



MBHP Provider Manual

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Welcome and Introduction

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Welcome and Introduction

Welcome to the Massachusetts Behavioral Health Partnership's (MBHP) provider network. We at MBHP feel privileged to work with a network of behavioral healthcare professionals who share our commitment to providing the highest quality mental health and substance use disorder services to our Members. We especially appreciate your support in advancing the Commonwealth's vision of a comprehensive, integrated, equitable healthcare delivery system that ensures access, quality, and cost-effectiveness, with an emphasis on being person-centered and recovery-oriented.

Under contract with the Commonwealth's MassHealth Behavioral Health Program, MBHP (a Beacon Health Options company) manages mental health and substance use disorder services for 678,864 Members in MassHealth's Primary Care Clinician (PCC) Plan, Community Care Cooperative (C3), Mass General Brigham ACO, Steward Health Choice, and 51,396 Members in the BeHealthy Partnership. In addition, MBHP manages these services for children in the care or custody of the state, including the Departments of Children and Families and Youth Services, and a subset of children who have commercial coverage as their primary insurance are also covered. MBHP's network includes more than 3,500 behavioral health providers, including more than 1,752 individual providers, 111 outpatient clinics, 356 group practices, and 100 inpatient mental health facilities. Currently, 74 percent of all child psychiatrists in Massachusetts are practitioners in our network. In addition, we work closely with more than 380 primary care practices across Massachusetts.

In addition to general network management, MBHP collaborates with our providers to address social determinants of health (SDOH), the conditions in which individuals live, work, and play that affect a wide range of health risks and outcomes. Through a variety of clinical initiatives and programming, we work with our providers to address factors in our Members' environments that impede their emotional well-being, such as a lack of stable housing, inadequate nutritious food, and racism. MBHP shares MassHealth's commitment to advancing health equity and reducing health disparities. This commitment is a guiding principle in all our work.

The MBHP Provider Manual has been developed to answer your questions about MBHP and to provide information about how our services are delivered and managed. The manual contains background information about MBHP clinical goals and important information and guidelines about referrals, service authorizations, and claims submission. Following these guidelines will help ensure that you receive timely service authorizations and claims reimbursement. A glossary of frequently used terms and copies of required forms are also included for your reference.

Thank you for your participation in the MBHP provider network. If you have any questions or comments regarding the manual, please contact our Community Relations Department at **1-800-495-0086**.



Important Notice

MBHP’s Provider Manual and Provider Agreement outline the current requirements for participation in the MBHP network. Please note that the Provider Manual is an online product that is continuously updated as information changes. Therefore, every time you access the Provider Manual on MBHP’s website, www.masspartnership.com, you will be accessing the most up-to-date information relevant to providers. The MBHP Provider Manual is an extension of MBHP Provider Agreements. In combination, the MBHP Provider Manual and the MBHP Provider Agreement outline the current requirements for participation in the MBHP network. To ensure that you have the most up-to-date information, MBHP will notify providers about any changes in its policies via Provider *Alerts* and Beacon/MBHP Broadcasts. It is important to note that the Provider Manual and all MBHP Provider *Alerts* and Beacon/MBHP Broadcasts are considered part of the Provider Agreement, and as such, providers are required to adhere to all changes outlined in these materials. MBHP reserves the right to interpret all terms or provisions in this manual and to amend the manual at any time.

To the extent that there is an inconsistency between the manual and the Provider Agreement, MBHP reserves the final and binding right to interpret such inconsistency.

MBHP providers may access the Provider Manual online at www.masspartnership.com. To do so, providers must complete a website registration form, which can be filled out electronically or downloaded from the “Behavioral Health Provider log in” page at www.masspartnership.com. Alternatively, a copy of the registration form may be requested by contacting the Community Relations Department at **1-800-495-0086**.

MBHP Goals

The mission of MBHP is to help Members live their lives to the fullest potential, to improve the quality of mental health and substance use disorder care for MBHP Members, and to support the goals of the MassHealth Behavioral Health Program.

In keeping with this mission, MBHP’s goals are to:

- ***Continuously improve the quality of care available to MBHP Members*** by monitoring, measuring, and addressing opportunities to improve all aspects of service delivery, including clinical, recovery, network, administrative, and quality management services;
- ***Meet the behavioral and primary healthcare needs of MBHP Members, as they define them***, and incorporate a strong focus on consumer and family involvement, rehabilitation, and recovery in all program aspects;
- ***Advance health equity*** by addressing social determinants of health and implementing initiatives to reduce health disparities;
- ***Strengthen the overall integration of the behavioral health service delivery system*** across state agencies, community-based organizations, and institutional providers;



- **Improve cost-effectiveness of care delivery** by ensuring the availability and appropriateness of services; and
- **Improve integration of primary care with behavioral healthcare** through quality-driven network management activities and care management.

MBHP's goals are reflected in virtually every action taken by MBHP staff on behalf of Members, from negotiating annual program goals and objectives, to monitoring program responsiveness and outcomes, training providers and families, and sponsoring joint quality initiatives.

MBHP Services

MBHP engages in a wide range of clinical and administrative activities to serve MBHP Members. The following material provides a sample of MBHP programs and focus areas.

Principles of Recovery and Rehabilitation

MBHP has a strong commitment to promoting the principles of recovery and rehabilitation in the treatment of its Members and aims to integrate recovery principles and values into its service system, creating conditions to empower individuals, organizations, and providers to achieve transformation throughout the state. These principles hold that working in partnership with people to assist them in meeting their self-generated life goals of increasing social connection, health, work, and/or other useful activity leads to greater safety, stability independence and inter-dependence. In a recovery-oriented health care system, an important source of support comes from "peer specialists" - that is, individuals with lives behavioral health experience, who are trained and certified, and are working in paid or voluntary capacities to support Members currently receiving services.

MBHP's dedicated Rehabilitation and Recovery (RR) Department provides the expertise and leadership in building a recovery infrastructure that allows MassHealth members to access timely and appropriate services and supports to lead lives of safety, stability, and contribution to their communities. MBHP also maintains strong ties to recovery-oriented community organizations, both by working with them on projects and by soliciting their input and feedback on services and supports. Member feedback is also obtained and implemented regularly through consultation with our Consumer and Family Advisory Councils, and Member and family voices have been prioritized since MBHP's inception. MBHP has been at the forefront of launching innovative programs that foster rehabilitation and recovery principles and has long supported organizations run by persons in recovery from behavioral health conditions.

MBHP is ensuring the provider network's dedication to the principles of recovery by:

1. Helping providers focus on recovery, strengths, and wellness, rather than on symptom management;
2. Offering Members the opportunity to learn from others who are in long-term recovery from behavioral health conditions;
3. Focusing on Members and families with advisory committees, trainings, and conferences in order utilize their unique perspective, add a recovery focus to existing services, and develop new recovery-oriented services;

4. Requiring providers to use outcome measurement tools that assess life skills, quality of life, and completed stages of recovery;
5. Identifying programs and treatments that are most effective for people with mental health and substance use disorder conditions and promoting their usage; and
6. Identifying and promoting recovery programs and services from across the commonwealth to our Members.

Cultural Humility

In accordance with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Healthcare, MBHP strives to provide effective, equitable, understandable, and respectful quality mental health and substance use disorder services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs of all our Members. MBHP Members represent a mix of cultures, backgrounds, religions, race/ethnicities, sexual orientation, languages, and countries of origin. MBHP strives to decrease barriers that discourage Members from seeking treatment.

MBHP works with providers, local stakeholders, and others to develop culturally sensitive, accessible information on services and help foster a welcoming environment for those from all cultures and backgrounds. In total, these initiatives are designed to strengthen and deepen the cultural humility of the MassHealth Behavioral Health Program.

Special Populations

MBHP shares the Commonwealth's commitment to caring for residents with the most complex needs. MBHP has worked with its provider network, advocacy organizations, and state agencies to identify effective treatment models and available resources for residents with highly complex needs to improve quality of care and increase access to available resources.

MBHP has developed various programs and initiatives to meet the unique needs of the following special populations:

- *Children and adolescents:* Given the financial and social strain felt by many MBHP families, children and adolescents are considered to be among MBHP's most high-risk Members. As a coordinator of many services mandated by the Children's Behavioral Health Initiative (CBHI), MBHP sponsors various initiatives and prevention, education, and outreach programs for children, adolescents, and their families. MBHP has committed staff resources to support these efforts.
- *Persons with co-occurring disorders:* Members who have multiple disorders, which present with any combination of psychiatric, substance use, medical, and/or intellectual disability diagnoses, represent a significant clinical challenge. MBHP is committed to developing a continuous, comprehensive, and integrated system of care as well as creating programs targeted to this complex population. In collaboration with MassHealth and the Departments of Mental Health, Developmental Services, and Public Health, MBHP has developed programs and protocols intended to address the needs of Members with co-occurring disorders.
- *Members who are homeless:* Homeless individuals, many of whom experience co-



occurring mental health and substance use disorders, are often difficult to assess and treat. Many provide a significant challenge to network providers. MBHP is committed to offering services to aid providers in serving people who are experiencing homelessness.

Data-Driven Network and Utilization Management

MBHP uses a profile-based approach to utilization management, whenever feasible, to promote the self-management of providers.

Outpatient

Providers can register many routine services using MBHP's Interactive Voice Registration (IVR) technology. Outpatient medication management is now authorization exempt and no longer requires registration through the IVR.

Emergency Services Program (ESP)

MBHP has developed reports that provide the ESP and Mobile Crisis Intervention (MCI) programs with information on their performance relative to the three Quality Indicators; response time, intervention location and disposition. These reports are provided to the ESPs monthly and reviewed by the PQMs at Provider Quality Management meetings. Quality improvement plans are jointly developed by the ESP provider and PQM.

Inpatient

MBHP has developed a data-driven utilization management program in which data including admission, length of stay, daily census, and various quality indicators is provided to inpatient providers. MBHP grants initial pre-authorizations for longer periods to inpatient providers who have consistently demonstrated the ability to effectively manage utilization. This strategy makes it possible for MBHP to target resources to providers requiring additional support.

Provider quality managers (PQMs) meet with high-volume behavioral health providers to review several key performance indicators including: Member demographics, diagnostic data, utilization data, quality indicators, coordination of care, and integration with primary care providers.

Clinical Outcomes Management Program

MBHP requires that all providers use a standardized assessment instrument to inform discharge planning from 24-hour care services and treatment planning for community-based services. Facilities that provide 24-hour treatment for acute psychiatric disorders or substance use disorders are required to complete a discharge planning assessment for each Member using a standardized assessment instrument. Community-based service providers are required to administer an assessment instrument during the Member's intake evaluation and periodically, at clinically reasonable intervals, to inform treatment planning and choice of treatment interventions. For both acute, 24-hour services and community-based services, MBHP regards the use of clinical information gathered through a standardized assessment to be an important resource for care management, discharge planning, and treatment planning.



Evidence-Based Clinical Practices

MBHP is committed to supporting evidence-based clinical practices and enhancements to services that yield measurably positive clinical outcomes. MBHP works with providers and Commonwealth stakeholders to offer incentives to providers for incorporating certain evidence-based practices into their treatment programs.

Integration of Medical and Behavioral Healthcare

Clinical outcomes are improved when behavioral health services are coordinated and integrated with medical care to ensure that a Member's care is appropriate and services are easily accessible. Medical problems are frequently accompanied by behavioral health complications and co-morbidities, or may mask underlying mental health disorders. MBHP is committed to the implementation of programs and practices that promote the integration of primary medical care and behavioral healthcare to the extent possible under existing Member confidentiality statutes and regulations.

Integrated Care Management Services

What is the Integrated Care Management Program (ICMP)?

The Integrated Care Management Program (ICMP) aims at expanding access to services and promoting the integration of medical, mental health, and substance use disorder care for eligible PCC Plan Members.

The goal of the ICMP is to provide care that is well-coordinated, flexible, and targeted to Members' specific needs. It includes emphasis on engaging Members in their own healthcare, often through direct, face-to-face care management visits, and in promoting integration of physical and behavioral health services. These initiatives allow individuals to receive the best possible care, leading to improved health outcomes. The ICMP creates a comprehensive and collaborative healthcare system for Members while reducing the costs of unnecessary or inappropriate care.

Who is eligible for the ICMP?

The ICMP's comprehensive approach, utilizing a predictive modeling tool, analyzes behavioral health and pharmacy claims data to identify Members with the highest need for integrated physical and behavioral health services and care coordination. This enhanced care management program targets individual needs of Members with complex medical, mental health, and/or substance use disorders and provides them with one point of entry into the healthcare system. Members can also be referred for the ICMP from primary care clinicians, behavioral health providers, state agencies, other health professionals, family members, or the Members themselves.

MBHP asks that providers encourage Members to participate in the ICMP. For Members already receiving care management/coordination services in another program (i.e., Children's Behavioral Health Initiative (CBHI), Patient-Centered Medical Home Initiative), the ICMP staff will work with you to ensure that there is coordination, not duplication of services.



Enrollment procedures

A Member may be referred to the Integrated Care Management program by the Member's clinician, an MBHP clinician, a state agency, a Member, family, or significant others by calling or faxing referrals using the ICMP numbers below, or by completing an online referral form..

ICMP phone number: **1-800-495-0086, Press 2, Ext. 706870**

ICMP fax number: 1-855-895-9758

Online referral: <https://www.masspartnership.com/provider/apps/ICMP/ICMRForm.aspx>

Enhanced Care Coordination

Enhanced care coordinators (ECCs) provide clinical service coordination to Members not enrolled in the PCC Plan, including youth in the care of DCF and/or state agency involvement, with the goal of promoting service delivery coordination and improved outcomes. These Members experience high utilization of both psychiatric inpatient and detoxification services, ongoing active involvement with other state agency services and programs, frequent ESP utilization and/or co-existing medical and behavioral health. Referrals are accepted from the individual, providers, family members, state agencies, or EOHHS. MBHP assigns an ECC to coordinate all care, develop and implement a service plan, and facilitate communication among the Member, treating providers, state agency-assigned staff, and the PCC.

MBHP Contact Information

The Massachusetts Behavioral Partnership (MBHP) has its headquarters in Boston.

1000 Washington Street, Suite 310

Boston, MA 02118-5002

Toll-Free Number: 1-800-495-0086

TTY: 1-877-509-6981

General Correspondence Address:

Massachusetts Behavioral Health Partnership

P.O. Box 55871

Boston, MA 02205-5871

Northeast Access Line

Toll-Free Number: 1-800-495-0086

Fax: (855) 685-5170

The Northeast Access Line assists Members and providers with referrals to MBHP network providers, Member appeals, authorization requests, and information on utilization management issues and inquiries. Clinical staff members are available to accept calls 24 hours per day, 7 days per week, 365 days per year. Routine calls (regarding non-urgent care) should be made during normal business hours, 8 a.m. – 5 p.m., Monday through Friday.



Member Engagement Center

Phone: 1-800-495-0086

Fax: (877) 334-9615

The Member Engagement Center is available to MBHP Members throughout the Commonwealth. Member Engagement specialists assist Members with using PCC Plan services, accessing health education materials, and completing and interpreting a health needs assessment. They also provide health coaching and help transition Members into programs such as the Integrated Care Management Program.

Provider Quality Management Department

The Provider Quality Management Department works together with the MBHP and BeHealthy Partnership provider networks. MBHP's approach integrates provider quality management, utilization management, quality management, and rehabilitation and recovery into all our interactions with the provider network. The needs and perspectives of our Members and their families are essential in prioritizing our interventions. PQMs work closely with network providers, community programs, state agencies, and consumer and family advocacy organizations to strengthen continuity of care within a community-based, locally integrated service delivery system.

Community Relations

Phone: 1-800-495-0086

Fax: (877) 334-9615

PO Box 55870

Boston, MA 02205-5870

Community Relations representatives assist providers with questions regarding claims, benefits, eligibility, and other general issues. The lines are staffed Monday through Thursday from 8 a.m. to 5 p.m., and Friday from 9:30 a.m. to 5 p.m. After hours, providers can leave a confidential voicemail message, and a representative will return the call the next business day.

Claims

Massachusetts Behavioral Health Partnership

P.O. Box 55871

Boston, MA 02205-5871

Departments at the Boston Office:

- Executive Administration
 - Behavioral Health Equity
 - Communications
- Medical Affairs
 - MCPAP/MCPAP for Moms
 - MCSTAP
- Utilization Management
 - Northeast Access Line
- Integrated Care Management Program (ICMP)
- Finance
- Provider Quality Management
 - Emergency Services Program Management
- Statewide Services
 - Child and Adolescent Services Management
 - PCC Plan Support Services Program
 - Substance Use Disorder Services Management
- Member and Provider Services
 - Claims Operations
 - Member Engagement Center
 - Community Relations (Customer Service)
- Management Information Systems
 - Informatics and Analytics
 - IT
- Quality Management
 - Fraud and Abuse

Glossary of Terms

Adolescent – A person age 13 to 18 years

Adult – A person age 19 to 64

Adverse Action – The following actions or inactions by the Contractor:

- (1) The failure to provide MassHealth Covered Services in a timely manner in accordance with the waiting time standards in **Section 3.1.G.8**;
- (2) The denial or limited authorization of a requested service, including the determination that a requested service is not a MassHealth Covered Service;
- (3) The reduction, suspension, or termination of a previous authorization for a service;
- (4) The denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue; provided that procedural denials for requested services do not constitute Adverse Actions, including but not limited to denials based on the following:
 - failure to follow prior authorization procedures;
 - failure to follow referral rules;



- failure to file a timely Claim; and

(5) The failure to act within the timeframes in **Section 4.2.A.2.e** for making authorization decisions.

Alternative Formats – Provision of information in a format that takes into consideration the special needs of those Members who, for example, are visually limited or have limited reading proficiency. Examples of Alternative Formats include, but are not limited to: Braille, large font, audio tape, video tape, and information read aloud to a Member.

ASAM – American Society of Addiction Medicine

ASAP – Assessment for Safe and Appropriate Placement

ATS – Acute Treatment Services (formerly known as Level 3A detoxification service)

Authorized Representative – An individual who has been either legally designated or authorized by the Member to act on the Member’s behalf (with proof of documentation). If a provider is acting as the Authorized Representative, written authorization signed by the Member must be submitted to MBHP.

Beacon Health Options – the parent company of MBHP

Behavioral Health (BH) – Mental health and substance use disorder

Behavioral Health Clinical Assessment – The comprehensive clinical assessment of a Member that includes a full bio-psycho-social and diagnostic evaluation that informs behavioral health treatment planning. It is performed when a Member begins behavioral health treatment and is reviewed and updated during the course of treatment. Behavioral Health Clinical Assessments provided to Members under the age of 21 require the use of the Child and Adolescent Needs and Strengths (CANS) Tool to document and communicate assessment findings.

Behavioral Health Covered Services – The services the Contractor is responsible for providing to Members, as applicable and as described in **Appendix A-1**

MBHP Network Provider (or Network Provider) – A provider who has contracted with the MBHP to provide behavioral health covered services under the Behavioral Health Program

Board of Hearings (BOH) – The Board of Hearings within the Executive Office of Health and Human Services’ Office of Medicaid

BOH Appeal – A written request to the BOH, made by a Member or Appeal Representative who has been authorized by a Member in writing to act on their behalf with respect to a BOH Appeal, to review the correctness of an Internal Appeal decision by the Contractor

Care Team – A group of individuals led by the care coordinator or care manager, including the Member, the primary care clinician (PCC), and any other medical or behavioral health provider,



case manager from another state agency, and any family member or other individual requested as part of the team by the Member

CBAT – Community-Based Acute Treatment

CCS – Community Crisis Stabilization

Centers for Medicare and Medicaid Services (CMS) – The federal agency that oversees states’ Medical Assistance programs and states’ Children’s Health Insurance Programs (CHIP) under Titles XIX and XXI of the Social Security Act and waivers thereof

Child – An MBHP-eligible Member age 0 to 12 years

Child and Adolescent Needs and Strengths (CANS) Tool – A tool that provides a standardized way to organize information gathered during Behavioral Health Clinical Assessments and during the discharge planning process from Inpatient Psychiatric Hospitalizations, Intensive Community-Based Acute Treatment Services (ICBAT), and Community-Based Acute Treatment Services (CBAT). A Massachusetts version of the CANS Tool has been developed and is intended to be used as a treatment decision support tool for Behavioral Health providers serving MassHealth Members under the age of 21.

CANS IT System – A web-based application accessible through the EOHHS Virtual Gateway into which behavioral health providers serving MassHealth Members under the age of 21 will input: (1) the information gathered using the CANS Tool; and (2) the determination whether or not the assessed Member is suffering from a Serious Emotional Disturbance

Children’s Behavioral Health Initiative (CBHI) – An interagency undertaking by EOHHS to strengthen, expand, and integrate behavioral health services for MassHealth Members under the age of 21 into a comprehensive system of community-based, culturally competent care

Children’s Behavioral Health Initiative Services (or CBHI Services) – Any of the following services: Intensive Care Coordination (ICC), Family Support and Training (FS&T), In-Home Behavioral Services (IHBS) (including Behavior Management Therapy and Behavior Management Monitoring), Therapeutic Mentoring (TM) Services, In-Home Therapy Services (IHT) (including Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support), and Mobile Crisis Intervention (MCI)

Children in the Care and/or Custody of the Commonwealth – Children who are Members and who are in the care or protective custody of the Department of Children and Families (DCF) or in the custody of the Department of Youth Services (DYS). Children in the Care and/or Custody of the Commonwealth are eligible to receive services through the BHP without being required to enroll in the PCC Plan; however, any such children who are enrolled in the PCC Plan are considered Enrollees.

Claim – A bill for services, a line item of service, or all services for one Member or Uninsured Individual



Claim Review – A process available to the provider for reviewing denied claims and payment disputes

Clean Claim – a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating from the Contractor’s claims system. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for Medical Necessity.

Clinical Criteria – The criteria used to determine the most clinically appropriate and necessary level of care and amount, duration, or scope of services, to ensure the provision of medically necessary behavioral health covered services

Clinical Support Services (CSS) (formerly known as Level 3B short-term substance abuse residential treatment) – 24-hour treatment, usually following Acute Treatment Services (ATS) for Substance Use Disorders. This service includes intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

Community Service Agency (CSA) – A community-based behavioral health provider organization whose function is to facilitate access to the continuum of behavioral health services by providing an organized pathway to care for children and families where the child is referred for Intensive Care Coordination. A primary mechanism through which CSAs serve this function is as the provider of Intensive Care Coordination and Family Support and Training Services, which are defined as BH Covered Services.

Complaint – Any telephonic, written, or face-to-face communication by a Member or uninsured DMH client that involves a problem other than a medical necessity or service coverage determination

Concurrent Review – A clinical review to determine the medical necessity and appropriateness of continued treatment at the present level of care

Continuing Services – Disputed BH Covered Services provided by the Contractor to a Member notwithstanding the Date of Action, following an Adverse Action that terminates, modifies or denies BH Covered Services that the Member is receiving at the time of the Adverse Action, pending the resolution of an Internal Appeal and/or a BOH Appeal

Co-occurring Disorder – A co-existing mental health, substance use disorder, and/or medical diagnosis

Coverage Type – A defined scope of medical services, other benefits, or both, that are available to individuals who meet specific MassHealth eligibility criteria. Coverage Types for this Contract include MassHealth Standard, CommonHealth, and Family Assistance. See 130 CMR 450.105 for an explanation of each Coverage Type.

Covered Services – Those services MBHP is responsible for providing to Members as defined



by MBHP's contract with MassHealth

Credentialing Criteria – Criteria that a provider must meet to be qualified as a Network Provider

Crisis Prevention Plan – A plan directed by the Member, or in the case of Members under the age of 18, their legal guardian, designed to expedite a consumer- or family focused clinical disposition in the event of a psychiatric crisis, based on the experience gained from past treatment. The Crisis Prevention Plan provides a thorough checklist of the triggers that may lead to or escalate a psychiatric crisis. The plan also includes potential clinical presentations and a preferred disposition and treatment plan for each of these presentations as well as the Member's preferences with respect to involvement of the Member, their family, and other supports, such as behavioral health providers, community social service agencies, and natural community supports. With the Member's consent, the plan may be implemented by an ESP, other BH network provider, the PCC, the staff from the CSA, or another provider. This type of plan may also be referred to as a Wellness Recovery Action Plan (WRAP) for adults with Severe and Persistent Mental Illness (SPMI), and a Risk Management Safety Plan for children with Severe Emotional Disturbance (SED) and their families.

Date of Action – The effective date of an Adverse Action

DBT – Dialectical Behavior Therapy

Department of Children and Families (DCF) – A division of the Massachusetts Executive Office of Health and Human Services

Department of Correction (DOC) – A division of the Massachusetts Executive Office of Public Safety and Security

Department of Developmental Services (DDS) – A division of the Massachusetts Executive Office of Health and Human Services

Department of Mental Health (DMH) – The department within the Massachusetts Executive Office of Health and Human Services designated as the Commonwealth's mental health authority pursuant to M.G.L. c. 19 and M.G.L. c. 123, et seq

Department of Public Health (DPH) – A division of the Massachusetts Executive Office of Health and Human Services

Department of Youth Services (DYS) – A division of the Massachusetts Executive Office of Health and Human Services

DMH Case Management – A service operated by DMH that is performed in accordance with DMH regulations for DMH Clients. DMH Case Management includes those services enumerated in 104 CMR 29.00



DMH Clients – For purposes of this Contract, individuals whom EOHHS identifies to the Contractor as being eligible for and recipients of DMH services

DMH Continuing Care Consumer – Individuals and children with mental illness who meet DMH Continuing Care eligibility criteria and have been determined eligible for services by DMH

DMH Continuing Care Services – DMH non-acute mental healthcare services provided to DMH Continuing Care Consumers. These services have the following characteristics: a long-term focus; a rehabilitative nature; and intent to assist with symptom management, independent living, attainment of optimal level of functioning, and reduced inpatient episodes. Services include: intensive and long-term inpatient care; community aftercare such as housing and support services; and non-acute residential services.

DMH Service Authorization – The process by which a Member is found to be eligible and approved for a service provided through DMH

Designated Forensic Professional – A physician or psychologist designated by the Department of Mental Health as qualified to perform a clinical assessment of the mental status of a prisoner and provide recommendations to an on-call judge regarding the need for brief psychiatric hospitalization or commitment. See M.G.L. c. 123, § 18(a)

Discharge Planning – The evaluation of a Member’s medical and behavioral healthcare needs and coordination of any other support services in order to arrange for safe and appropriate care after discharge from one level of care to another level of care, including referral to appropriate services

Dual Diagnosis – Co-occurring mental health and substance use disorder conditions

Electroconvulsive Therapy (ECT) – A specialized behavioral health service provided by a licensed physician in an inpatient or outpatient setting

Eligibility Verification System (EVS) – EOHHS’s computerized system for verifying MassHealth Member eligibility

Emergency – A medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of a beneficiary or another person or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act (42 U.S.C. § 1395dd(e)(1)(B))

Emergency Services Programs (ESPs) – The network providers, identified in **Appendix A-3**, that provide ESP services as described in **Appendix A-1, Part III** in accordance with the requirements of the contract



Emergency Services – MassHealth covered services that are furnished to a Member by a provider qualified to furnish such services under Title XIX of the Social Security Act and that are needed to evaluate or stabilize a Member’s emergency medical condition

Emergent Services – A situation in which either mental illness or substance use disorder symptoms increase and become so severe that the individual requires an immediate response to avoid a clinical deterioration and/or need for hospitalization. Services are provided within an hour of the request on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present at any qualified provider, whether a network provider or non-network provider.

Enhanced Acute Treatment Services (E-ATS) – A 24-hour level of care provided for Members with co-occurring mental health and substance use disorders

Enrollment Broker – The EOHHS-contracted entity that provides MassHealth Members with assistance in enrollment into MassHealth managed care plans, including the PCC Plan

EPSDT Periodicity Schedule – The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical and Dental Protocol and Periodicity Schedules that appears in Appendix W of all MassHealth provider manuals and is developed and periodically updated by MassHealth in consultation with the Massachusetts Chapter of the American Academy of Pediatrics, Massachusetts DPH, dental professionals, the Massachusetts Health Quality Partners, and other organizations concerned with children’s health. The Schedule consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be provided.

Executive Office of Health and Human Services (EOHHS) – The executive agency within Massachusetts that is the single state agency responsible for the administration of the MassHealth program (Medicaid), pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and other applicable laws and waivers thereto

Expedited Member Appeal – A Member request that should be resolved in a shorter timeframe (within 60 minutes) than other requests because of clinical urgency

Forensic Evaluation Services – A clinical assessment of the mental status of a prisoner, performed by a physician or psychologist designated by the Department of Mental Health as qualified to perform such examination in accordance with M.G.L. c. 123, § 18(a). Such examination shall include recommendations to an on-call judge regarding the need for brief psychiatric hospitalization or commitment, if so indicated.

Grievance – Any expression of dissatisfaction by a Member or appeal representative about any action or inaction by the contractor other than an Adverse Action. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee of the Contractor, or failure to respect the Member’s rights.

Group Practice – A multi-disciplinary team of individual practitioners contracted as one entity. Each practitioner within the group is credentialed individually. The head of the group

practice must be one of the following: a full-time psychiatrist; a master's-level, advance-practice registered nurse, board-certified in adult or child psychiatric nursing under the supervision of a licensed psychiatrist; a licensed psychologist (including PhD, EdD, and PsyD); an LICSW; or an LMHC. MBHP/HNE BH will only consider the following licensure levels for group contracting: MD, APRN-BC, LICSW/LCSW, LMHC, or licensed psychologist (including PhD, EdD, and PsyD).

Healthcare Acquired Conditions (HCACs) – Conditions occurring in an inpatient hospital setting, which Medicare designates as hospital-acquired conditions (HACs) pursuant to Section 1886 (d)(4)(D)(iv) of the Social Security Act (SSA)(as described in Section 1886(d)(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

Healthcare Effectiveness Data and Information Set (HEDIS®)¹ – A standardized set of health plan performance measures developed by the National Committee for Quality Assurance (NCQA) and utilized by EOHHS and other purchasers and insurers

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Federal legislation (Pub. L. 104-191, as amended), enacted to improve the continuity of health insurance coverage in group and individual markets, combat waste, fraud, and abuse in health insurance and healthcare delivery, simplify the administration of health insurance, and protect the confidentiality and security of individually identifiable health information

Health Needs Assessment (HNA) – A tool that identifies and quantifies an Enrollee's physical and behavioral health status and morbidity and mortality risk derived from the collection and review of demographic, physical and behavioral health, and lifestyle information

Homeless – Individuals who lack regular, fixed, and adequate nighttime residence, and who, on a temporary or permanent basis, have a primary residence that is a shelter or similar facility, or who have no primary residence and utilize public areas for sleep, shelter, and daily living activities

Individual Care Plan (ICP) – The plan of care developed by a clinical care manager in conjunction with an individual's Care Team, when appropriate and possible. The ICP includes: (1) the individual's detailed and comprehensive needs assessment; (2) identified short-term and long-term treatment goals; (3) a service plan to meet those goals; and (4) the creation of a defined course of action to enhance the individual's functioning and quality of life.

Integrated Care Management – A systematic approach to coordinating an individual's care, which is designed to efficiently utilize healthcare resources to achieve the optimum healthcare outcome in the most cost-effective manner

Interactive Voice Registration (IVR) – MBHP's IVR system enables eligible providers to

¹ HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).



obtain authorization for designated levels of care.

Intensive Outpatient Program (IOP) – Provides comprehensive, behaviorally oriented treatment services that are significantly more structured than traditional outpatient therapy, yet significantly less structured than a traditional inpatient hospital program

Internal Appeal – A request by a Member or appeal representative made to the Contractor for review of an Adverse Action

Internal Review Panel – The panel that reviews Member Appeals with the exception of expedited appeals. Membership of this panel includes: one board-certified or board-eligible psychiatrist in the same or similar specialty who typically treats the condition, performs the procedure, or provides the treatment being considered (for appeals related to psychological testing, the psychiatrist is replaced by a psychologist); and either the medical director, associate medical director, or their designee. Internal Review Panel members must not have been involved in prior decisions that led to the Adverse Action being appealed.

Lead Agency – A designated provider who serves as the contracting and management agent for certain programs, such as Assessment for Safe and Appropriate Placement (ASAP) services

Level of Care – A differentiation of services depending on the setting in which care is delivered and the intensity of the services

Local Credentialing Committee (LCC) – The LCC reviews all provider credentialing and re-credentialing applications, requests for waivers of the credentialing criteria, quality of care issues, documentation standards, and issues pertaining to the adherence to the provider contract.

Massachusetts Behavioral Health Access (MABHA) System – A web-based searchable database maintained by the Contractor that contains up-to-date information on the number of available beds or available service capacity for certain MassHealth behavioral health services, including psychiatric hospitals, Community-Based Acute Treatment (CBAT) providers, providers of Intensive Home- and Community-Based Services, and SUD services

Massachusetts General Laws (MGL) – A statute enacted by the Commonwealth of Massachusetts

MBHP – Massachusetts Behavioral Health Partnership

MCSTAP – Massachusetts Consultation Service for Treatment of Addiction and Pain

Medicaid Management Information System (MMIS) – The MassHealth management information system of software, hardware, and manual procedures used to process Medicaid claims and to retrieve and produce eligibility information, service utilization, and management information

Medical Necessity Criteria – The factors/conditions used to determine the most clinically



appropriate level of care and amount, duration, or scope of services as set forth in MBHP clinical criteria to ensure the provision of medically necessary covered services

Medically Necessary (or Medical Necessity) – A service is “Medically Necessary” if:

- (1) It is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and
- (2) There is no other medical service or site of service, comparable in effect, available, and suitable for the Member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, healthcare reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior authorization request, to be available to the Member through sources described in 130 CMR 450.317(C), 503.007, or 517.007. See, 130 CMR 450.204.

Medication Reconciliation – The process of avoiding inadvertent inconsistencies in medication prescribing that may occur in transition of a patient from one care setting to another (e.g., at hospital admission or discharge, or in transfer from a hospital intensive care unit to a general ward) by reviewing the patient’s complete medication regimen at the time of admission, transfer, and discharge and comparing it with the regimen being considered for the new care setting

Member – A person determined by EOHHS to be eligible for MassHealth

Member Appeal – A request by a Member or their authorized representative for the reconsideration of any adverse action by MBHP that impacts the Member’s treatment

Member Identification Number (MID) – The 10-digit identification number assigned to each MassHealth Member

National Credentialing Committee (NCC) - A Beacon Health Options committee that oversees the decisions made by the LCC

National Provider Appeals Committee (NPAC) – A group within the Beacon Health Options organization that oversees the NCC and LCC decisions. Providers may appeal to the NPAC according to the LCC policies and procedures.

Natural Service Area (NSA) – A geographically defined service “catchment” area defined by the cities and towns covered by DMH-designated Emergency Services Programs. The NSAs serve as comprehensive, area-based systems designed to provide community-oriented mental health and substance use disorder services in close proximity to where Members live. Organizing services within the NSAs provide opportunities for integration of clients into community life and promote speed, convenience, and safety of access to services for clients and their families.



Network (or Provider Network) – The collective group of network providers who have entered into Provider Agreements with the Contractor for the delivery of BH Covered Services

Network Group Practice/Individual in a Group – A multi-disciplinary team of individual practitioners, contracted as one entity that has a Provider Agreement with MBHP or any subcontractor for the delivery of covered services under MBHP’s contract with EOHHS. Each practitioner within the group is credentialed individually. The head of the group practice must be one of the following: a full-time psychiatrist; a master’s-level, advance-practice registered nurse, board-certified in adult or child psychiatric nursing under the supervision of a licensed psychiatrist; a licensed psychologist (including PhD, EdD, and PsyD); an LICSW; or an LMHC. MBHP will only consider the following licensure levels for group contracting: MD, APRN-BC, LICSW/LCSW, LMHC, or licensed psychologist (including PhD, EdD, and PsyD).

Network Individual Private Practitioner/Practitioner – Individual psychiatrist, psychologist, LICSW, LMHC, or board-certified, advance-practice registered nurse who meets MBHP credentialing criteria, who has a Provider Agreement with MBHP or any subcontractor for the delivery of Covered Services under MBHP’s contract with EOHHS, and who is not applying as a member of a group practice

Network Organizational Provider/Organizational Provider – A hospital-based organization, clinic-based organization, free-standing organization, or other organizational setting that is organized and operated as a business entity providing services through employees of the organizational provider and not through independent practitioners, that has a Provider Agreement with MBHP, or any subcontractor, for the delivery of covered services under MBHP’s contract with EOHHS

Network Provider/Provider – An individual practitioner, group practice, organizational provider (i.e., facility, agency, institution, organization), or other entity that has a Provider Agreement with MBHP, or any subcontractor, for the delivery of services covered under MBHP’s contract with EOHHS and that is credentialed according to this policy

Northeast Access Line – MBHP’s contact number (1-800-495-0086) for behavioral health referral information and authorization to services. Clinicians are available to accept calls 24 hours per day, seven days per week, 365 days per year.

Other Provider Preventable Condition (OPPC) – A condition that meets the requirements of an “Other Provider Preventable Condition” pursuant to 42 C.F.R. 447.26(b). OPPCs may occur in any healthcare setting and are divided into two subcategories:

1. National Coverage Determinations (NCDs) – The NCDs are mandatory OPPCs under 42 C.F.R. 447.26(b) and consist of the following:
 - a. Wrong surgical or other invasive procedure performed on a patient;
 - b. Surgical or other invasive procedure performed on the wrong body part;
 - c. Surgical or other invasive procedure performed on the wrong patient.

For each of a. through c., above, the term “surgical or other invasive procedure” is defined in CMS Medicare guidance on NCDs.



2. Additional Other Provider Preventable Conditions (Additional OPPCs) – Additional OPPCs are state-defined OPPCs that meet the requirements of 42 C.F.R. 447.26(b). EOHHS has designated certain conditions as “Additional OPPCs.”

Peer Support – Activities to support recovery and rehabilitation provided to consumers of behavioral health services by other individuals with personal experience with behavioral health conditions and services

Performance Specifications – Performance requirements for each level of care developed with extensive consumer, family, provider, and state agency representation. These specifications reflect recognized standards of quality care. Performance specifications are listed in the Provider Policy and Procedures Manual and are considered part of a provider’s contractual agreement with MBHP.

Post-Stabilization Care Services – Covered Inpatient and Outpatient Services, related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or when covered pursuant to 42 CFR 438.114(e) to improve or resolve the Member’s condition

Practice Guidelines – Systematically developed descriptive tools or standardized specifications for care to assist provider and patient decisions about appropriate healthcare for specific circumstances. Practice Guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.

Pre-Arrest Protocol (PAP) – A protocol that sets forth a legal-clinical assessment process which allows local police departments to obtain psychiatric hospitalizations, where appropriate, for persons who are arrested but not yet arraigned when the court is closed

Pre-certification – A clinical decision that establishes the medical necessity and appropriateness of treatment with MBHP’s clinical criteria *prior to an actual admission or initiation of services*. This review should occur immediately following a provider’s evaluation and authorizes medical necessity of the proposed admission but does not address initial length of stay. Based on clinical data, the clinical care manager and/or physician advisor will do one of the following:

- Authorize the treatment based on medical necessity;
- Suggest an alternate level of care; or
- Determine that certification is not appropriate.

Prevalent Languages – Those languages spoken by a significant percentage of Members in the Commonwealth, as determined by EOHHS. Currently, EOHHS has determined that English and Spanish are Prevalent Languages.

Prevention – A community-based, focused effort to address identified risk factors and the impact they have on the lives of individuals, families, and communities

Primary Care – All healthcare services and laboratory services customarily furnished by or through a family physician, internal medicine physician, obstetrician/gynecologist, pediatrician,



or nurse practitioner, to the extent the furnishing of those services is legally authorized by the Commonwealth, as further described in 130 CMR 450.101

Primary Care Clinician (PCC) – An EOHHS-contracted primary care practitioner participating in the Managed Care program pursuant to 130 CMR 450.118. PCCs provide comprehensive primary care and certain other medical services to PCC Plan Enrollees and function as the referral source for most other MassHealth services.

PCC Plan – A MassHealth managed care option, which includes EOHHS’s network of PCCs, specialty care providers, and the BHP

PCC Plan Support Services Program – Services designed to support MassHealth in managing the PCC Plan in a cohesive fashion with a focus on quality management and operational support

PCC Plan Support Services Program Materials – Educational materials distributed by the Contractor to PCCs (and other providers as appropriate) to promote improvement in the delivery of healthcare services and in Enrollee health outcomes

PCC Service Location – The site at which an enrollee is enrolled once an enrollee chooses or is assigned to the PCC Plan. A PCC service location is denoted by a Provider Identification and Service Location (PID/SL) number which is system-generated by the EOHHS MMIS. A PCC may have one service location or multiple service locations.

Primary Care Practitioner (PCP) – A healthcare professional who provides primary care services

Primary Source Verification (PSV) – A process used to verify provider credentialing information

Privacy Rule – The standards for privacy of individually identifiable health information required by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (HIPAA), and the associated regulations (45 CFR parts 160 and 164, as currently drafted and subsequently amended)

Program for Assertive Community Treatment (PACT) – A multidisciplinary team approach to providing acute, active, long-term, community-based psychiatric treatment, assertive outreach, rehabilitation, and support to people with serious mental illness

Protected Health Information (PHI) – Any information in any form or medium: i) relating to the past, present or future, physical or mental condition of an Individual; the provision of healthcare to an Individual; or the past, present or future payment for the provision of healthcare to an Individual, and ii) identifying the Individual or with respect to which there is a reasonable basis to believe can be used to identify the Individual. PHI shall have the same meaning as used in the Privacy Rule. PHI constitutes Personal Data as defined in M.G.L. c. 66A, § 1.



Providers – An individual, group, facility, agency, institution, organization, or business that furnishes or has furnished medical services to Members

Provider Agreement – A binding agreement between the Contractor and a BH Network Provider that includes, among other things, all of the provisions set forth in **Section 3.1.C**

Provider Network – The collective group of network providers who have entered into Provider Agreements with MBHP for the delivery of services covered under MBHP’s contract with EOHHS

Provider Preventable Conditions (PPC) – As identified by EOHHS through bulletins or other written statements policy, which may be amended from time to time, a condition that meets the definition of a “Healthcare Acquired Condition” or an “Other Provider Preventable Condition” as defined by CMS in federal regulations at 42 C.F.R. 447.26(b)

Quality Improvement Goals – Targets for clinical or service performance that are negotiated between MBHP and certain providers during the contract period

Quality Management (QM) – The process of reviewing, measuring, and continually improving the outcomes of care delivered

Recredentialing Process – A process whereby contracted providers submit updated credentialing information. Network providers are required to meet the recredentialing criteria in order to remain in the MBHP network.

Reportable Adverse Incident – An occurrence that represents actual or potential serious harm to the well-being of a Member, or to others by the actions of a Member, who is receiving services managed by the Contractor or has recently been discharged from services managed by the Contractor

Routine Care – Outpatient behavioral health services that are provided within 10 working days of request. Services are not urgent or emergent in nature.

Serious Emotional Disturbance (SED) – A behavioral health condition that meets the definition set forth in the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1401(3)(A)(i) and its implementing regulations or the definition set forth in regulations governing the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services, 58 Fed. Reg. 29422-02 (May 10, 1993), as currently drafted and subsequently amended

Serious Mental Illness – A substantial disorder of thought, mood, perception, orientation, or memory in an adult, which: significantly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life; has lasted or is expected to last at least one year; has resulted in functional impairment that substantially interferes with or limits the performance of one or more major life activities; meets diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) American Psychiatric Association, Washington, DC (2000), as currently drafted and subsequently

amended; and is not based on symptoms primarily caused by substance use, mental retardation, or organic disorders

Serious and Persistent Mental Illness (SPMI) – A mental illness that includes a substantial disorder of thought, mood, or perception, which grossly impairs judgment, behavior, capacity to recognize reality, or the ability to meet the ordinary demands of life; and is the primary cause of a functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year; and meets diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) American Psychiatric Association, Washington, DC (2000), which indicates that the individual has a serious, long term mental illness that is not based on symptoms primarily caused by: (a) developmental disorders usually first diagnosed in infancy, childhood or adolescence, such as mental retardation or pervasive developmental disorders; or (b) cognitive disorders, including delirium, dementia or amnesia; or (c) mental disorders due to a general medical condition not elsewhere classified; or (d) substance-related disorders

Serious Reportable Event (SRE) – An event that is specified as such by EOHHS

Service Authorization – The clinical review and approval process that approves the provision of a service to a Member and ensures that a Member’s psychiatric and/or substance use disorder condition is treated with the appropriate type and intensity of service(s) and that such service(s) can reasonably be expected to improve the Member’s condition or prevent further deterioration of functioning

Structured Outpatient Addictions Program (SOAP) – SOAP consists of clinically intensive, structured day and/or evening substance use disorder services. Some SOAPS offer Motivational Interviewing or enhanced services for adolescents and adults who are homeless.

Third-Party Liability (TPL) – Other insurance resources, such as Medicare and commercial insurance, available for services delivered to MassHealth Members

Uninsured Individuals – Those individuals who are not MassHealth- or CommCare-eligible for any reason and do not have commercial insurance

Urgent Care – Urgent care is designed for a behavioral health need that is **not** of an emergent nature, but without intervention will likely lead to the decompensation of the Member, resulting in the possibility of a more-intensive level of care than traditional outpatient treatment. Services are provided within 48 hours of the request for services.

Urgent Care Services – Services that are not Emergency Services or routine services

Utilization Management (UM) – The process of evaluating the clinical necessity, appropriateness, and efficiency of care and services. This may include service authorizations and prospective, concurrent, and retrospective review of services and care delivered by providers.



Virtual Gateway – An Internet portal designed and maintained by EOHHS to provide the general public, medical providers, community-based organizations, MassHealth managed care contractors, and EOHHS staff with online access to health and human services

Wellness Programs – Programs that promote an active process to help individuals become aware of and learn to make healthy choices that lead toward a longer and more successful existence

Youth – An individual age 18 years and younger

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Introduction to Medical Necessity Criteria and Utilization Management

The following section provides criteria to determine medical/clinical necessity and appropriate level of behavioral healthcare for individuals who receive services through MBHP programs. The goal of these criteria is to promote recovery from the symptoms of mental illness and substance use disorders and to support the Member's stabilization at the highest level of functioning.

These criteria must be applied in the context of other critical issues, such as an individual's psychosocial needs, desired outcomes, access to community resources, and coordination of care between behavioral health, physical health, specialty providers, and other systems of care.

MBHP's approach to clinical care management is based on the premise that ***individuals are more likely to access appropriate services and remain engaged in treatment when they feel that their needs are understood and met.*** Through application of these criteria, MBHP clinical staff and provider networks will be able to provide Members with comprehensive and individualized services, including:

- Assessment and referral to clinical practitioners and programs;
- Coordination of a continuum of services;
- Identification of community support resources, including local support and/or self-help groups;
- Identification of resources to meet basic necessities; and
- Provision of educational materials concerning behavioral health disorders.

Clinical Philosophy

MBHP supports Members in achieving optimal outcomes and encourages Members to become responsible participants in the treatment process.

The clinical philosophy of MBHP is grounded in the fostering of an understanding, compassionate environment in which the unique clinical and social needs of each Member are addressed in the context of hope and recovery. Our care management process is designed to ensure that consistent, high-quality services are provided in a culturally and linguistically competent manner. The foundation of our programs is based on the following essential elements:

- Clinical excellence;
- Ethical care;
- Coordination of care;
- Professional integrity;
- Clinical and technical innovation;
- Rehabilitation and recovery; and
- Cultural humility.



MBHP has worked collaboratively with providers to develop a comprehensive array of treatment and support services. These services are based on the latest scientific principles for treatment of mental illness and substance use disorders and are targeted to meet the needs of special populations, including individuals with serious and recurrent mental illness, individual with co-occurring substance use disorder issues, homeless individuals, and children in the care and custody of the state.

In addition, these programs:

- offer Members easy access to services;
- are monitored and evaluated with an accountable, data-supported continuous quality improvement (CQI) process to determine if they are effective;
- emphasize prevention, education, and outreach;
- promote the integration of recovery and rehabilitation; and
- facilitate and emphasize family involvement.

Definition of Medical Necessity

MBHP clinicians must ascertain that the proposed service meets the following definition of "medical necessity":

1. The proposed service must be ***reasonably calculated to prevent, diagnose, alleviate, correct, prevent the worsening of, or cure conditions*** in the Member that:
 - a. endanger life;
 - b. cause suffering or pain;
 - c. cause physical deformity or malfunction; and
 - d. threaten to cause or aggravate a handicap or result in illness or infirmity.
2. There is ***no other medical service or site of service comparable*** in effect and available or suitable for the Member requesting the service that is more-conservative or less-costly.
3. The service ***meets professionally recognized standards of healthcare*** and is substantiated by records, including evidence of such medical necessity and quality.

Determining the Appropriate Level of Care

Three concepts underlie determinations of the appropriate level of care:

1. Severity of condition
2. Intensity of service
3. Psychosocial, occupational, cultural, and linguistic factors

When synthesized, these concepts provide the foundation from which providers and clinical care managers can make recommendations. The concepts are based on ***a comprehensive understanding of an individual's clinical, psychosocial, and related needs***.

For example, a diagnosis alone does not determine the necessity of treatment at a given level. Individuals with the same diagnosis or even one individual over time may exhibit a wide range of severity of symptoms or psychosocial needs. The applicability of these criteria to individual



circumstances will depend on information obtained by the MBHP care manager from the Member, behavioral health and medical providers, family members, and caregivers.

Medical necessity criteria, also known as clinical criteria, can be found for each level of care on the MBHP website or in the Clinical Operations section of this manual, which is available on MBHP's website. Alternatively, MBHP providers may call MBHP toll-free at 1-800-495-0086 to have the clinical criteria read to them over the phone, faxed, emailed, or sent to them via mail.

Severity of Condition

The determination of the severity of a condition requires consideration of the ***signs, symptoms, and functional impairments that necessitate treatment at a specified level of care at a given moment in time***. In addition, certain high-risk clinical factors warrant consideration in the evaluation of severity. These factors include but are not limited to:

- Repeated attempts at self-harm, with documented suicidal intent;
- Significant co-morbidities (e.g., psychiatric and medical, psychiatric and substance use disorder);
- Developmental disabilities;
- Personality factors;
- Coexisting pregnancy and substance use disorder;
- Medication noncompliance;
- Unstable mental health or behavioral health disorder;
- History of violent or assaultive behavior;
- Multiple family members requiring treatment; and
- Decline in ability to maintain previous levels of psychosocial functioning.

Intensity of Service

To determine whether an individual's condition and situation (e.g., behavior, symptoms, and psychosocial issues) warrant a particular level of care (i.e., is it medically or clinically necessary), the clinician must consider the individual's developmental strengths and limitations (e.g., physical, psychological, social, cognitive, intellectual, and academic) and psychosocial and related needs. Intensity of service issues are addressed in MBHP, ASAM, and InterQual medical necessity criteria.

Cultural, Ethnic, and Linguistic Assessment Considerations

Responsiveness to an individual's cultural, linguistic, and/or ethnic specific needs is required in order to complete an ethical and accurate assessment. A culturally and linguistically competent assessment will adapt assessment criteria and services to meet an individual's unique needs at all levels, such as performing the assessment and other services in the Member's primary language. Additionally, assessment findings must be considered in the context of the individual's race, ethnicity, and culture. When an individual's specific cultural customs and communication norms guide the information sharing process, the content and accuracy of the assessment and treatment plan are enhanced.

Evaluating Medical Necessity for Continued Care

When evaluating the need for continued care, the clinical care manager and primary behavioral health provider must confirm that the treatment plan: 1) remains clinically appropriate and 2) reflects any change in psychosocial, occupational, cultural, or linguistic factors that affect the level of care determination. The following criteria must be met in order **for a treatment plan extension to be approved**:

- **Progress** in relation to specific symptoms or impairments is clearly evident, and the maximum level of functioning has not been obtained;
- **Active evaluation and treatment appropriate for the condition are occurring** with cooperation of the individual and their family or other support system, and timely relief of symptoms is either evident or reasonably expected;
- **Treatment goals are realistic** and established within an appropriate time frame for the current level of treatment;
- **Psychosocial, cultural, and linguistic issues are addressed** through timely referral to and coordination with community and psychosocial rehabilitation resources (e.g., culturally specific treatment modalities, social service agencies, peer support, recovery/self-help groups, legal aid, credit counseling, assertive community treatment, and clubhouse programs); and
- All **services, resources, and treatment modalities are carefully structured** to achieve maximum results with the greatest efficiency, which allows the individual to be treated at the least-intensive level of care appropriate for the condition and the desired results (e.g., move to less-intensive level of care or reunification of the family).

Discharge Criteria

Discharge criteria describe the circumstances under which an individual qualifies for transition to a different level of care.

MBHP expects providers of all levels of care to begin discharge planning at admission, making adjustments as required throughout the course of treatment. Major highlights that should be noted in the revised medical necessity criteria are as follows:

- All medical necessity criteria contain an expanded introduction and description of each level of care.
- To the extent possible, all medical necessity criteria have been standardized across levels of care to ensure that language used is consistent and definitions are clear.
- All substance use disorder levels of care have been standardized to ASAM criteria and referenced to specific ASAM levels.
- Exclusion criteria, when applicable, have been reformulated to eliminate barriers to access and increase the opportunity for collaborative treatment of Members with concurrent medical, organic, or cognitive disorders.
- When appropriate, child, adolescent, and adult criteria for levels of care have been combined.

Clinical Criteria Development

Clinical criteria address all levels of behavioral healthcare and are designed to **facilitate continuity of care throughout the course of service delivery**. The clinical criteria contained in this manual were developed by MBHP medical and clinical staff with input from community clinicians who have expertise in the diagnosis and treatment of individuals with mental illness and/or substance use disorders, national experts, standard clinical references, and professional organizations.

To ensure that the clinical criteria reflect the latest developments in psychiatric and substance use disorder treatment, educational material from professional, consumer, and family advocacy groups, such as the following, is incorporated:

- American Psychiatric Association
- American Psychological Association
- American Academy of Psychiatrists in Alcoholism and Addictions
- American Academy of Child and Adolescent Psychiatry
- American Society of Addiction Medicine
- Consumer and family empowerment organizations (e.g., M-Power, Alliance for the Mentally Ill)
- International Association of Psychosocial Rehabilitation Services
- National Institute of Health
- National Institute on Alcohol Abuse and Alcoholism
- National Institute of Drug Abuse
- Department of Health and Human Services' Center for Substance Abuse Treatment
- Academic psychiatric texts
- Current publications in professional journals and books

The clinical criteria are modified as necessary based on input from the provider community. In addition, these criteria are updated to reflect new treatment modalities and programs.

Proposed revisions to the MBHP state-specific custom clinical criteria are presented to the Regional Quality Management/Utilization Management/Care Management Committee (QM/UM/CM), a committee that meets monthly. Its membership includes a broad representation of clinical specialties and licensure levels. Final approval of InterQual, ASAM, and the national criteria is the responsibility of the Corporate Clinical Management Committee (CMMC). The MBHP chief medical officer conducts a comprehensive review of the criterion annually.

In addition to the MBHP state-specific custom clinical criteria for behavioral health services, MBHP utilizes the InterQual level of care criteria, a nationally recognized, peer-reviewed, and evidence-based criteria. The InterQual criteria is reviewed and updated annually or more often as needed to incorporate new treatment applications and technologies that are adopted as generally accepted professional medical practice. MBHP also utilizes criteria developed by the American Society of Addiction Medicine (ASAM). ASAM medical necessity criteria are nationally certified for substance use disorders. The ASAM committee reviews their criteria

regularly and updates MBHP about any changes that occur, which MBHP then conveys to providers.

Clinical Review Information Requirements

MBHP shares with providers the common goal of delivering care that is the most appropriate given the severity of illness and intensity of service needed. Clinical reviews performed by MBHP support this goal. The initial review seeks to identify problems that require treatment at the identified level of care, the treatment approach that will be used to resolve the current problems, and objectives by which progress is monitored, including length of stay. Further reviews will focus Member progress on a solution-oriented response to treatment, revisions in the treatment plan, and the discharge plan.

Commonly Requested Information

The information listed below is required from providers when requesting authorization for certain services. Please note this list is not exhaustive; more detailed information may also be requested.

1. Presenting problem/reason for admission, including precipitant
2. Diagnostic profile - mental health diagnosis including personality disorders, developmental disabilities and substance use disorders; medical diagnoses that are also the focus of treatment or help explain the need for treatment
3. What are the current symptoms being treated that meet level of care (specific symptoms, e.g., they appear depressed as evidenced by crying, staying in room, don't want to tend to ADLs)?
 - a. Why does the Member require this current level of care?
 - b. Could the Member receive treatment in a less-restrictive environment? If not, why?
4. What are the interventions taking place? Measurable goals? Each discipline should have some targeted interventions (for each level of care these interventions should be specific to the level of care and comply with medical necessity criteria for that level of care). Could these interventions be performed in a less-restrictive environment?
5. Medication management regime - dose, frequency, and outcome (What is the rationale for the medications, and how do they correspond to the diagnosis?) Has it been effective, have symptoms been alleviated, is Member taking meds?
6. Has the Member been making progress? Please describe in objective and specific terms. What is the Member's baseline functioning? Is the Member still experiencing any acute symptoms that cannot be treated at a lower level of care or put the Member at risk? Is there reasonable expectation of progress with continuation at current level of care?
7. What is the discharge plan for ongoing therapeutic services and living/housing situation? Have referrals been made, and when is the service to begin? Is the service going to work with family and acute setting through this admission? Has there been contact with current treating providers/state agencies/family/natural supports?
8. What are the barriers to the Member making progress, if any? What are the barriers to discharge? Has treatment been adjusted to account for barriers? Have the appropriate resources been contacted in a timely manner to decrease barriers and enhance treatment

needs? Is assistance needed regarding any identified barriers?

For acute inpatient stays, treatment plans must be documented and include at a minimum the following:

- Specification of all services required during the acute inpatient stay;
- Identified discharge plans;
- When appropriate, indications of the need for DMH continuing care services and/or other state agency services;
- Evidence that Members, guardians, and family members are given the opportunity to participate in the development and modification of the treatment plan, the treatment itself, and to attend all treatment plan meetings according to the bounds of consent; and
- Contact with collateral providers.

For acute inpatient stays, multidisciplinary treatment teams must, at a minimum, meet and review the treatment plan within 24 hours of an admission. The treatment and discharge plans are reviewed by the multi-disciplinary team at least every 48 hours (maximum 72 hours on weekends) and are updated accordingly.

When it is anticipated that the Member's discharge plan will include DMH continuing care services and/or other state agencies, the DMH continuing care services or other state agency management staff should be included during treatment team meetings. Family members should be included in the treatment/discharge planning process for all Members, following the applicable state/federal consent guidelines

Authorization Review

Northeast Access Line

The Northeast Access Line is staffed by licensed clinical care managers 24 hours a day, seven days a week, 365 days a year.

MBHP requires providers to request pre-authorization for admission of eligible Members into the following levels of care (see table at the end of this section):

- All Psychiatric Inpatient Services including Developmental and Eating Disorders
- Assessment/Observation/Holding Beds-24 hours
- Community-Based and Intensive Community-Based Acute Treatment (CBAT) (ICBAT) for Children and Adolescents

Providers must obtain pre-authorization for the above listed levels of care to receive payment.

Members seeking admission to the above levels of care must be evaluated by an MBHP-contracted ESP before admission. Requesting providers should contact the closest ESP directly. Northeast Access Line clinicians are available 24 hours a day, seven days per week to provide information regarding ESP locations. After completing the evaluation, the ESP will contact MBHP to obtain authorization of services.



If a provider and MBHP care manager do not agree about an authorization decision, the provider may request a consultation with a peer advisor (an MBHP psychiatrist, doctoral-level clinical psychologist, or certified addiction medicine specialist who is designated by MBHP to conduct peer advisor reviews) at any time during the authorization process to encourage agreement about the authorization decision.

Please note that all authorization decisions will be completed within the timeframes specified below. If a request for a peer advisor review is made by either the provider or MBHP, the consultation must be completed within the timeframes set forth in the below chart. If the provider/facility does not respond within the required timeframe, MBHP will decide on the request for authorization based on the available information.

Decision time table

Type of Service	Timeframe
For non-urgent pre-service decisions	14 days of receipt of the request
For urgent pre-service decisions	24 hours of receipt of the request
For urgent concurrent review	24 hours of receipt of the request
For post-service decisions	30 calendar days of the receipt of the request

Reviewer availability policy

Providers or Members may contact the Northeast Access Line through MBHP's toll-free number at 1-800-495-0086 for services including referral information, authorization of services, and information and inquiries regarding the utilization management process. Clinical staff members are available to accept calls 24 hours per day, seven days per week, 365 days per year.

If a denial has been issued and the provider has not had an opportunity to speak with the MBHP peer advisor reviewer or has new information they would like to discuss regarding this denial, they should call the Clinical Department/appeal coordinator within three calendar days of the date on the Notice of Adverse Action at 1-800-495-0086 to request a reconsideration of the decision. Any reconsideration requests received after three calendar days of the adverse determination letter will be considered an Appeal. Internal Member Appeals need to be requested by either the Member or the Member’s authorized representative.

Authorization Approvals Only Available Online

Notices of new authorization approvals, and the letters themselves, will only be available on the MBHP/Beacon online provider portal, ProviderConnect. Adverse determination letters will continue to be mailed to the recipient with a copy to the provider.

Providers can register for ProviderConnect at www.valueoptions.com/pclogin and become familiar with the online provider tool. With ProviderConnect, you can view and print all of your authorization letters.

Electronic authorization letters provide several advantages over paper letters:

- Natural resources are conserved;



- Providers are able to access authorization letters anytime using a secure internet browser;
- Providers may access authorizations within 24-48 hours of a decision instead of waiting days for the mail;
- Electronic authorization letters are not lost in the mail or a busy office; and
- Providers may save the electronic image of the letter instead of printing.

Additionally, providers can gain several other immediate benefits by registering for ProviderConnect, including the ability to:

- Request and view authorizations;
- Submit claims and view status;
- Access provider summary vouchers;
- Submit customer service inquiries; and
- Submit updates to provider demographic information.

Please note that ProviderConnect may have different functionalities based on individual contract needs. Therefore, some functions may not be applicable to your specific contract.

Referral Process/Assistance

The Northeast Access Line is available to assist Members with referrals to MBHP network providers for routine, urgent, and emergent (life-threatening) situations. Northeast Access Line clinicians provide Members with the names and telephone numbers of providers who meet their clinical, geographic, cultural, linguistic, and other requirements.

Each Member accessing care through the Northeast Access Line is assessed for risk of self-harm, harm to others, and harm by others. A Member with clinical needs assessed as urgent is offered an appointment with a network provider within 48 hours of the Member's initial request for care. A Member determined to have a condition requiring emergency intervention receives immediate assistance from the Northeast Access Line clinician to ensure the safety of the Member and others, as well as Member access to services.

Emergency Services

Emergency Services Programs (ESPs) are the primary mechanism through which MBHP Members access emergency and acute care services. ESPs evaluate Members for admission to all acute care services or for referral to a non-acute or diversionary level of care. If an acute care service is needed, the ESP submits clinical data through a web-based portal. The clinical data goes through an algorithm which either auto-authorizes a Member for acute level of care, or if there are clinical complexities that require a clinical discussion, the review pends for further clinical review. Once the review is completed, a clinical decision is made. If care is authorized, an authorization number is given once a bed is found. Northeast Access Line clinicians are also available for assistance with and consultation regarding determination of the appropriate level of care for a Member.



The Northeast Access Line clinician assigns an authorization number to each admission. Authorizations are valid only for the specific placement facility identified in the authorization. ***The ESP is required to notify the MBHP care manager to review the final disposition to ensure that the most-appropriate level of care determination is made.***

ESPs may be contacted directly by network providers, Members, Member representatives, and community organizations to request an emergency intervention or crisis stabilization service. The Northeast Access Line clinicians are available to provide callers with the name(s) and telephone number(s) of the nearest ESP(s). The toll-free number of any ESP can also be obtained by calling the statewide toll-free number (877-382-1609) and entering your local zip code.

Emergency Admissions without Pre-Certification

Emergency admissions may occur without an ESP intervention in circumstances where an intervention is identified as unsafe for the Member, the ESP, and/or other involved providers or members of the community. These situations exceed general commitment criteria and are considered unmanageable by the provider, although the provider has demonstrated attempts to intervene in accordance with standard policy. Issues of ***real, significant, and imminent danger*** must be present. Please be aware that if an emergency admission does not meet these criteria, it will be considered an unauthorized admission. In the case of an unauthorized admission, services, including both the inpatient care and evaluation, will not be reimbursed.

Emergency admissions may also occur without an ESP intervention when the admission is required for provider compliance with the Emergency Medical Treatment and Labor Act (EMTALA). Any hospital with an emergency department must provide medical screening examinations to an individual who comes to the emergency department to determine if the individual is suffering from an emergency medical condition. An “emergency medical condition” is a medical condition with acute symptoms of sufficient severity (including severe pain) that if not immediately treated could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any organ or body part. If the individual requires stabilizing treatment, the hospital must provide such treatment, including an emergency admission if necessary, or, if the hospital lacks the capability or capacity to provide stabilizing treatment, conduct appropriate transfers.

When an emergency admission has occurred without ESP involvement, authorization for the inpatient care must be requested as soon as possible after the placement of the Member, and in all cases within 24 hours. MBHP reserves the right to authorize individual exceptions to this policy as indicated by clinical or best practice considerations.

Authorization Requests from the Courts/Evaluations by Court Psychologists

A Northeast Access Line care manager must review all court-ordered referrals for services that require pre-authorization. A pre-admission review is conducted between the ESP or the court psychologist and an MBHP care manager to determine medical necessity for the proposed level of care and to authorize treatment. With the exception of Members on a Section 12-e (a writ of



apprehension), these reviews are based on the medical necessity level of care criteria.

Mandated treatment

If a treatment is mandated (i.e., Section 12-e), MBHP will authorize admission for the Member for 24 hours to an acute setting for a more complete assessment and to determine the continued level of care.

Treatment that is not mandated

If the treatment is not mandated, but a court psychologist is requesting the treatment, the Member must meet level-of-care criteria. If MBHP authorizes treatment, the court psychologist must be prepared with a complete clinical review and must facilitate the Member's placement. The court psychologist may request assistance from the local ESP at any time during the evaluation and placement of the Member.

Concurrent Review

Providers are required to contact MBHP to request ongoing authorization for treatment for the levels of care listed in this section. A clinical care manager will conduct the concurrent review.

For ongoing treatment requests of acute levels of care, please call the Concurrent Review Department at 1-800-495-0086, Ext. 455620. For initial or ongoing requests of outpatient levels of care, please refer to the authorization chart below. All requests for authorization of concurrent reviews must be made before the expiration of the last authorized day of treatment. Please keep the following important points in mind when contacting MBHP to request authorization for ongoing treatment:

- The **information presented should be concise, behaviorally oriented, and make a clear case** for the level of care being requested.
- **Acute care should be goal-focused and involve the amelioration of specific symptoms** and issues that will result in the Member transitioning to the least restrictive level of care in the most efficacious time period possible.
- Acute care treatment requires, with consent, **timely contact with family, significant others, provider(s), and other collateral contacts** who are important to the Member's level of functioning and eventual discharge. Failure to make these collateral contacts may be perceived by MBHP as lack of aggressive treatment.
- **Discharge planning should begin at the time of admission.** Any barriers to discharge should be identified at the outset. MBHP expects providers to pursue the services of collateral agencies that will have a favorable impact on discharge.

Transfers/Step-Ups/Step-Downs: Guidelines to All Levels of Acute Care

The transfer, step-up, and step-down of all Members should be reviewed with the assigned MBHP care manager in advance of any move taking place.

It is the responsibility of the current treating facility to locate the facility to which the Member is to be transferred and to facilitate that transfer in a safe and coordinated manner. Within the bounds of consent, **the provider must ensure the oral or written transfer of relevant clinical information regarding the Member** whose care is being referred or transferred.

This should include, at a minimum, the following:

- Brief history of present illness;
- Current treatment/crisis plan;
- Response to treatment;
- Medical status;
- Current medications, including type, dosage, and prescribing clinician; and
- Coordination with family, as applicable.

Authorization/Registration Process by Level of Care

Authorization request process is dependent on level of care, type of request (continued stay dates or an increase in intensity and frequency of service) and provider eligibility in administrative efficiency programs. Requests are made via phone contact with a care manager, through our automated IVR telephone system, various web based forms, or fax forms. Please note all requests (regardless of format) are subject to possible live clinical review with a care manager.

Level of Care		ESP Eval	Telephone	Auth Exempt	IVR	Web Request	Notes
Psychiatric Inpatient Services	Initial admission	X				Expedited Auth	
	Cont. Stay Review		CSR Team			*Extended Auth Website	*Identified providers may use Extended Auth system to request units for discharge
Level IV Medically Managed Withdrawal Management	Initial Admission					ProviderConnect	
	Cont. Stay Review					ProviderConnect	
Acute Treatment Services for Substance Use Disorders (ATS)	Initial Admission					ProviderConnect	
	Cont. Stay Review					ProviderConnect	
Enhanced Acute Treatment Services for Substance Use Disorders (E-ATS)	Initial Admission		Northeast Access Line			Expedited Auth	
	Cont. Stay Review		CSR Team			*Extended Auth Website	*Providers may use Extended Auth system to request units for discharge. For time beyond the 2 days requested, must call CSR team for review.

Level of Care		ESP Eval	Telephone	Auth Exempt	IVR	Web Request	Notes
Clinical Support Services for Substance Use Disorders (CSS)	Initial Admission					ProviderConnect	
	Cont. Stay Review					ProviderConnect	
Individualized Treatment and Stabilization Services (ITS)	Initial Admission					ProviderConnect	
	Cont. Stay Review					ProviderConnect	
Transitional Care Unit (TCU)	Initial Admission		CSR Team				
	Cont. Stay Review		CSR Team				
Community-Based Acute Treatment for Youth (CBAT or ICBAT)	Initial Admission	X	Northeast Access Line			Expedited Auth	
	Cont. Stay Review		CSR Team				
Partial Hospitalization Program (PHP)	Initial Admission				X		*Identified providers may use IVR for precert; all others should call Northeast Access Line for precert.
	Cont. Stay Review		CSR Team				
Structured Outpatient Addiction Services (SOAP)	Initial Registration					ProviderConnect	
	Cont. Stay Review					ProviderConnect	
Acupuncture Substance Use Disorder Treatment Services	Initial Registration			X			
	Cont. Stay Review			X			
Medication-Assisted Treatment (MAT)	Initial Registration			X			
	Cont. Stay Review			X			
Residential Recovery Service (RRS)	Initial Registration					ProviderConnect	
	Cont. Stay Review					ProviderConnect	
Recovery Coach (RC)	Initial Registration					ProviderConnect	
	Cont. Stay Review					ProviderConnect	

Level of Care		ESP Eval	Telephone	Auth Exempt	IVR	Web Request	Notes
Recovery Support Navigator (RSN)	Initial Registration					ProviderConnect	
	Cont. Stay Review					ProviderConnect	
Community Support Services (CSP)	Initial Registration				X*		*Refer to IVR Manual for details
	Cont. Stay Review				X*		
Community Support Services Justice Involved (CSP-JI)	Initial Registration					ProviderConnect	*Refer to IVR Manual for details
	Cont. Stay Review					ProviderConnect	
Inpatient ECT	Precert		CSR Team				
	Cont. Stay Review		CSR Team				
Outpatient ECT	Precert		OP Team				
	Cont. Stay Review		OP Team				
Repetitive Transcranial Magnetic Stimulation (rTMS)	Initial Registration					ProviderConnect	
	Cont. Stay Review					ProviderConnect	
Bridge Consult	Initial Registration			X			Subject to medical record review to verify medical necessity
	Cont. Stay Review			X			
Assessment for Safe and Appropriate Placement (ASAP)	Initial Registration					ProviderConnect	
	Cont. Stay Review					ProviderConnect	
Crisis Stabilization (CCS)	Initial Registration			X*			*Auth exempt 5 days for adults, 3 days for children/adolescents
	Cont. Stay Review		Northeast Access Line				
Outpatient Services (therapy)	Initial Registration				X		
	Cont. Stay Review			X			

Level of Care		ESP Eval	Telephone	Auth Exempt	IVR	Web Request	Notes
Outpatient Services (Medication Management)	Initial Admission			X			
	Cont. Stay Review			X			
Collateral Contact				X*			*Subject to health record review to verify medical necessity
Family Consultation				X*			*Subject to health record review to verify medical necessity
Case Consultation				X*			*Subject to health record review to verify medical necessity
Dialectical Behavior Therapy (DBT)					X		
Psychological Testing					X*		Fax PER form. Refer to IVR manual for details.
Intensive Care Coordination (ICC)	Initial Registration					ProviderConnect	
	Cont. Stay Review					ProviderConnect	
Therapeutic Mentoring (TM)	Initial Registration				X		
	Cont. Stay Review				X		*Email form for additional units/frequency within current authorization date range
In-Home Behavioral Services (IHBS)	Initial Registration					ProviderConnect	
	Cont. Stay Review					ProviderConnect	*Email form for additional units/frequency within current authorization date range

Level of Care		ESP Eval	Telephone	Auth Exempt	IVR	Web Request	Notes
Family Support and Training (FS&T)	Initial Registration				X		
	Cont. Stay Review				X		*Email form for additional units/frequency within current authorization date range
In-Home Therapy (IHT)	Initial Registration				X		
	Cont. Stay Review				X		*Email form for additional units/frequency within current authorization date range
Community Support Program for Chronically Homeless Individuals (CSP-CHI) (formally known as CSPECH)	Initial Registration				X		
	Cont. Stay Review				X		
Program for Assertive Community Treatment (PACT)	Initial Registration					ProviderConnect	
	Cont. Stay Review					ProviderConnect	
Applied Behavior Analysis (ABA)	Initial Registration					ProviderConnect	
	Cont. Stay Review					ProviderConnect	
Early Intensive Behavioral Intervention (EIBI)	Initial Registration					ProviderConnect	
	Cont. Stay Review					ProviderConnect	
Psychiatric Day Treatment	Initial Registration				X*		*Refer to IVR Manual for details
	Cont. Stay Review					*Extended OP Treatment Form	



Information on Authorization Request Methods

Please review above table to identify authorization request method.

Expedited Auth Form

For precertification of admission to identified acute levels of care, all ESPs may complete the Expedited Auth Form on the MBHP website.

For continued stay for psychiatric inpatient, previously identified eligible providers may use the Expedited Concurrent Review Form on the MBHP website. Please note; use of this form is limited to parameters outlined in the instructions section of the form.

All Expedited Forms may be accessed through this address:

<https://www.masspartnership.com/provider/m/expedited.aspx>

*Use of streamlined processes or forms does not negate providers from ensuring medical necessity criteria is met and documented. All authorization requests are subject to possible clinical review. Please check ProviderConnect to verify authorization status.

ProviderConnect

For new authorizations, additional units, or to extend an authorization date range, please complete a request form on the MBHP/Beacon web application, ProviderConnect. The ProviderConnect address is <https://www.valueoptions.com/pc/eProvider/providerLogin.do>. New users may use this same link to register for a login.

Interactive Voice Registration (IVR)

The IVR telephonic system simplifies the registration process for outpatient treatment services by permitting providers to register units of care and check the status of claims over the phone. The system is available seven days a week between the hours of 7 a.m. and 9 p.m. by calling (888) 899-6277.

This system registers treatment in units rather than service codes, which allows the provider to have more flexibility in treatment planning. In addition, the IVR shifts greater control to the provider, eliminates paperwork, and accelerates the response time for authorizations.

The IVR Manual details the registration procedures for applicable levels of outpatient care. The manual provides information regarding the IVR system, instructions for registering for each level of outpatient service, parameters for utilization management, and instructions for *over-guideline requests* that exceed the standard IVR parameters. Please review the manual's materials carefully prior to using the IVR.

Providers can access the IVR Manual via www.masspartnership.com.

Please note that all contracted providers are required to register to use password-protected sections of the MBHP website via submission of the Provider Website Registration form. The form is located in the "Administrative Operations" section of this Provider Manual and on the MBHP website at www.masspartnership.com. The completed form can be filled in electronically, faxed, mailed, or emailed to MBHP's Network Operations Department. Notices



and a corresponding link to the website will be sent to the email address provided on the registration form(s). Once registered on the website, providers will have access to their restricted provider information, such as confidential reporting data, Provider *Alerts*, Beacon/MBHP Broadcasts, and levels of care and eligible providers, access to web forms for authorization requests. For additional information or instructions, please contact the MBHP Community Relations Department at 1-800-495-0086.

Northeast Access Line

Providers may contact the Northeast Access Line through MBHP's toll-free number at 1-800-495-0086.

Concurrent Review Team

For ongoing treatment requests of identified levels of care, please call the Concurrent Review Department at 1-800-495-0086, Ext. 455620, or your assigned care manager.

Outpatient Treatment Screen

The Outpatient Treatment Screen is on the MBHP website. You may locate and submit the form by going to <https://www.masspartnership.com>.

Additional Units Request Form (CBHI: TM, IHBS, FS&T, and IHT)

For additional units beyond the max amount allowed by the IVR or ProviderConnect, for a particular authorization period, use Additional Units Request Form. You may locate and download the form by going to <https://www.masspartnership.com>. Please email this form to MBHP.AdditionalUnits.CBHI@beaconhealthoptions.com.

Psychological Evaluation Request (PER)

If a Psychological Testing request does not meet parameters as outlined in the IVR Manual, please fax a Psychological Evaluation Request (PER) to MBHP. You may locate and download the form by going to <https://www.masspartnership.com>. Please fax the form to the phone number listed on the form.

Behavioral Healthcare Access Protocol for DYS and MBHP

To ensure safety, access, and quality of care for DYS youth needing MBHP behavioral health services, network providers as well as DYS and MBHP staff should adhere to the following protocol.

The protocol is to serve as a resource for MBHP providers, MBHP staff, and DYS staff. The documents below are an integral part of this protocol and are included as appendices in the “Clinical Operations” section of this manual.

- A. Discharge Planning Policy for DYS and MBHP
- B. DYS Release of Medical Information Statement

Communication and Collaboration

Within MBHP, the Clinical Department will provide assistance with access to behavioral health services. The Northeast Access Line is available 24 hours a day, providing authorizations for



inpatient/ICBAT/CBAT levels of care, assisting the ESP with bed availability, and resolving access issues for Members.

The need for timely and thorough communication and collaboration are central to the issues outlined above, which are summarized below and further addressed throughout this protocol.

Managing the service access needs and quality of care for DYS youth can best be accomplished at a local or regional level. The following chain of communication should be followed throughout the processes delineated in this protocol. Please refer to Attachment A for contact lists.

- Whenever concerns arise, the DYS regional clinical coordinator (or designee) should first contact the MBHP network provider involved, and both should make every effort to resolve any issues.
- If the DYS regional clinical coordinator needs further assistance, they should contact the MBHP provider quality managers (PQMs) with any clinical issues relating to accessing behavioral health services. If the DYS regional office needs further assistance, or for more complicated systemic access issues, the DYS regional director should contact the MBHP provider quality regional director.
- If these issues cannot be resolved at the regional level, the DYS director of Clinical Services will contact the MBHP senior Provider Quality or Clinical Management staff.

Crisis prevention, crisis intervention, assessment, and disposition planning should also be coordinated on a local or regional level. It should involve the director of the local ESP/MCI (or designee), the DYS regional clinical coordinator (or designee), and the MBHP provider quality manager assigned to the identified local ESP/MCI. If assistance is needed from MBHP during the weekend or after 5 p.m., the ESP/MCI or DYS may contact the Northeast Access Line, which may contact the administrator on call (AOC) if needed.

Efforts should be made to **avoid potential problems** by anticipating them through risk management safety planning and related communication. However, there will inevitably be communication problems, differences in perception, and procedural issues that may arise. These issues should also be addressed at the local/regional level whenever possible.

Procedures

Crisis Intervention and Management Strategies

Safety Plan: In the Children's Behavioral Health Initiative (CBHI), there are a set of [Crisis Planning Tools](#) that include the Safety Plan and the advance Communication to Treatment Providers form. For any youth in advance of a behavioral health crisis, a Safety Plan can be utilized for the purpose of avoiding, or intervening more effectively. DYS coordinates with the local ESP/MCI provider, the youth, the youth's parent/guardian/caregiver, and any existing services providers as indicated, to develop or update the Safety Plan. The parent/guardian/caregiver also has the option of completing the Advance Communication to Treatment Provider form.

To avoid multiple admissions to different hospitals, a primary hospital provider should be identified in the Member's MBHP Risk Management Safety Plan. Identifying a primary



hospital provider does not preclude a Member from being admitted to another appropriate hospital provider if the primary facility is not available.

DYS “Alert” to the ESP/MCI provider: For youths in the custody of DYS who may be at risk or have specifically been placed on “watch status” as defined by the DYS Suicide Prevention Policy or other applicable policies, when appropriate, contact is made with the local ESP/MCI team by the DYS program’s clinical director, regional clinical coordinator, or designee. The purpose of this communication is to identify youths who may require an ESP Mobile Crisis Intervention at a later time. The following elements frame the communication:

- A description of the precipitant and current behavioral management strategy
- A list of interventions considered (e.g., medication, use of a special DYS staff relationship) that might defuse the situation
- A description of the program, staff, or other resources that have been identified to manage the situation

Upon receipt of the DYS Alert, the local ESP/MCI and DYS will review any existing Safety Plan and determine what the next steps will be, based on that plan.

Three-Way Consultation: For some complex situations, a three-way consultation may be set up between DYS, the local ESP/MCI, and MBHP. The purpose of a three-way consultation is to review the ESP/MCI assessment and disposition, ensure that the ESP/MCI has all pertinent information, develop a strategic bed search, and determine if specific resources are needed. A three-way consultation may be initiated by any of the three entities once the initial ESP/MCI assessment has been completed.

Throughout the crisis intervention and management process, MBHP and DYS staff should communicate according to the chain of communication outlined in the Communication section above.

Interventions

For those DYS youths in residential programs who are experiencing a behavioral health crisis (i.e., are at risk to self or others), a master’s-level DYS program clinician (or designee) will contact the local ESP/MCI and discuss the situation. If needed, a mobile crisis intervention will then be arranged within one hour of the initial phone call or within another agreed-upon timeframe. Due to security and safety concerns, the preferred location for the evaluation is at the DYS facility.

- **DYS should provide all pertinent clinical information**, including prescription medications, treatment history, psychosocial history, and current providers. When appropriate, DYS should also provide a list of criminal charges.
- **If at any time DYS has concerns about the response from an ESP**, such as response time, response to multiple concurrent assessments, and/or quality of care, the ESP director should be contacted. If this contact does not resolve the issue, DYS may contact the MBHP ESP provider quality manager (PQM) or ESP director.

Accessing Care

For **interventions taking place in the emergency department (ED)** of a hospital:



- DYS staff will make appropriate staffing arrangements in order to facilitate a timely intervention.

At the conclusion of the intervention process, ESP/MCIs and MBHP staff will use **medical necessity criteria** to determine the disposition of those youths.

If a youth is evaluated by the ESP/MCI and found to meet the criteria for inpatient acute care, a hospital bed is identified by the ESP/MCI team.

If a bed search has been exhausted (i.e., the ESP/MCI has called every applicable network facility and a bed has not been secured), the ESP/MCI Team will call the DYS program director about the current status of the bed search and plan. In addition, the ESP/MCI will call the Northeast Access Line to report the exhausted bed search. The Northeast Access Line will alert MBHP for assistance.

- DYS, in collaboration with the ESP, ED staff, and MBHP, will make a determination as to where and how a youth will be maintained in safety and security until a bed is located and transport arranged. All parties agree to remain actively engaged in the case until resolution is reached.
- If the DYS regional directors or regional clinical coordinators have concerns about this process, the MBHP ESP provider quality manager (PQM) or ESP director will be contacted (i.e., between 8 a.m. and 5 p.m.), or the Northeast Access Line after business hours.

Care Management

The MBHP Integrated Care Management Program (ICMP) and Enhanced Care Coordination (ECC) are available to DYS youth.

Internal Member Appeals and Board of Hearing Appeals

Definitions

Adverse action - Any one of the following actions or inactions by MBHP:

1. The failure to provide MCO covered services in a timely manner in accordance with the accessibility standards established by MBHP;
2. The denial or limited authorization of a requested service, including the determination that a requested service is not an MCO covered service;
3. The reduction, suspension, or termination or a previous authorization by MBHP for a service;
4. The denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including but not limited to denials based on the following:
 - a. Failure to follow prior authorization procedures
 - b. Failure to follow referral rules
 - c. Failure to file a timely claim
5. The failure to act within the timeframes for making authorization decisions; and



6. The failure to act within the timeframes for reviewing an Internal Member Appeal and issuing a decision.

Appeal representative - Any individual who MBHP can document has been authorized by the Member in writing to act on the Member's behalf with respect to all aspects of an Internal Member Appeal or Board of Hearing (BOH) Appeal. MBHP must allow a Member to give a standing authorization to an appeal representative to act on their behalf for all Internal Member Appeals. Such standing authorization must be done in writing according to MBHP's procedures and may be revoked by the Member 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/guardian.

Board of Hearings (BOH) - The BOH is within the Executive Office of Health and Human Services' Office of Medicaid.

BOH appeal - A written request to the BOH made by a Member or appeal representative to review the correctness of a Final Internal Member Appeal decision by MBHP

Continuing services - MCO covered services that were previously authorized by MBHP and are the subject of an Internal Member Appeal or BOH Appeal, if applicable, involving a decision by MBHP to terminate, suspend, or reduce the previous authorization, and which are provided by MBHP pending the resolution of the Internal Member Appeal or BOH Appeal, if applicable

Internal Expedited Member Appeal - A request by a Member or the Member's Appeal Representative made to MBHP for review of an adverse action concerning admission or continued stay for urgent services; or for when a delay in decision-making might seriously jeopardize the life or health of the Member

Internal Member Appeal - A request by a Member or the Member's appeal representative made to MBHP for review of an adverse action

Member - A person or enrollee determined by EOHHS to be eligible for MassHealth

General Policies

MBHP will provide a written Notice of Adverse Action to Members (with a carbon copy to providers) following the determination of an adverse action.

This Notice of Adverse Action will detail appeal rights and instructions on how to request an Internal Member Appeal.

All notices pertaining to adverse actions, internal Member appeals, and BOH appeals must be made available to the Member in their requested language. Notices must be written in a manner, format, and language that is easily understood by a Member, including written at no higher than a sixth-grade level. Notices must also be available in a format that takes into consideration the special needs of those Members who are visually limited or have limited reading proficiency.



Members or their appeal representatives have the right to request Internal Member Appeals either orally or in writing within 60 calendar days of the date on the Notice of Adverse Action. If a Member submits an appeal more than 60 days after the date on the Notice of Adverse Action, MBHP may dismiss the appeal.

MBHP shall ensure that individuals who make decisions on Internal Member Appeals are non-subordinate reviewers who were not involved in any previous level of review or decision-making.

Members must exhaust MBHP's Internal Member Appeal process before filing an appeal with MassHealth's BOH. MBHP shall provide reasonable assistance to Members in completing both Internal Member Appeals and BOH Appeal-related forms and following Internal Member Appeal and BOH Appeal-related procedures including, but not limited to, providing interpreter services and TTY/TDD telephone capability.

When an adverse action is overturned through the Internal Member Appeal or BOH appeal process, MBHP will authorize the appealed services as promptly as required by the Member's condition. If the services are continuing services, MBHP shall pay for those services provided during the Internal Member Appeal and/or BOH Appeal.

MBHP shall not take punitive action against providers who request an expedited internal Member appeal or support a Member's internal Member appeal or BOH appeal.

If MBHP fails to resolve an internal Member appeal within the appropriate timeframes, Members have the right to appeal directly to the BOH.

Information gathered during the internal Member appeal process will be utilized to inform required network and quality improvements, including discussing specific internal Member appeals with providers, as appropriate.

Member Rights Concerning the Internal Appeal Process

Members have the right to:

- Designate an appeal representative
- Present evidence and allegations of act or law, either verbally or in writing. In the case of an expedited internal Member appeal, MBHP shall notify the Member of the limited time availability for this opportunity.
- Before and during the internal Member appeal process, review their case file, including medical records, and any other documentation considered during the internal Member appeal process
- Be included in the internal Member appeal process and to have their appeal representative or the legal representative of a deceased Member's estate participate in the process

Appeal Representatives

Members have the right to designate, in writing, an appeal representative. The notice must



indicate the name of the appeal representative and must be signed and dated by the Member; no specific format is required. MBHP will work to resolve the internal Member appeal pending receipt of such notice from a Member.

Time Limits for MBHP to Resolve Internal Member Appeals

Internal Expedited Member Appeals

For Members receiving urgent levels of care, the internal Member appeal will be expedited and completed within three calendar days following MBHP's receipt of the appeal. This timeframe can be extended for up to 14 calendar days.

Standard Internal Member Appeals

Level I

For non-urgent levels of care, the internal Member appeal is standard, and the Level I appeal will be completed within 30 calendar days following MBHP's receipt of the appeal. This timeframe can be extended for up to five calendar days.

Level II

Level II appeals (if applicable) will be completed within 10 calendar days following MBHP's receipt of the appeal. This timeframe can be extended for up to five calendar days.

Members or their appeal representatives may waive their right for a Level II internal Member appeal and appeal to the BOH.

Extensions to these timeframes may be allowed only under the following circumstances:

1. The Member or their appeal representative requests the extension; or
2. MBHP believes that there is a need for additional information *and* that the extension is in the Member's best interest *and* MBHP can justify the extension to EOHHS upon request. If MBHP chooses to implement an extension, it shall notify the Member in writing of the reason for the extension and inform the Member of their right to file a grievance should they disagree with that decision.

MBHP's failure to resolve an internal Member appeal within these timeframes is considered an adverse action, and Members can immediately request an appeal with MassHealth's BOH.

The Provision of Continuing Services While an Internal Member Appeal Is Pending

If the subject of the internal Member appeal involves the reduction, suspension, or termination of a previously authorized service and the request for the internal Member appeal is received by MBHP within 10 calendar days of the date on the Notice of Adverse Action, MBHP shall ensure that the Member receives continuing services while an internal Member appeal is pending unless the Member indicates they do not want to receive such services or the Member withdraws the internal Member appeal.



The Provision of Continuing Services While a BOH Appeal Is Pending

If the subject of the BOH appeal involves the reduction, suspension, or termination of a previously authorized service, and the request for the BOH appeal is within 10 calendar days of the date on the internal Member appeal notice by MBHP, MBHP shall ensure that the Member receives continuing services while the BOH appeal is pending unless the Member indicates they do not want to receive such services or the Member withdraws the BOH appeal.

Procedure for Filing Internal Member Appeals

A Member or their appeal representative can request an internal appeal by calling the Northeast Access Line at **1-800-495-0086** (press 1 for English or 2 for Spanish, then option 4, then option 2), or by writing to the following address:

MBHP
Member Appeals Coordinator
1000 Washington Street, Suite 310
Boston, MA 02118-5002

Procedures for Filing a Board of Hearing Appeal

A Member or their appeal representative may request a fair hearing before MassHealth's BOH only after they have exhausted MBHP's internal Member appeal process. For any internal Member appeal that is resolved not wholly in favor of the Member, MBHP will provide the Member or their appeal representative an internal Member appeal determination notice and a copy of this notice along with MassHealth's "Fair Hearing Request" form.

The "Fair Hearing Request" form and the copy of MBHP's internal Member appeal determination notice should be mailed to the following address:

Board of Hearings
Office of Medicaid
100 Hancock Street, 6th Floor
Quincy, MA 02171

The Member or their appeal representative may fax the "Fair Hearing Request" form and the copy of MBHP's internal Member appeal determination notice to the BOH at **(617) 847-1204**. The Member or their appeal representative may request that MBHP assist with facilitating this process by calling MBHP's Member appeals coordinator at **1-800-495-0086** (press 1 for English or 2 for Spanish, then option 2).

Primary Care Clinician (PCC) Plan Integrated Care Management Program (ICMP)

The ICMP is designed to support medical and behavioral healthcare providers by providing services to Members to better manage their complex conditions and improve their health. It is staffed with behavioral healthcare managers who are independently licensed clinicians or registered nurses. The ICMP is a voluntary service provided to eligible Members of all ages who



have complex health conditions.

Member Eligibility and Identification

PCC Plan Members are identified and stratified into care management risk levels using historical claims data and clinical information. Members may be referred from primary care practices, behavioral health practices, other community agencies, and they may self-refer.

How it Works

Once Members are identified as eligible for the program, the ICMP team reaches out to the Member telephonically and conducts an assessment with the Member. (Assessments may also be conducted face-to-face in the Member's home, or other community location, if appropriate and clinically indicated). The assessment identifies strengths and barriers that impact the Member's health. The ICMP team uses state-of-the-art information systems for providing educational materials, support, and monitoring for Members between visits with their providers. The program follows current nationally recognized, evidence-based clinical guidelines. Monitoring may involve telephonic or face-to-face visits in the community, based on Member preference. The integrated care manager (ICM) coaches Members on understanding their conditions and adhering to treatment plans and lifestyle modifications. The ICM helps to reinforce the PCC treatment plans and recommendations, if available. ICMs will also coordinate services among different providers and agencies as well as assist Members to overcome any barriers to their ongoing care.

For any Member enrolled in ICMP, the program communicates with PCCs upon enrollment in ICMP and ongoing to coordinate care. Additionally, ICMP staff will also outreach providers as needed for urgent or emergent situations.

Referrals and Information

To refer Members (children, youth, and adults), to request a copy of the clinical guidelines the program follows, or to learn more about this program please contact the ICMP at 1-800-495-0086, Ext. 706870 or go to www.masspartnership.com for our [online referral form](#) and additional information about the program.

Enhanced Care Coordination (ECC)

For MBHP Members who are not in the PCC Plan but are in need of care coordination, we have developed the ECC program. ECC provides supportive services for Members who are having difficulty transitioning from hospitalization to community-based services. The care coordination program reviews the care Members are currently receiving to ensure that it is the most appropriate and coordinates treatment services to support their recovery. Care coordination also monitors the provision of the Member's medical care. This includes ensuring treatment compliance with any chronic conditions and developing a crisis prevention plan with the Member to reduce further hospitalizations.



MBHP Clinical Operations Forms

- [Psychological Evaluation Request \(PER\) form](#)
- [Integrated Care Management Program Referral form](#)

MBHP Clinical Operations Appendices

- Attachment A: [Medical Necessity Criteria](#)
- Attachment B: [DYS Discharge Planning Protocols](#)

Appendix B.

DYS Discharge Planning Protocols

A. Discharge Procedures

1. Discharge procedures are the same for committed and detained youth.

B. Preparing for Discharge

1. Youth who have benefited from treatment and are ready for discharge should be discharged in a timely fashion.
2. When the youth no longer needs hospital level of care, the hospital should contact the DYS regional clinical coordinator or designee.
3. Assessment of readiness for discharge needs to be in the context of the environment to which the youth is returning to in addition to the context of the hospital milieu. For youth who are returning to a DYS facility, the youth needs to be functioning at a level at which they can be safe and function in a DYS program, including attending school six hours per day, participating in clinical individual and group treatment, etc.
4. As with all individuals, DYS youth should be discharged when they are safe, with minimal support, i.e., not on 1:1, etc. If the youth needs more than minimal support, an alternative discharge plan needs to be made.

C. Disagreement about Readiness for Discharge

1. **At any time during the discharge process, DYS may disagree regarding the readiness for a DYS youth to be discharged.**
2. If the DYS regional clinical coordinator (or designee) believes that resources to meet the youth's needs are not available at a DYS facility, then they must contact the DYS director of Clinical Services (or the DYS assistant commissioner for Program Services, if the DYS director of Clinical Services is not available).
3. The DYS director of Clinical Services will contact the MBHP provider quality regional director to discuss the youth and jointly decide a plan of action. The existing protocol for Administratively Necessary Days will be utilized while a disposition plan is being addressed.

D. Aftercare Planning Including Medications

1. **An aftercare plan, as well as a written letter from the hospital psychiatrist stating that the youth has reached a level of stabilization that no longer requires ongoing hospitalization for psychiatric reasons and can be safely managed in the community or the setting for which the youth is returning,** is provided to the DYS regional clinical coordinator (designee) by fax or in person prior to the youth leaving the hospital.
 - a. The aftercare plan includes a written record of any new or significant medication changes made during the hospitalization.
 - b. The written record will outline how the provider received the guardian's permission for medication changes (i.e., "parent/guardian gave verbal permission to Dr. Smith for dosage increase of Prozac on 1/5/12").
 - i. If the hospital is unable to reach the parent/guardian, the DYS regional clinical coordinator should be contacted prior to discharge.

2. The hospital is responsible for providing a prescription (not the actual medications) for at least 14 days for any and all current medications prescribed for the youth during the inpatient stay.
 - a. Paper prescriptions should be provided to the DYS staff who picks up the youth upon discharge or phoned into the designated pharmacy for which DYS will provide a phone # if requested prior to discharge. DYS cannot provide PRN medication to DYS youth.
 - b. As referenced in the MBHP Inpatient performance specifications, providers will keep abreast of state agency regulations regarding the provision of certain medications and provide appropriate documentation to DYS.
3. DYS does not have the ability to accommodate a Rogers Order if it has been obtained during the course of the hospitalization.
4. The aftercare plan must be discussed with the DYS regional clinical coordinator (or their designee) prior to the discharge-planning meeting at the hospital.
 - a. The hospital should first attempt to reach the DYS regional clinical coordinator and then the DYS regional director.
 - b. If the hospital is unable to reach the DYS regional clinical coordinator or the DYS regional director within 24 hours of the call to discuss discharge, hospital staff should call the CIC at (617) 960-3333. CIC staff will ensure appropriate follow up from a senior manager at DYS.

E. Discharge Day

1. Hospitals should inform DYS in advance of discharge
 - a. if a youth was chemically restrained on the day of discharge; or
 - b. if a youth made suicidal threats on the day of discharge.
2. To avoid possible aggressive behavior or other difficulties at time of discharge, it is recommended that the hospital inform the youth of their discharge date once it is determined and not at the time of discharge.

F. Transportation

1. DYS plans transportation a day in advance and not on the weekends. As such, they require at least 24-hour advanced notification regarding discharges.
2. DYS requires a letter from the hospital noting **that the youth has reached a level of stabilization that no longer requires ongoing hospitalization for psychiatric reasons and can be safely managed in the community or the setting for which the youth is returning.** The DYS transportation staff cannot transport youth without that letter. The letter needs to include verification that the hospital obtained consent for all the medications they are prescribing at discharge. The letter should be signed by the hospital psychiatrist and faxed to the DYS program from which the youth was admitted either the day before or the day of discharge.
3. Discharge instructions and prescriptions should also be given by the hospital to the driver.
4. Typically it is the drivers who pick up the youth, not case managers or clinical or program staff. As such, communication between the hospital and clinical or program DYS staff should be done in advance by phone or in person.

G. Inpatient Provider Responsibilities

1. For all youth under the age of 21, the provider will ensure a smooth transition for the return to home or discharge location by
 - a. linking to necessary services and making appropriate referrals, including CBHI services, if indicated;
 - b. documenting all efforts related to these activities, including DYS, the Member's, and the families/guardian/caregivers' active participation in discharge planning;
 - c. reviewing and updating the safety plan in collaboration with the youth, family, and ICC provider if enrolled in ICC, and if indicated with the youth's ESP/MCI provider, sending a copy to those providers with consent; and
 - d. if the youth is being discharged to the community, the parent/guardian should be educated regarding use of the ESP/MCI service if needed in the future, including access to their community-based services.

H. DYS Responsibilities

1. **DYS is encouraged to consult with the discharging hospital** about how DYS can continue effective strategies employed by the inpatient provider during the admission.
 - a. This may occur at a discharge planning meeting.
 - b. There is also an opportunity at time of discharge if the youth is transported by clinical or program staff, but this is not typical, as noted above.
 - c. DYS should discuss with the hospital if they would like the facility to be the designated facility for any future hospitalizations. Upon agreement, DYS should inform the ESP/MCI team about the preferred facility so it can be documented accordingly within the safety plan or Advance Communication to Treatment Provider. Alternatively, a discussion should occur if either party feels there is a clinical reason to preclude a readmission to that facility.



Administrative Operations

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Administrative Operations Overview

In the Administrative Operations Section of this manual, you will find information regarding Member eligibility, claims policies and procedures, instructions on how to submit a claim, and information regarding Member appeals.

To ensure that you have the most up-to-date information, MBHP will notify providers about any changes in its policies via *Provider Alerts* and Beacon/MBHP Broadcasts. It is important to note that the Provider Manual and all MBHP *Provider Alerts* and Beacon/MBHP Broadcasts are considered part of the Provider Agreement and, as such, requires providers to adhere to all changes outlined in them.

Please refer to the information in the Administrative Section of this manual if you have any claims-related questions. For additional assistance, please contact the MBHP Community Relations Department at **1-800-495-0086 (press 1 for the English menu, then press 3, then 1 to skip prompts.)**

Important Resources

Providers are required to utilize available resources to submit correct claims in a timely manner, track the status of claims, work on their claim denials and accounts receivables, and stay current on any changes to billing requirements.

These resources include:

- The MBHP website, found at www.masspartnership.com;
- The MBHP Welcome Packet and Fee Schedule that providers receive when they join our network. The fee schedule will list what services providers are contracted for and their payment rates;
- The MBHP Benefit Service Grid, which explains what billing codes, modifiers, place-of-service codes, etc., are acceptable to bill for which services, as well as whether a service requires an authorization or registration and what resource to use to obtain that authorization or registration; and
- ProviderConnect, our easy-to-use online application that providers can use to submit claims, track and edit claim submissions (whether claims were submitted through ProviderConnect, through clearinghouses, direct EDI, or by paper), obtain their weekly Provider Summary Vouchers (Remittance Advices), etc.

How to Get a Claim Paid

MBHP appreciates the valuable service that our providers perform for our Members, so we strive to pay all appropriate claims as quickly and accurately as possible. This section is set up to help you get your claims paid as quickly and accurately as possible.



Verifying an MBHP Member's Eligibility

To be eligible for reimbursement for MBHP services, providers **must** verify the Member's eligibility and participation in MBHP through the Eligibility Verification System (EVS) on the day that the service is provided and for each date of service. This verification is solely for eligibility and is not a guarantee of payment.

MBHP recommends that providers check for possible MassHealth and/or MBHP eligibility for each individual who seeks care. An individual may have applied for MassHealth previously and may not be aware that their coverage was approved. Verifying the available coverage affords a provider the opportunity to complete all necessary MBHP authorization procedures and prevents unnecessary claim denials.

Emergency Services Program (ESP) providers are also responsible for verifying Member eligibility and should continue to use EVS for eligibility information.

For more information on checking a Member's eligibility, please visit MassHealth's website at www.mass.gov/MassHealth.

Submitting a Complete and Accurate Claim Form

Faxing to 1-877-334-9615 is the preferred method of submission.

Claims Mailing Address:

MBHP Claims
P.O. Box 55871
Boston, MA 02118-5002

The second step in getting a claim paid is to submit a complete and accurate claim. Please refer to our Online Benefit Service Grid at www.masspartnership.com.

Click [here](#) for information on submitting electronic claims.

Service Facility Address Required on All Claims

All paper and electronic claims must have the Service Facility Address completed with the appropriate MBHP-contracted site for that particular service for all Places of Service.

A Member's home address or the address of a school should not be listed as the Service Facility Address. For Places of Service 12 (Home) and 03 (School), please use the contracted facility address where the provider of the service normally provides the service when not at a Member's home or school.

Claims without a contracted MBHP facility address in the appropriate place on the form risk being unnecessarily suspended and/or denied. The information below is provided to help providers understand how to submit the Service Facility Address on their claims to MBHP.



Electronic claims

The Service Facility Address should be in Loop 2310D for 837P (Professional) claims and in Loop 2310E for 837I (Institutional) claims.

Paper claims

- **On the CMS-1500**
 - The Service Facility Address should be Box 32.
- **On the UB-04 (CMS 1450)**
 - The Service Facility Address should be in FL01.

Third-Party Liability (TPL) Claims

The provider must submit documentation confirming that they have indeed exhausted all the levels of appeal with the primary insurance carrier. Valid documentation is defined as a letter or Summary Voucher from the primary insurer stating that all levels of appeals have been exhausted.

MBHP will deny claims unless this supporting documentation is provided along with the original denied EOB.

To determine if a service requires an EOB or not, please refer to the MBHP Benefit Services Grid located at www.masspartnership.com. Column “O” will let you know if an EOB is required.

Providers must exhaust all avenues of other insurance coverage and payment prior to billing MBHP. If a Member indicates that they are covered by a third-party insurer and EVS indicates they are enrolled in MBHP, it is the provider's responsibility to obtain reimbursement from the third-party insurer and notify MBHP of the active third-party coverage by completing the Third-Party Liability form located in the forms section of this Provider Manual.

Faxing to 1-877-334-9615 is the preferred method of submission.

Please mail this form to:

MBHP-TPL Unit
P. O. Box 55871
Boston, MA 02118-5002

If there is a possibility that the provider will not receive complete reimbursement from the third-party insurer, it is the provider's responsibility to follow MBHP's Service Authorization procedures outlined in the Clinical section of this Provider Manual to obtain an authorization for any service that requires one.

Providers must bill the third-party insurer prior to billing MBHP. When the provider receives the Explanation of Benefits (EOB) from the third-party insurer, they must send a copy of it along with their claim to MBHP. Claims involving TPL must be submitted within 90 days of the date on the third-party insurer's EOB, including MassHealth EOBs. EOBs reflecting a timely filing denial from the third-party insurer or MassHealth will also be denied for timely filing by MBHP.

All claims have specific time frames in which they have to be submitted to MBHP for payment.



Time limits for filing claims

Outpatient Covered Service and ESP claims must be submitted within 90 days of the date of service to be considered for reimbursement; all claims submitted after 90 days will be denied.

Inpatient and Diversionary Covered Service claims must be submitted within 90 days of the discharge date to be considered for reimbursement; all claims submitted after 90 days will be denied. Interim billing on MBHP Inpatient and Diversionary Covered Service claims is allowed, but the claims must be submitted within 90 days from the last date billed on the claim.

The claim must be physically or electronically delivered to MBHP by the close of business on day 90, **NOT** just postmarked by day 90.

Timely filing waiver process

MBHP has determined that the following reasons justify a waiver of the 90-day time limit for claims submissions. Other reasons may be considered on a case-by-case basis.

Timely Filing Waivers must be received within 180 days of the original denial date.

Retroactive Member eligibility:

If MassHealth enrolls a Member with MBHP on a retroactive basis, the Timely Filing Waiver Unit will approve waiver requests submitted within 90 days of the EVS change. Please be advised that retroactive MassHealth eligibility does not generally indicate retroactive MBHP eligibility. Due to MassHealth eligibility restrictions, if a Member is retroactively enrolled in MassHealth and receives MBHP, the Member's MBHP effective date is usually the day that the enrollment information is changed in EVS.

Retroactive clinical authorization for service:

If MBHP's Clinical Department authorizes service on a retroactive basis, the Timely Filing Waiver Unit will approve waiver requests submitted within 90 days of the approval date. A copy of the approval letter must accompany the waiver request. To apply for a Timely Filing Waiver, the provider must complete a Timely Filing Waiver form, found in the Forms area of this section, for each original claim being submitted. Claims may be grouped together by reason, and only one form must be submitted.

All the Timely Filing Waiver Request form items listed below are required. Incomplete forms will be returned.

Provider name: Enter the name of the provider who rendered the service and is seeking reimbursement.

Provider number: Enter the provider's Medicaid number.

Provider address: Enter the address of the provider seeking reimbursement.

Member name: Enter the Member's name as it appears on the MassHealth card or claim form. One waiver form can be submitted for multiple Members if the waiver request has the same reason for all claims entered in field #8. In this instance, "multiple" should be entered in the Member Name field.



Member number: Enter the ID number as it appears on the MassHealth card or claim form. One waiver form can be submitted for multiple Members if the waiver request has the same reason for all claims entered in field #8. In this instance, “multiple” should be entered in the Member Number field.

Date of service: Enter the date(s) of service. One waiver form can be submitted for multiple dates of service if the waiver request has the same reason for all claims entered in field #8. In this instance, “multiple” should be entered in the Date of Service field.

Original claim number: Enter the claim’s original claim number found on the Summary Voucher. In addition, indicate whether the original claim was timely filed by placing an “X” in the “Yes” or “No” box. One waiver form can be submitted for multiple claims if the waiver request has the same reason for all claims entered in field #8. In this instance, “multiple” should be entered in the Original Claim Number field.

Reason: Place an “X” on the line that best describes the reason for requesting the timeliness waiver.

Signature: The waiver request cannot be processed without a typed, signed, stamped, or computer-generated signature. MBHP will not accept “SIGNATURE ON FILE” as an acceptable provider signature.

Date: Indicate the date that the form is completed.

Send the completed Timely Filing Waiver form and completed claim forms along with any supporting documentation to justify the waiver of the 90-day time.

Faxing to 1-877-334-9615 is the preferred method of submission.

Or mail to:

MBHP -Timely Filing Waiver Unit
P. O. Box 55871
Boston, MA 02118-5002

All Timely Filing Waiver Requests will be reviewed to determine the appropriateness of the request. The waiver request will either be approved or denied. The approval of a waiver request does not exempt claims from standard claim processing rules and edits. After approval of a waiver request, a claim can still be denied for reasons unrelated to the actual waiver request.

All Timely Filing Waiver Requests will appear on a future Summary Voucher as either a paid or denied claim. Any approved waiver requests will appear accompanied by an EOB code that states “Timeliness Waiver Request Approved.” Any denied waiver requests will be accompanied by an EOB code that states “Timeliness Waiver Request Denied.”

Resubmission of denied claims

Claims that have been denied due to incorrect or incomplete required data elements may be resubmitted with the appropriate information, but must be resubmitted for payment consideration within 90 days from the date of denial by MBHP.



Corrected claims may be resubmitted either on paper or electronically using the Original Claim Number from the original claim located on the Provider's Summary Voucher. The Original Claim Number needs to be on the resubmitted claim in fields:

**FL 64 on the UB-04 (CMS-1450)
Item 22 on the CMS-1500**

Electronic submitters should place this information in the corresponding fields on the electronic claim formats. Failure to put in the Original Claim Number on the paper or electronic claim will result in the claim being denied.

Resubmitted claims received after 90 days from the date of the EOB will be denied. The claim must be physically or electronically delivered to MBHP by the close of business on day 90, **NOT** postmarked by day 90.

Adjusting incorrectly paid claims

Claims requiring reconsideration of incorrect payment amounts, **excluding denials**, must be resubmitted to MBHP on an Adjustment/Reversal Request form within 180 days from the date of service to be considered for adjustment. Denied claims should follow the Resubmission of Denied Claims process previously described. Electronic submissions of the Adjustment/Reversal Request form will not be accepted. The Adjustment/Reversal form can be found in the forms area of this section. One form should be completed for each original claim being adjusted. If multiple claims are being adjusted for the same reason, one Adjustment/Reversal form can be completed for the group of claims. Each claim must still be accompanied by any required documentation. All items on the form are required.

Instructions for completing the Adjustment/Reversal form are:

Provider information: Enter the name, number, and address of the provider to whom the payment was made.

Member information: Enter the Member's name and number as it appears on the Summary Voucher.

Claim information: Enter the claim number and date as listed on the Summary Voucher.

Reason for adjustment: Place an "X" on the line that best describes the reason for requesting the adjustment/reversal and enter the required information. If "Other, Please Explain" is marked, describe the reason for the adjustment/reversal request.

Provider signature and date: An Adjustment/Reversal request cannot be processed without a typed, signed, stamped, or computer-generated signature and the date that the form was completed.

A copy of the corrected claim form and a copy of the Summary Remittance Voucher page on which the original claim appears must be included with the Adjustment/Reversal form. It is not necessary to attach a refund check to the Adjustment/Reversal form. Any reduction or increase in payment will be applied to the weekly payment cycle following processing. The adjustments/reversals will appear as negative claim amounts regardless of whether a refund check is submitted. If submitted, the refund check will appear as an applied amount at the end of the Summary Remittance Voucher detailing the



claims that were adjusted/reversed. The check number of the provider's refund check will appear as the transaction reference number on an MBHP Summary Remittance Voucher.

Please mail completed forms and claims to:

MBHP
Attn. Adjustments/Reversals
P. O. Box 55871
Boston, MA 02118-5002

Claim review process

Prior to submitting a Claim Review Form, the provider may choose to contact MBHP's Community Relations Department at 1-800-495-0086 to rectify the issue; if the issue cannot be resolved by the Community Relations representative, a claim review may be necessary. A claim review is a review of a denied claim or a payment dispute. Therefore, a claim review must be preceded by a claim submission.

Requests for a claim review concerning retroactive Member eligibility and retroactive clinical authorization for service should only be submitted after completion of the Timely Filing Waiver Process.

Providers must submit a Claim Review Form to MBHP and a formal letter explaining the rationale for the request in order to initiate the claim review process. For a claim review involving a clinical level of care issue, a copy of the entire medical record may be required. If the claim review concerns a claim or claims that have not met the original timely filing requirement, you must also complete the section detailing the reason that the claim was not submitted within the required filing time.

Some examples of supporting documentation that may help in getting the claim review approved should accompany the Claim Review Form and formal letter. Such supporting documentation may include:

- EOB from primary insurance carrier;
- Time-stamped faxes or copies of authorizations;
- Printouts from EVS; and/or
- Monthly EDS Summary Reports indicating eligibility checks performed during the month in question

Faxing to 1-877-334-9615 is the preferred method of submission.

This information should be mailed to:

MBHP
Claim Review Coordinator
P. O. Box 55871
Boston, MA 02205-5871

The claim review must be received by MBHP within 180 days from the date of service or date of discharge on the claim. Any claim review received after 180 days will be returned with a letter of denial, and MBHP's Claim Review Committee will take no further action.



MBHP's Claim Review Committee may request additional information before rendering a decision. The provider will be notified in writing of the final decision. As set forth in the Provider Agreement, the provider shall have no recourse against the MassHealth Behavioral Health Program for a decision made by MBHP.

Specific outpatient instructions:

- Providers must submit a separate claim for each treating practitioner.
- A provider may render two separate and distinct outpatient services to the same recipient on the same day when clinically necessary. Providers may render the same service to the same recipient on the same day only in exceptional cases when it is clinically necessary and pre-authorized by MBHP. Deviation from these guidelines must be clinically necessary and pre-authorized by MBHP.

MBHP Administrative Operations Forms

- [Claim Review form](#): used for Adjustment Reversals, Timely Filing Waiver, and Retroactive Authorization Requests
- [Claim Review-Additional Members form](#)
- [Website Registration form](#)

MBHP Administrative Operations Appendix

- [Benefit Service Grid](#)

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Quality Management

The Behavioral Health Quality Management Program

A major internal operating principle for MBHP is that “quality is everyone’s job.” All employees receive training annually on principles of quality management and are expected to apply these principles to their day-to-day responsibilities. As such, the Quality Management (QM) Program applies to each department and all operations. The QM Department is one component of this broader QM Program, and a primary role of the QM Department is to provide support and technical assistance in quality management internally to staff and externally to the provider community and other stakeholders.

The QM Program includes the following basic tenets:

- Quality improvement should be a part of each employee’s day-to-day work.
- People closest to a quality problem are the most knowledgeable in terms of finding a solution to the identified problem.
- Education, training, and retraining are critical to quality and facilitate improvements in job performance.
- Accessible, reliable, and current data are vital to identifying system strengths and opportunities for improvement.
- Poor quality is costly in both human and financial terms.
- Inefficient or substandard service frequently stems from faulty processes and systems, rather than individual performance.
- Systematic monitoring, evaluation, feedback, and training concerning internal and external processes can resolve quality concerns and improve services.

The behavioral health quality management process is structured to:

- Delineate thresholds and benchmarks for key processes;
- Clearly delegate leaders and processes that will lead to process improvements;
- Implement corrective action plans and procedures for monitoring process improvements; and
- Monitor the corrective action to ensure that the process modifications continue to enhance performance.

This philosophy necessitates an ongoing process that spans every aspect of program operations and unites Members, families, Member advocates, providers, and other stakeholders in a continuously repeating cycle of quality planning, action, and evaluation.

The cycle of behavioral health quality improvement includes, but is not limited to:

- Data collected from monitoring mechanisms is carefully examined. These mechanisms include routine reports, health record audits, and ad hoc analyses.
- As data and experience indicate a need for quality improvement, project teams are formed.
- These teams assess the process to be improved and identify root causes of the problem.



- The team proposes solutions with stakeholder input and management review.
- From this input, the team develops a work plan.
- The team collects indicator data and evaluates the results of the interventions.
- Based on this evaluation, the work plan is revised.

Employees and network providers are responsible for maintaining quality in all aspects of service and project management. Therefore, MBHP is committed to providing training to ensure the success of the quality improvement process and to creating a quality culture throughout the provider network.

MBHP Quality Management Work Plan

Annually, MBHP develops a QM work plan addressing the quality and safety of clinical care and the quality of service. The QM work plan includes QM goals and objectives, areas of focus, and identifies specific QM-related activities scheduled for the upcoming year. Scheduled activities include identifying the target date for completion and responsible party as well as the tracking of previously identified issues and planned evaluation of the QM Program.

Annual evaluation of the MBHP Quality Management Work Plan

The QM work plan is reviewed and evaluated annually. The evaluation consists of a comprehensive summary of the accomplishment of objectives, committee activity, quality improvement activities, and indicators. The evaluation assesses the effectiveness in improving quality of care and service delivered by MBHP.

Role of Providers in the Behavioral Health Quality Management Program

MBHP shares information about the QM Program as well as the results of its program evaluation with network providers. Network providers can learn more about the QM Program, Quality Committees, and evaluation of the program through this manual, Provider *Alerts* and Beacon Health Options (Beacon)/MBHP Broadcasts, MBHP's website (www.masspartnership.com), quality forums, and training programs. This information is updated at least annually. MBHP provides network providers the opportunity to participate in the QM Program through their representation on behavioral health advisory councils, the local credentialing committee, and quality improvement workgroups and committees. Through these committees, network providers may:

- Review, evaluate, and make recommendations for credentialing and recredentialing decisions;
- Participate in the development or review of clinical practice guidelines that are distributed to providers;
- Provide peer review and feedback on proposed best practice guidelines, clinical quality indicators, and any critical issues regarding policies and procedures;
- Participate in the planning, design, implementation, and review of the QM Program;
- Review quality improvement program initiatives and activities and make recommendations for plans to improve quality of clinical care and service; and



- Review proposals to conduct clinical data evaluations and develop profile reports that identify best practices and aid in development of initiatives that will result in improved treatment and improved systems of care.

Providers interested in participating in one of our Quality Committees or who want to learn more about our QM Program should contact MBHP's Quality Management Department at **1-800-495-0086**.

Provider Involvement in Behavioral Health Quality Review of Network Services

As part of its QM Program, MBHP conducts a range of quality measurement and improvement initiatives on an ongoing basis for the purpose of ensuring quality of network services and the quality and safety of clinical care. Providers are required to cooperate with all quality improvement activities and, should areas of improvement be identified, develop and implement quality improvement plans that address the identified areas of improvement. It is important to note that the quality review process is intended as a consultative and educational process which allows us the opportunity to acknowledge areas of strength and identify opportunities for improvement in our provider network.

MBHP does not make public provider-identifiable reports based on its quality reviews without the consent of the provider.

Examples of quality measurement and improvement initiatives in which MBHP requires provider participation include:

- Providing MBHP with access to Member health records (to the extent permitted by state and federal law) for the purposes of quality reviews such as clinical practice guideline adherence and health record-keeping standards distributed to providers;
- Assisting with collection of data on access and availability;
- Collecting clinical outcome data;
- Providing access to consumer satisfaction interview teams to assess Member satisfaction;
- Participating in provider satisfaction surveys;
- Participating in on-site program reviews, including review of provider profiling data;
- Participating in the investigation and resolution of critical incidents, complaints, and grievances;
- Participating in site visits for credentialing and recredentialing (when applicable); and
- Participating in MBHP efforts to assess and monitor office-site quality.

Member Rights and Confidentiality

Providers are required to cooperate with MBHP in its education efforts to improve understanding about Member rights and responsibilities, both those mandated by statute and those defined by MBHP. It is the policy of MBHP to ensure that Members are treated in a manner that respects their rights and responsibilities as Members. The MBHP Member Rights



and Responsibilities Statement can be copied and posted or distributed to Members at their initial visit by providers.

MBHP employees routinely maintain as confidential all information collected relating to past and present Members, including identity, as well as personal information. Protected Health Information (PHI) is maintained on a confidential basis in accordance with all applicable regulatory (e.g., Health Insurance Portability and Accessibility Act (HIPAA®)) and accreditation requirements. MBHP ensures that all such information obtained during the utilization management process is used solely for the purposes of utilization management, quality management, discharge planning, case management, and claims payment. All MBHP employees are required to sign a statement of confidentiality at the time of employment and annually thereafter.

All MBHP employees, providers, and delegated entities are required to safeguard the confidentiality of Clinical Management (CM) and Treatment Records information related to both enrolled and dis-enrolled Members. MBHP maintains information systems to collect, maintain, and analyze information necessary for utilization management that incorporates adequate safeguards to ensure the confidentiality and security of UM and Treatment Records as well as a plan for secure storage, maintenance, tracking, and destruction of Member-identifiable clinical information.

All requests for authorizations for disclosure of information are reviewed and responded to in accordance with the MBHP policy, as well as all applicable laws and regulations. Members or their personal representatives are entitled to receive copies of any information pertaining to themselves, on request, subject to limits placed by state and federal laws, regulations, and guidelines, and an evaluation of any potential risk of harm to the Member entailed by such disclosure of information.

Confidential information may include but is not be limited to:

- Protected Health Information (PHI)
- Certification of mental health treatment
- Claims processing information
- Utilization review
- Peer review
- Response to congressional inquiries (made at the request of the Member)
- Appeals
- Quality assurance

Individuals engaged in quality improvement activities maintain the confidentiality of the information used in such activities. All written reports, records, or any work product or communication related to quality improvement activities are considered privileged and confidential information. Except when specific reference is necessary to meet the goals of the QM Program, references to individual providers or Members are redacted to safeguard the person's identity.



Periodic re-training efforts reinforce the importance of confidentiality. All consumers and providers who participate on any MBHP committees must also demonstrate their understanding of the MBHP confidentiality policies and procedures by signing confidentiality statements prior to committee participation.

For additional information, please see the *Member Rights* section detailed later in this chapter.

Concerns and Grievances

One method of identifying opportunities for improvement in processes at MBHP is to collect and analyze the content of Member grievances and provider concerns. Please see the *Questions and Concerns* section detailed later in this chapter. MBHP's grievance process has been developed to:

- Enable the company to address Member grievances, provider concerns, and quality of care issues in a timely manner; and
- Provide a structure for individual service centers to track and trend concern and grievance data by providing categories into which concerns and grievances can be sorted.

Improving Patient Safety

MBHP is committed to supporting high-quality and cost-effective care provided in a safe and supportive environment. We recognize our responsibility to maintain a high-quality, safe, and secure health delivery system and to ensure that MBHP is in compliance with local, state, and federal regulatory requirements. We recognize the need to develop systems and structures that can identify cases of poor quality of care or service. These cases increase the risk of injury to our Members and represent performance improvement opportunities. MBHP is committed to collecting meaningful data regarding these cases, investigating them thoroughly, and identifying potentially high-risk behavior on the part of MBHP or its network that might threaten the safety of our Members.

MBHP has a defined procedure for the identification, investigation, resolution, and monitoring of quality of care, service issues, and trends. Quality of care, service issues, and trends are those that decrease the likelihood of desired health outcomes and that are inconsistent with current professional knowledge. Quality of care and quality of service issues are primarily identified via grievances from Members and are resolved and monitored at both the service center and network-wide level in order to identify providers who are providing poor quality care. MBHP has a designated committee, in which the medical director participates, that oversees the investigation and resolution of these issues. Potential quality of care and/or service indicators monitored by MBHP include but are not limited to those listed in the Adverse Incident Reporting section of this chapter.

Policy Statement on Behavioral Health Standardized Assessments

The quality of behavioral health treatment services is enhanced when providers use standardized assessment instruments, ones that have good psychometric properties, to supplement the clinical judgments of the clinician. For both acute 24-hour services and community-based services, MBHP regards the use of clinical information gathered through a standardized assessment to be



an important resource for care management, treatment, and discharge planning. Therefore, MBHP requires that all providers use a standardized assessment instrument to inform:

- Discharge planning from 24-hour care services; and
- Treatment planning for community-based services.

Provider selection of a standardized assessment tool should reflect their practice as well as clinical and quality improvement efforts.

Facilities that provide 24-hour treatment for acute psychiatric disorders or substance use disorders are required to complete a discharge planning assessment for each Member. Community-based service providers are required to administer an assessment instrument during the Member's intake evaluation and periodically at clinically reasonable intervals, to inform treatment planning and choice of treatment interventions. Please see the Provider Specifications in the Quality Management chapter for the operational details for this policy statement.

For Members under the age of 21, the Child Adolescent Needs and Strengths (CANS) tool must be administered and entered into the Virtual Gateway for:

- Intensive Care Coordination (ICC);
- In-Home Therapy (IHT);
- Outpatient Therapy (diagnostic evaluations and individual, family, and group therapy);
- Psychiatric inpatient hospitalization;
- Community-Based Acute Treatment (CBAT);
- Intensive Community-Based Acute Treatment (ICBAT); and
- Transitional Care Units (TCU).

Goal of the policy on standardized assessments

The goal of the policy on standardized assessments is to improve the quality of care provided to Members by ensuring that:

- All Members have the benefit of objective, standardized assessment, with periodic re-assessments;
- The results of the standardized assessments are incorporated into each Member's treatment planning process; and
- All assessments are reviewed by the treating clinician to identify clinical changes in subsequent reassessments that could lead the clinician to make service improvements based on changes in the Member's needs.

MBHP staff monitor compliance via:

- Monitoring of adult outcomes through providers attesting to using an outcomes instrument
- Identifying evidence that they are doing so via MBHP medical record review
- Requiring outcomes compliance in our rate strategy

Definitions of Key Terms

Behavioral Healthcare	This term includes all treatment and support services related to mental health disorders, mental illnesses, and substance use disorders, as these disorders are referenced in the Diagnostic and Statistical Manual IV.
Standardized Assessment Instrument	A standardized assessment instrument is one that measures behavioral health needs and may include life-functioning needs. The instrument can be clinician-administered or self-administered by the Member. The instrument is developed through research on the validity and reliability of the assessment items. Some instruments are broad measures of clinical and life-functioning domains, while others are narrow (e.g., an assessment of depression only). The essential feature is that the assessment items are research-validated indicators of the measurement construct.
Change in Clinical Status	To measure a change in a Member’s clinical status, the clinician must administer a standardized instrument at some point in the treatment process (typically, upon intake) and then re-administer the <u>same</u> instrument at a second point-in-time (typically, prior to a review of the treatment plan). The difference in the Member’s evaluation between the first assessment and subsequent assessment is the measure of “clinical change.” Many standardized instruments characterize this change in the form of a score related to level of disability. While summary scores are useful for documenting change, clinicians are advised to review a Member’s response to individual assessment items to learn about the personal content of the change, and not just focus on change scores.
Treatment Outcome	The term “treatment outcome” is equivalent to the term “change in clinical status.” Typically, outcomes are measured by changes in scored measured of severity. As noted above, clinicians should focus not only on numeric scores, but also on the content of assessment items in which the Member has changed between evaluations.
Data-Informed Service Planning	The numeric and content information (data) gathered from a standardized assessment and reassessment must be incorporated into a Member’s service plan. That is, if the assessment instrument indicates an elevated concern about depression that was not otherwise noted by the clinician’s own assessment, the clinician should explore the question of depression with the Member during the intake or review process. Based on this review of the standardized assessment with the Member, the results of this review should be incorporated into the treatment goals and interventions included in the service plan. If a standardized assessment points to a clinical concern that is not confirmed with the Member, then the clinician must document in the Member’s medical record that a concern was identified but not substantiated through further discussion with the Member.

Behavioral Health Profile Management Services

The Profile Management Services Program is a quality improvement reporting process that makes demographic, quality, and utilization data available to MBHP staff and network providers, allowing them to benchmark the success of their clinical practices. MBHP has a well-established, multi-pronged, data-driven system for monitoring the performance of our provider network across all levels of care. MBHP is in a unique position to monitor and enforce compliance issues



and performance expectations due to our regional provider quality management structure and extensive interface with providers, including onsite visits.

MBHP has created several provider profile reports that contain core measurements of provider performance, quality, and continuity of care. PCC and BH provider quality managers (PQMs) utilize this provider profiling data to monitor provider performance, identify and manage providers who fall below established benchmarks and performance standards, and work with providers to improve quality and continuity of care. This process includes in-person site visits to review the data and develop improvement plans to track progress on goals. MBHP has enhanced the reports repeatedly to produce data requested by providers.

Note that all provider reports are confidential, and MBHP will not make these reports public without the consent of the provider and/or at the direction of EHS.

MBHP's provider profile reports include:

Inpatient Hospital FUH and IET Provider Profile Reports: MBHP has a structured inpatient quality and utilization management strategy that is implemented by PQM staff and our Medical Affairs Department. PQMs provide inpatient mental health providers with standard, authorization-based data reports on a monthly basis, and conduct in-person or virtual site visits, often in collaboration with Medical Affairs, to review this data. The site visits occur monthly, bimonthly, or quarterly, depending on provider performance. The profile reports are based on a risk adjustment methodology and provide facility-specific data and statewide comparative data. Some of the core measurements used to monitor inpatient provider performance and identify opportunities for improvement through these reports are length of stay and both 7- and 30-day readmission rates.

Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) Encounter Form Reports: Data reports are provided monthly to each ESP/MCI provider that include both provider-specific and statewide comparative data. These reports focus on the following key indicators: volume, intervention location, response time, and disposition. Data is trended over time. Statewide data is included to provide benchmarks. PQMs utilize this data with ESP/MCI providers to monitor and improve performance through monthly or bimonthly site visits, depending on each provider's performance.

Provider Quality Improvement (QI) Programs and Plans

Network providers are required to have internal processes, policies, procedures, programs, and/or activities aimed at monitoring and improving quality of care. Providers are required to identify a manager responsible for the provider's quality improvement process. Providers work collaboratively with MBHP staff in developing, implementing and monitoring quality improvement plans in response to adverse incidents, concerns and grievances, or such quality initiatives as provider profiles, health record review, etc. Providers engage Members, families, and other relevant stakeholders in their quality management activities.

Providers are required to demonstrate a commitment to continuously improve the quality of care they provide. This can be done by participation in a variety of activities that include, but are not limited to, the following:

- Participating in continuing education sufficient to meet licensing requirements;
- Complying with periodic reviews of Member health records;
- Complying with appointment access standards; and
- Participating in provider performance profiling activities and outcomes initiatives and working with MBHP to improve services based on data derived from Member and provider satisfaction surveys conducted by MBHP.

Behavioral Health Quality Management Initiatives and Conferences

MBHP sponsors a variety of quality management forums and other conferences. Providers are encouraged to attend these forums. Whenever possible, MBHP makes continuing education credits available to licensed providers for their participation in these trainings and forums.

Cultural humility

MBHP is committed to exploring and incorporating concepts that ensure a system designed to provide care and services delivered in a culturally competent, sensitive, and equitable manner. At least annually, MBHP gathers Members' cultural, ethnic, racial, linguistic, and other special needs and preferences through a number of sources to ensure that MBHP Members have access to culturally appropriate behavioral health providers and practitioners, interpreter services, and translated materials. These data are compiled and analyzed to identify opportunities for improvement (e.g., adding language services, recruiting behavioral health practitioners or providers, or designing trainings). MBHP recognizes the importance of culture and diversity and incorporates the following principles into its QM Program:

- Assessment of cross-cultural relations
- Expansion of cultural knowledge
- Adaptation of services to meet the specific cultural and linguistic needs of our Members

Continuity and coordination of care

MBHP monitors continuity and coordination of care throughout its continuum of behavioral health services. Monitoring may include audits of treatment records, coordination of discharge planning between inpatient and outpatient providers, and monitoring provider performance on pre-determined coordination of care indicators. Processes are established to ensure that Members do not experience disruption of care when there is a change in their provider. Such changes may include, but are not limited to:

- The Member requires a change in level of care, necessitating the Member's need for a new provider;
- There are multiple providers involved in treatment simultaneously (e.g., psychiatrist for medication management, therapist for on-going treatment);
- There is a change in health plans or benefit plans;
- There is termination of an existing Beacon provider; or
- The Member is being treated for several (co-morbid) conditions simultaneously with multiple providers (both behavioral health provider(s) and a PCP or medical specialist).



As an MBHP provider, you will be required to provide coordination of care as appropriate, sharing information with a Member's other provider(s) within the context of providing quality care and the guidelines of protecting a Member's privacy. The company has mechanisms in place to monitor continuity of care and coordination with general medical care and to evaluate the use of psychopharmacological medications.

Integration of Care with Primary Care Providers

MBHP is committed to supporting integrated care provided to Members by primary care providers and other relevant treatment providers. Throughout treatment and as applicable, providers are required to assess the Member's health status, utilization of medical visits, and compliance with medical treatment. MBHP expects providers to identify the Member's primary care provider, and, if there is none, to make best efforts to assist the Member in obtaining a primary care provider by: directing them to the telephone number for MassHealth's Customer Service Center located on the back of their MassHealth ID card; directing them to the PCC section of the MBHP website which contains the telephone number for MassHealth's Customer Service Center; or directly providing them with the telephone number for MassHealth's Customer Service Center.

MBHP expects providers to obtain a Release of Information from Members to contact their primary care provider. If the Member declines, the provider documents this in the Member's health record and continues to engage the Member around this issue. MBHP expects providers to communicate with the Member's primary care providers for the following purposes: a) to notify them regarding admission or enrollment in services and the reason(s) for such admission/enrollment; b) to obtain information regarding health status, including but not limited to medical and medication information; c) to coordinate assessment, treatment, and discharge and aftercare planning; d) to share diagnostic and treatment/care plan information; and e) to coordinate medication, if applicable. With appropriate consent, providers maintain ongoing communication and collaboration with the Member's primary care provider for these purposes, as well as to provide information to the primary care provider about the course of the Member's behavioral health treatment, including psychopharmacology and notable metabolic studies and/or other medical information. Providers utilize information from the primary care provider to inform the Member's assessment, treatment/care plan, and discharge plan on an ongoing basis. To facilitate communication to the behavioral health provider, the primary care provider, and providers of all levels of care are encouraged to utilize the Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form in "Forms" in the Quality Management Section of this manual.

Member Rights and Responsibilities

MBHP Members have the following rights and responsibilities:

- Your behavioral health provider cannot refuse to give you medically necessary treatment, but you may be referred to a specialist for treatment.
- The employees of MBHP and your behavioral health providers must treat you with respect and dignity, and respect your right to privacy.

- MBHP and your providers must keep your health information and records private. They must not give other people information about you unless you give permission or the law says they must (see “Notice of Privacy Practices” on www.masspartnership.com).
- You have a responsibility to supply information (to the extent possible) that MBHP and its providers need in order to provide care.
- Your providers must tell you in advance – in a manner you understand – about any appropriate treatment options and alternatives that the providers think should be done, regardless of cost or coverage.
- Your providers must make you part of decisions about your healthcare. You can refuse treatment if you want to (as far as the law allows). You can also know what might happen if you refuse treatment. You have the right to sign a healthcare proxy to designate someone close to you to act as your agent and make healthcare decisions on your behalf if you are unable to make those decisions yourself, talk, or write due to sickness or injury.
- You have a responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible. In addition, you have a responsibility to follow plans and instructions for care that you have agreed to with your provider.
- You can talk about your healthcare records with your providers and get copies of all your records. You can also ask for changes to the records as the law allows.
- If you speak a language other than English, you can ask for an interpreter when you call **MBHP's Community Relations Line at 1-800-495-0086** (press 1 for the English menu or 2 for the Spanish menu, then press 4 then 1 to skip prompts). For Members who have trouble hearing or speaking our **TTY number is 1-877-509-6981**.
- If you read a language other than English, you can ask that printed materials be read aloud to you in your language by calling **MBHP's Community Relations Line at 1-800-495-0086** (press 1 for the English menu or 2 for the Spanish menu, then press 4 then 1 to skip prompts). For Members who have trouble hearing or speaking our **TTY number is 1-877-509-6981**.
- If you have trouble seeing or reading, you can ask that printed materials be read aloud to you by calling **MBHP's Community Relations Line at 1-800-495-0086** (press 1 for the English menu or 2 for the Spanish menu, then press 4 then 1 to skip prompts). For Members who have trouble hearing or speaking our **TTY number is 1-877-509-6981**.
- You can choose your own behavioral health provider from MBHP's provider network. You can change this provider at any time.
- You must get behavioral healthcare within the timeframes in your Member Handbook. If you do not get behavioral healthcare when you should, you can file an appeal with MBHP.
- You can file an appeal or grievance regarding MBHP or your behavioral health providers by calling **MBHP's Community Relations Line at 1-800-495-0086** (press 1 for the English menu or 2 for the Spanish menu, then press 4 then 1 to skip prompts). For Members who have trouble hearing or speaking our **TTY number is 1-877-509-6981**.
- You can also appeal to the Board of Hearings and request a fair hearing if you disagree with certain actions or inactions by MBHP. See your Member Handbook or www.masspartnership.com for more information.



- You have the right to know about all benefits, services, rights, and responsibilities you have. Please see your Member Handbook for more information.
- You can ask for a second opinion from another MBHP behavioral health provider.
- You can get emergency care 24 hours a day, seven days a week. Please see your Member Handbook or www.masspartnership.com for more information about emergencies.
- No one can physically hold you, keep you away from other people, or force you to accept treatment in order to make you to do something, to punish you, or because it is more convenient for them.
- You can make recommendations regarding this Member rights and responsibilities policy.
- You can do anything on this list without worrying that MBHP or providers will treat you differently because you did it.

These rights and responsibilities must be taken into consideration when furnishing services to Members. Network providers are responsible for compliance with the rights above and with federal and Massachusetts' laws and regulations governing Member rights, including those put forth in the Balanced Budget Act. Providers are prohibited from engaging in any practice with respect to any Member that constitutes unlawful discrimination on the basis of health status, need for healthcare, race, color, national origin, or any other basis that violates any state or federal law or regulation, including, but not limited to 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90.

The Americans with Disabilities Act

MBHP expects providers to comply with all provisions of The Americans with Disabilities Act (ADA) and other federal, state, or local laws or municipal codes applicable to MBHP services. Services should be handicap-accessible for physically, visually, and hearing-impaired participants. Providers are encouraged to adapt their environment to meet the special needs of Members. Accessibility of services is an integral component to meeting need equitably. Providers should attempt to deploy and adapt their office or facility space so that they are usable by all those in need and otherwise eligible. This includes providing or arranging for communication assistance for persons with special needs, who have difficulties making their service needs known, by providing assistance such as a computer, telephone amplification, sign language services, or other communication methods to facilitate service.

Copies of DMH policy memorandum #96-3r of August 22, 1996 on informed consent; DMH regulations on human rights at 104 CMR 27.13; and M.G.L. C 123 section 23, which codifies Chapter 166 of the Acts of 1997, an act relative to certain rights of persons with mental illness have been included in Appendices A-D. MBHP monitors provider compliance with the requirements of laws and regulations and works with providers in their efforts to achieve compliance.

Additionally, MBHP acknowledges its own responsibilities to comply with applicable federal and state laws including, but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; Titles II and III of the Americans with Disabilities Act; Section 542 of the Public Health Service Act; and Title 45



Part 46 of the Code of Federal Regulations pertaining to research involving human subjects.

Confidentiality of Member Healthcare Information

All MBHP providers are required maintain the confidentiality of Member information and records. Providers shall safeguard the confidentiality of personally identifiable health information for both enrolled and dis-enrolled Members. MBHP providers are required to adhere to all federal and state laws and regulations governing the privacy of Member information, including HIPAA.

In addition, MBHP does not disclose clinical information other than identifying information (such as Member name and eligibility) to providers rendering treatment to the Member unless the Member has signed an authorization for the Release of Information form. Only information related to specific benefit determinations for treatment provided by the requesting provider is disclosed or discussed. In the event of an urgent or emergency request for care from a Member, MBHP will release pertinent clinical information necessary for an appropriate response.

Restraint and Seclusion

MBHP supports the principles that guide the use of restraint and seclusion put forward by the Massachusetts Coalition for the Prevention of Medical Errors: “the adoption of an approach that minimizes the use of restraints and seclusion; supports the use of restraint and seclusion only in emergency situations and after less-restrictive interventions have been determined to be ineffective; ensures patient/resident and staff safety; and promotes an approach that values risk assessment, early intervention, and education.” Network providers are responsible for compliance with federal and state regulations governing the restraint and seclusion of Members. Copies of these laws are included as Appendix D. The appendices include:

- Appendix A: DMH regulations concerning restraint and seclusion at 104 CMR 27.00; and
- Appendix B: Centers for Medicare and Medicaid Services rules entitled, “Medicaid Program: use of restraint and seclusion in psychiatric residential treatment facilities providing services to individuals under 21,” at 42 CFS parts 441 and 483.

MBHP monitors provider compliance with the requirements of these laws and regulations and works with providers in their efforts to achieve compliance. Additional information on these principles is available from MBHP’s quality coordinator for incidents at **1-800-495-0086**. All providers, as applicable, are required to submit a copy of their restraint and seclusion policy and procedure during the re-credentialing process, or as otherwise indicated by MBHP.

Exchange of Information with Primary Care Providers

MBHP is committed to supporting the role that primary care providers and other relevant treatment providers have in coordinating all aspects of a Member’s care. To that end, MBHP expects that behavioral health providers will obtain, when at all possible, a release from Members authorizing the exchange of treatment information between primary care providers, behavioral health providers, relevant state agencies, family members, and others as appropriate.

Authorization for the Release of Information

It is recommended that the Release of Information form be presented to the Member at the point of initial intake. Please be aware of the provision of federal confidentiality requirements in 42 CFR section 2.22, especially as the requirements relate to the release of substance use disorder information. The Release of Information form recommended by MBHP authorizes, with the Member's consent, the exchange of healthcare information. It facilitates communication between primary care providers, behavioral healthcare providers, state agencies, MBHP, family members, and other parties identified by the Member.

Network providers electing not to use the Release of Information form put forward by MBHP should ensure that their own consent forms are compliant with all Massachusetts privacy laws and federal HIPAA regulations.

Members rights to continue course of treatment when provider leaves the network

When a provider resigns or is dis-enrolled from the network, the provider must continue to provide covered services, at the rate and pursuant to the contractual requirements and to adhere to MBHP's policies and procedures, to Members receiving active treatment at the time of termination until the course of treatment is completed or until MBHP makes reasonable and medically appropriate arrangements to have another provider render such services. MBHP will work with providers no longer under contract to develop a reasonable transition plan for Members in active treatment as long as the provider agrees to continue to provide covered services, at the rate and pursuant to the contractual requirements and to adhere to MBHP's policies and procedures. Members and providers are encouraged to contact the Northeast Access Line for assistance with referrals.

Provider/Member relationship

Nothing in our relationship changes or alters any clinical relationship that exists or may come to exist between a provider and any Member(s). The provider shall always exercise their best medical judgment in the treatment of Members. Determinations by MBHP shall not be construed as a directive from MBHP that medically necessary treatment be withheld. The provider will not be prohibited from or penalized for a communication between provider and Members regarding available treatment options, including appropriate or medically necessary care for the Member.

Members' Right to Access Interpreter Services

Members with limited English-speaking proficiency have the right to access proficient interpreters. In addition, all written materials produced by MBHP for Members are available in English and Spanish. Members may also request for oral translation of MBHP materials and/or have letters from MBHP translated into their language. If Members have trouble reading, Members can request MBHP materials be read to them over the phone.

Providers seeking such services should contact the Community Relations Department at **1-800-495-0086 (press 1 for the English menu or 2 for the Spanish menu, then press 3 and then 1 to skip prompts)**. MBHP also provides a TTY Line for those who are hearing or speech impaired: **1-877-509-6981**.



Member Grievances and Provider Concerns

Member Grievances

Members, their guardians, or their authorized representatives have a right to file a grievance with MBHP about any aspect of their participation in MBHP or the services received through the plan.

Grievances can be filed with any MBHP staff person and can be made telephonically or in writing. Sources of dissatisfaction can include any aspect of MBHP's services as well as access of care and the quality of care received from network providers. Grievances should be directed to:

Quality Analyst
MBHP Quality Management Department
1000 Washington St., Suite 310
Boston, MA 02118-5002

Grievances are investigated and resolved by MBHP's quality analyst within 30 calendar days of the date that the original grievance was received. The individual is informed in writing of the completion of the investigation and is advised that the resolution of the grievance by MBHP is final.

Provider Concerns

MBHP encourages its network providers to relay any concerns they have regarding any aspect or action of MBHP or its providers. This includes, but is not limited to, quality of care, administrative operations, and access to care. Concerns can be submitted in writing or by telephone to:

Quality Analyst
MBHP Quality Management Department
1000 Washington St., Suite 310
Boston, MA 02118-5002
Phone: (800) 495-0086
Fax: (877) 335-5452
Email: MBHPQualityManagement@beaconhealthoptions.com

The quality analyst documents, reviews, and resolves provider concerns within 15 calendar days of receipt. The findings of MBHP's concerns review process are final. Providers may not appeal to MassHealth for review of the resolution of a concern.

Incident Reporting

Adverse Incident Reporting

MBHP has expanded upon the Department of Mental Health's protocol and categories for adverse incident reporting. All 24-hour level of care providers (e.g., inpatient psychiatric units and acute treatment services for substance use disorders) must report each occurrence that

represents actual or potential serious harm to the well-being of a Member or to others by the actions of a Member. Reporting requirements for providers of non-24-hour levels of care are limited to Member deaths, serious injuries requiring urgent or emergent treatment that occurred while a Member was receiving services from the providers of MBHP Members, and any serious attempted suicides that occur during the time span that a Member is receiving services from the provider, during and outside a treatment session. Incidents must be reported to MBHP by fax at (877) 335-5452 within 24 hours of their occurrence. Examples of Reportable Adverse Incidents are provided below.

Examples of Reportable Adverse Incidents

Death: all deaths of Members, regardless of cause

Injuries/accidents (non-24-hour providers): Any injury occurring in a behavioral health treatment setting that requires urgent or emergent medical treatment

Absence without Authorization (AWA): Please file an Incident Report for individuals who are AWA or absent beyond authorized leave who are in the following circumstances:

- Are Members who are committable or are under the age of 18;
- Have been admitted or committed to a facility pursuant to M.G.L. chapter 123, §§ 7-8, 10-11, or 12, and who are a danger to self or others;
- Are considered “dangerous persons” and have been voluntarily committed or committed under statutes involving the commitment, retention, and emergency restraint of dangerous persons; or
- Have been admitted under M.G.L. chapter 123, §§ 15, 16, 17, or 18, which includes competency to stand trial and the hospitalization of mentally ill prisoners.

*Note: AWA incidents differ from a discharge that occurs Against Medical Advice (AMA).

Sexual Assault: Any sexual assault or alleged sexual assault where the Member is either the alleged perpetrator or the alleged victim. This involves any assault that is sexual in nature, such as:

- Any touching or fondling that is physically forceful;
- Forced penetration;
- Sexual contact between patients, whether consensual or not, when at least one of the patients is a Member; or
- Sexual contact between staff and Members, whether consensual or not.

Serious injury/medical emergency requiring transport and admission to an acute care facility: injury or medical condition requiring medical treatment more intensive than first aid that is provided off of the psychiatric unit and requires medical hospitalization

Serious injury/medical emergency requiring transport to an acute care facility for ambulatory treatment and release: injury involving a Member requiring medical treatment more intensive than first aid that is provided off of the psychiatric unit but that does not require admission to a hospital



Violations or alleged violations of DMH restraint and seclusion regulations: any restraint or seclusion that is administered outside the purveyance of DMH licensing and operational standards for restraints and seclusions 104 CMR 27.12

Absence without Authorization (Members who are not committable and are over the age of 18): any Members who do not meet the criteria in Category I and are determined through their clinical presentation to be AWA, or absent beyond authorized leave; Also, any Member who has not returned to the facility by the midnight census, unless otherwise indicated by their treatment plan.

* Note: AWA incidents differ from a discharge that is Against Medical Advice (AMA).

Any physical assault or alleged physical assault to or by Members: physical aggression to or by Members either directed at, or exhibited by, another patient that exceeds normative clinical behavior addressed in the treatment plan. This includes hitting, kicking, and/or use of a weapon, as well as staff mistreatment of Members, and any physical aggression that produces tissue damage.

Unscheduled event that results in the evacuation of a program: any event that occurs whereby all the patients on the unit must be evacuated, such as fire, unsafe air quality, flooding, or serious threats against the facility

Public health hazard: any introduction of extraordinary elements into the environment that could be considered hazardous to the community (e.g., food contamination or lice infestation) that causes a major disruption to the unit and results in medical treatment or hospitalization of Member(s)

Medication errors: any medication error whether through omission, duplication, incorrect dosage, order missing, incorrect patient, packaging/labeling, transcription, incorrect drug, incorrect time, or Members “cheeking” medications that result in the need for urgent or emergent medical treatment and/or admission to an acute care facility

Riot: any organized or other significant event on the unit that causes disruption to the milieu and that could result in a potentially harmful situation for Members

General Guidelines for Adverse Incident Reporting

All incidents must be reported to MBHP by fax (877-335-5452) within 24 hours of their occurrence. The incident reporting form is available on the website www.masspartnership.com. It is also available in the Quality Management section of this Provider Manual under “Forms.” A PDF version is available, as well as a Microsoft Word version for providers who prefer to type the incident information into the form.

Proper Format and Submission

The incident report must be either printed legibly or typed. Reports that are illegible due to either poor handwriting or fax quality will not be accepted. Please contact the MBHP quality analyst for assistance with submission of adverse incidents at 1-800-495-0086 or for questions



regarding the incident reporting process. **This form cannot be emailed. It must be printed and then faxed to MBHP.**

Adverse Incident Report Form Requirements

Notifications: Check off all agencies that have been notified of the event. Please specify the name of the agency if using the “other” category.

Member information: Fill in the name of the Member, their social security number, date of birth, age, and gender.

Facility information: Include the name of the facility, the unit on which the event occurred, the city or town in which the facility is located, and the level of care provided by the facility.

Date and time of incident: Include both the time (as well as it can be ascertained) and the date the incident was discovered by staff.

Type of incident: Refer to the incident definition document to complete the “type of incident” section. Choose the category that best describes the event and enter it in the space provided.

Describe incident: Please describe the event to the best of your ability in several sentences. Include the events that led up to the incident as well as a detailed description of the incident itself. If the event involves an Absence without Authorization (AWA), please include information about the search, notification, and commitment status of the Member.

Response to incident: Please describe what actions staff took immediately following the discovery of the incident, including steps to ensure the safety of the Member and/or others, if appropriate. Please also reference any facility protocols that were indicated with respect to the event.

Restraints used: If restraints were used, please indicate whether they were mechanical, physical, or chemical restraints and include the amount of time the Member was in restraints.

Facility recommendations: Indicate whether the facility is recommending an internal investigation, a review of policies and procedures, staff training, and/or disciplinary action to staff.

Attached additional information: Indicate whether any additional information concerning the event and/or the Member is attached to the incident report form.

Person reporting the incident: Print the name of the person reporting the incident as well as their telephone number, and sign and date the form.

MBHP Record Review and Audit Program

Providers are required to ensure that all health records and clinical files are maintained in accordance with applicable state and federal law, including but not limited to those contained in:



M.G.L. chapter 66A; M.G.L. chapter 123; DMA regulations 130 CMR 433.409 and 450.250; and DMH regulations 104 CMR 2.07 and 15.03(9), and related amendments.

MBHP core health record-keeping standards for all covered services guidelines can be found in the *MBHP Health Records Guidebook: Core Health Record Documentation Standards*. You can access the Health Records Guidebook at www.masspartnership.com.

Through its contract with the Commonwealth, MBHP has the right and obligation to review the health records of its Members for the purposes of quality management, documentation of medical necessity, and appropriateness of claims submissions. The MBHP Provider Manual, which is an extension of your Provider Agreement, requires that providers participate in quality activities including providing MBHP with access to Member health records (to the extent permitted by state and federal law) for the purposes of quality review. Failure to provide the aforementioned record(s) in a timely manner shall constitute a breach of the Provider Agreement with MBHP and may result in administrative action.

Record Review and Audit Process

Providers are selected for audit by a random selection process based on a monthly utilization report. Records are reviewed using a standardized instrument encompassing all standards and criteria listed below. A paid claims report is utilized to match payment of services with supporting documentation.

In-office, retrospective health record reviews may be conducted on site or remotely. The Quality Department will confirm point of contact at the provider site and notify via email of upcoming audit. Once contact is confirmed, the Quality Department will share a list of Member names and dates of service that are requested for review. Once the provider has the materials necessary for the audit, they are to connect with the MBHP reviewer to discuss details of audit (remote vs. on-site).

Providers may send physical copies (cannot be original versions) or electronic copies of Member records to the Beacon Quality Department. The provider has 14 days from the day of request to submit copies of the records to Beacon Quality. Once records are obtained, Beacon Quality will notify the MBHP reviewer that records are ready for review. If missing documentation of paid services is noted, the provider has one business day to submit missing documentation. Any missing documentation after one business day will be subject to recovery of payment.

Routine or ad hoc, on-site retrospective health record reviews are typically scheduled within a two-week notice to providers of such review. When the MBHP reviewer arrives at the provider's office, the provider is to acclimate the reviewer with their organization of records, EHR system, etc. If a provider maintains health records off-site from where the review is being conducted, the provider should inform the MBHP reviewer at the beginning of the review. If missing documentation of paid services is noted, the provider has one business day to submit missing documentation. Any missing documentation after one business day will be subject to recovery of payment.



All records reviewed by MBHP must include any and all documentation submitted to the record review staff at the time of the review. The reviewer has the ability to allow for up to one week of an extension to provide missing materials. Any materials submitted after one week will not be included in the audit.

Upon completion of an on-site health record review, the MBHP reviewer will give verbal feedback to the provider regarding the preliminary findings of the review. MBHP will send the provider a final written report for all health record reviews, ordinarily within 30 days. Providers are required to meet an overall score of 80 percent. If a provider falls below the 80 percent goal, they are required to develop an improvement plan and submit to the MBHP reviewer for review. If a provider falls below 65 percent, they are required to develop an improvement plan and will be automatically audited the following year to monitor progress.

MBHP record-keeping standards that are subject to recovery of payment

If MBHP determines that any administrative or medical necessity criteria are not sufficiently documented for a particular unit of a covered service, MBHP may recover payment for those units of service. MBHP will coordinate this process with the provider.

The following record-keeping standards have one or more elements that may require a recovery of payment for failure to meet one or more criteria:

Standard One: Comprehensive Assessment

Standard Five: Progress Notes, Medical Necessity Criteria

Standard Seven: Documentation of Paid Services

See standards below for additional information concerning recovery of payment.

Requests for reconsideration of documentation deficiency determination

The provider may submit a written request to MBHP for a reconsideration of documentation deficiency determinations within 30 days of a deficiency notification. The provider will be notified of a decision of reconsideration within 30 days. All administrative decisions made by MBHP regarding claims recovery are final.

Provider's reconsideration requests should be sent to:

Health Record Review Manager
Massachusetts Behavioral Health Partnership
1000 Washington Street, Suite 310
Boston, MA 02118-5002

Online availability of standardized clinical forms

Under the leadership of the Association for Behavioral Healthcare (ABH), a set of standardized clinical forms is now available for behavioral health documentation. These forms were created with an extensive review of regulatory, accrediting body, and payer requirements over a two-year period by clinical staff representing various levels of care and by payer representatives. The use of these forms is not required by MBHP, but is available for those providers who would like access to quality clinical documentation forms. They are available free of charge at



<https://www.abhmass.org/msdp/forms-and-manuals/forms-and-manuals-by-program-type.html>. As providers have converted to Electronic Medical Records (EMRs), these forms have provided the foundation that these systems were built upon.

Provider Performance Specifications: Assessment-Informed Service Planning Using Standardized Instruments

Section 1: Selecting the Standardized Assessment Instrument

1.A	Assessment Instruments
	<p>MBHP recommends the following standardized assessment instruments for use in its Clinical Outcomes Measurement Protocol. Some MBHP services require certain instruments; for a description of required instruments by service, refer to Section 1.D.</p> <ol style="list-style-type: none"> 1. Overall functioning – <ul style="list-style-type: none"> ▪ PHQ 9 – youth and adults ▪ General screening Child and Adolescent Needs and Strengths (CANS) -youth – See CANS Section 1. 2. Depression: <ul style="list-style-type: none"> ▪ Patient Health Questionnaire (PHQ-9) ▪ Montgomery-Åsberg Depression Rating Scale (MADRS) ▪ Hamilton Depression Inventory ▪ Beck Depression Inventory (BDI)- adolescent and adult ▪ Children’s Depression inventory – child and adolescent (7-17) 3. Suicide Screening (use based on screening for depression): <ul style="list-style-type: none"> ▪ Columbia-Suicide Severity Rating Scale (C-SSRS) ▪ Columbia-SSRS recent self-report 4. SUD: <ul style="list-style-type: none"> ▪ <i>NIDA-Modified ASSIST (NM ASSIST) - adults</i> ▪ CRAFFT – adolescents 5. Anxiety: <ul style="list-style-type: none"> ▪ General Anxiety Disorder (GAD-7) youth and adults ▪ Screen for Child Anxiety Related Emotional Disorders (SCARED)- youth 6. ADHD: <ul style="list-style-type: none"> ▪ Child Behavior Checklist (CBCL)-youth ▪ Connor’s Rating Scales – Revised (CRS-R)-youth ▪ Vanderbilt ADHD Assessment Scales – teacher, parent, patient forms – youth and adult 7. Mania: <ul style="list-style-type: none"> ▪ Young Mania Rating Scale – youth and adults 8. OCD: <ul style="list-style-type: none"> ▪ YBOCS – adult ▪ YBOCS-child version-child CY-BOCS 9. Psychosis: <ul style="list-style-type: none"> ▪ Psychosis screening in primary care: bidmc psychosis pcp booklet final.pdf (psychosisscreening.org)- see questions on p. 15 ▪ BPRS – not a screening test – for psychosis 10. Cognition Decline: <ul style="list-style-type: none"> ▪ Montreal Cognitive Assessment (MoCA)



	<ul style="list-style-type: none"> ▪ Mini-Cog - Universal-Mini-Cog-Form-011916.pdf (mini-cog.com) <p>11. Autism:</p> <ul style="list-style-type: none"> ▪ m-CHAT – early childhood ▪ PEDS – older children <p>12. Catatonia:</p> <ul style="list-style-type: none"> ▪ Bush Francis Catatonia Scale <p>13. Domestic Violence/abuse screening:</p> <ul style="list-style-type: none"> ▪ These are the standard questions: <ol style="list-style-type: none"> 1. In the past 12 months, have you been in a relationship with a person who hurts, threatens, or tries to control you? 2. Has anyone else in your life physically hurt, threatened, or tried to control you? 3. Are you having difficulty getting access to basic needs such as food, clothing, or medical care? <p>14. Post-Natal Depression:</p> <ul style="list-style-type: none"> ▪ Edinburgh Postnatal Depression Scale (EPDS) <p>15. Elder Abuse</p> <p>Others:</p> <ul style="list-style-type: none"> ▪ Adolescent Treatment Outcomes Module (ATOM) ▪ Behavior and Symptom Identification Scale (BASIS-32) ▪ Behavioral and Emotional Rating Scale (BERS) ▪ Child-Adolescent Functional Assessment Scale (CAFAS/PECFAS) ▪ Current Evaluation of Risk and Functioning – Revised (CERF-R) ▪ Global Appraisal of Individual Needs (GAIN) ▪ Methadone Treatment Quality Assurance System (MTQAS) ▪ Personal Experience Inventory (PEI and PEI-Adult) ▪ Quality of Life Inventory (QOLI) ▪ SF8, 12, 36 ▪ SOCRATES ▪ Symptom Checklist-90-Revised (SCL-90-R) ▪ Treatment Outcome Package (TOP, TOP-SA) ▪ Youth Outcome Questionnaire (YOQ) <p>This list may be supplemented from time-to-time with the addition of instruments with good psychometric properties for outcomes assessment.</p>
1.B	Specifications for the Use of the Child and Adolescent Needs and Strengths (CANS) tool
	<p>For Members under the age of 21, the CANS tool is the required instrument as part of an initial behavioral health assessment for the following services and must be updated at least every 90 days when the treatment plan is reviewed:</p> <ul style="list-style-type: none"> • Outpatient Therapy (diagnostic evaluations and individual, family, and group therapy) • Intensive Care Coordination (ICC) • In-Home Therapy (IHT) <p>The CANS must also be completed as part of a discharge planning process in the following 24-hour level of care services:</p>

- Psychiatric inpatient hospitalization
- Community-Based Acute Treatment (CBAT)
- Transitional Care Units (TCU)

For additional information on the CANS, please refer to the following resource:

- Children’s Behavioral Health Initiative (CBHI) web site
<http://www.mass.gov/eohhs/consumer/insurance/cbhi/>

1.C 24-Hour Acute Services (Psychiatric or Detoxification)

Providers of 24-hour acute psychiatric or detoxification services are required to conduct a comprehensive assessment of the Member for discharge planning purposes. This assessment must include the use of a standardized assessment instrument (see Sections 1.A and 1.E).

The results of the standardized assessment must inform and be incorporated into the discharge plan. It is the responsibility of the 24-hour provider to obtain the necessary authorizations from the Member, as agreed to by the Member, and to make a copy of the discharge plan for the non-24-hour provider from whom the Member will receive after-care services.

Note 1: For Members under the age of 21, acute service providers must use the CANS as part of the discharge planning process. Additional instruments can be used to supplement the CANS at the provider’s discretion.

Note 2: The Brief Psychiatric Rating Scale (BPRS) is not required for acute psychiatric facilities for discharge planning purposes. With the exception of Section 1.C, Note 1 above, acute service providers can select an appropriate assessment instrument for discharge planning purposes, which reflects their clinical practice.

1.D Overview of Required Assessment Instruments by Service

Many MBHP services have requirements or restrictions for assessment instruments to be used. The following grid outlines the various services and required or restricted assessment tools. For services that do not require a specific assessment instrument, providers may choose an assessment instrument to implement from the recommended instrument list (see Section 1.A).

Service	Assessment Tool	
	Members under age 21	Members 21 and older
Outpatient Therapy (diagnostic evaluations and individual, family, and group therapy)	CANS	Any instrument
Intensive Care Coordination (ICC)	CANS	N/A
In-Home Therapy (IHT)	CANS	N/A
Community-Based Acute Treatment (CBAT)	CANS (discharge)	N/A
Transitional Care Units (TCU)	CANS (discharge)	N/A

Psychiatric inpatient hospitalization	CANS (discharge)	Any instrument (discharge)
Emergency Services Provider (ESP) evaluations	Any instrument	Any instrument
Community Support Program (CSP)	Any instrument	Any instrument
Acute Treatment Services for substance use disorders (ATS, E-ATS, Level IV detox)	Any instrument (discharge)	Any instrument (discharge)
Community Support Services (CSS) for Substance Use Disorders	Any instrument	Any instrument
Structured Outpatient Addiction Program (SOAP)	Any instrument	Any instrument
Psychiatric Day Treatment	Any instrument	Any instrument
Partial hospitalization	Any instrument	Any instrument
Psychopharmacology evaluations	Exempt	Exempt
Psychological/neuropsychological testing	Exempt	Exempt
Ongoing medication management	Exempt	Exempt
Family consultation	Exempt	Exempt
Case consultation	Exempt	Exempt
Inpatient-outpatient bridge	Exempt	Exempt
Assessment for Safe and Appropriate Placement (ASAP)	Exempt	Exempt
Collateral Contact	Exempt	Exempt
Specialing	Exempt	Exempt
IM injections	Exempt	Exempt

Section 2: Administering the Standardized Assessment Instrument

2.A	Members to be Included in the Standardized Assessment Process
	<p>All Members shall be included in the standardized assessment process, as specified in this protocol. MassHealth Members are defined as those who are eligible to receive covered services under the Office of Medicaid, Office for Behavioral Health, including MBHP enrollees.</p> <p>To comply with the MBHP standardized assessment policy, the provider must select an assessment(s) to be used for each age group(s) served by the provider caseload (children and/or adolescents and/or adults).</p>

2.B	MBHP Covered Services Exempted from Standardized Assessments
	<p>With the exception of the services listed below, all behavioral health services covered by MBHP will be evaluated through this outcomes protocol. The services (with their associated CPT codes) that are exempt from this protocol are:</p> <p>Medication Evaluation Services¹</p> <ul style="list-style-type: none"> • Simple and complex medication visit (90862) • Medication diagnostic visit (99404) • 60-minute medication evaluation groups (90857) • Psychiatric consultation on a medical floor (99251, 99252, 99253, 99254, 99255) <p>Mental Health and Substance Use Disorder Outpatient Services</p> <ul style="list-style-type: none"> • Family consultation (90887) • Case consultation (90882) • Inpatient-outpatient bridge (H0032) • Collateral contact (H0046) • Psychological testing (96101, 96111, 96116, 96118, 96119, 96120, 99402) • IM injections (90772) <p>Other Services</p> <ul style="list-style-type: none"> • Specialing (T1004) • Assessment for Safe and Appropriate Placement (ASAP) (H2028)
2.C	Intake/Baseline Assessments and Periodic Reassessments for Outpatient and Other Non-24-Hour Services
	<p>The assessment process shall include the administration of the assessment instrument by the clinician, or self-administration by the Member, at the time of the Member’s intake for treatment (baseline assessment), with additional administrations (reassessments) given at least every 90 days (required for youth under the age of 21 (see below, this section) and recommended for adults). If there is a specified end to treatment or the time of discharge is known, the standardized assessment should also be administered at discharge.</p> <p>In the case of a clinician administering the evaluation instrument, the clinician can bill MBHP for the evaluation session within the regular parameters of direct Member contact for that session.</p> <p>The CANS is required to be updated every 90 days for services outlined in Section 1.B above. Intensive Care Coordination (ICC) and In-Home Therapy (IHT) services: CANS assessment is required upon enrollment and every 90 days thereafter. The assessment is billed as part of the typical day/unit rate. Inpatient services: CANS assessment must be completed within 2 weeks of discharge from the facility.</p>

¹ The exemption for medical evaluation services is made on the assumption that Members for whom psychotropic medications are being prescribed by a network psychiatrist are also receiving psychotherapy or other treatment services and that such Members are receiving outcomes evaluations through these other services. **Generally, MBHP recommends against Members receiving medication services only, without receiving other psychosocial treatment in addition to the medication treatment.**

2.D	Special Considerations Regarding Assessments
	<p>Clinical contraindications: If a Member’s individual practitioner or treatment team decides that the administration of a standardized assessment instrument is not clinically indicated, or the Member refuses to complete the assessment, then the Member can be exempt from the assessment. These instances should be exceptional and must be justified in the Member’s medical record by the clinician.</p> <p>Multiple services: Members ages 21 and older, receiving multiple concurrent services at a single LOC, do not need to have multiple assessments. <i>If a Member is receiving services from multiple practitioners, it is the responsibility of the practitioners to jointly identify a lead practitioner who would be responsible for a single outcomes assessment protocol and for the communication of outcome results to subordinate clinicians.</i></p> <p>For example, if a Member is receiving outpatient services and day treatment services, the provider of the core ongoing psychotherapeutic service should take the lead in conducting the assessments.</p> <p>If outpatient psychotherapy is provided by a clinician and medication management is provided by a psychiatrist, the psychotherapist would in most instances be the provider responsible for the outcome measurement. It would be important that the psychotherapist communicate the results of the outcome measurements to the psychiatrist.</p> <p><i>For Members under the age of 21, the CANS is an integral, requisite part of the behavioral health assessment process. When a Member is treated by more than one provider, each provider is required to perform their own behavioral health assessment, which must include the CANS.</i></p> <p>Family therapy: When an entire family is being treated through family therapy sessions, it may not be feasible to administer an assessment to every member of the family. Many times, one or more members of the family are concurrently receiving individual therapy.</p> <p>In such cases, the <i>routine outcomes assessment completed for the Member of the family who is receiving individual therapy will suffice.</i> That is, the family members not seen individually do not need to be included in the outcomes assessment, unless the provider otherwise decides to assess each family member or the family as a unit.</p> <p>If a family is being seen as a unit with no other services being provided to individual family members, then the administration of an assessment instrument for the family is at the discretion of the clinician.</p> <p>Group therapy: Each Member involved in group therapy is expected to have an assessment as part of the Member’s intake assessment and revision of the Member’s treatment plan.</p>

Section 3: Incorporating Result of Standardized Assessments into Treatment Plans

3.A	Provide Feedback to the Member About the Intake Assessment and Reassessments (Outcomes)
	<p>The clinical implications of the initial assessment and the “outcome or change scores” (i.e., the differences between the Member’s baseline measurement values and the remeasurement values) should be explained to the Member (or Member’s guardian) at the same or next session following each administration. It should be noted in the Member’s record that an assessment was completed, and the results were discussed with the Member.</p> <p>This explanation should be made in clinically appropriate, non-technical language that is understandable to the Member. If such an explanation is deemed by a psychiatrist to be clinically contra-indicated, a clinical note to this effect should be made in the Member’s medical record.</p>

Helpful references:

Dickey, B. and Sederer, L. (2001). *Improving Mental Health Care: Commitment to Quality*. Washington, DC: American Psychiatric Publishing, Inc.

Epstein, M., Kutash, K. and Duchnowski, A. (1998). *Outcomes of Children and Youth with Emotional and Behavioral Disorders and Their Families: Programs and Evaluation Best Practices*. Austin: PRO-ED, Inc.

Hernandez, M. and Hodges, S. (2001). *Developing Outcome Strategies in Children’s Mental Health*. Baltimore: Paul H. Brookes Publishing, Inc.

IsHak, W., Burt, T. and Sederer, L. (2002). *Outcome Measurement in Psychiatry: A Critical Review*. Washington, DC: American Psychiatric Publishing, Inc.

Nathan, P. “Assessing Substance Abusers”. (1996) In Murphy, L. and Impara, J. *Buros Desk Reference: Assessment of Substance Abuse*. Lincoln: The Buros Institute of Mental Measurements.

Sederer, L. and Dickey, B. (eds) (1996). *Outcomes Assessment in Clinical Practice*. Baltimore: Williams & Wilkins.

Child and Adolescent Needs and Strengths (CANS) Tool

MBHP requires a uniform behavioral health assessment process that includes a comprehensive needs assessment employing the Massachusetts CANS tool for MassHealth Members under the age of 21.

The CANS tool, developed by John S. Lyons, PhD, is a document that organizes clinical information collected during a behavioral health assessment in a consistent manner to improve communication among those involved in planning care for a child or adolescent. The CANS tool is also used as a decision-support tool to guide care planning and track changing strengths and needs over time. The CANS tool is used in child-serving systems in more than 30 states across the country.

There are two forms of the Massachusetts CANS tool: “CANS Birth through Four” and “CANS Five through Twenty.” In addition, the CANS tool assessment form includes a determination of whether a child meets the criteria for Serious Emotional Disturbance (SED).

CANS action checklist for network providers

Network providers need to take the following steps to meet their obligations concerning the CANS tool:

- [] Ensure that all clinical staff members who are required to use the CANS tool are CANS-trained and certified. Information on CANS certification and training can be found on the web at <https://masscans.ehs.state.ma.us/login.aspx?ReturnUrl=%2f>. This website includes an online training course, online certification exam, and more. For more information on training, contact the Massachusetts CANS Training Center by calling 774-455-4057 or sending an email to MassCans@umassmed.edu.
- [] Ensure that your organization is enrolled with the Virtual Gateway (VG). This enrollment is necessary to access the web-based CANS application. *Enrollment with the VG for other business applications (such as STARS, EIM/EIS, etc.) does not satisfy this requirement.* For information on how to enroll, email the VG customer service group at VirtualGatewayCBHI@state.ma.us. If technical assistance is needed with the VG, please contact the VG Customer Service group at **1-800-421-0938, Ext. 5**.
- [] When a provider organization terminates employment of a CANS-certified employee, the provider organization must submit a request to the Virtual Gateway to have the staff person deactivated *as soon as access to the Virtual Gateway is no longer required by the provider organization*. For more information about using the CANS application on the Virtual Gateway, please refer to <http://www.mass.gov/eohhs/consumer/insurance/cbhi/cans/using-the-cans-application-on-the-virtual-gateway.html>.

CANS paper form

Links to paper copies of the appropriate version of the Massachusetts CANS tool (either “Birth through Four” or “Five through Twenty”) are found at the CBHI website at <http://www.mass.gov/eohhs/consumer/insurance/cbhi/cans/cans-forms.html>.

The paper version of the CANS tool must be stored and maintained with the Member's medical record for audit purposes. The paper version of the CANS tool must be used if a Member denies consent for a provider to enter information into the VG. Please note that if a Member denies consent for a provider to enter information into the VG, then providers must still enter the demographic information and Serious Emotional Disturbance determination into the Virtual Gateway. For audit purposes, the paper version of the CANS tool must be stored and maintained with the Member's medical record.

The CANS requirement applies to behavioral health clinicians with the following credentials

The following types of clinicians are required to pass the online CANS certification examination and use the CANS tool:

- Psychologist
- LICSW
- LMHC
- LMFT
- LCSW
- Unlicensed, master's-level clinicians working under the supervision of a licensed clinician
- Master's-level clinical interns in psychology and social work working under the supervision of a licensed clinician
- Bachelor's-level intensive care coordinators

Psychiatrists, psychiatric residents, and psychiatric nurse mental-health clinical specialists who provide outpatient therapy to Members under the age of 21 also must pass the online CANS certification examination and use the CANS tool.

Non-24-hour level of care services that require use of the CANS tool

The use of the CANS tool is *required to be completed and entered into the Virtual Gateway* as part of an initial behavioral health assessment for the following service for Members under the age of 21 and must be updated *and entered into the Virtual Gateway* at least every 90 days thereafter

- Outpatient Therapy including diagnostic evaluations, individual, family, and group therapy for clinics that hold *only* a DPH outpatient mental health license and clinics that hold both a DPH outpatient mental health license *and* a DPH outpatient substance use disorder license, private practitioners, and group practices
- In-Home Therapy (IHT)
- Intensive Care Coordination (ICC)

24-hour level of care services that require use of the CANS tool

The CANS tool is *required to be completed and entered into the Virtual Gateway* as part of the discharge planning process in the following 24-hour level of care services:

- Psychiatric inpatient hospitalization
- Community-Based Acute Treatment (CBAT)
- Intensive Community-Based Acute Treatment (ICBAT)

- Transitional Care Units (TCU)

With Member consent, all of the above 24-hour and non-24-hour providers are required to enter all information from the CANS tool into the Virtual Gateway at the above required frequency. If no consent to enter the CANS into the Virtual Gateway is given, providers are required to complete the paper version of the CANS *and* also enter the demographic information and Serious Emotional Disturbance determination into the Virtual Gateway.

When a Member is receiving multiple CANS administering services

When a Member is treated by more than one of the above services, each service provider is required to complete the CANS as described above.

CANS and Hub-dependent providers

MBHP requires the use of the CANS when a referral is made for a youth by any of the Hub providers (Intensive Care Coordination, In-Home Therapy, or Outpatient) to any of the Hub-dependent services (Family Support and Training and/or Therapeutic Mentoring). MBHP requires that the Hub provider, with consent, furnish a copy of the most recent CANS and comprehensive assessment to the Hub-dependent provider. This helps to ensure that: 1) a comprehensive behavioral health assessment inclusive of the CANS indicates the clinical need for the Hub-dependent service; and 2) the Hub-dependent service is needed/required in order to achieve a goal(s) established in the existing behavioral health treatment plan/care plan of the Hub provider.

The Hub-dependent provider is required to keep a copy of the CANS and comprehensive behavioral health assessment on file. If the Member has MassHealth as a secondary insurance and is being referred to a Hub-dependent service by an outpatient provider who is paid through the Member's primary insurance, the Hub-dependent provider is required to keep a copy of the comprehensive behavioral health assessment in the Member's record. A CANS is not required.

Services and providers that are NOT required to complete the CANS tool or become CANS certified

The CANS tool is not required in the following circumstances:

- Psychopharmacology evaluations
- Psychological/Neuropsychological Testing
- Emergency Services Provider (ESP) evaluations
- Acute Treatment Services (ATS) for Substance Use Disorders
- Community Support Services (CSS) for Substance Use Disorders
- Ongoing medication management
- Psychiatric Day Treatment
- Partial Hospitalization
- Structured Outpatient Addiction Program (SOAP)
- Community Support Program (CSP)
- DPH-licensed substance use disorder providers that do not hold a DPH outpatient mental health license (even when billing 90801 code)



- Therapeutic Mentoring (TM)
- In-Home Behavioral Services (IBHS)
- Family Support and Training (FS&T)

CANS in other EOHHS Agencies

Separate from MassHealth, certain other EOHHS agencies including the Departments of Mental Health (DMH), Children and Families (DCF), and Youth Services (DYS) will adopt or have adopted the Massachusetts CANS tool for use within their programs. Those agencies will provide instructions to their providers.

CANS as an Outcome Instrument in Relation to MBHP's Outcomes Management Policy

The CANS tool is a required standardized assessment instrument for MBHP's Members under the age of 21.

Inpatient providers can use the CANS tool as part of the discharge planning process in lieu of the Brief Psychiatric Rating Scale (BPRS). A provider still has the option of using additional standardized assessment instruments for its own clinical or quality improvement purposes for youth under the age of 21.

Billing for CANS

Billing is permitted, and reimbursement will be provided for 90791-HA when the CANS tool is used as part of the initial outpatient comprehensive assessment for eligible Members under the age of 21. Outpatient individual, family, and group therapists are required to complete the CANS and enter it into the Virtual Gateway as part of the initial comprehensive assessment and every 90 days thereafter. If the Member leaves treatment and subsequently returns to the provider for a new course of treatment, the provider must perform a new initial assessment inclusive of the CANS tool, enter it into the Virtual Gateway, and may bill a 90791-HA. Outpatient billing and reimbursement are not permitted for use of the CANS tool during the 90-day updates. MBHP allows doctoral-level psychology interns and master's-level social work interns to bill for 90791 and 90791 HA.

Billing is permitted, and reimbursement will be provided for H2019-HO when the initial CANS tool and 90-day reassessment CANS tool is completed by master's-level providers of In-Home Therapy.

ICC is reimbursed on a daily rate; completing the CANS is part of that rate and therefore can't be billed separately.

Consistent with the current MBHP Policy Statement on Behavioral Health Standardized Assessments, providers are required to incorporate the results of the CANS evaluations into the Member's treatment plan.



Clinical Practice Guidelines

MBHP has adopted three clinical practice guidelines from nationally recognized sources for behavioral health disorders relevant to its population. These guidelines, which are not intended to replace clinical judgment, are statements designed to assist contracted practitioners in making decisions about appropriate healthcare for specific clinical circumstances.

Prior to the adoption and dissemination of each guideline, the relevant scientific literature is reviewed by a multidisciplinary team that includes board-certified psychiatrists. MBHP reviews and approves clinical practice guidelines at least every two years and updates them as needed. As part of MBHP's routine monitoring of adherence to generally accepted standard clinical practice, MBHP performs an annual audit of at least two important criteria contained within each of the guidelines to assess provider adherence to the evidence-based treatment recommendations described in the guidelines. In 2021, MBHP retired one clinical practice guideline (CPG) and adopted one new guideline to align with Beacon-recommended practices.

Clinical Practice Guidelines (CPGs):

National Action Alliance For Suicide Prevention - Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe
(https://s21151.pcdn.co/wp-content/uploads/action_alliance_recommended_standard_care_final-1.pdf)

Psychiatric Evaluation of Adults - Practice Guidelines for the Psychiatric Evaluation of Adults
(<http://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760>)

New: American Academy of Pediatrics - Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents
(<https://s21151.pcdn.co/wp-content/uploads/AAP-ADHD-CPG-for-the-Diagnosis-Evaluation-and-Treatment-of-ADHD-in-Children-and-Adolescents-Pub-2019-Adopted-Oct-2020.pdf>)

MBHP asks providers to consider including these guidelines with their scientifically based reference materials for clinical staff. MBHP also asks providers and their clinicians to consider these guidelines whenever they think the guidelines may promote positive outcomes for clients. If you are unable to access the guidelines through the internet, please contact the MBHP **Quality Management Department** at **1-800-495-0086**, and they will provide you with a paper copy.

Behavioral Health Screening

MBHP is committed to improving quality in all aspects of our Members' lives. We believe that preventive healthcare services are an important part of our Members' overall behavioral health.

As part of our preventive health programming, MBHP offers services such as:
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- **Educational Opportunities** on relevant behavioral health topics through multiple platforms including informational one-pagers, consumer information guides, online webinars, in-person trainings, and articles in our Member and provider newsletters;
- **Specialized Care Management Services** targeted to the specific needs of Members with mental illness and substance use disorders, including targeted outreach, care coordination, and intensive clinical management (ICM); and

MBHP also has several specific preventive health programs that are designed to ensure the early identification and treatment of, as well as reduce impairment of, behavioral health disorders. MBHP reviews and updates these services annually. MBHP encourages its providers to use the MBHP preventive health programs with Members. MBHP also encourages its providers to provide feedback and input on the MBHP preventive health programs. If providers are interested in participating in the design or implementation of MBHP preventive health programs or have questions about the current MBHP programs, please contact MBHP's Quality Management Department at **1-800-495-0086**. Please see below for information about these specific preventive health activities and programs.

MBHP has developed and supports two new screening programs:

Metabolic Screening for Youth with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications

Several studies have shown that use of antipsychotic medications has significantly increased among youth in recent years, posing a greater risk for developing metabolic syndrome.^{2,3} In addition, MBHP's performance rates for the Healthcare Effectiveness Data and Information Set (HEDIS®)⁴ measure on metabolic monitoring for children and adolescents on antipsychotics (APM) continue to be lower than the 75th percentile Medicaid benchmark, suggesting a necessity to promote metabolic screening across MBHP's provider network. In 2017, MBHP began the Metabolic Screening Mailing Initiative to remind PCCs and prescribers to screen Members for metabolic syndromes, using a lipid and glucose test, if the Member had not had those tests within the last two years. Within six months of the notifications, over 25 percent of Members whose provider received the notification received appropriate metabolic screening. In 2020, MBHP promoted universal screening for this population by sending mailings to prescribing providers of eligible Members without metabolic screenings in the past year and saw a 34 percent improvement in screening rates.

Screening for metabolic syndrome can improve health outcomes among this population for the following reasons:

- Allows for timely diagnosis and treatment of diabetes for Members identified as susceptible to metabolic syndrome;

² Galling, B., Roldán, A., Nielsen, R. E., Nielsen, J., Gerhard, T., Carbon, M. & Kahl, K. G. (2016). Type 2 diabetes mellitus in youth exposed to antipsychotics: a systematic review and meta-analysis. *JAMA psychiatry*, 73(3), 247-259.

³ Morrato EH, Nicol GE, Maahs D, et al. Metabolic Screening in Children Receiving Antipsychotic Drug Treatment. *Arch Pediatr Adolesc Med*. 2010;164(4):344–351. doi:10.1001/archpediatrics.2010.48

⁴ HEDIS is a registered trademark of the National Committee for Quality assurance (NCQA).

- Leads to Members receiving integrated care between pharmaceutical care, nutritional counseling, behavioral health, and medical care services that can improve health outcomes; and
- Educates providers at all levels on how to effectively treat this Member population through an integrated approach across the continuum of care.

With this ongoing initiative, MBHP aims to increase screening rates among Members to meet national HEDIS benchmarks on the APM measure and to ensure early detection and effective prevention and management of metabolic syndrome and associated disorders. MBHP will continue to promote screenings in addition to providing informational resources on referral services for prescribing providers so that Members are directed to appropriate forms of care to effectively address and manage chronic metabolic conditions. Additionally MBHP will expand the program to improve diabetes screening for adult Members with severe mental illnesses and using antipsychotic medications.

MCPAP for Moms Depression and Substance Use Disorder Screening for Pregnant Women

Recent studies indicate women who are pregnant or have recently given birth are at increased risk for both depression and substance use disorders,^{5, 6} The Massachusetts Department of Public Health Executive Office of Health and Human Services (EOHHS) issued Postpartum Depression (PPD) regulations to establish a PPD Legislative Commission charged with promoting screening for perinatal mood disorders and requiring family care providers including OB-GYNs, family medicine practitioners, and nurse practitioners in a family care setting to screen pregnant women or women who have given birth within the last six months for PPD using a validated screening tool during routine clinical appointments.⁷ Furthermore, mortality rates linked to substance use have risen significantly in the last decade among postnatal women in Massachusetts. To address the rising epidemic in substance use disorders among pregnant perinatal women, the Massachusetts Child Psychiatry Access Program for Moms (MCPAP for Moms) expanded their program to improve access to services for perinatal women with substance use disorders. MCPAP for Moms developed the following initiatives:

1. Expand the MCPAP for Moms Toolkit to include resources and practice guidelines on screening for substance use disorders, associated maternal and infant health risks, treatment options available, and referral information;
2. Educate obstetric providers and promote screening for substance use disorders among perinatal women presenting with mental health conditions; and
3. Hire a dedicated program manager to educate substance use disorder providers treating pregnant and perinatal women to screen for depression and perinatal mood disorders.

⁵ Chapman, S. L. & Wu, L. T. (2013). Postpartum substance use and depressive symptoms: a review. *Women & health*, 53(5), 479–503. doi:10.1080/03630242.2013.804025

⁶ Benningfield, M. M., Dietrich, M. S., Jones, H. E., Kaltenbach, K., Heil, S. H., Stine, S. M. & Martin, P. R. (2012). Opioid dependence during pregnancy: relationships of anxiety and depression symptoms to treatment outcomes. *Addiction*, 107, 74-82.

⁷ CY16 Summary of Activities Related to Screening for Postpartum Depression. Executive Office of Health and Human Services at the Department of Public Health.

<https://malegislature.gov/Reports/5302/postpartum.pdf>



MBHP Quality Management, Clinical leadership and the MCPAP for Moms program will continue to work collaboratively in disseminating the expanded toolkit more widely to providers treating pregnant perinatal women presenting with mental health conditions in addition to working with BSAS-licensed providers specializing in substance use disorders to screen for depression and perinatal mood disorders to better assess pregnant women with co-occurring disorders.

If you are interested in learning more about MBHP’s screening programs and would like to work with us in promoting these screenings, please contact the MBHP’s **Quality Management Department** at **1-800-495-0086**.



MBHP Quality Management Forms

- [Adverse Incident Reporting form](#)
- [Behavioral Health Provider/Primary Care Clinician Two-Way Communication form](#)

MBHP Quality Management Appendices

- A: [DMH Human Rights Regulations and Use of Restraint and Seclusion](#)
- B: [Massachusetts General Law Chapter 123, Section 21, Transportation of mentally ill persons; restraint](#)
- C: [Center for Medicare/Medicaid Services and Use of Restraint & Seclusion of Individuals Under the age of 21](#)
- D: [DMH Policy on Informed Consent 96-3R](#)
- E: [Massachusetts General Law Chapter 123, Section 23, Telephone access Rights; Mail Rights; Visitation Rights; Legal and Civil Rights; Suspension of Rights; and Notice of Rights](#)

Provider Quality Management and Credentialing

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Provider Quality Management

Provider Quality Management Program Description

The purpose of the Beacon Health Options (Beacon)/MBHP Provider Quality Program Description (PQPD) is to define the Provider Quality (PQ) program mission, philosophy, goals, and objectives. The PQPD describes the framework, structure and responsibilities of Provider Quality and a process intended to support provider interventions intended to improve clinical and quality outcomes, while contributing to ensuring fidelity to the medical necessity of care and appropriate utilization of services.

A division of Clinical Provider Strategy, the Provider Quality Department offers a collaborative and data informed approach to working with providers. Clinical Provider Strategy bridges a key gap in many managed care approaches, working innovatively to increase Beacon/MBHP's ability to meet goals through collaborating with providers on shared outcomes informed by provider-facing reports using aligned data definitions.

Provider quality managers (PQM) are independently licensed clinicians who excel at collaborating with those providers identified for participation in the PQ program, which is based on such factors as volume of Beacon/MBHP Members served and how integral they are to the care delivery system. PQMs are selected for their clinical expertise, knowledge of their local delivery system of care, and their ability to analyze and assess patterns and trends in aggregated data.

Mission

Provider Quality's mission is to improve Member health outcomes and administrative efficiencies by building collaborative partnerships with providers to drive performance improvement, using aggregate data to educate and impact provider behavior.

Provider Quality strives to promote evolution of the managed care process from labor-intensive transactional utilization oversight to collaborative analysis of aggregate data patterns targeting improvements in quality of and access to medically necessary care.

Philosophy

The behavioral health delivery system is constantly evolving to keep pace with developments in best practices, growing demand for services, changing regulations, and the demand to manage cost of care while ensuring access to quality services. Beacon/MBHP's Provider Quality program advances clinical and systemic improvements by collaborating with providers to address deficiencies in care and operational practices. By leveraging managed care expertise and sharing comprehensive utilization and quality data, Beacon contributes to improvements in services at the patient, provider, and systems level.

Beacon and our network providers share the goals of ensuring access to medically necessary services, delivering quality patient care and sustaining long-term recovery. The Provider Quality Program promotes provider partnerships targeting the standards and best practices that improve health outcomes. PQMs engage providers by establishing collaborative relationships, then leveraging data to identify opportunities for improved outcomes, impacting provider performance to achieve clinical, quality, and administrative process improvements. PQMs access Beacon/MBHP's broad array of



subject-matter expertise to provide information pertaining to best practices when engaging providers. While it is the shared responsibility of all departments, Provider Quality strives to take the lead in the integration of information and data from across Beacon/MBHP to present a strategic, unified message to providers, assisting in the navigation of Beacon/MBHP departments to ensure consistent messaging and excellent customer service. PQMs pro-actively coordinate interdepartmentally to:

- Align with Clinical and Quality Departments to ensure integration of their priorities and annual goals;
- Inform the Network Operations Department of provider performance to best identify opportunities for program development informed rate setting, and establishment of Alternative Payment Models (APM) such as Value-Based Payments (VBP);
- Support account partnerships in ensuring Beacon's customers are well informed about provider performance, activities to promote continuous improved outcomes and progress toward those goals, and;
- Collaborate with Operations and Provider Relations Departments to ensure providers are adequately supported in the resolution of operational issues that may arise.

Scope

PQMs serve as a direct contact for a subset of Beacon/MBHP providers known as strategic providers. Provider Quality identifies strategic providers based on market volume, with consideration given to providers of specialty services that improve quality and/or access to care for target populations. The number of strategic providers assigned to a PQM may vary, due to such factors as geography, type of service, and level of intensity needed to impact change.

Strategic providers encompass both mental health (MH) and substance use disorder (SUD) treatment for all levels of care, including (but not limited to) inpatient, outpatient, intensive outpatient, partial hospitalization, Applied Behavior Analysis (ABA), and primary care (PCP).

Provider Quality collaborates interdepartmentally on the development of APM and preferred provider network (PPN) opportunities. Provider Quality is responsible for the clinical and quality component of APM and PPN, and for the development of key standard metrics. In order to operationalize VBP and PPN efforts, Provider Quality supports implementation by understanding the quality and clinical performance of prospective providers, and contributing this information to integrate into determinations for eligibility. Upon initiation of APM or PPN agreements, PQMs act as point of contact for clinical and quality oversight to operationalize processes and subsequently monitor performance.

Goals and objectives

PQM performance is assessed not only on the ability to establish relationships and engage providers, but by evidence of measurable improvements in clinical and quality outcomes. Data trends to be measured for improvement may include (but are not limited to):

- Healthcare Effectiveness Data and Information Set (HEDIS®)¹ outcomes
- Cost metrics
- Length of treatment episode
- Readmission rates
- Access to medically necessary care

¹ HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).



- Transitions of care
- Quality outcomes
- Other utilization patterns and trends

The primary goals and objectives of the Provider Quality Department are:

1. **Transform provider relationships to improve health outcomes.** As the strategic connector between Beacon/MBHP and providers, PQMs provide clinical support and technical assistance, enabling providers to focus resources on patient care and quality initiatives rather than administrative processes.
2. **Drive clinical and quality improvements.** Compare clinical, quality, and financial results against historical provider data and the market aggregate, highlighting opportunities to improve performance over time.
3. **Promote innovation through new program development.** Collaborate with providers to identify best practices and implement new treatment approaches to enhance clinical programming.

Measuring impact on provider performance

PQMs track trends in key clinical and quality metrics to compare between like typed providers, as well as each provider against their own historical performance. PQMs collaborate with providers to improve the quality of care offered to Members and use data to allow for an objective and efficient avenue for collaboration on performance improvement. Data is primarily obtained from analysis of claims and is updated quarterly. Comparative analysis is within state/market parameters to ensure similarities in population and other determinants of provider performance. PQMs target those metrics that most reflect opportunities for clinical and quality performance improvement and develop strategic plans with providers, which serve as a road map for performance improvement. PQMs monitor progress toward goals continually and interventions are adjusted accordingly.

Provider Performance Specifications

MBHP has developed performance specifications that delineate requirements for all covered services. An essential element of provider quality management involves working with providers to ensure compliance with these performance specifications and related quality improvement. The specifications represent a primary structure and focus of MBHP's provider quality management activities, which measure, monitor, and manage provider performance with respect to these specifications on a regional and statewide basis.

General performance specifications

The General performance specifications include a philosophy statement and performance specifications that apply to all covered services. MBHP created these performance specifications, applicable to all covered services, in anticipation that it will promote a better understanding of MBHP's expectations across the continuum of care, especially for providers who are contracted for more than one covered service.

In accordance with MBHP's mission and values, particular emphasis has been placed in the General performance specifications on recovery, wellness, and resilience; cultural humility in serving our Members; and integration of physical and behavioral health. Also of note, the General performance specifications reiterate the responsibility of providers to immediately notify MBHP of revocation,



limitation, suspension, or other conditions placed on the license, certification, or accreditation, in compliance with all applicable state and federal laws, regulations, licensing, policies, and accreditation requirements, as well as any proposed changes in location of services for which the provider is contracted. The General performance specifications articulate providers' responsibility to meet with MBHP staff for the purposes of care management, provider quality management, quality management, and/or utilization management.

Performance specifications for particular levels of care

In addition to the General performance specifications, MBHP maintains performance specifications specific to each covered service. Each provider should be sure to read the performance specifications related to any service for which the provider is contracted with MBHP, train staff, and ensure compliance.

Implementation

MBHP expects all providers to be in full compliance with the performance specifications and to comply with any revisions to performance specifications and/or additional requirements issued through Provider Alerts, Beacon/MBHP Broadcasts, and/or other contractual documents on an ongoing basis.

Provider Responsibilities

Liaison: Providers are required to designate a representative to act as a liaison with MBHP.

This representative shall be responsible for:

- representing the provider with regard to all matters pertaining to the provider agreement;
- monitoring the provider's compliance with the terms and conditions of the provider agreement;
- receiving and responding to all inquiries and requests made by MBHP in the required time frames; and
- meeting with MBHP's representatives on a periodic or as-needed basis to collaborate on ongoing quality improvement and to resolve issues that may arise.

Health Insurance Portability and Accountability Act (HIPAA) Compliance: Providers are expected to adhere to the privacy requirements of HIPAA and implementing regulations. Please refer the Quality Management/Member Rights section of the Manual for additional information.

Emergency Medical Treatment and Labor Act (EMTALA) Compliance: Hospitals must comply with the EMTALA of 1986. Under EMTALA, a hospital is required to provide a medical screening examination to an individual who comes to the emergency department to determine if the individual is suffering from an emergency medical condition. An "emergency medical condition" is a medical condition with acute symptoms of sufficient severity (including severe pain) that if not immediately treated could result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any organ or body part. EMTALA is triggered when an individual comes to a dedicated emergency department, which also includes the area within 250 yards of hospital property (except for offices and facilities not owned by the hospital), an ambulance once it is on hospital property, or an off-campus, provider-based emergency department, like an urgent care center.



If the individual requires stabilizing treatment, the hospital must provide such treatment, or, if the hospital lacks the capability or capacity to provide stabilizing treatment, conduct an appropriate transfer. The requirements of EMTALA are applicable to hospitals with dedicated emergency departments as well as hospitals without dedicated emergency departments that may be required under EMTALA to receive an unstable transfer patient who is in need of that hospital's specialized services.

When an emergency admission occurs as part of the hospital's EMTALA obligations and without ESP involvement, authorization for the inpatient care must be requested as soon as possible after the placement of the Member, and in all cases within 24 hours. MBHP reserves the right to authorize individual exceptions to this policy as indicated by clinical or best practice considerations.

Electronic Access: Providers are required to have access to the Internet for the purpose of receiving communications from MBHP and to maintain an active email address that remains on file with MBHP.

Operating Hours: Every provider shall maintain hours of operation for Members in the same manner as maintained for all other populations who utilize the provider's services. In addition, all outpatient providers are expected to provide emergency services 24 hours per day, seven days per week to all Members enrolled in the outpatient program/clinic/practice. These services are intended to be the first level of crisis intervention whenever needed by the Member. During operating hours, these services are provided by phone and face-to-face through emergency appointments as warranted by the Member's clinical presentation. After hours, the program provides an emergency phone number that accesses a clinician either directly or via an answering service. Any call that is identified as an emergency by the caller is immediately triaged to a clinician. A clinician must respond to emergency calls within 15 minutes. This clinician provides a brief assessment and intervention minimally by phone. Based upon these emergency services conducted by the provider both during operating hours and after hours, the provider may refer the Member, if needed, to an ESP for an emergency behavioral health evaluation. Providers must have a policy and procedure for how to respond to after-hours emergencies and must be familiar with how to access the local ESP/MCI.

Access: MBHP is committed to Member choice and ensuring immediate access to appropriate treatment services. We ensure access to services and availability of providers for Members in accordance with our accessibility and availability standards. Providers shall ensure access to services for Members consistent with the degree of urgency and in accordance with the following standards.

- Emergency services shall be provided immediately (respond to call with a live voice; face-to-face within 60 minutes) on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present at any qualified provider, whether a network provider or a non-network provider;
- Emergency Services Program (ESP) services shall be provided immediately on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present, including covered individuals, uninsured individuals, and persons covered by Medicare only;
- Urgent Care Services shall be provided within 48 hours; and
- All other care shall be provided within 14 calendar days.

All providers shall manage services to eliminate the necessity of maintaining waiting lists. Providers who are not able to offer access that comply with the MBHP access standards outlined below must



refer Members to another MBHP provider to ensure that Members receive services in a timely manner. Providers will contact the Northeast Access Line for assistance with making referrals as needed.

Inpatient Facility Compliance with “No Reject” Requirements

MBHP requires that all inpatient acute mental health service providers comply with requirements to accept for admission all covered individuals in need of inpatient admissions who are referred by ESPs, regardless of the availability of insurance, capacity to private pay, or clinical presentation.

Access to provider and Member records: Providers at all times shall make available to MBHP, upon its request, any and all records relating to the treatment of Members (except as otherwise limited by state or federal law or regulations), including but not limited to: Member medical records; service authorization data; claims submission data; clinical protocols; quality management records; and incident, compliance, appeal, and grievance information. Providers at all times shall make available to MBHP, upon its request, documentation relating to the administration of the provider in connection with the service it provides to Members and its relationship with MBHP, including, but not limited to, financial and cost data, benefit coordination, and staff qualifications and credentialing. Requested information must be provided in accordance with reasonable timelines, definitions, formats, and instructions as specified by MBHP. MBHP may conduct on-site reviews and conduct staff interviews. In the event of a record request, and to the extent permitted by law, the provider shall provide MBHP with copies of all requested information. When a copy of a Member’s current or closed medical record is requested, submitted documentation shall include: documents completed by the provider (e.g., assessments, treatment plans, progress notes, multi-disciplinary team reviews, and outcome measurement); forms that Member has signed or declined to sign (e.g., consent to treatment and releases of information); copies of documents given to the Member; and lab report results. When group therapy is provided, submitted documentation should include a description of each group therapy service such as: description of group, population serviced, and group treatment plan.

Record retention: The provider shall maintain books, records, and other compilations of data pertaining to its provision of covered services to the extent and in such detail as shall properly substantiate claims for payment. The provider’s financial books and records shall be maintained in accordance with generally accepted accounting principles. All such records shall be kept for the time periods required by state and federal law and regulation provided, however, that if any litigation, claim, negotiation, audit, or other action involving such records is commenced prior to the expiration of such retention period, all records shall be retained until completion of such action and resolution of all issues resulting there from, or until the end of said retention period, whichever is later.

Notification of change in status: Providers must notify MBHP in writing to MBHP_PR@beaconhealthoptions.com within 24 hours upon the occurrence of the following:

- Any legal or governmental action initiated against provider and/or the members of its clinical staff whenever the existence or outcome of such action could materially affect the performance of provider and/or the members of its clinical staff;
- Any action taken against the licensure or Drug Enforcement Agency (DEA) authorization of provider and/or the members of its clinical staff;
- Any action causing a loss of admitting privileges of provider and/or the members of its clinical staff with a participating provider or any other hospital, provider, or program;



- Any action by an insurance carrier indicating that it will lower coverage, cancel, or non-renew the insurance coverage required to be carried by provider and/or the members of its clinical staff;
- Any malpractice litigation in which provider and/or the members of its clinical staff are named as defendants and the plaintiff is asking for damages in excess of \$25,000;
- Any action or event known to provider and/or the members of its clinical staff which could materially impair the performance of provider and/or the members of its clinical staff; or
- Any action through which provider and/or the members of its clinical staff are excluded from participation as a Medicaid or Medicare provider, or are excluded from any private payer network or plan.

Notification of inability to provide services:

Providers must also notify MBHP:

- Immediately of their inability to provide emergency care by contacting the Northeast Access Line at **1-800-495-0086** (press 3 and then 1 to skip prompts);
- Within 24 hours of their inability to deliver urgent care also by contacting the Northeast Access Line at **1-800-495-0086** (press 3 and then 1 to skip prompts); or
- Within seven days of their inability to provide routine care by faxing notice to the Northeast Access Line fax number at **1-855-685-5170**.

Delegation of Subcontractor Agreements

In the event that a provider wishes to engage any subcontractors to assist with its obligations to provide covered services, the provider must:

- Complete the [MBHP Organizational Providers Subcontracting Application](#) and provide a written description of any subcontracted relationships to the MBHP Network Operations Department no later than 60 days prior to the agreement;
- Maintain all subcontracts or agreements in writing;
- Monitor the quality of care provided to Members under the MBHP agreement and any subcontract;
- Remain fully responsible for meeting all of the terms and requirements of the provider agreement. No provider agreement or subcontract agreement will relieve the provider of its legal responsibilities under the provider agreement; and
- Submit claims for the delivery of all services in accordance with MBHP's claims policies and procedures. Claims must contain the name and tax ID number of the provider who has the contract with MBHP. MBHP reserves the right to determine approval or denial of all subcontractor agreements.

Information can be submitted to MBHP_PR@beaconhealthoptions.com.

Performance Evaluation/Audits

MBHP monitors network provider performance and compliance. MBHP shall have access at all times to provider and Member information in accordance with the "Access to Provider and Member Records" section under "Provider Responsibilities." MBHP's monitoring activities generally include, but are not limited to, the following:

- Reviewing reports and data submitted by the provider and/or generated by MBHP;
- Requesting additional reports that MBHP deems necessary for purposes of monitoring and evaluating the performance of the provider under the agreement;
- Performing periodic programmatic and financial reviews of the provider’s performance and responsibilities. These reviews may include, but are not limited to, on-site inspections, staff interviews, and audits of the provider’s records (by MBHP or its agent). MBHP reviews and audits will generally focus on the following topics: administration, operations, financial reports, benefit coordination, staff qualifications (including primary source documentation), Member access, clinical protocols, quality management program, appeals (including complaints and grievance procedures and data), Member satisfaction, quality of care evidenced in Member medical record, comprehensive assessment of the need for behavioral health services, individualized action plan based on assessed needs of the Member, documentation to support claims payment, and medical necessity documentation;
- Giving the provider prior notice of any on-site visit by MBHP or its agents to conduct a site visit or audit. MBHP reserves the right to make on-site visits without prior notice to ensure Member safety and quality of care;
- Notifying the provider of any records that MBHP or its agent may wish to review;
- Conducting Member and provider satisfaction surveys;
- Informing the provider of the results of any performance evaluations conducted by MBHP;
- Meeting with the provider periodically to assess performance on quality improvement goals as established by MBHP for the provider network, or individually with a given provider in response to any of the activities listed above;
- Informing the provider of any noncompliance and/or opportunities for improvement within the provider’s performance and include requirements for quality improvement and/or corrective action; and
- When significant non-compliance or quality concerns are identified, corrective actions may include:
 - Nondisciplinary sanctions
 - Development, implementation and monitoring of quality improvement and/or corrective action plan
 - Disciplinary sanctions
 - Formal written warning
 - Suspension from the IVR system
 - Suspension/probation
 - Breach of Contract

MBHP will notify the MassHealth Office of Behavioral Health regarding all provider disciplinary sanctions that reach the level of suspension/probation and/or breach of contract. MBHP may also notify, in its sole discretion, the relevant licensing boards, other state agencies and/or law enforcements regarding a provider sanction.



Provider Appeals Related to Credentialing, Sanctions, or Terminations

Termination

The provisions concerning the termination of the participation agreement are set forth in the agreement itself. In cases of material breach, the provider will be given an opportunity to cure the breach and upon termination will have a right to request an appeal of the termination decision within 30 days of receiving notice. In situations when immediate termination is necessary (as defined in the agreement) or when termination is not based on cause, an appeal is not available. MBHP will stop making any new referrals to practitioners as of the date that notice of termination is delivered.

Appeals

Practitioners have the right to appeal any adverse National Credentialing Committee (NCC) decision regarding network participation. Beacon Health Options (Beacon) has established a Provider Appeals Committee (PAC) to hear provider appeals. This committee is comprised of representatives of major clinical disciplines, network providers, and clinical representatives from corporate departments within Beacon, none of whom compete with the appealing provider.

Members of the PAC must not have participated in the original NCC decision under review. Providers are given written notice of the NCC decision, the reason for the decision, and of their right to appeal the decision along with an explanation of the applicable appeals procedures. Providers have 30 days from the date of the NCC notice to file a written request for an appeal. The request for an appeal should include an explanation of the reasons the provider believes the NCC reached a decision in error and include supporting documentation. The PAC will review the explanation provided by the provider, the information previously reviewed by the NCC, and any additional information it determines to be relevant. The PAC will support, modify, or overturn the decision of the NCC. The PAC may request additional information from the provider necessary for it to make a determination or decision. The PAC provides written notification of its decision to the provider within 14 business days after its record is complete. The written notification will include an explanation of the PAC decision and additional detail regarding the practitioner's appeal and fair hearing rights.

Fair Hearing process

Providers may request a second level of appeal or a Fair Hearing when the PAC denies credentialing or re-credentialing, issues a sanction, or dis-enrolls a provider from the network based on issues related to competence or professional conduct. A request for a Fair Hearing must be made within 30 calendar days of the date of the PAC's notification. The provider will receive written notice of the place, time, and date of the Fair Hearing, which shall not be less than 90 calendar days after the date that the request for appeal was received from the provider.

Additionally, the provider will receive an explanation of the hearing procedures and a list of witnesses, if any, expected to testify on behalf of Beacon. The chair of the PAC will identify peer reviewers who will participate as the Fair Hearing panel, assuring representation of the discipline of the provider requesting the appeal. These peers will not have any economic interest adverse to the provider, nor will they have participated in the prior decisions of the PAC or NCC. One member of the Fair Hearing panel will be selected to act as the hearing officer and will preside over the Fair Hearing. Both Beacon and the provider will make reasonable efforts to establish a mutually agreed upon date for the hearing. Both Beacon and the provider have the right to legal representation at the Fair Hearing. The provider will receive a written recommendation from the panel within 15 business days



after the Fair Hearing. The Fair Hearing process as set forth above is subject to applicable state and federal laws and regulations.

Provider sanctions

Notification: If a provider is placed on any type of disciplinary sanction, MBHP's Network Operations Department will notify the provider verbally and in writing. The written notification will include:

- Identification of the problem(s)
- Expectations for correction of the problem(s)
- A specific period for completion/correction
- Consequences for failure to comply with the corrective action plan
- Expectations regarding the frequency of follow-up meetings and any documentation or reporting requirements

Though MBHP is able to resolve most provider credentialing and quality issues through consultation and education, occasionally further action is necessary to ensure quality service delivery and protection of Members. The NCC may impose provider sanctions for issues related to Member complaints/grievances, quality of care, or violations of state and federal laws and regulations. Beacon will comply with all applicable local, state, and federal reporting requirements regarding professional competence and conduct to ensure the highest quality of care for our Members. A provider has the right to appeal any sanction through the PAC/Fair Hearing Appeals Process set forth above. The following are sanctions available to the LCC, NCC, and PAC:

1. MBHP Network Provider Terminations

Either MBHP or a provider may choose to terminate the provider agreement. If a **provider** chooses to resign from the network, MBHP must be notified in writing as specified in the termination section of the provider contract. MBHP will acknowledge receipt of the provider's request and confirm the disenrollment date. A provider who has terminated a contract voluntarily with MBHP and wishes to rejoin the network is not eligible for participation until one year after termination.

If **MBHP** chooses to terminate a provider, written notification of the disenrollment including the effective date will be given as specified in the provider's contract. MBHP may terminate the provider agreement either with 30 days' notice upon the provider's breach of contract, or immediately upon certain events, detailed below.

2. Immediate Termination

MBHP may immediately terminate a provider's agreement upon the occurrence of any of the following events:

- a. End of Contract with MassHealth: MBHP's contract with the MassHealth program terminates.
- b. Insolvency or Dissolution: The provider, group, or facility of which the provider is employed becomes insolvent or the subject of a bankruptcy, receivership, reorganization, dissolution, liquidation, or other similar proceeding.
- c. Loss of License: The provider license issued by the Commonwealth of Massachusetts is revoked, suspended, surrendered, or not renewed.
- d. Conviction of Fraud



- e. **Limited Ability to Practice:** Final disciplinary action by a governmental agency or licensing board that impairs the professional's ability to practice
- f. **Death:** The death of the provider
- g. **Immediate Termination:** We may immediately terminate this Agreement upon the occurrence of any one of the events set forth in this Section 4.1. In cases of immediate termination, an appeal is not available. In addition, in cases of immediate termination, we will provide written notice to Members of your termination from the network within 30 days of the date of the termination notice provided to you.

If for any reason our contract to provide behavioral health management to the Commonwealth's MassHealth program terminates, this Agreement will terminate also effective on the same day our contract terminates with EOHHS. While we hope to be able to provide ample notice of such a situation, we cannot guarantee that we will be able to do so. As such, notice to you will not be required to terminate our Agreement under these circumstances.

We reserve the right also to terminate this Agreement immediately upon verbal notice if we determine that you are endangering the health and wellbeing of a Member in any way. The verbal notice will be confirmed in writing within five business days.

We can immediately terminate this Agreement upon written notice to you if any governmental agency or authority (including Medicare or Medicaid) sanctions you; if your professional license is withdrawn, suspended, or otherwise limited, including probation; if any of the hospitals or facilities where you practice terminate or limit your privileges; if your insurance carrier decides to cancel or non-renew your professional liability coverage; or if you are charged with a felony or convicted of a crime.

Finally, you are required to notify us if you have reason to be considering insolvency or are otherwise financially unsound. We are required to notify EOHHS within one business day of receipt of such financial notification. We may immediately terminate this Agreement if you become insolvent or are the subject of bankruptcy, receivership, reorganization, dissolution, liquidation, or other similar proceeding.

Non-renewal of provider agreement

The MBHP Provider Agreements are effective from the date specified on the execution page of the MBHP Provider Agreements and can be terminated within 30 calendar days prior to the renewal date of the agreement. Either party must provide written notice of their intent to terminate the agreement(s).

Inspection Authority

The U.S. Department of Health and Human Services and officials of the Commonwealth of Massachusetts, namely, the governor, the secretary of Administration and Finance, the comptroller, the state auditor, the attorney general, and the secretary of Health and Human Services, or any of their duly authorized representatives or designees, shall have the right at reasonable times and upon reasonable notice to examine and copy the books, records, and other compilations of data belonging to the provider which pertain to the provisions and requirements of this Agreement. Such access shall include, but not be restricted to, on-site audit, review, and copying of records.



Fraud, Waste and Abuse Detection

We are committed to protecting the integrity of our healthcare programs and the effectiveness of operations by preventing, detecting, and investigating fraud, waste, and abuse (FWA). Combating FWA begins with knowledge and awareness.

- **Fraud:** Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it - or any other person. The attempt itself is fraud, regardless of whether or not it is successful.
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** When healthcare providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary

To help prevent fraud, waste, and abuse, providers can assist by educating Members. For example, spending time with Members and reviewing their records for prescription administration will help minimize drug fraud. One of the most important steps to help prevent Member fraud is as simple as reviewing the Member identification card to ensure that the individual seeking services is the same as the Member listed on the card. It is the first line of defense against possible fraud. Learn more at www.fighthealthcarefraud.com.

Reporting fraud, waste, and abuse

If someone suspects any Member or provider (a person who receives benefits) has committed fraud, waste, or abuse, they have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and their callback number will be kept in strict confidence by investigators.

Report concerns by:

- Visit www.fighthealthcarefraud.com. At the top of the page click “Report it” and complete the “[Report Waste, Fraud and Abuse](#)” form.
- Calling Provider Services

Any incident of fraud, waste or abuse may be reported to Beacon anonymously; however, Beacon’s ability to investigate an anonymously reported matter may be limited if Beacon doesn’t have enough information. Beacon encourages providers and facilities to give as much information as possible. Beacon appreciates referrals for suspected fraud, but be advised that Beacon does not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of Member fraud, waste, and abuse:

- Forging, altering, or selling prescriptions
- Letting someone else use the Member’s ID (identification) card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service Plan area
- Using someone else’s ID card

When reporting concerns involving a Member, include:



- The Member's name
- The Member's date of birth, Member ID, or case number if available
- The city where the Member resides
- Specific details describing the fraud, waste, or abuse

Examples of provider fraud, waste, and abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address, and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if available
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

To learn more about healthcare fraud and how to aid in the prevention on it, visit www.fighthealthcarefraud.com.

Investigation process

The Special Investigations Unit (SIU) investigates suspected incidents of FWA for all types of services. Beacon may take corrective action with a provider or facility, which may include, but is not limited to:

- *Written warning and/or education:* Beacon sends letters to the provider or facility advising the provider or facility of the issues and the need for improvement. Letters may include education or requests for repayment, or may advise of further action.
- *Medical record review:* Beacon reviews medical records to investigate allegations or validate the appropriateness of claims submissions.
- *Edits:* A certified professional coder or investigator evaluates claims and places payment or system edits in Beacon's claims processing system. This type of review prevents automatic claims payments in specific situations.
- *Recoveries:* Beacon recovers overpayments directly from the provider or facility. Failure of the provider or facility to return the overpayment may result in reduced payment for future claims, termination from our network, or legal action.

Prepayment review

One method Beacon uses to detect FWA is through prepayment claim review. Through a variety of means, certain providers or facilities, or certain claims submitted by providers or facilities, may come to Beacon's attention for behavior that might be identified as unusual for coding, documentation, and/or billing issues, or claims activity that indicates the provider or facility is an outlier compared to their peers.

Once a claim or a provider or facility is identified as an outlier or has otherwise come to Beacon's attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination that the provider's or facility's actions may involve FWA, unless exigent circumstances exist, the provider or facility is notified of their placement on prepayment review and given an opportunity to respond.

When a provider or facility is on prepayment review, the provider or facility will be required to submit medical records and any other supporting documentation with each claim so Beacon can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation to Beacon in accordance with this requirement will result in a denial of the claim under review. The provider or facility will be given the opportunity to request a discussion of their prepayment review status.

Under the prepayment review program, Beacon may review coding, documentation, and other billing issues. In addition, Beacon may use one or more clinical utilization management guidelines in the review of claims submitted by the provider or facility, even if those guidelines are not used for all providers or facilities delivering services to Plan Members.

The provider or facility will remain subject to the prepayment review process until Beacon is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the provider or facility could face corrective measures, up to and including termination from our network.

Finally, providers and facilities are prohibited from billing a Member for services Beacon has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue, or for failure to submit medical records as set forth above. Providers or facilities whose claims are determined to be not payable may make appropriate corrections and resubmit such claims in accordance with the terms of their provider and facility agreement, proper billing procedures, and state law. Providers or facilities also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on investigative findings

In addition to the previously mentioned actions, Beacon may refer suspected criminal activity committed by a Member, provider, or facility to the appropriate regulatory and/or law enforcement agencies.

If a provider appears to have committed fraud, waste, or abuse, the provider:

- Will be referred to the Special Investigations Unit



- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a Member appears to have committed fraud, waste, or abuse or has failed to correct issues, the Member may be involuntarily dis-enrolled from our healthcare plan, with state approval.

Recoupment/offset/adjustment for overpayments

Beacon shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Beacon to provider or facility (Overpayment Amount) against any payments due and payable by Beacon or any affiliate to provider or facility with respect to any health benefit plan under this agreement or under any agreement between provider and an affiliate regardless of the cause. The provider or facility shall voluntarily refund the overpayment amount regardless of the cause, including, but not limited to, payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive, or wasteful. Upon determination by Beacon that an overpayment amount is due from provider or facility, provider or facility must refund the overpayment amount to Beacon within 30 calendar days of the date of the overpayment refund notice from Beacon to the provider or facility. If the overpayment amount is not received by Beacon within the 30 calendar days following the date of such notice letter, Beacon shall be entitled to offset the unpaid portion of the overpayment amount against other claims payments due and payable by Beacon or an affiliate to provider or facility under any health benefit plan in accordance with regulatory requirements. In such event, the provider or facility agrees that all future claim payments, including affiliate claim payments, applied to satisfy provider's or facility's repayment obligation shall be deemed to have been legally paid to provider or facility in full for all purposes, including affiliates and/or regulatory requirements as defined by the provider or facility agreement. Should the provider or facility disagree with any determination by Beacon or a plan that the provider or facility has received an overpayment or improper payment, the provider or facility shall have the right to appeal such determination under Beacon's procedures set forth in the Provider Manual, provided that such appeal shall not suspend Beacon's right to recoup the overpayment amount during the appeal process unless required by regulatory requirements. Beacon reserves the right to employ a third-party collection agency in the event of non-payment.

Relevant legislation

False Claims Act

We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA). The FCA is a federal law allowing the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of \$5,500 to \$11,000 per false claim.

The FCA also contains Qui Tam or "whistleblower" provisions. A whistleblower is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.



Employee Education about the False Claims Act

As a requirement of the Deficit Reduction Act of 2005, contracted providers who receive Medicaid payments of at least 5 million dollars (cumulative from all sources), must comply with the following: Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the network provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).

Include as part of such written policies detailed provisions regarding policies and procedures for detecting and preventing fraud, abuse, and waste. Include in any employee handbook a specific discussion of the laws described in Section 1902(a) (68) (A), the rights of employees to be protected as whistleblowers, and policies and procedures for detecting and preventing fraud, abuse and waste.

Address Changes, Mergers, Acquisitions, and New Sites

MBHP requires providers to notify Network Operations of an address change or any mergers, acquisitions, changes, or transfers of control or ownership, as well as any requests to add and/or remove a practice site, in writing 30 days before such events occur. MBHP, at its sole discretion, shall determine whether such changes may require reapplication depending on the nature and scope of the change.

Providers should not assume that satellite offices or facilities acquired or operated as a result of such transactions will be covered under the provider's original provider application. The addition of a satellite office or facility may require a separate application and may not receive approval as a contracted site.

Failure to notify Provider Quality Management and/or Network Operations of changes may result in delay in payment of claims or change in the provider's network status to include suspension or termination from the network.

In addition, if your MassHealth number changes due to a merger, acquisition, or any other legal change, you must notify MBHP in writing within 30 days of the change. Failure to provide proper notice will result in the denial of claims on the remittance advice.

The request for all address changes or request to add an additional location has to come from the practitioner. Please email MBHP_PR@beaconhealthoptions.com for address changes, address terminations, pay to address, W-9, and additional locations.

MBHP Obligations

Protection of communication to Members: MBHP will not restrict a healthcare professional acting within the lawful scope of practice from advising or advocating on behalf of a Member who is their patient with regard to the following:

- The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the Member needs in order to decide among all relevant treatment options;



- Risks, benefits, and consequences of treatment or non-treatment; and
- The Member's right to participate in decisions regarding their healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

Prohibition against discrimination: MBHP shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. If MBHP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reasons for its decisions. This section shall not be construed to prohibit MBHP from including providers only to the extent necessary to meet the needs of Members, from using different reimbursement methodology for different providers, or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of MBHP.

Affirmative Statement Regarding Incentives

MBHP in no way rewards or incentivizes, either financially or otherwise, practitioners, utilization reviewers, clinical care managers (CCMs), physician advisers, or other individuals involved in conducting utilization review, for issuing denials of coverage or service or for inappropriately restricting care.

MBHP utilization management and other care management staff base their utilization-related decisions on the clinical needs of the Members, benefit availability, and appropriateness of care. Objective, scientifically based clinical criteria and treatment guidelines, in the context of provider or Member-supplied clinical information, guide the decision-making process.

Credentialing

In this section you will find information regarding the following:

- National Credentialing Committee (NCC)
- Initial Credentialing Process
- Re-credentialing Process
- Confidentiality of Credentialing Information
- Requesting a Waiver of the Credentialing Criteria
- Credentialing Criteria for Individual Practitioners, Groups of Individual Practitioners and Organizational Providers

National Credentialing Committee (NCC)

The MBHP/Beacon Health Options National Credentialing Committee (NCC) determines the contract status of present and future practitioners. All potential practitioners, groups of individual practitioners, and organizational providers who submit a complete application and are approved by MBHP staff for contracting must be reviewed by the NCC to determine participation status. NCC considerations include, but are not limited to, pending lawsuits, malpractice history, insufficient professional liability coverage, access in a particular area, and all credentialing waiver requests. All recommendations and decisions are forwarded to the NCC for final review and/or approval. Once the



NCC makes a decision regarding network participation status, a letter is sent to the practitioner, group of individual practitioners, or organizational provider by MBHP.

Initial Credentialing Process

Credentialing is one component of the initial contracting process. MBHP credentialing specialists review the applications, resumes, and other supporting documents submitted by practitioners, groups of individual practitioners, or organizational providers applying to join the network. All of the documentation in the application is reviewed via the Primary Source Verification (PSV) process, which allows MBHP to verify the validity of the documentation submitted in an application. Inpatient and outpatient organizational providers are required to do PSV on all clinicians who are treating MBHP Members as outlined in the Credentialing Criteria.

If you are a hospital-based organizational provider, clinic-based organizational provider, or a free-standing organizational provider, you are required to complete a PSV for the following information on each staff person who works with MBHP Members:

- Licenses
- Highest level of education
- Educational Commission for Foreign Medical Graduates certificate (MDs/DOs only)
- History of actions by licensing boards
- Federal and State Drug Enforcement Administration (DEA) certificates (MDs/Dos/PNMHCSs only)
- Malpractice history through the National Provider Data Bank (NPDB)
- American Board certification (MDs/DOs only)
- American Nurses Credentialing Center certification (PNMHCS only)
- Sanctions from Medicare or Medicaid (Office of Inspector General (OIG))
- Admitting privileges, if applicable
- CANS certification (practitioners who treat MBHP Members under the age of 21)

If you are an individual practitioner or a group of individual practitioners*, MBHP completes a PSV on the following:

- Licenses
- Highest level of education
- Educational Commission for Foreign Medical Graduates certificate (MDs/DOs)
- History of actions by licensing boards
- Federal and state DEA certificates (MDs, DOs, and PNMHCSs only)
- Malpractice history through the National Provider Data Bank (NPDB)
- American Board certification (MDs/DOs)
- American Nurses Credentialing Center certification (PNMHCS only)
- Sanctions from Medicare or Medicaid (Office of Inspector General)
- Admitting privileges, as applicable



***Note** regarding individual practitioner or a group of individual practitioners:

A “group practice” is defined as a multi-disciplinary team of individual practitioners contracted as one entity. Each practitioner within the group is credentialed individually.

MBHP will only consider the following licensure levels for individual contracting: MD, DO, PNMHCS, LICSW, LMHC, LMFT, and licensed psychologist (including PhD, EdD, and PsyD).

MBHP will only consider the following licensure levels for individuals in a group contracting setting: MD, DO, PNMHCS, LICSW, LCSW, LMHC, LMFT, licensed psychologist (including, PhD, EdD, and PsyD) and certificate levels: board-certified behavioral analyst or behavioral management monitor.

MBHP does not allow for individually contracted practitioners or groups of individual practitioners to bill for services provided by another practitioner.

Re-credentialing Process

The re-credentialing process occurs every three years for all practitioners, groups of individual practitioners, and organizational providers. Each network practitioner receives a re-credentialing application that is completed and returned to MBHP. The re-credentialing process enables MBHP to update information including demographics, practitioner specialties, and language capacities and to verify that the practitioner continues to meet the credentialing criteria. Re-credentialing also enables MBHP to review information about the practitioner’s quality of care and utilization. Network practitioners are required to meet the credentialing criteria in order to continue their contract with MBHP. Practitioners who do not meet the credentialing criteria will be terminated from the MBHP network as specified in the Behavioral Health Program provider agreement.

If you are a hospital-based organizational provider, clinic-based organizational provider, or a free-standing organizational provider, you are required to complete a PSV for the following information on each staff person who works with MBHP Members:

- Licenses, as applicable
- Highest level of education
- Educational Commission for Foreign Medical Graduates certificate (MDs/DOs)
- History of actions by licensing boards
- Federal and state DEA certificates (MDs/DOs/PNMHCSs only)
- Malpractice history through the National Provider Data Bank (NPDB)
- American Board certification (MDs/DOs)
- American Nurses Credentialing Center certification (PNMHCS only)
- Sanctions from Medicare or Medicaid (Office of Inspector General)
- Admitting privileges, if applicable
- CANS certification (practitioners who treat MBHP Members under the age of 21)

If you are an individual practitioner or group of individual practitioners*, MBHP completes a PSV on the following information:

- Licenses
- Highest level of education



- Educational Commission for Foreign Medical Graduates certificate (MDs/DOs)
- History of actions by licensing boards
- Federal and state DEA certificates (MDs/DOs/PNMHCSs only)
- Malpractice history through the National Provider Data Bank (NPDB)
- American Board certification (MDs/DOs)
- American Nurses Credentialing Center certification (PNMHCS only)
- Sanctions from Medicare or Medicaid (Office of Inspector General)
- Admitting privileges, as applicable
- Grievance and complaint letters from MBHP’s QM Department

***Note** regarding individual practitioner or a group of individual practitioners:

A “group practice” is defined as a multi-disciplinary team of individual practitioners contracted as one entity. Each practitioner within the group is credentialed individually.

MBHP will only consider the following licensure levels for individual contracting: MD, DO, PNMHCS, LICSW, LMHC, LMFT, and licensed psychologist (including PhD, EdD, and PsyD).

MBHP will only consider the following licensure levels for individuals in a group contracting setting: MD, DO, PNMHCS, LICSW, LCSW, LMHC, LMFT, licensed psychologist (including, PhD, EdD, and PsyD) and certificate levels: board certified behavioral analyst or behavioral management monitor.

MBHP does not allow for individually contracted practitioners or groups of individual practitioners to bill for services provided by another practitioner.

Confidentiality and Accuracy of Credentialing Information

Network practitioners have the right to:

- review information submitted to support the credentialing application;
- correct erroneous information collected during the credentialing process;
- be informed of the status of the credentialing or re-credentialing application; and
- be notified of these rights.

Network practitioners have the right to review the credentialing and re-credentialing information MBHP uses to evaluate provider applications. The information includes information obtained from malpractice insurance carriers, state licensing boards, OIG, and/or the NPBD. A practitioner may not, however, review references, recommendations, or other information that is peer-review protected. MBHP does not release data to external entities in any form that would allow the identification of practitioners by name. Items of a confidential nature in the credentialing and re-credentialing process include, but are not limited to: license, professional liability insurance, degree, American Board certification, American Nurses Credentialing Center certification, federal and state DEA certificates, and information gained from the NPDB and OIG. Adverse findings that may impact a credentialing or re-credentialing decision will only be released to the practitioner if requested in writing by the practitioner.



A credentialing specialist will notify a practitioner if the information MBHP receives from outside sources differs substantially from the information given to MBHP by the practitioner. The practitioner will have the opportunity to correct erroneous information. When information is received by a third party that conflicts with information submitted by the provider. The discrepancy must be corrected in writing within seven (7) calendar days of notification and submit any corrections directly to the credentialing staff's attention. Beacon releases information when federal and state laws or established company policy does not prohibit disclosure. Please contact the credentialing specialists using the contact information provided in the correspondence. Please contact Provider Relations at MBHP_PR@beaconhealthoptions.com for information on the process for viewing practitioner credentialing and re-credentialing files or for information on the status of a credentialing or re-credentialing application.

Requesting a Waiver of the Credentialing Criteria

Credentialing criteria were developed to reflect issues of access, performance, quality, liability, experience, and licensure. Only those practitioners who meet the MBHP credentialing criteria may provide behavioral health services to MBHP Members. Although these criteria were developed to ensure that all services provided to Members reflect the best practice of the professional field, it is understood that there may be certain situations where MBHP chooses to waive a specific item for a practitioner. Examples include waivers of a staff member's license, training, or education, or waiver of an organizational provider's physical plant requirements. The NCC will review a request for a credentialing waiver.

Circumstances for which a waiver may be approved include, but are not limited to, the following:

- Ensuring Member access;
- Meeting Member's linguistic or cultural needs; and
- Meeting Member's need for specialized care.

Please note that individually contracted practitioners may not request a waiver to bill for services provided by another practitioner. If you want to request a waiver, please submit a written request that details the following:

- The criteria you want waived;
- The rationale underlying your request (e.g., specific need that the waiver will meet); and
- Documentation that a need exists.

If the waiver pertains to a staff member's qualifications, the waiver request must include the following:

- How this staff can address this need;
- Copy of the staff member's resume (month/year format);
- Official transcripts from the highest level of education;
- A copy of their license or certification, if applicable; and
- Two letters of reference from behavioral health practitioners who are familiar with the staff member's work.



The completed request may be submitted via fax to (781) 496-4769 or by email to MBHP_PR@beaconhealthoptions.com.

MBHP maintains the right to offer credentialing waivers based on the overall mission of MBHP. Practitioners will be notified in writing of the outcome of the NCC recommendations and decisions regarding each waiver request.

Site Visits

MBHP staff may conduct site visits at practitioners' offices to assess the appearance and adequacy of waiting and treatment room space, availability of appointments, accessibility, and record-keeping practices (if applicable).

Quality

MBHP may conduct a structured site visit to practitioners' offices for all practitioners with two or more documented Member complaints in a six-month time frame relating to physical accessibility, physical appearance, adequacy of waiting/examining room space, availability of appointments, adequacy of treatment recordkeeping, or quality of care issues. This visit includes an evaluation using the MBHP site and operations standards and an evaluation of the practitioner's clinical recordkeeping practices to ensure conformity with MBHP standards.

Credentialing

Organizational providers (facilities) must be evaluated at credentialing and re-credentialing. Those who are accredited by an accrediting body accepted by MBHP (currently The Joint Commission, CARF, COA, or another recognized accreditation service, as applicable for behavioral healthcare) must have their accreditation status verified. In lieu of accreditation, non-accredited organizational providers must provide proof of a CMS/state site visit to confirm that they meet all MBHP standards. This requirement is waived if the facility is deemed rural as defined by HRSA.gov or is a satellite clinic of a participating organization. Standing with state and federal authorities and programs will be verified. MBHP will not reimburse an organizational provider if a service is a non-credentialed and/or non-contracted, non-covered benefit.



MBHP Provider Quality Management and Credentialing Appendices

- A: [Credentialing Criteria](#)
- B: [Regional Zip Code Listing](#)
- C: [Performance Specifications](#)

Appendix B – Regional Zip Code List

Zip	State	City	Region Name
01116	MA	Longmeadow	Western
01001	MA	Agawam	Western
01002	MA	Amherst	Western
01003	MA	Amherst	Western
01004	MA	Amherst	Western
01007	MA	Belchertown	Western
01008	MA	Blandford	Western
01009	MA	Bondsville	Western
01011	MA	Chester	Western
01012	MA	Chesterfield	Western
01013	MA	Chicopee	Western
01014	MA	Chicopee	Western
01020	MA	Chicopee	Western
01021	MA	Chicopee	Western
01022	MA	Chicopee	Western
01026	MA	Cummington	Western
01027	MA	Easthampton	Western
01028	MA	East Longmeadow	Western
01029	MA	East Otis	Western
01030	MA	Feeding Hills	Western
01032	MA	Goshen	Western
01033	MA	Granby	Western
01034	MA	Granville	Western
01035	MA	Hadley	Western
01036	MA	Hampden	Western
01038	MA	Hatfield	Western
01039	MA	Haydenville	Western
01040	MA	Holyoke	Western
01041	MA	Holyoke	Western
01050	MA	Huntington	Western
01053	MA	Leeds	Western
01054	MA	Leverett	Western
01056	MA	Ludlow	Western
01057	MA	Monson	Western
01059	MA	North Amherst	Western
01060	MA	Northampton	Western
01061	MA	Northampton	Western
01062	MA	Florence	Western
01063	MA	Northampton	Western
01066	MA	North Hatfield	Western
01069	MA	Palmer	Western
01070	MA	Plainfield	Western
01071	MA	Russell	Western
01072	MA	Shutesbury	Western



Zip	State	City	Region Name
01073	MA	Southampton	Western
01075	MA	South Hadley	Western
01077	MA	Southwick	Western
01079	MA	Thorndike	Western
01080	MA	Three Rivers	Western
01082	MA	Ware	Western
01084	MA	West Chesterfield	Western
01085	MA	Westfield	Western
01086	MA	Westfield	Western
01088	MA	West Hatfield	Western
01089	MA	West Springfield	Western
01090	MA	West Springfield	Western
01093	MA	Whately	Western
01095	MA	Wilbraham	Western
01096	MA	Williamsburg	Western
01097	MA	Woronoco	Western
01098	MA	Worthington	Western
01101	MA	Springfield	Western
01102	MA	Springfield	Western
01103	MA	Springfield	Western
01104	MA	Springfield	Western
01105	MA	Springfield	Western
01106	MA	Longmeadow	Western
01107	MA	Springfield	Western
01108	MA	Springfield	Western
01109	MA	Springfield	Western
01111	MA	Springfield	Western
01114	MA	Springfield	Western
01115	MA	Springfield	Western
01118	MA	Springfield	Western
01119	MA	Springfield	Western
01128	MA	Springfield	Western
01129	MA	Springfield	Western
01133	MA	Springfield	Western
01138	MA	Springfield	Western
01139	MA	Springfield	Western
01144	MA	Springfield	Western
01151	MA	Indian Orchard	Western
01152	MA	Springfield	Western
01199	MA	Springfield	Western
01201	MA	Pittsfield	Western
01202	MA	Pittsfield	Western
01203	MA	Pittsfield	Western
01220	MA	Adams	Western
01222	MA	Ashley Falls	Western
01223	MA	Becket	Western



Zip	State	City	Region Name
01225	MA	Cheshire	Western
01226	MA	Dalton	Western
01227	MA	Dalton	Western
01229	MA	Glendale	Western
01230	MA	Great Barrington	Western
01235	MA	Hinsdale	Western
01236	MA	Housatonic	Western
01237	MA	Lanesboro	Western
01238	MA	Lee	Western
01240	MA	Lenox	Western
01242	MA	Lenox Dale	Western
01243	MA	Middlefield	Western
01244	MA	Mill River	Western
01245	MA	Monterey	Western
01247	MA	North Adams	Western
01252	MA	North Egremont	Western
01253	MA	Otis	Western
01254	MA	Richmond	Western
01255	MA	Sandisfield	Western
01256	MA	Savoy	Western
01257	MA	Sheffield	Western
01258	MA	South Egremont	Western
01259	MA	Southfield	Western
01260	MA	South Lee	Western
01262	MA	Stockbridge	Western
01263	MA	Stockbridge	Western
01264	MA	Tyringham	Western
01266	MA	West Stockbridge	Western
01267	MA	Williamstown	Western
01270	MA	Windsor	Western
01301	MA	Greenfield	Western
01302	MA	Greenfield	Western
01330	MA	Ashfield	Western
01337	MA	Bernardston	Western
01338	MA	Buckland	Western
01339	MA	Charlemont	Western
01340	MA	Colrain	Western
01341	MA	Conway	Western
01342	MA	Deerfield	Western
01343	MA	Drury	Western
01344	MA	Erving	Western
01346	MA	Heath	Western
01347	MA	Lake Pleasant	Western
01349	MA	Turners Falls	Western
01350	MA	Monroe Bridge	Western
01351	MA	Montague	Western



Zip	State	City	Region Name
01360	MA	Northfield	Western
01367	MA	Rowe	Western
01370	MA	Shelburne Falls	Western
01373	MA	South Deerfield	Western
01375	MA	Sunderland	Western
01376	MA	Turners Falls	Western
01379	MA	Wendell	Western
01380	MA	Wendell Depot	Western
01354	MA	Northfield	Western
01224	MA	Berkshire	Western
01369	MA	Shattuckville	Western