop clinical coverage criteria used to administer WellSense's 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 (and, as applicable, by the NH DHHS).

The P&T Committee may also advise WellSense on other pharmacy-related issues that would enhance WellSense's ability to deliver pharmacy benefits to members and improve the quality of the pharmacy management program.

13.3 Drug Utilization Evaluation program

Pursuant to WellSense's Drug Utilization Evaluation policy, as approved by the P&T Committee, Pharmacy Services can perform an ongoing drug use evaluation of physician prescribing patterns, pharmacist dispensing activities, and member use of medications. This involves a comprehensive review of member prescription and medication data before, during, and after dispensing, to ensure appropriate medication decision-making and positive member outcomes. WellSense may then recommend interventions to physicians, pharmacists, and members, as necessary. To determine effectiveness, the P&T Committee also monitors utilization and compliance with the identified interventions. Participating providers shall provide WellSense with data on substance dispensing to members prior to releasing such medications to members, to the maximum extent possible.

13.4 Prescription Drug Monitoring Program/Controlled Substance Management Program (PDMP/CSMP) or Drug Monitoring Program (DMP)

The Prescription Drug Monitoring Program/Controlled Substance Management Program (PDMP/CSMP) identifies members at risk for inappropriate use of medications that have potential for abuse, including schedule II-V 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 identify the appropriate intervention(s) to be completed, if any.

Intervention actions may include direct provider communication, restriction of all prescriptions with the exception of specialty drugs through a single pharmacy and/or physician (physician group), as well as referrals to fraud, waste, and abuse for further evaluation. The goal of the program is to assist health care providers to be better informed of their patients' medication use patterns, and promote proactive management to minimize the potential for medication misuse.

In addition to regularly identifying individuals for enrollment, the PDMP/CSMP also enrolls members through provider referrals. To learn more or to enroll a member, call the Provider Service Center at 877-957-1300.

Additionally, Providers who prescribe or dispense schedule II-V controlled substances are required to comply, as applicable, with the New Hampshire PDMP requirements, including but are not limited to the opioid prescribing guidelines.

The Drug Monitoring Program (DMP) identifies Medicare members who are potentially over-utilizing frequently abused drugs (FADs). Members are identified for enrollment into the program through internal reports as well as reports provided by the Centers for Medicare and Medicaid (CMS). The goal of this

program is to address overutilization of FADs while maintaining access to such drugs as medically necessary.

The program consists of a pharmacy case management program that will review overutilization to assess member safety, fraud, waste, and abuse. After clinical review a pharmacist will perform coordination of care through prescriber outreach and consultation to determine if medication use is appropriate. If medication use it determined to be inappropriate members will be considered at-risk beneficiaries and interventions may include restriction of medication access through point-of-sale quantity limits, single pharmacy restrictions, or restrictions to a single prescriber. Outcomes of case management review and interventions will be reported to CMS.

13.5 Retrospective Drug Utilization Review for members receiving Medication Assisted Treatment Services and also taking Opioids and/or benzodiazepines

Retrospective Drug Utilization (RDUR) Program identifies New Hampshire Medicaid members who are receiving Medication Assisted Treatment (MAT) services and have also received at least a forty-five (45) day supply of an opioid and/or benzodiazepine in the last ninety (90) days and are therefore at increased risk for medication abuse and overdose. The program incorporates interventions targeted at provider education and care coordination through provider outreach. Overall, the Program aims to assist providers with coordination of care and reduce the number of opioid/benzodiazepine prescriptions in members receiving MAT services.

13.6 WellSense's formulary

WellSense's formulary is the primary source of information on medications available through the prescription pharmacy benefit. The formulary contains information on medication coverage, applicable pharmacy programs, and copayment tier status. Providers should use the formulary as a reference when prescribing medications to WellSense members. WellSense updates the formulary with new medications and medication coverage changes every three (3) months or more frequently as needed. Changes to WellSense's formulary are also mailed to the provider network as needed.

13.7 Pharmacy benefits

Pharmacy benefits manager (PBM)

The Pharmacy Benefits Manager administers WellSense's prescription drug benefits. This includes contracting with a comprehensive network of retail pharmacies available to members. Use the Find a Pharmacy tool to access a list of in-network retail pharmacies affiliated with the Pharmacy Benefits Manager.

Over-the-counter formulary

The over-the-counter (OTC) coverage includes many commonly used over-the-counter medications and select medical devices that are available through the retail pharmacy network. Generic medications, devices, or specific brand medications that are explicitly listed on the OTC formulary are covered through

the OTC benefit. A prescription must be written for the covered item so that it can be processed as a pharmacy claim. Refer to the drug formulary for NH Medicaid, , and NH ACA at wellsense.org for OTC coverage.

13.8 Pharmacy Utilization Management programs

Our Pharmacy Utilization Management (UM) programs are designed to manage the utilization of drugs that can be obtained through retail pharmacies, specialty pharmacies, or mail order pharmacies. These programs include prior authorization, step therapy, quantity limitations, generic substitution, new-to-market (NTM) medication program, and the medication exceptions process. Medications managed through any of these programs require submission of a Prior Authorization request. A utilization review decision will be rendered on the coverage of the requested medication. These programs are updated regularly, based on WellSense's P&T Committee's recommendations, and reflect the ever-changing field of pharmaceuticals.

To ensure timely and appropriate medical necessity decisions, a pharmacy Prior Authorization form must be submitted in advance of the service and must be completed in its entirety. This ensures all relevant clinical information necessary to render a decision has been provided. Incomplete requests may result in a denial due to lack of sufficient clinical information. Requests may be resubmitted with the necessary supporting information. WellSense's Prior Authorization forms and clinical coverage policies are available at wellsense.org/providers.

If WellSense or its delegates denies a pharmacy prior authorization request due to medical necessity, the member and the member's 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 the applicable timeframe by line of business. See Section 10: Member Appeals, Inquiries, and Grievances .

Pharmacy Utilization Management (UM) program descriptions:

Pharmacy Prior Authorization (PA) program

WellSense utilizes prior authorization and clinical guidelines/criteria for decisions related to 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 prior authorization program require prior approval for coverage.

If a provider believes it is medically necessary for a member to take a drug managed under WellSense's pharmacy programs, an appropriate Prior Authorization request should be submitted via an online electronic prior authorization tool available at wellsense.org or to the fax number indicated on the form or via phone. A clinician will review the request, and WellSense will notify the provider of the decision in accordance with applicable regulatory and accreditation standards. See Section 8: Utilization Management and Prior Authorization for timeframe requirements.

See WellSense's Prior Authorization forms and Clinical Guidelines available on our website to access a list of medications that are subject to the prior authorization program.

Step Therapy program

The Step Therapy program is a form of prior authorization. It generally requires the use of more cost-effective or preferred medication(s) before WellSense will approve non-preferred medication(s). If the required therapeutic benefit is not achieved using the preferred medication, the prescriber may request the use of a non-preferred medication by submitting a prior authorization request.

See WellSense's Prior Authorization forms and Clinical Guidelines available on our website to access a list of medications that are subject to the Step Therapy program.

Quantity Limitation program

The Quantity Limitation program ensures the safe and appropriate use of a selected 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 and Prior Authorization form available on our website.

Generic substitution 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 State of New Hampshire allows dispensing of "AB rated" generics unless the practitioner indicates that the brand medication is medically necessary. In addition, coverage for most brand medications is subject to WellSense's clinical criteria. See Generic Substitution Program guidelines on our website.

New-to-market medication program

WellSense reviews all new-to-market drugs before adding them to the formulary or covering them under the 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. See New-to-Market Medication program guidelines on our website.

13.9 Medical Drug Management Program

The Medical Drug Management program is designed to manage the utilization of drugs that are billed under the medical benefit and are often administered in an outpatient provider setting. This program incorporates claims edits and prior authorization requirements to ensure the appropriate utilization of medical drugs. Medications managed through this program requires the submission of a Prior Authorization request. A utilization review decision will be rendered on the coverage of the requested medication.

To ensure timely and appropriate medical necessity decisions, a Prior Authorization form must be submitted in advance of the service and completed in its entirety. This ensures all relevant clinical information necessary to render a decision has been provided. Incomplete requests may result in a denial due to lack of sufficient clinical information. Requests may be resubmitted with the necessary supporting information. WellSense's Prior Authorization forms and clinical coverage policies are available at Pharmacy – Prior Authorizations | Providers | WellSense Health Plan. See Section 8.2 Utilization Management Vendors for information on how to submit requests.

If medical drug prior authorization request is denied due to lack of medical necessity, the member and the member's 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 the applicable timeframe by line of business. See Section 10: Member Appeals, Inquiries, and Grievances

13.10 Pharmacy copayments

Member copayment amounts

Medicaid Members are charged a copayment for medications, ***with the exception of the following***:

- Members with income at or below 100% of the Federal Poverty Level (FPL).
- Members under age 18.
- Members in a nursing facility or an Intermediate Care Facility for individuals with intellectual disabilities.
- Members participating in a home and community-based care (HCBC) waiver program.
- Members who are pregnant and receiving services related to the pregnancy or any other medical condition that might complicate the pregnancy. Please notify WellSense if a member is currently pregnant.
- Members who are receiving services for conditions in accordance with 42 CFR 447.56(a)(2)(iv), or complications related to the pregnancy.
- Members in the Breast and Cervical Cancer program.
- Members receiving hospice care.
- Members who are Native American or Alaskan Natives
- Members who are receiving family planning products (e.g., birth control pills).
- Preventive services recommended by the U.S. Preventive Services Task Force with a grade of A or B (including but not limited to medications for nicotine cessation and Pre-Exposure Prophylaxis (PrEP) for the prevention of HIV).
- Clozaril (clozapine) prescriptions.
- Tobacco cessation products

See Section 7: Member Benefit Information for additional details for all lines of business

Pharmacy copayment compliance

All pharmacies are expected to comply with the cost-sharing rules. For Medicaid members, it is the pharmacy's responsibility to collect copayments from the member. If the copayment is due, but the member reports he/she is unable to pay it at the time of service, the member remains responsible for the copayment and the pharmacy may bill the member. However, pharmacies may not refuse to dispense a prescription(s) in its entirety to a member who reports he or she is unable to pay the copayment at the time of service.

Please check the specific WellSense benefits for clarification in Section 7: Member Benefit Information

13.11 Clinical programs

Polypharmacy/Medication Management Program

The Polypharmacy/Medication Management Program identifies Medicaid members using multiple medications, possibly from multiple prescribers, which may result in adverse reactions due to non-

compliance, overutilization, duplicate therapy, suboptimal medication adherence, and/or drug-drug interaction (DDI). The Plan provides support for medication management for members meeting polypharmacy criteria, and for other members requesting medication reviews to ensure the PCP, community pharmacist, or other qualified health care individual has the information necessary to conduct polypharmacy and medication management reviews also known as Comprehensive Medication Reviews (CMR) for child/adolescent and adult members. The related CMR counseling is an interactive person-to-person, telephonic, or telehealth consultation conducted in real-time between the patient, authorized representative, and the PCP, community pharmacist, or other qualified health care individual, with the intent to improve a Member's knowledge of their prescriptions, address gaps in care, and/or coordinate care. Targeted member populations are based on DHHS requirements and guidance. The program targets adult members (age ≥ 18 years) who are dispensed five (5) or more maintenance drugs over a rolling sixty (60) day period, each drug filled for at least ninety (90) days in duration, allowing each drug up to one (1) fifteen (15) day gap between fills. In addition, pediatric members (age <18 years) with and without Special Health Care Needs who are dispensed four (4) or more maintenance drugs over a rolling sixty (60) day period, filled for at least ninety (90) days in duration and members with Special Health Care Needs who do not have polypharmacy eligibility are included. The program incorporates interventions that are member and provider-focused to educate members and keep health care providers better informed of patient utilization trends where there may be the potential for adverse reactions as a result of multi-medication treatment regimens.

Comprehensive medication reviews will be offered to eligible members and must be completed within six (6) months from the date in which a member was identified as meeting criteria.

The purpose of a successful CMR is to:

- Collect patient-specific information and assess medication therapies to identify medication-related problems.
- Develop a prioritized list of medication-related problems and a care plan to address identified problems
- Communicate with other providers to improve coordination of care and to resolve medication-related problems
- Identify adherence issues, detect adverse drug reactions (ADRs), educate patients, and review potential drug interactions
- Improve patient's knowledge of their prescriptions, over-the-counter medications, herbal therapies, and dietary supplements
- Identify and address any barriers to care a patient may face with their current medication regimen
- Empower patients to self-manage their medications and their health conditions
- Patient follow-up as a critical component of medication management to ensure resolution of medication-related issues and/or barriers to care

The role of WellSense

WellSense will support the program and provide the necessary information to PCPs, community pharmacists, and other qualified health care individuals to complete CMRs in accordance with regulatory requirements.

Specifically:

- Identify eligible members meeting criteria and produce Provider-specific reporting

- Provide data, including pharmacy claims and medical claims
- Supply resources, including Polypharmacy and CMR training as well as CMR templates to facilitate the completion of CMRs
- Monitor member program eligibility

The PCP, community pharmacist, or other qualified health care individual will:

- Conduct face-to-face, telephonic or telehealth CMRs in accordance with requirements for eligible members within 6 months of identification
- Document CMRs within the patient health records
- Conduct appropriate follow-up to resolve medication-related issues and/or barriers
- All completed CMRs shall be reimbursed in accordance with WellSense reimbursement policies

Behavioral Health program

Members in the pediatric population may benefit from psychiatric specialist consultation when medications for behavioral health disorders are prescribed by a non-psychiatric prescriber.

Outpatient behavioral health treatment is an essential component of a comprehensive health care delivery system. WellSense members may access covered outpatient behavioral health services, including consultation with a psychiatrist for medication management, by self-referring to a network provider, by calling WellSense care management, or by a referral through acute or emergency department encounters. Members may also access outpatient care with a referral from their primary care practitioner (PCP). However, covered behavioral health services never require a PCP referral.

*For assistance finding in-network behavioral health care providers, please visit wellsense.org, choose “Locate a Provider” then follow the steps;. Or contact WellSense Provider Services at 877-957-1300

Section 14: Quality Management

14.1 General information

WellSense's Quality Management program works to ensure that WellSense and its network of providers are able to deliver quality services to members. Providers are required to participate in the program as part of the agreement between the provider and WellSense. Providers shall cooperate with our quality improvement activities to improve the quality of care and services and member experience. This shall include allowing 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 time), or other initiatives aimed at increasing quality of care or member satisfaction. WellSense develops these programs and initiatives to meet contractual, regulatory, and accreditation requirements and to address opportunities for improvement identified through the Plan's Quality Assessment and Performance Improvement (QAPI) Program and analysis of available data (e.g., HEDIS and CAHPS). The Plan also facilitates a Member Advisory Board and a Provider Advisory Committee as mechanisms for collecting input on quality of care and improvement goals, quality improvement activities, and prioritization of improvement strategies.

14.2 Scope of the Quality Improvement Program

Through the Quality Improvement Program (QIP), and in collaboration with members and providers, WellSense 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
- Member and provider 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 to, 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
- CMH Programs and CMH Providers work with WellSense to achieve program improvement goals outlined in applicable Quality Improvement Plans to achieve full implementation of the quality improvement model and support evidenced based supportive employment (EBSE), Illness Management and Recovery, dialectical behavior therapy (DBT), peer support services (PSS), Modular Approach to Therapy for Children, First Episode Psychosis Programming, Child-parent psychotherapy, and engagement in healthy behaviors such as In Shape and tobacco cessation. CMH Programs are audited twice a year to ensure compliance with He-M 401.02; 403.02 and 426 requirements.

- SUD provider audits for members receiving substance use disorder services provided by substance use disorder programs and medication assisted treatment services provided by Opioid Treatment Programs (OTPs) to ensure compliance with He-W 513.0 and Substance Abuse and Mental Health Services Administration (SAMHSA) competencies.

14.3 WellSense Quality Improvement Goals

WellSense's Quality Improvement Program identifies the key areas of focus for each year by developing an annual Quality Improvement (QI) work plan. Many factors are considered when deciding on the QI initiatives or projects for the annual plan. Some factors include projects that:

- Support WellSense's mission and strategic goals
- Were identified through monitoring quality metrics, evaluating previous QI work plans, and input from practitioners and/or members
- Improve overall health, well-being and safety of WellSense members
- Improve member and provider satisfaction
- Improve member access to health care
- Achieve and maintain health plan accreditation from NCQA, including the NCQA Medicaid Module, and fulfill DHHS contract and other regulatory requirements.

WellSense:

- Collects information and data relevant to objectives and measures of QI goals
- Implements well-designed, innovative, targeted, and measurable interventions to achieve objectives; and evaluates the effectiveness of interventions
- Evaluates performance using objective quality indicators utilized to drive improvement
- 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.
- Keeps participating providers informed and engaged in the QAPI program and related activities.

Examples of QI goals

- 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 in need of preventive healthcare screenings (examples: breast cancer, cervical cancer, well child visits) and working to increase awareness from both the member and provider perspective regarding the risks of late diagnosis and treatment. We work with providers to identify best practices regarding member preventive healthcare screenings.
- 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.
- WellSense communicates updates on progress toward QI goals to members and providers.

14.4 Quality Assessment and Performance Improvement (QAPI)

The goal of the WellSense's QAPI Program is to assess the performance in quality of care and quality of service consistent with the requirements of the Medicaid contract between WellSense and DHHS and 42 CFR 438.330. The QAPI program requires collaboration and cooperation from providers and aligns with other health plan initiatives and Alternative Payment Models (APMs).

WellSense's QAPI program ensures the quality program:

- Is organization-wide with clear lines of accountability
- Establishes roles and responsibilities for the oversight of QAPI activities
- Sets annual objectives and/or goals for clinical and non-clinical activities aimed at improving member engagement and health outcomes
- Outlines mechanisms for measurement and evaluation of the overall effectiveness of the quality management program.

14.5 Quality Metrics: Healthcare Effectiveness Data and Information Set (HEDIS®) Guidelines

HEDIS® is a set of standardized performance measures designed to ensure that purchasers and consumers have information 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, patient experience, 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 United States. A subset of the HEDIS performance measures are reported to certain regulatory bodies on an annual basis according to state requirements.

HEDIS methods

HEDIS measurement data is collected in a variety of ways. WellSense uses administrative data captured on its systems (e.g., claims data) and medical record data not available in claims. Medical records are requested from providers and reviewed by Plan staff.

WellSense works with provider sites to coordinate medical record and data collection. The Plan will report both the Child and Adult Core Set of Health Care Quality Measures for Medicaid and CHIP as specified by DHHS.

HEDIS medical record data collection timeframes	
February-April	Record requests distributed to providers
Five days after you receive the medical record request from WellSense	Return requested medical records documentation
March-May	WellSense follows 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
June	WellSense HEDIS results are reported to CMS and NCQA

WellSense strives to make these reviews as easy as possible for provider practices. We rely on the cooperation of providers to make these reviews successful. Providers' prompt attention and response to requests for chart information is critical and greatly appreciated.

Member Experience of Care Survey: Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CAHPS is a nationally recognized member experience 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). CAHPS is a component of HEDIS and is used to assess members' subjective experience of accessing health care. The Plan administers the Member Experience of Care CAHPS survey on an annual basis for both adults and children between late February and May, as defined by DHHS and as required by NCQA for Medicaid health plans' accreditation. The Qualified Health Plan Enrollee Experience Survey includes questions from the CAHPS survey and is administered annually to a random sample of Clarity adult members.

14.6 WellSense investigation and reporting of adverse events (AEs): sentinel events (SEs), serious reportable events (SREs), hospital acquired conditions (HACs), and provider-preventable conditions (PPCs)

Providers and/or health systems must report SEs, AEs, SREs, HACs, PPCs related to a WellSense member within the following timelines for the identified event categories

Sentinel events (SEs)

These events must be reported to the Plan immediately upon discovery or within the same day of discovery. DHHS Bureau of Quality Assurance and Improvement (BQAI) defines a Sentinel Event as "an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof," as well as high profile events that may draw media attention.

Client Centered Sentinel events (NH DHHS-DPQI-BPQ PO.100309/30/2022) include:

- Any sudden, unanticipated, or accidental death, not including homicide, suicide, and not related to the natural course of an individual's illness or underlying condition.
- Permanent loss of function, not related to the natural course of an individual's underlying condition, resulting from such cases including but not limited to:
  - A medication error; and/or
  - An unauthorized departure or abduction from a facility providing care; and/or
  - A delay or failure to provide requested and/or medically necessary services due to waitlists, availability, insurance coverage, or resources.
- Homicide
- Suicide

- Suicide attempt, such as self-injurious behavior with a non-fatal outcome, with explicit or implicit evidence that the person intended to die and medical intervention was needed.
- Rape or any other sexual assault
- Serious physical injury to or by a client
- Serious psychological injury that jeopardizes the person's health that is associated with the planning and delivery of care
- Injuries due to physical or mechanical restraints
- High profile event, such as:
  - Media coverage;
  - Police involvement when police involvement is related to a crime or suspected crime; and/or
  - An issue that may present significant risk to DHHS or Plan staff or operations.
- Note: If an event overlaps with the criteria for an SRE, HAC, or PPC and meets the specifications of an SE, the event should be reported as an SE.
- For details specific to the NH DHHS Sentinel Event policy refer to: dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/bpq-hsa-sentinel-event-policy.pdf

Adverse events (AEs): serious reportable events (SRE) hospital acquired conditions (HAC) and provider preventable conditions (PPC) and other provider preventable conditions (OPPCs)

Adverse Events (AEs) such as SREs, HACs, PPCs (described below) that do not qualify as Sentinel Events (SE) (described above), must be reported to DHHS within 15days of becoming aware of the event. Within 60 days of identification of the event, the facility will submit a Root Cause Analysis and Corrective Action Plan. In accordance with RSA 151:38, all New Hampshire Hospitals and Ambulatory Surgical Centers (ASC), except for New Hampshire Hospital, are required to report serious reportable events, also referred to as "never events." Adverse events are outcomes determined to be unrelated to the natural course of the patient's illness or underlying condition, or the proper treatment of that illness or underlying condition.

Definitions

- **Adverse event (AE)**
  An unexpected occurrence that results in or has the potential to result in serious harm or to the well-being of a member, who is receiving services from the Plan or has been recently discharged from services managed by the Plan. Examples include: Death from a condition not present on admission and/or caused by medical management rather than due to the patients underlying disease, death related to a surgical or invasive procedure, any other event during the member's care or treatment that results in or has the potential to result in serious harm.
- **Serious reportable event (SRE)**
  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, serious in their 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).

- **Health care acquired condition (HAC)**
  Health Care Acquired Conditions are conditions occurring in any inpatient hospital setting that Medicare designates as hospital-acquired conditions (HAC) pursuant to section 1886(d)(4)(D)(iv) of the Social Security Act (SSA) (as described in Section 1886(d)(4)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT)/pulmonary embolism (PE) as related to total knee replacement or hip-replacement surgery in pediatric and obstetric patients.
- **Provider preventable condition (PPC)**
  A PPC is a condition that meets the definition of a "Health Care Acquired Condition (HCAC)" or "Hospital Acquired Conditions" or an "Other Provider Preventable Condition (OPPC)" as defined by the Centers for Medicare and Medicaid Services (CMS) in federal regulations at 42 CFR 447.26(b).
- **Other provider preventable conditions (OPPCs)**
  OPPCs are conditions that meet the requirements of an OPPC pursuant to 42 CFR 447.26(b). Examples include: Wrong surgical site or other invasive procedure, surgical or invasive procedure performed on the wrong body part or performed on the wrong patient.

WellSense maintains an established and detailed Adverse Event / Serious Reportable Event (SRE) / Hospital Acquired Conditions (HAC) / Provider Preventable Condition (PPC) / Sentinel Event (SE) Reporting Policy and regularly assesses compliance with this policy.

WellSense complies with State and federal laws regarding non-payment or retraction of payments to a participating provider for Hospital-Acquired Conditions (HACs) and for Provider-Preventable Conditions (PPCs) and Other Provider Preventable Conditions (OPPCs). A Serious Reportable Event (SRE), Hospital Acquired Conditions (HAC), and Provider-Preventable Conditions (PPC) can occur on premises covered by a private practice, hospital's license, or under the care of an entity subcontracted by the Plan; that results in an adverse patient outcome; is clearly identifiable and measurable; usually or reasonably preventable; and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the facility. SREs, HACs, and PPCs are events included on the National Quality Forum's (NQF) table of reportable events as established by guidelines issued by the Division of Public Health and 42 CFR 438.3 (g) and as described related to nonpayment for such events as identified in CFR 447.26

The Plan requires all providers' report Hospital Acquired Conditions (HACs) and Provider-Preventable Conditions (PPCs) and Other Provider Preventable Conditions (OPPCs) associated with claims for payment or member treatments for which payment would otherwise be made in accordance with Federal regulations.

Note: There may be overlap between SEs, AEs, SREs, HACs, PPCs, and OPPCs. Any SRE or HAC that overlaps with a PPC will be categorized as a PPC. Any event(s) that overlap with a SE will be categorized as an SE. Identification of such events is crucial in upholding the required reporting requirements and associated timelines.

14.7 Medical record charting standards

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, 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, documentation of clinical findings and evaluation at each visit.
- Working diagnoses are consistent with findings.
- All diagnoses, conditions, 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.
- 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 site has policies and procedures for consent and share member health

- records, in accordance with professional standards.
- Records include prominent display of allergy and adverse reactions documentation or no known allergy.
- 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 age 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

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 standards.
- All diagnostic and therapeutic services for which a member was referred by a practitioner, which includes but is not limited to home health nursing reports, specialty physician reports, hospital discharge reports and physical therapy reports as noted in the charting standards.

Preventive care services must include documentation for mammograms, pap smears, adult and pediatric immunizations, risk screening, adolescent guidance, and any other preventive health standards adopted by WellSense.

Pediatrics charting standards

In addition to the medical record charting standards for all providers and for preventive care, pediatric charting must include the following:

- Flow chart for immunizations
- Growth and development chart
- Physical activity and nutritional counseling
- Anticipatory guidance documentation
- Appropriate developmental screenings
- Behavioral health screenings and referrals as appropriate

All PCPs treating children and adolescent Medicaid members must follow and document the Early Periodic Screening Diagnosis and Treatment Program guidelines approved by DHHS and the American Academy of Pediatrics, per CMS.

Behavioral Health charting standards

In addition, the medical record charting standards for all providers and for preventative care charting must also include the following:

- 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

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 diagnosis, 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 WellSense's Utilization Management staff believes appropriate to be included in the record.

14.8 Medical record audits

Each provider site must participate in and cooperate with medical record audits. These audits are necessary to ensure compliance with WellSense's 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 specialty 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.

WellSense's 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 and or quality department when requested by WellSense.

14.9 Provider communication

Providers may freely communicate with members about their treatment options, including medication treatment options, regardless of benefit coverage limitations.

14.10 Clinical practice guidelines

Considering the needs of our members, WellSense has adopted several preventive and disease management clinical practice 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 (QAPI). WellSense encourages providers to refer to these guidelines to assist in delivering clinically appropriate care to members. The guidelines are available in the Provider Section at wellsense.org. If you need a printed copy of these guidelines, please contact WellSense at 877-957-1300, provider service.