Optum

Mass General Brigham Health Plan

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Manual Addendum

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Table of Contents

Introduction 3
Governing Law 3
Authorization or Notification Information 3
Emergency Department Boarding 6
Specialing Services.....7
Consent for Treatment, Minors 7
Coordination of Care and Transition of Care 8
Compliance with Discharge Planning Procedures for Enrollees Experiencing or at Risk of Homelessness.....8
MassHealth/ACO Covered Services 12
Behavioral Health Clinical Assessment and Treatment Planning..... 13
Children's Behavioral Health Initiative (CBHI) Services for MassHealth/ACO Members..... 14
Child and Adolescent Autism Services for MassHealth/ACO Members..... 14
Child and Adolescent Needs and Strengths (CANS) for MassHealth/ACO Members..... 15
Child and Adolescent Preventative Care 16
Access Standards Specific to MassHealth/ACO Members 16
Documentation Standards..... 17
Adverse Incident Reporting 22
Serious Reportable Events / Provider Preventable Condition Reporting.... 23
Network Requirements 24
21st Century CURES Act Requirements 24
Member Rights 25
Appeals (Provider Disputes) 25
Claims Information..... 26
Process for Communication of Policy and Process Changes..... 26

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Introduction

United Behavioral Health (UBH) operating under the brand Optum administers mental health and substance use disorder benefits for Mass General Brigham Health Plan in Massachusetts. Generally, the Optum National Network Manual applies to all types of business managed by Optum, including Mass General Brigham Health Plan's Medicare Advantage (MA) products – please refer to the Optum National Network Manual for questions related to Medicare Advantage. There are some sections that may differ based on specific benefit plans. This addendum highlights areas in which Mass General Brigham Health Plan procedures, in order to meet regulatory requirements, supersede procedures set forth in the Optum National Network Manual.

Our relationship with you is foundational to the recovery and well-being of the individuals and families we serve. We are driven by a compassion that we know you share. As we work together, you will find that we seek and pursue opportunities to collaborate with you to set the standard for industry innovation and performance.

We encourage you to make use of our industry-leading website, Providerexpress.com where you can get news, access resources and, in a secure environment, make demographic changes at a time and pace you most prefer. The Optum National Network Manual is located on Provider Express. From the Home page, select Clinical Resources > Network Provider Manuals > National Network Manual. We continuously expand our online functionality to better support your day-to-day operations. Visit us often. If you would like to speak with a live representative please call the number on the back of the member's card.

Governing Law

This manual shall be governed by, and construed in accordance with, applicable federal, state and local laws. To the extent that the provisions of this manual conflict with the terms and conditions outlined in your Agreement, the subject matter shall first be read together to the extent possible; otherwise, and to the extent permitted by, in accordance with, and subject to applicable law, statutes or regulations, the Agreement shall govern.

Authorization or Notification Information

Services Requiring Prior Authorization:

- Partial Hospitalization/High-Intensity Outpatient *

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- Intensive Outpatient Program *
- Day Treatment
- Applied Behavioral Analysis (ABA) Services for Members with Autism Spectrum Disorder
- Transcranial Magnetic Stimulation
- Acute Residential Treatment (ART)
- Structured Outpatient Addictions Program (SOAP) *
- Specialing Services

Providers can obtain authorization for the above services by calling the number on the back of the member's identification card. Contracted providers may also request authorization for the services listed above online through Provider Express.

*Optum complies with all requirements outlined in Session Laws, Acts (2014), Chapter 258

Services Requiring Notification to Optum (but NOT Prior Authorization):

- Acute Inpatient Hospitalization: In Massachusetts prior authorization is not required for emergent admissions, but providers are required to notify Optum of the member's admission within 72 hours of admission
- Community Based Acute Treatment (CBAT)/Intensive Community Based Acute Treatment (ICBAT): Providers are required to notify Optum of the member's admission within 72 hours of admission
- Substance Use Disorder Acute and Residential (ASAM 4.0, 3.7, 3.5):
    - Optum complies with all requirements outlined in Session Laws, Acts (2014), Chapter 258
    - NOTE: authorization requirements begin on day 15. SUD Residential Rehabilitation - no authorization is required for the first fourteen (14) days but providers are required to notify Optum of the member's admission within 48 hours
- Residential Rehabilitation Services – Medicaid only Benefit (RRS) (ASAM 3.1):
    - Must provide notification within 7 calendar days of admission
    - Authorization is not required for the first 90 days; concurrent review needed to request additional days past the initial 90 days

Services that Do Not Require an Authorization or Notification:

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- Standard Office Visit for Therapy or Medication Management
- Outpatient Opioid Treatment
- Electroconvulsive Treatment
- Extended Outpatient Treatment (90837)
- Children's Behavioral Health Initiative (CBHI) Outpatient Medicaid Services
- Behavioral Health Children and Adolescents (BHCA) Outpatient Commercial Services
- Neuropsychological Testing (NOTE: billing for the testing episode from evaluation through final report should be submitted on a single claim)
- Routine outpatient services
- Optum does not require members to obtain prior authorization to be admitted to a facility to receive mental health inpatient treatment from an emergency department and/or after receiving emergency services if deemed appropriate by a provider, regardless of whether the member has been stabilized

Special Consideration for Program of Assertive Community Treatment (PACT) – Medicaid only Benefit:

- Providers must meet requirements set forth in Performance Specifications posted on Provider Express, including clinical staff (Psychiatrist, Addiction Specialist, Nurses), bachelor's-level and paraprofessional mental health workers, including a Peer Recovery Specialist and Housing Resource Specialist
- Providers contracted for PACT must hold a Department of Public Health License
- Authorization is required for this service (standard authorization processes apply)
- 90 units are authorized over 90 calendar days
- Services are comprehensive and highly individualized
- PACT providers who would like to obtain initial authorization and/or concurrent review for a member for this service must call Optum at **1-844-451-3519** to complete clinical review
- Standard billing guidelines apply
- Specific coding as noted:
  - PACT 50 – H0040 HT
  - PACT 80 – H0040, no modifier
- Members actively engage in a Community Support Program (CSP) or similar duplicative services are excluded

Psychological Testing:

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- Psychological Testing requests for 5 hours or less (test evaluation 96130/96131 and administration-scoring 96136-96139 time combined):
    - Advanced Notification can be obtained by calling the Intake Department. Notification allows for review of members eligibility, member specific benefit coverage and any requirements that may supersede the members benefit coverage
    - Testing cannot be due to a court order, employment, or educational/school purposes; and no recent testing within the last 6 months
- Psychological Testing requests for more than 5 hours service time (test evaluation 96130/96131 and administration-scoring 96136-96139 time combined):
    - Authorization is required
- Written request must be submitted with clinical information by using the online portal located on Provider Express:
    - Provider Express > Clinical Resources > Forms > Optum Forms - Authorization > Massachusetts
- NOTE: providers should bill for the entire testing episode from evaluation through feedback session on a single claim submission
- Base code billing: maximum of one unit for each base code is permitted one time per episode even if testing takes place over multiple dates of service

Important Reminder: Covered services for Mass General Brigham Employee Plan members seeing a contracted provider **DO NOT require authorization**.

Timelines for Authorization Decisions:

- Authorization requests made while a member is in the emergency room are processed within 30 minutes of the request
- Non-urgent authorization requests are processed within 24 hours
- On-going review frequency is determined based on an individual's need and medical necessity criteria

Emergency Department Boarding

Optum will follow MA-specific guidelines established to facilitate admission to an appropriate inpatient psychiatric facility within a reasonable period of time after presenting in the emergency department (ED) and meeting medical necessity criteria. Once notified by a facility that a member is in the ED and in need of inpatient treatment, Optum follows an established criterion that is compliant with the Expedited Psychiatric

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Inpatient Admission (EPIA) process and does not cause inappropriate delays or denials of inpatient admissions for covered members with acute behavioral and substance use disorder needs.

When a member's care meets Optum medical necessity criteria for an individual inpatient room or any other special services (identified in the Section below for Specialing Services), then Optum will arrange for these special services to be covered when provided to the member.

When a member's care meets Optum medical necessity criteria for an individual inpatient room or any other special services, Optum will approve a member's inpatient treatment unless Optum has secured alternative medically appropriate placement of the member.

It is the expectation that members receive the best continuity of care for inpatient treatment in order to improve patient outcomes. Patients should be re-hospitalized at the same inpatient treatment facility whenever possible.

Optum does not require prior authorization to be admitted to a facility to receive behavioral health services for treatment after emergency department or receiving emergency services regardless of whether member has been stabilized.

Specialing Services

Specialing services are those services that have been identified by the facility or unit as needed to admit a member and exceed the typical capabilities and/or competencies of the facility or unit.

Optum specialing services include:

1. Caregiver / Personal Attendant
2. Security
3. Mental Health Worker
4. Other additional staffing (e.g., Tech / counselor / nursing)
5. Intensive RN and Physical Care
6. Single Room

Consent for Treatment, Minors

In certain situations, according to state law, a minor is able to consent for treatment. Examples may include:

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- Treatment for Substance Use: minors who are 12 or older, who have been found to be substance dependent by at least two doctors, may consent to substance use treatment (except for methadone maintenance therapy)
- Mental Health treatment: minors who are 16 or older may consent to admission at a mental health treatment facility

Coordination of Care and Transition of Care

Coordination of Care Between Behavioral Health Providers and Primary Care Physicians or Other Health Professionals:

Optum expects behavioral health providers to coordinate care with the member's primary care physician as well as other treating medical or behavioral health providers. A signed release of information should be maintained in the clinical record.

In the event a member declines consent to the release of information, his or her refusal should be documented, along with the reason for refusal. In either case, education you provide regarding benefits and risks of coordinated care should be noted.

Coordination Between Behavioral Health Providers and State Agencies:

Behavioral health providers are expected to coordinate care with any relevant state agencies that are working with a member or member's family. This includes but is not limited to the Department of Children and Families (DCF), Department of Youth Services (DYS), Department of Mental Health (DMH), Department of Transitional Assistance (DTA), Department of Developmental Services (DDS), and local education authorities.

Protocols for Transitioning Members from One Behavioral Health Provider to Another:

If a member transfers from one behavioral health provider to another, the transferring provider must obtain a release of information from the member and send a case summary, including the reason for the transition to the new provider.

Compliance with Discharge Planning Procedures for Enrollees Experiencing or at Risk of Homelessness

All psychiatric inpatient hospitals participating in MassHealth must contact Optum at the time of admission in order to collaborate in identifying resources to assist with the housing situation of enrollees experiencing homelessness or are at risk of homelessness. In addition, all psychiatric inpatient hospitals

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participating in MassHealth must ensure that the following discharge planning activities occur at the time of admission:

- At the time of admission, and as part of its general discharge planning processes, each hospital must assess each admitted member's current housing situation. At a minimum, the hospital must assess whether such member is experiencing or at risk of homelessness. To aid in this assessment, hospitals must also ensure that their discharge planning staff screen admission data, including but not limited to age, diagnosis, and housing status, within 24 hours of admission. For any member determined by the hospital to be experiencing or at risk of homelessness, the hospital must commence discharge-planning activities no later than three working days after the member's admission unless otherwise required to commence such activities at an earlier time following admission
- To assist in the discharge planning process for each member experiencing homelessness or at risk of homelessness, the hospital must, to the extent consistent with all applicable federal and state privacy laws and regulations, invite and encourage the following persons to participate in or otherwise contribute to such member's discharge planning activities: the member; the member's family members, guardians, primary care providers, behavioral health providers, key specialists, Community Partners, case managers or other representatives, emergency shelter outreach or case management staff, or care coordinators; and any other supports identified by the member. For any such member who is a client of the Department of Mental Health (DMH), the Department of Developmental Services (DDS), or the Massachusetts Rehabilitation Commission (MRC), the hospital must, to the extent consistent with all applicable federal and state privacy laws and regulations, invite and encourage designated staff from each such agency to participate in such Member's discharge planning activities
- The hospital must determine whether any non-DMH-, non-DDS-, or non-MRC-involved member experiencing or at risk of homelessness may be eligible to receive services from some or all of those agencies. For any such member, the hospital must, within two business days of admission, and to the extent consistent with all applicable federal and state privacy laws and regulations, offer to assist the member with completing and submitting an application to receive services from DMH, DDS, or MRC, as appropriate. Please click the following links to obtain additional information about the process of applying to receive services from DMH, DDS, and MRC
- The hospital must determine whether any member experiencing or at risk of homelessness has any substance use disorder. For any such member, the hospital must contact the DPH-sponsored Helpline **1-800-327-5050**, the statewide public resource for finding substance use treatment recovery options

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and assistance with problem gambling. The Helpline's trained specialists will help the member understand the available treatment services and their options

- For any member experiencing homelessness who is expected to remain in the hospital for fewer than 14 days, the hospital must contact:
    - The emergency shelter in which the member most recently resided, if known, to discuss the member's housing options post discharge; or
    - If the member has not resided in an emergency shelter, or if the emergency shelter in which the member most recently resided is unknown, the local emergency shelter to discuss the member's housing options post discharge
    - The names and contact information for emergency shelters is available via: hedfuel.azurewebsites.net/iShelters.aspx.

Assessing Discharge Options

Options for discharge must be assessed as follows:

- Hospitals must ensure that their discharge planning staff are aware of and utilize available community resources to assist with discharge planning for members experiencing homelessness or at risk of homelessness. For example, hospitals must provide regular training to discharge planning staff on available resources and/or up-to-date resource guides. Various resources are available on *Helping Patients who are Homeless or Housing Unstable* website***:*** mass.gov/info-details/helping-patients-who-are-homeless-or-housing-unstable
- Hospitals must make all reasonable efforts to prevent discharges to emergency shelters of members who have skilled care needs, members who need assistance with activities of daily living, or members whose behavioral health condition would impact the health and safety of individuals residing in the shelter. For such members, hospitals should seek placement in more appropriate settings, such as DMH community-based programs or skilled nursing facilities. EOHHS has established a website to assist hospital discharge staff when helping members with skilled nursing or other long-term care needs. This website also includes information about EOHHS's new Long Term Care Discharge Support Line. See *Helping Patients with Skilled Nursing Needs* website: mass.gov/info-details/helping-patients-with-skilled-nursing-or-other-long-term-care-needs#eohhs-long-term-care-discharge-support-line-
- For certain members, discharge to an emergency shelter or the streets may be unavoidable. For example, certain members may choose to return to the streets or go to an emergency shelter despite the best efforts of the hospital. For these members, the hospital shall:
    - Discharge the member only during daytime hours;

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- Provide the member a meal prior to discharge;
- Ensure that the member is wearing weather appropriate clothing and footwear;
- Provide the member a copy of their health insurance information;
- To the extent clinically appropriate and consistent with all applicable laws and regulations, provide the member with a written copy of all prescriptions and at least one week's worth of filled prescription medications;
- If the member is to be discharged to an emergency shelter:
  - Provide at least 24 hours advance notice to the shelter prior to discharge;
  - Provide the member with access to paid transportation to the emergency shelter;
  - Ensure that the shelter has an available bed for the member. In the event that a shelter bed is unavailable on the planned discharge date, but a bed will be available soon, the hospital should delay discharge until a bed is available. In these cases, the hospital may bill the managed care plan or the PACE organization at the Administratively Necessary Day (AND) rate for each such day on which the member remains in the hospital

Tracking and Reporting Discharge Planning Activities

The following discharge planning tracking and reporting activities are required:

- Hospitals must document in each member's medical record all efforts related to the discharge planning activities described above, including options presented to the member and, if applicable, the member's refusal of any alternatives to discharge to the streets or emergency shelters
- Hospitals must track discharges of members to local emergency shelters or the streets in a form, format, and cadence to be specified by MassHealth

Available Resources:

Discharge Planning Toolkit – a series of guidance documents and technical assistance products. These materials can be accessed online at: *Helping Patients who are Homeless or Housing Unstable* website: mass.gov/info-details/helping-patients-who-are-homeless-or-housing-unstable. This website includes resources, information, and a support line to assist hospital staff in placing members who are experiencing or at risk of homelessness.

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MassHealth/ACO Covered Services

The following behavioral health and substance use disorder services are covered for MassHealth/ACO members:

Service	ACO MassHealth Standard & CommonHealth	ACO MassHealth Family Assistance
Inpatient Mental Health	X	X
Inpatient Substance Use Disorder Services (Level 4)	X	X
Observation/Holding Beds	X	X
Administratively Necessary Day (AND) Services	X	X
Community Crisis Stabilization	X	X
Community Based Acute Treatment (CBAT) for Children and Adolescents	X	X
Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	X	X
Clinical Support Services for Substance Use Disorders (Level 3.5)	X	X
Transitional Care Unit (TCU)	X	X
Residential Rehabilitation Services (Level 3.1)	X	X
Community Support Program (CSP)	X	X
Partial Hospitalization (PHP)	X	X
Program of Assertive Community Treatment (PACT)	X	X
Psychiatric Day Treatment	X	X
Structured Outpatient Addiction Program (SOAP)	X	X
Intensive Outpatient Program (IOP)	X	X
Recovery Coaching	X	X
Recovery Support Navigators	X	X
Family Consultation	X	X
Case Consultation	X	X
Diagnostic Evaluation	X	X
Dialectical Behavioral Therapy	X	X
Psychiatric Consultation on an Inpatient Medical Unit	X	X
Medication Visit (Office)	X	X
Couple/Family Treatment	X	X

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Service	ACO MassHealth Standard & CommonHealth	ACO MassHealth Family Assistance
Group Treatment	X	X
Individual Treatment	X	X
Inpatient-Outpatient Bridge Visit	X	X
Assessment for Safe and Appropriate Placement (ASAP)	X	X
Collateral Contact	X	X
Opioid Treatment Services	X	X
Ambulatory Withdrawal Management	X	X
Psychological Testing	X	X
Special Education Psychological Testing	X	X
Applied Behavioral Analysis for Members Under 21 Years of Age (ABA Services)	X	X
Family Support and Training	X	N/A
Intensive Care Coordination	X	N/A
In-Home Behavioral Services	X	N/A
In-Home Therapy Services	X	X
Therapeutic Mentoring Services	X	N/A
Emergency Services Program (ESP) Encounter	X	X
Youth Mobile Crisis Intervention	X	X
Electroconvulsive Therapy (ECT)	X	X
Specialing – therapeutic services provided to a member in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety	X	X
Behavioral Health Urgent Care	X	X
Behavioral Health Preventative Care	X	X

Behavioral Health Clinical Assessment and Treatment Planning

Optum providers shall follow behavioral health clinical assessment and treatment planning in accordance with the Accountable Care Partnership Plan Contract for the MassHealth Accountable Care Organization Program.

More detailed information can be found on the Performance Specifications page on Provider Express.

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Children's Behavioral Health Initiative (CBHI) Services for MassHealth/ACO Members

The Children's Behavioral Health Initiative is an interagency undertaking whose mission is to strengthen, expand and integrate behavioral health services for children and adolescents. These services are provided to youth under the age of 21 in a community-based setting such as home, school or the community.

- Family Support and Training (no authorization required)
- Therapeutic Mentoring (no authorization required)
- Intensive Care Coordination (ICC) (no authorization required)
- In-Home Behavioral Services (no authorization required):
  - Behavior Management Therapy
  - Behavior Management Monitoring
- In-Home Therapy Services (no authorization required)
- Youth Mobile Crisis Intervention (no authorization required)
- CBAT/ICBAT (authorization is required)

CBHI services that do not require an authorization will be managed using our outpatient management strategy. Member claims data and service combinations are reviewed to identify services that occur at a frequency and/or duration that is higher than expected. A licensed care advocate will outreach the provider by telephone to collaborate with the provider to:

- Review eligibility for service(s)
- Review the treatment plan/plan of care
- Identify treatment plan gaps, best practices and potential treatment/service options

The review can lead to one of the following outcomes:

- Recommendations to enhance the treatment plan
- Close the review and continue services as indicated with no recommendations

Child and Adolescent Autism Services for MassHealth/ACO Members

Services are available for youth under the age of 21:

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- Applied Behavioral Analysis (ABA) Services for Members with Autism Spectrum Disorder (authorization required)

Child and Adolescent Needs and Strengths (CANS) for MassHealth/ACO Members

The requirement to use the Child and Adolescent Needs and Strengths (CANS) is part of the Final Order resulting from the *Rosie D. v. Patrick* lawsuit (Civil Action Number 01-30199-MAP). This was a class action lawsuit filed in 2001 on behalf of children and adolescents with serious emotional disturbance. The lawsuit alleged that the Massachusetts Medicaid program, MassHealth, failed to meet the obligations of certain federal Medicaid laws, including the Early and Periodic Screening Diagnosis and Treatment (EPSDT) statute.

The Court's Final Order was issued on July 16, 2007. The requirement to use the CANS became effective on November 30, 2008.

All behavioral health clinicians treating children and adolescents who are enrolled in MassHealth and under the age of 21 must use the CANS tool as part of the clinical assessment process. The CANS must be updated every 180 days to ensure that treatment plans address strengths and needs as they evolve.

Services that Require Use of the CANS:

- Outpatient Therapy (diagnostic evaluations and individual, family and group therapy)
- In-Home Therapy Services
- Intensive Care Coordination
- The CANS must also be completed as part of the discharge planning process for the following 24-hour level of care services:
    - Psychiatric inpatient hospitalization at acute inpatient hospitals, psychiatric inpatient hospitals and chronic and rehabilitation inpatient hospitals
    - Community-Based Acute Treatment (CBAT) and Intensive Community-Based Acute Treatment (ICBAT)
    - Transitional Care Units (TCU)

Important Reminders:

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The CANS is not a clinical assessment tool; it is used to organize information gathered during the assessment process and to guide treatment planning. Clinicians must be trained and certified to use the CANS.

Additional information related to CANS requirement is located on the Child and Adolescent Needs and Strengths (CANS) | Mass.gov website, including a "Frequently Asked Questions about the CANS Requirements and Billing" document.

Child and Adolescent Preventative Care

Optum must cover up to **8 preventive BH sessions** without prior authorization. Members under age 21 are eligible for preventive behavioral health services if they have a positive behavioral health screen (or, in the case of an infant, a positive post-partum depression screening), even if they do not meet criteria for behavioral health diagnosis and therefore do not meet medical necessity criteria for behavioral health treatment.

Preventive behavioral health services must be recommended by a physician or other licensed practitioner practicing within their scope of licensure to recommend such services. To determine the member's needs, a provider must administer and document the results of an age-appropriate behavioral health screen using a tool from the list of MassHealth approved screeners in Appendix W of the MassHealth provider manual.

Access Standards Specific to MassHealth/ACO Members

The access standards outlined below are applicable to MassHealth/ACO members.

Emergency Services:

- Immediately, on a 24-hour basis, seven days a week, with unrestricted access to members who present at any qualified Provider, whether a Network Provider or a non-Network Provider

MCI Mobile Crisis Intervention Services:

- Immediately, on a 24-hour basis, seven days a week, with unrestricted access to members who present for such services

CBHC (Community Behavioral Health Centers):

- Community Behavioral Health Centers (CBHCs) will serve as an entry point for the treatment for mental health conditions and substance use disorders and will

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provide routine appointments, urgent visits, and 24/7 community-based crisis intervention and stabilization services.

Urgent Care:

- Within 48 hours for services that are not Emergency Services or routine services

All Other Behavioral Health Services:

- Within fourteen (14) calendar days

For Services Described in the Inpatient or 24-Hour Diversionary Services Discharge Plan:

- Non-24-Hour Diversionary Services: within two (2) calendar days of discharge;
- Medication Management: within fourteen (14) calendar days of discharge;
- Other Outpatient Services: within seven (7) calendar days of discharge; and
- Intensive Care Coordination Services: within the time frame directed by EOHHS (Executive Office of Health and Human Services)

Documentation Standards

Providers are required to maintain high quality medical records for all members that you serve; these are outlined below.

General Practice:

- All providers must have unique member charts that are stored in a secure location
- All members must sign the appropriate releases of information to facilitate billing and review of the necessary member records
- All behavioral health services require consents to treatment prior to any behavioral health service being rendered or paid
- All providers must ensure that the consent to treatment, release of information, and any other forms meet all regulatory requirements, including 45 CFR Parts 160, 162, 164 and 42 CFR Part 2
- Providers are responsible to obtain the appropriate order, referral, and/or determination of medical necessity for service

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- All documentation and medical record requirements must be legible with a unique identifier on every page
- All requirements for documentation must be completed prior to the claim form submission date
- All documentation must meet the requirements of the service codes that are submitted on the claims form. Best practice is for all progress notes and billing forms to be completed during the session or immediately after the session
- Documentation of treatment should be individualized to the specific encounter. Copying and pasting from previous encounters should not occur
- All encounters must have documentation to support the service billed
- All amendments or changes to paper or electronic documentation must be signed and dated by the clinician amending or changing the documentation
- All providers should provide a notice to all patients regarding clinic procedures, including the patient's rights to terminate treatment and the process for filing a grievance
- All providers must have the following minimum documentation for the consent to treatment, assessment, treatment plan, progress notes, and discharge summary to receive payment for all claims billed
- All providers must comply with state and regulatory requirements as is indicated in their provider agreements

Consent to Treatment:

Consent to treatment is obtained prior to initiating services and includes the following:

- Name and signature of the member, or if appropriate, the legal representative or guardian
- Name of the provider (should correspond with license)
- Type of services and/or treatment offered
- Benefits and any potential risks of treatment
- Alternative services and/or treatment that is discussed
- Date and time consent is obtained
- Statement that treatment and services were explained to member or guardian
- Signature of person witnessing the consent (clinician)
- Name and signature of person who explained the procedure to the member or guardian if different from the person witnessing (above)

Release of Information:

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- Signed and dated by Member and Clinician
- In accordance with all federal regulations, including 45 CFR Parts 160, 162, 164 and 42 CFR Part 2

Assessment:

Depending on the scope of the assessment, the following components may require multiple visits and/or be completed by multiple clinicians involved in the care of a member and should be entered into an integrated medical record:

- Presenting concerns
- Current treatment for presenting concerns, including medications
- Treatment history:
    - Medical history
    - Psychiatric history, including previous medication trials
    - Therapy history
- Substance use history, including any treatment for SUD
- Risk assessment including Overdose Risk Assessment, when applicable
- Developmental history (for children and adolescents)
- Family history
- Allergies/adverse reactions
- Mental status exam
- Member strengths
- Clinical formulation informed by clinical data
- Clinical formulation is validated by clinical data
- Diagnosis is validated by clinical data
- CANS administered and integrated (for members under the age of 21) as applicable by CANS certified clinician
- Outcome assessment tool(s) administered and integrated, as applicable
- Initial treatment plan/next steps
- Documentation of time spent and duration of assessments
- Clinician's signature, credentials, and signature date

Other Clinical Documentation Expectations:

- Evaluations must meet clinical practice standards
- Releases of information are valid and signed by the clinician and member

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Individual Treatment Plan or Plan of Service:

- Must be completed according to service requirements
- Date of treatment plan initiation
- Diagnoses and/or symptoms being addressed
- Clinician's signature, credentials and signature date
- Member or guardian's signature and signature date (or acknowledgement that the member or guardian participated in the development of the plan)
- Evidence that the member of guardian participated in the development of the treatment plan or plan of service, including the member's statement of desired goal(s) or outcomes from treatment and/or member or guardian's signature and signature date
- Goals and objectives based on assessment, diagnosis, and behavioral health strengths and needs
- Treatment goals are measurable and person-centered
- Treatment objectives describe an integrated program of therapies, activities, experiences, and appropriate education designed to meet stated goals
- Treatment plan or plan of service has established time frames for goal attainment
- Treatment plan or plan of service includes references to less restrictive treatment alternatives that were considered
- Treatment plan or plan of service is easy to read and understand
- Treatment plan or plan of service documents the necessity for services
- Treatment plan or plan of service documents the services to be provided
- Treatment plan or plan of service documents the utilization of services
- Treatment plan or plan of service is reviewed in accordance with clinical standards

Progress Notes:

- Each billable encounter is documented with a progress note
- Documentation for each progress note includes the following:
    - Name and/or unique member identification number
    - Date of service that matches the date the claim is billed
    - Duration of session in minutes or stop and start times of services to support the procedure code billed
    - Number of units matches the information on the claim

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- State the specific location of services provided. Place of service on the claim is supported in the documentation (including specific locations for community services)
- Reason(s) for the session or encounter
- Documentation supports the procedure code that is billed
- Group counseling and group educational session progress notes may describe the session in general, but must also include specific comments on the client's participation and progress in the group
- Documentation in support of the treatment plan or plan of service goals, objectives, and interventions
- Documentation of current symptoms and behaviors as well as problems addressed, related interventions, and response to treatment
- Updated Risk Assessment, including Overdose Risk Assessment when appropriate
- Next steps and progress in treatment plan or plan of service
- Narrative with clinical justification to support utilization and time billed
- Supporting documentation for intervention development and indirect services is attached to the progress note
- Clinician's signature, credentials and signature date

Discharge Summary:

All services should be provided prior to the discharge summary date:

- Summary, including date range, of services provided
- Status towards meeting goals
- Diagnosis at the time of discharge
- Reason for discharge
- Medications prescribed (when applicable) during course of treatment and at discharge
- Risk assessment completed with any remaining risk issues identified and documented
- Documentation of referrals
- Identification of aftercare options
- Clinician's signature, credentials and signature date

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Optum may review your records during a scheduled on-site audit or may ask you to submit copies of records to Optum for review. Reviews may occur for a number of reasons, including, but not limited to:

- On-site reviews of facilities and agencies without national accreditation such as the Joint Commission, Commission on Accreditation of Rehabilitation (CARF) or other accrediting organizations approved by Optum
- Audits of services and programs including, but not limited to, Applied Behavioral Analysis, CBHI and Residential Rehabilitation Services (RRS)
- Audits of high-volume providers
- Routine audits
- Audits related to claims, coding, or billing issues
- Audits concerning quality of care issues

Telehealth Services:

- Documentation standards and best practices are available on providerexpress.com or by following this direct link Behavioral Health Services Documentation Requirements – Reimbursement Policy
- Medicaid servicing providers are expected to be compliant with all applicable laws and regulations including but not limited to state licensing, Centers for Medicare and Medicare and Medicaid Services (CMS) and/or national certification board standards in the states where you are licensed.

Adverse Incident Reporting

When an adverse incident occurs, the provider must complete the applicable Adverse Incident Report form and submit it to Optum within 24 hours of discovery of the incident; if the incident occurs on a holiday or weekend, the form must be submitted on the next business day.

All reporting forms are available on Provider Express:

- From the Home page, select Our Network > State-Specific Provider Information > Massachusetts
- From the Welcome to the Optum Network page, select Adverse Incident Reporting Forms under the Mass General Brigham Health Plan section

Forms are faxed to Optum once they are complete. The fax number is **1-844-814-5698**.

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Behavioral Health reportable adverse incidents include, but are not limited to the following:

- Any absence without authorization (AWA)
- Any contraband found that is prohibited by provider policy
- Any death (including cause of death if known)
- Any physical assault or alleged physical assault on or by a covered individual or by staff
- Any serious injury resulting in hospitalization
- Any sexual activity in a 24-hour level of care facility
- Any sexual assault or alleged sexual assault
- Any treatment or illness requiring transportation to an acute care hospital for treatment while in a 24-hour program
- Any violation or alleged violation of the Department of Mental Health physical restraint and/or seclusion regulations
- Accidental injuries
- Any unscheduled event that results in the evacuation of a program or facility
- Fall
- Fire setting
- Homicide
- Medication abuse or error
- Property damage
- Seizure
- Self-injury
- Substance use
- Suicide attempt or gesture

Serious Reportable Events / Provider Preventable Condition Reporting

Providers subject to Massachusetts requirements agree to appropriately report Serious Reportable Events ("SRE") as defined under 105 CMR 130.332 to both the Department of Public Health (DPH) and Optum by submitting a Serious Incident Report Form within seven (7) and thirty (30) calendar days from the date the event took place. The 30-day

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SRE report should include the root cause analysis of the event, determination of preventability, and corrective measures (as applicable).

Optum has a responsibility to ensure all SREs are appropriately reviewed and monitored as part of an overall patient safety program. Optum BH will contact practitioners/facilities as needed to obtain the necessary information to conduct the review. Optum BH will review occurrences that have been designated as an SRE and make recommendations for improving patient care and safety, including recommendations to conduct site audits and/or record reviews of practitioners/facilities. Optum BH may also provide facilities and practitioners with written or oral feedback related to observations made as a result of the review of the SRE.

All reporting forms are available on Provider Express:

- From the Home page, select Our Network > State-Specific Provider Information > Massachusetts
- From the "Welcome to the Optum Network!" page for Massachusetts, select Serious Reportable Events under the Mass General Brigham Health Plan section

Forms are faxed to Optum once they are complete. The fax number is **1-844-814-5698**.

Provider agrees to report "provider preventable conditions" (PPCs) and appropriately include the Present on Admission (POA) indicator on all inpatient hospital claims in accordance with Section 2702 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) (the ACA) and federal regulations at 42 CFR 438.3(g), 42 CFR.447.26. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions, Provider Preventable Conditions based on the Present on Admission (POA) as identified by the department or Serious Reportable Events that are preventable and unambiguously the result of a system failure as described under 105 CMR 130.332.

Network Requirements

Network Requirements are outlined in the Network Requirements section of the Optum National Network Manual.

21st Century CURES Act Requirements

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In accordance with 21st Century Cures Act regulations, all providers rendering services to Medicaid or Medicare members must be enrolled with the State in which those members are covered. Mass General Brigham Health Plan is complying with those regulations and the guidance outlined by MassHealth for providers rendering services to MassHealth members.

For questions and answers regarding this process, please consult the FAQ document on Provider Express: 21st Century Cures Act MassHealth Frequently Asked Questions

Member Rights

- Member rights are outlined in the Member Rights and Responsibilities section of the Optum National Network Manual. Members who receive benefits through Mass General Brigham Health Plan have the right to file a grievance if they have an unsatisfactory experience with either Optum or a provider who is contracted with Optum. All grievances will be reviewed by one or more people who were not involved in the problem or situation that the grievance involves. If the grievance involves a clinical matter, a health care professional will review the grievance
- Members may file a grievance by calling the customer service phone number on the back of their identification card

Appeals (Provider Disputes)

Non-Urgent (Standard) Appeals:

- Non-urgent appeals for commercial members must be requested within 180 days from receipt of the notice of a non-coverage determination. Non-urgent appeals for MassHealth/ACO members must be requested within 60 calendar days from receipt of the notice of a non-coverage determination. All appeal determination decisions will be made within 30 calendar days of receipt of the request

Urgent (Expedited) Appeals:

- Urgent appeals must be requested as soon as possible after the non-coverage determination. All appeal determination decisions will be completed and you will be notified of the decision within 72 hours of receipt of the request

Submission Information:

Fax: **1-855-312-1470**

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Address: Optum Appeals & Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512

Phone: **1-866-556-8166**

Claims Information

Claims must be submitted within ninety (90) days of the date of service. Clean claims will be adjudicated within forty-five (45) days of receipt of the claim.

Claims may be submitted in three (3) ways:

- Online via Provider Express
- Online via Electronic Data Interchange (EDI)
- Paper claims via US Mail

Mailing addresses for paper claims:

Commercial Claims	Medicaid Claims
Optum P.O. Box 30757 Salt Lake City, UT 84130-0757	Optum P.O. Box 30760 Salt Lake City, UT 84130-0760

Process for Communication of Policy and Process Changes

When there is a change to an existing policy or process, information will be communicated to providers in multiple ways:

- Provider Notifications sent via email, fax and/or mail
- Posting on Provider Express: from the Home Page, select Our Network > Click here for state-specific information > Massachusetts. All information related to Mass General Brigham Health Plan is on the right side of the screen

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