Optum

Mass General Brigham Health Plan

Mass General Brigham Health Plan

Manual Addendum

June 1, 2026

Table of Contents

Change Index

SECTION	PAGE(S)	CHANGE TO CONTENT
MassHealth Services	4	• Added new section describing MassHealth Services
Massachusetts Senior Care Options (SCO) and One Care Programs	5	• Added new section describing Massachusetts Senior Care Options (SCO) and One Care Programs
Authorization or Notification Information	6-7	• Removed prior authorization requirements for Partial Hospitalization (PHP) and Intensive Outpatient Program (IOP) services • Updated ASAM notification requirements • Added prior authorization is not required for CBAT in Massachusetts, but providers are required to notify Optum of the member's admission within 72 hours • Added new prior authorization/notification information and service chart • Added Family-Based Intensive treatment (FIT) information • Added new website and phone number resources
Special Accommodation Services	10	• Changed section name from Specialing Services • Added details on when services are to be requested
Coordination of Care and Transition of Care	11	• Information added when providers are required to share an enrollee's clinical information to other providers
MassHealth, ACO, One Care, and SCO Specific Covered Services	15-17	• Updated Covered Services chart to include Care Plus, OneCare and SCO information
Applied Behavioral Analysis Services for MassHealth/ACO Members	19	• Changed name of section from Autism to ABA • Added Down Syndrome
Access Standards Specific to MassHealth/ACO Members	20-21	• Added new section on Behavioral Health Inpatient and 24-hour Diversionary Services.
Telehealth services	26	• Added new reimbursement policy links
Network Requirements	29	• Added hospital expectations for treatment information
21st Century CURES Act Requirements	29	• Added 120 days enrollment period requirement
Provider Enrollment	29	• Added new section with FAQ link
Payment for Non-Network Providers	30-31	• Added new section with fee schedule information for dual eligible members
Process for Communication of Policy and Process Changes	31	• Added information on 30 days written notice for providers before policy change and education and training requirement before implementation
Miscellaneous Legal, Regulatory and Compliance minor updates to comply with Massachusetts state requirements	23 24 24 27 Throughout	• Announced and Unannounced Onsite Reviews • Quality Improvement Goals and Ongoing Performance Monitoring • Provider Profiling and Benchmarking System • Network Management Strategy – Foundational Principles • Applicability to network providers

(NOTE: The change index does not include minor changes to content or formatting)

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 2 key online tools:

- The **Provider Express website**, **Providerexpress.com** -- You'll find state-specific news and plan information, and access to clinical guidelines, reimbursement policies, administrative updates and more. The website is also how you'll access our secure portal.
- The **Provider Express secure portal** – It's where you can access patient- and practice-specific information that helps you check member eligibility and benefits, check prior authorization requirements and submit requests, get updates on claims, reconsiderations and appeals, and more. It is available to network clinicians and group practices, as well as out-of-network individual clinicians. You must register for a One Healthcare ID and password to access the secure portal.

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.

MassHealth Services

MassHealth is Massachusetts' Medicaid and CHIP program, providing comprehensive health coverage to eligible low-income individuals and families, including children, pregnant women, people with disabilities, and seniors. It covers a wide range of services such as primary and specialty care, hospital visits, behavioral health, prescription drugs, dental and vision care, long-term services and supports, and transportation. MassHealth also offers managed care options like Accountable Care Organizations (ACOs), which promote coordinated, value-based care through provider networks focused on improving outcomes and reducing costs.

Massachusetts Senior Care Options (SCO) and One Care Programs

Effective Jan. 1, 2026, Optum will partner with Mass General Brigham Health Plan (MGBHP) to manage behavioral health services for SCO and One Care members in Bristol, Dukes, Essex, Middlesex, Nantucket, Norfolk, Plymouth, and Suffolk counties.

Senior Care Options (SCO) is a fully integrated Medicare Advantage Special Needs plan serving members within the SCO service area who are age 65 and older and are dually eligible for Medicare and Medicaid. SCO combines Medicare and Medicaid benefits into one plan, covering medical, behavioral health, pharmacy, and long-term services and supports (LTSS). Care is coordinated by an interdisciplinary team led by a primary care provider and supported by a Geriatric Support Services Coordinator. Members receive comprehensive services, including hospital and physician care, behavioral health, adult day health, personal care assistance, and respite care, with no copayments for covered services.

One Care serves adults with disabilities within the service area who are ages 21 – a 64 and are dually eligible for Medicare and Medicaid. This program integrates primary, acute, behavioral health, and LTSS into a single plan focused on independent living, recovery, and wellness. Members receive person-centered care through an Interdisciplinary Care Team and a dedicated Care Coordinator. Coverage includes medical, behavioral health, pharmacy, dental, vision, and LTSS.

United Behavioral Health (UBH), operating under the brand Optum, supports **Massachusetts Program Goals** of improving health outcomes and quality of life through integrated care, reducing fragmentation, supporting independence and community living, and addressing social determinants of health.

Provider Responsibilities include delivering medically necessary services, participating in care coordination, supporting person-centered planning, maintaining accurate records, ensuring accessibility, and complying with non-discrimination standards.

Compliance Requirements include completing mandatory training, adhering to prior authorization protocols, maintaining appointment availability, and following documentation and reporting standards. Providers must not bill members for covered services and must obtain prior authorization for out-of-network care.

The document provides an overview of all Mass General Brigham Health Plan programs and requirements, which Optum will support in partnership with Mass General Brigham Health Plan beginning January 1, 2026. These programs serve distinct populations with integrated care models designed to improve health outcomes and support independent living. Understanding the structure and goals of each program is essential for providers delivering behavioral health services under this new arrangement.

Authorization or Notification Information

Benefit coverage is determined by individual plan; you may refer to plan materials for covered benefits.

- Prior authorization is not a guarantee of provider payment.
- Prior authorizations should be entered using Mass General Brigham Health Plan Provider Portal. The rendering facility and physicians are strongly encouraged to verify, using the Provider Portal linked above, the existence of an authorization before the service is rendered. Prior to scheduling a service, providers should check member eligibility, and evidence of coverage for the member's Product/Plan.
- If inpatient admission is emergent, then notification is required. Concurrent authorization that follows the initial authorization is required.

Service	MGB ACO MassHealth Standard & Common Health Enrollees	MGB ACO MassHealth Family Assistance Enrollees	CarePlus	OneCare	SCO
Partial Hospitalization / High-Intensity Outpatient *	No authorization required	No authorization required	No authorization required	Notification within 48 hours	Notification within 48 hours
Intensive Outpatient Program *	No authorization required	No authorization required	No authorization required	Notification within 48 hours	Notification within 48 hours
Day Treatment (Mass Health only)	Authorization required	Authorization required	Authorization required	Notification within 48 hours	Notification within 48 hours
Applied Behavioral Analysis (ABA)	Authorization required over age 3	Authorization required over age 3	Authorization required over age 3	Not Covered	Not Covered
Transcranial Magnetic Stimulation	Authorization required	Authorization required	Authorization required	Authorization required	Authorization required
Acute Residential Treatment (ART)	Authorization required	Authorization required	Authorization required	Authorization required	Authorization required
Structured Outpatient Addictions Program (SOAP)*	Notification within 48 hours	Notification within 48 hours	Notification within 48 hours	Notification within 48 hours	Notification within 48 hours
Observation Notification	Notification within 72 hours	Notification within 72 hours	Notification within 72 hours	Notification within 48 hours	Notification within 48 hours
Family-Based Intensive Treatment (FIT)	Authorization required	Authorization required	Authorization required	Authorization required	Not Covered

Family-Based Intensive Treatment (FIT) is a home-and community-based behavioral health service for youth under the age of 21 with serious emotional disturbance (SED). The service is only available through the member's local Community Service Agency.

- Family-centered therapy and care coordination aimed at:
  - Stabilizing the youth's mental health
  - Strengthening family dynamics and natural support
  - Preparing for transition to lower-intensity care within 4–6 months

Providers can also 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.

Additional resources are located at **Authorization guidelines | Mass General Brigham Health Plan.**

For behavioral health specific services, you may also contact Optum directly at the following numbers:

- **1-844-357-0946** – Mass General Brigham Health Plan Medicare Advantage
- **1-844-451-3518** – Mass General Brigham Health Plan Commercial
- **1-844-451-3519** – Mass General Brigham Health Plan ACOMassHealth/Medicaid

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

Services REQUIRING Notification – 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):** In Massachusetts prior authorization is not required for CBAT, but 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.
  - **For Medicaid (ASAM 4.0, 3.7):** Providers are required to notify Optum of the member's admission within 48 hours. No authorization is required.
  - **For Medicaid (ASAM 3.5):** Providers are required to notify Optum of the member's admission within 48 hours. No authorization is required for the first 14 days; Authorization requirements begin on day 15.
  - **For Commercial (ASAM 4.0, 3.7, 3.5):** Providers are required to notify Optum of the member's admission within 48 hours. No authorization is required for the first 14 consecutive days; Authorization requirements begin on day 15.
- **Residential Rehabilitation Services – Medicaid only Benefit (RRS) (ASAM 3.1)**
  - Providers are required to provide notification within 7 calendar days of admission.
  - Authorization is not required for the first 90 days; concurrent review is required to request additional days past the initial 90 days.

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

Services that DO NOT Require Authorization or Notification

- 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.

Medicaid-Only Benefit
Special Consideration for Program of Assertive Community Treatment (PACT)

- Providers must meet requirements set forth in Performance Specifications, 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.
- Members actively engaged in a Community Support Program (CSP) or similar duplicative services are excluded.

Service Code & Modifier	Service Description	Reimbursement Rate Details
H0040-U1	Assertive community treatment program, per diem (Medicaid level of care 1; PACT 50)	101 CMR 430.00
H0040-U2	Assertive community treatment program, per diem (Medicaid level of care 2; PACT 80)	101 CMR 430.00

Psychological Testing

- 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 can have been administered within the last 6 months.
- Authorization is required for psychological testing requests for more than 5 hours service time (test evaluation 96130/96131 and administration-scoring 96136-96139 time combined).
- The written request must be submitted with clinical information by using the Provider Express secure portal.
  - Review these instructions and tips.
- NOTE: Providers should bill for the entire testing episode from evaluation through feedback session on a single claim submission.

- Base code billing: Maximum of 1 unit for each base code is permitted once 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 receiving treatment 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 follows Massachusetts-specific guidelines to facilitate timely admission to appropriate inpatient psychiatric facilities for members presenting in the emergency department (ED) and meeting medical necessity criteria.

Upon notification from a facility that a member is in the ED and requires inpatient treatment, Optum applies criteria aligned with the Expedited Psychiatric Inpatient Admission (EPIA) process. This ensures there are no inappropriate delays or denials for covered members with acute behavioral health or substance use disorder needs.

If a member's care meets the Optum medical necessity criteria for an individual inpatient room or other special services (as outlined in the section below on Special Accommodation Services), and the facility identifies these services as necessary for safe and effective care, the facility must request them at the time of initial admission notification. Optum will then arrange coverage for these services.

When medical necessity criteria are met, Optum will approve inpatient treatment unless an alternative, medically appropriate placement has been secured.

Optum expects members to receive continuous, high-quality inpatient care to support improved outcomes. When appropriate, members should be re-hospitalized at the same facility to maintain continuity of care.

Prior authorization is not required for admission to a facility for behavioral health treatment following an ED visit or emergency services, regardless of whether the member has been stabilized.

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Special Accommodation Services (Formerly known as Specialing)

Special Accommodation services are those services that have been identified by the facility or unit as necessary to support a member's admission and exceed the typical capabilities and/or competencies of the facility or unit. If Accommodation services are identified by a facility as necuy7essary for safe and effective patient care, Special Accommodation services must be requested by the facility upon initial notification of the admission.

Optum Special Accommodation Services include:

- Caregiver / Personal Attendant
- Security
- Mental Health Worker
- Other additional staffing (e.g., Tech / counselor / nursing)
- Intensive RN and Physical Care
- Single Room

Consent for Treatment, Minors

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

- 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

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.

All providers are required to provide an Enrollee's clinical information to other Providers, as necessary, to ensure proper coordination and behavioral health treatment of Enrollees who express risk of harm to self or others, consistent with state law.

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, Senior Care Options (SCO), and One Care 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 who are at risk of homelessness.

In addition, all psychiatric inpatient hospitals 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 a member is experiencing or is 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 who is 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 those agencies.
    - For any such member, the hospital must, within two business days of admission, and to an 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 at **1-800-327-5050**, the statewide public resource for finding substance use treatment recovery options and assistance with problem gambling. The Helpline's trained specialists will help the members 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 the *Helping Patients who are Homeless or Housing Unstable* website.
- 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 staff when helping members with skilled nursing or other long-term care needs: *Helping Patients with Skilled Nursing Needs*.
- This website also includes information about EOHHS's new 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.
  - Provide the member with a meal prior to discharge.
  - Ensure that the member is wearing appropriate clothing and footwear.
  - Provide the member with 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 1 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. If 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 on the *Helping Patients who are Homeless or Housing Unstable* website. The website includes resources, information, and a support line to assist hospital staff in placing members who are experiencing or at risk of homelessness.

MassHealth, ACO, One Care and SCO-Specific Covered Services

Service	MGB ACO MassHealth Standard & Common Health Enrollees	MGB ACO MassHealth Family Assistance Enrollees	CarePlus	OneCare	SCO
Inpatient Services					
Inpatient Mental Health Services	X	X	X	X	X
Inpatient Substance Use Disorder Services (Level 4)	X	X	X	X	X
Observation/Holding Beds	X	X	X	X	X
Administratively Necessary Day (AND) Services	X	X	X	X	X
Diversionary Services / 24-Hour Diversionary Services					
Community Crisis Stabilization	X	X	X	X	X
Community-Based Acute Treatment for Children and Adolescents (CBAT)	X	X	Not covered	Not covered	Not covered
Medically Monitored Intensive Services - Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	X	X	X	X	X
Clinical Support Services for Substance Use Disorders (Level 3.5)	X	X	X	X	X
Transitional Care Unit (TCU)	X	X	Not covered	Not covered	Not covered
Diversionary Services / Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)					
Adult Residential Rehabilitation Services for SUD	X	X	X	X	X
Family Residential Rehabilitation Services for SUD	X	X	X	X	X
Transitional Age Youth and Youth Adult Residential Rehabilitation Services for SUD	X	X	X	Not covered	Not covered
Youth Residential Rehabilitation Services for SUD	X	X	X	Not covered	Not covered
Co-Occurring Enhanced Residential Rehabilitation Services for SUD	X	X	X	X	X
Pregnancy Enhanced Residential Rehabilitation Services for SUD	X	X	X	X	X
Non-24 Hour Diversionary Services					
Community Support Program (CSP)	X	X	X	X	X
Specialized CSP Programs: • CSP for Justice Involved • CSP for Homeless Individuals	X	X	X	X	X

Service	MGB ACO MassHealth Standard & Common Health Enrollees	MGB ACO MassHealth Family Assistance Enrollees	CarePlus	OneCare	SCO
• CSP Tenancy Preservation Program					
Partial Hospitalization (PHP)	X	X	X	X	X
Psychiatric Day Treatment	X	X	X	X	X
Structured Outpatient Addiction Program (SOAP)	X	X	X	X	X
Enhanced Structured Outpatient Addiction Program (ESOAP)	X	X	X	X	X
Intensive Outpatient Program (IOP)	X	X	X	X	X
Certified Peer Specialist	X	X	X	X	X
Recovery Coaching	X	X	X	X	X
Recovery Support Navigators	X	X	X	X	X
Program of Assertive Community Treatment (PACT)	X	X	X	X	X
Intensive Hospital Diversion (IHD)	X	X	Not covered	Not covered	Not covered
Outpatient Services / Standard Outpatient Services					
Family Consultation	X	X	X	X	X
Case Consultation	X	X	X	X	X
Diagnostic Evaluation	X	X	X	X	X
Dialectical Behavioral Therapy (DBT)	X	X	X	X	X
Psychiatric Consultation on an Inpatient Medical Unit	X	X	X	X	X
Medication Visit	X	X	X	X	X
Couples/Family Treatment	X	X	X	X	X
Group Treatment	X	X	X	X	X
Individual Treatment	X	X	X	X	X
Inpatient-Outpatient Bridge Visit	X	X	X	X	X
Assessment for Safe and Appropriate Placement (ASAP)	X	X	Not covered	Not covered	Not covered
Collateral Contact	X	X	Not covered	Not covered	Not covered
Acupuncture Treatment Medical Benefit	X	X	X	X	X
Opioid Treatment Services	X	X	X	X	X
Ambulatory Withdrawal Management (Level 2WM)	X	X	X	X	X
Psychological Testing	X	X	X	X	X
Special Ed Psychological Testing	X	X	Not covered	Not covered	Not covered

Service	MGB ACO MassHealth Standard & Common Health Enrollees	MGB ACO MassHealth Family Assistance Enrollees	CarePlus	OneCare	SCO
Applied Behavioral Analysis (ABA) for Members Under Age 21	X	X	Not covered	Not covered	Not covered
Preventative Behavioral Health Services	X	X	Not covered	Not covered	Not covered
Behavioral Health Urgent Care	X	X	X	X	X
Outpatient Services / Intensive Home or Community-Based Services for Youth					
Family Support and Training	X	Not covered	Not covered	Not covered	Not covered
Intensive Care Coordination	X	Not covered	Not covered	Not covered	Not covered
In-Home Behavioral Services	X	Not covered	Not covered	Not covered	Not covered
Behavior Management Therapy					
Behavior Management Monitoring					
In-Home Therapy Services	X	X	Not covered	Not covered	Not covered
Therapeutic Mentoring Services	X	Not covered	Not covered	Not covered	Not covered
Crisis Services (post 1/1/23 CBHC-Based)					
Adult Mobile Crisis Intervention (AMCI) Encounter	B	X	X	X	X
Youth Mobile Crisis Intervention (YMCI)	X	X	Not covered	Not covered	Not covered
Crisis Services (post 1/1/23 CBHC-Based)					
Emergency Department-Based Crisis Intervention Mental Health Services					
Crisis Evaluation	X	X	X	X	X
Crisis Stabilization Interventions					
Discharge Planning and Care Coordination					
Other Behavioral Health Services					
Electro-Convulsive Therapy (ECT)	X	X	X	X	X
Repetitive Transcranial Magnetic Stimulation (rTMS)	X	X	X	X	X
Special Accommodations	X	X	X	X	X

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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 in Performance Specifications.

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

The Children's Behavioral Health Initiative (CHBI) 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 (authorization not required)
- Therapeutic Mentoring (authorization not required)
- Intensive Care Coordination (ICC) (authorization not required)
- In-Home Behavioral Services (authorization not required)
- Family-based Intensive Treatment (FIT) (authorization is required)
  - Behavior Management Therapy
  - Behavior Management Monitoring
- In-Home Therapy Services (authorization not required)
- Youth Mobile Crisis Intervention (authorization not required)

CBHI services that do not require 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

Applied Behavioral Analysis Services for MassHealth/ACO Members

Services are available for youth under the age of 21:

- Applied Behavioral Analysis (ABA) Services for members
- Autism Spectrum Disorder and Down Syndrome (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
- 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)
  - Transitional Care Units (TCU)

Important Reminders

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.

Review these MassHealth resources for additional information related to CANS:

- Child and Adolescent Needs and Strengths (CANS)
- Frequently Asked Questions about the CANS Requirements and Billing

Child and Adolescent Preventative Care

Optum must cover up to 8 preventive behavioral health 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.

Behavioral Health Inpatient and 24-Hour Diversionary Services

- A Behavioral Health Inpatient and 24-hour Diversionary Services provider shall accept for admission or treatment all members for whom Optum has determined admission or treatment is medically necessary, regardless of clinical presentation, as long as a bed is available in an age-appropriate unit.
- Provider shall coordinate treatment and discharge planning with the state agencies (e.g., DMH, DDS) with which the member has an affiliation, and in no such case shall Provider discharge patients who are homeless or who have unstable housing without a plan for housing.
- Provider shall have human rights and restraint and seclusion protocols that are consistent with the DMH's Human Rights and Restraint Seclusion Policy and regulations, and include training of the provider's staff and education for members regarding human rights. Provider shall have a human rights officer, who shall be overseen by a human rights committee, and who shall provide written materials to members regarding their human rights, in accordance with DMH's Human Rights and Restraint and Seclusion Policy and with applicable DMH regulations and requirements.
- Provider shall coordinate with all contracted Community Behavioral Health Centers (CBHCs) in Optum service area(s), including procedures to credential and grant admitting privileges to AMCI provider psychiatrists, if necessary.
- As needed, provider shall participate in or convene regular meetings and conduct ad hoc communication on clinical and administrative issues with CBHCs to enhance the continuity of care for members.

Emergency Services

Immediately, on a 24-hour basis, 7 days a week, with unrestricted access to members who present at any qualified provider, whether a network provider or a non-network provider.

Mobile Crisis Intervention Services

Immediately, on a 24-hour basis, 7 days a week, with unrestricted access to members who present for such services.

Community Behavioral Health Centers (CBHC)

Community Behavioral Health Centers (CBHCs) will serve as an entry point for the treatment for mental health conditions and substance use disorders and will 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 14 calendar days.

Inpatient or 24-Hour Diversionary Services and Discharge Planning Services

- Behavioral Health Inpatient and 24-hour Diversionary Services providers must coordinate with all contracted CBHCs in the Contractor's Service Area(s), including procedures to credential and grant admitting privileges to AMCI provider psychiatrists.
- Non-24-Hour Diversionary Services: Within 2 calendar days of discharge.
- Medication Management: Within 14 calendar days of discharge.
- Other Outpatient Services: Within 7 calendar days of discharge.
- Intensive Care Coordination Services: Within the time frame directed by EOHHS (Executive Office of Health and Human Services).

Documentation Standards

Providers are required to maintain high quality medical records for all the members that you serve as 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 for obtaining the appropriate order, referral and/or determination of medical necessity for service.
- 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.

- All providers should provide 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.
- Members have the right to receive documents in alternative formats and/or oral interpretation services free of charge for any materials in any language.
- When requested, members have the right to receive a copy of their health record and request that it be changed or corrected as explained in the Notice of Privacy Practices in the MGBHP Member Handbook.

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 are 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

- 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
- History of substance use, 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

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
  - The number of units matches the information on the claim
  - State the specific location of services provided. The 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 the 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
- 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

Announced and Unannounced Onsite Reviews

As part of its quality management and oversight responsibilities, Optum may conduct announced and unannounced on-site reviews of network providers. These reviews may include, but are not limited to:

- Quality of care evaluations
- Medical record documentation reviews

- Compliance assessments
- Accessibility and ADA-related reviews
- On-site reviews are conducted in accordance with established Optum quality and audit protocols and support continuous quality improvement across the network.

Quality Improvement Goals and Ongoing Performance Monitoring

When provider profiling or quality review activities identify opportunities for improvement, Optum collaborates with network providers to:

- Review treatment plans, documentation, and service utilization
- Identify best practices and potential treatment or service adjustments
- Establish improvement recommendations or goals, as applicable

Provider performance is reassessed on a recurring basis using updated data to monitor progress toward identified improvement opportunities and to determine whether further outreach or corrective action is warranted.

Provider Profiling and Benchmarking System

Optum operates a systematic provider profiling and benchmarking framework to identify utilization and quality outliers within the MGBHP behavioral health network. This system includes, but is not limited to:

- Review of standardized claims and encounter data
- Analysis of utilization patterns relative to peer benchmarks
- Identification of providers exhibiting higher-than-expected utilization, frequency, or duration of services
- Findings from provider profiling activities are used to initiate targeted provider communications, clinical review, and quality improvement collaboration, as appropriate.

Telehealth Services

- Documentation standards and best practices are available:
  - Telemental Health Services - Medicaid
  - Telemental Health Services Reimbursement Policy - Medicare
  - Telemental Health Services Reimbursement Policy - Commercial
- 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.

- Mass General Brigham Incident Form
- MGBHP Incident Form - CarePlus
- MGBHP Incident Form - Commercial
- MGBHP Incident Form - Medicaid

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

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.

- Reporting is done by submitting a Serious Incident Report (SRE) Form within 7- and 30-calendar days from the date the event took place. Forms are faxed to Optum once they are complete. The fax number is **1-844-814-5698**.
- The 30-day 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 Behavioral Health will:

- Contact practitioners/facilities as needed to obtain the necessary information to conduct the review.
- 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 Behavioral Health may also provide facilities and practitioners with written or oral feedback related to observations made as a result of the SRE review.

In addition:

- 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 the All Provider Manual Appendix "V": MassHealth Billing Instructions for Provider Preventable Conditions.

Network Requirements

Network requirements are outlined in the Optum National Network Manual.

When applicable, Optum network (participating/contracted) practices must provide interpreter services free of charge to limited English proficiency (LEP) members, including but not limited to over-the-phone communication.

- This requirement is in keeping with Title VI of the Civil Rights Act of 1964 that requires recipients of federal financial assistance to provide translation or interpretation services as a means of ensuring that their programs and activities normally provided in English are accessible to LEP persons, and thus do not discriminate on the basis of national origin.
- The provision of translation or interpreter services must comply with applicable state and federal mandates, and take into account relevant guidance issued by the Department of Health and Human Services Offices of Civil Rights Minority Health, as well as the Massachusetts Office of Health Equity.
- Optum network (contracted) providers must have the capacity to communicate with members in languages other than English, communicate with individuals with special health care needs (including with those who are deaf, hard of hearing, or deaf/blind) and make materials and information available in alternative formats.

The following resources are available to assist providers in meeting this obligation:

- The US Department of Health and Human Services Office of Minority Health's publication, "A Patient- Centered Guide to Implementing Language Access Services in Healthcare Organizations," can be found at: https://minorityhealth.hhs.gov/. This website also includes information on interpreter services, regulations, and requirements.
- More detail on CLAS standards may be found here: https://www.mass.gov/info-details/clas-national-standards.

All hospitals in the Optum provider network, including those that do not have DMH-licensed beds, must have the capability to treat, in accordance with professionally recognized standards of medical care, all individuals admitted to any unit or bed within the hospital who present with co-occurring behavioral conditions, including, but not limited to, individuals with:

- Co-occurring Substance Use Disorders (SUD)
- Autism Spectrum Disorder
- Intellectual and Developmental Disabilities (ASD/ID/DD), and/or
- Individuals who present with a high-level of psychiatric acuity, including severe behavior and assault risk

Network Management Strategy – Foundational Principles

Optum, on behalf of Mass General Brigham Health Plan (MGBHP), maintains a network management strategy that applies to all contracted behavioral health providers and is designed to promote:

- Recovery-oriented, person-centered care
- Rehabilitation and independent living principles
- Cultural and linguistic competence
- Integrated medical and behavioral health care
- Cost-effective, evidence-based service delivery

These principles align with the SCO and One Care program models and are embedded across provider oversight, quality monitoring, and performance improvement activities.

21st Century CURES Act Requirements

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.

To fulfill these requirements, all health care professionals contracted must enroll with MassHealth within 120 days of enrollment. This will prevent billing delays and termination from the network.

For questions and answers regarding this process, please review 21st Century Cures Act MassHealth Frequently Asked Questions.

Provider Enrollment

For questions and answers regarding this process, please review MassHealth Enrollment FAQ.

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 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 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'll be notified of the decision within 72 hours of receipt of the request. Appeals can be submitted in 3 ways:

Phone: 1-866-556-8166

Fax: 1-855-312-1470

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

Claim Information

Claims must be submitted within 90 days of the date of service. Clean claims will be adjudicated within 45 days of receipt of the claim. Claims may be submitted in 3 ways:

- Online through the Optum Provider Express Secure Portal
- Via Electronic Data Interchange (EDI)
- Paper claims via U.S. mail:

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

Payment for Non-Network Providers

Comparable FFS Payment for Non-Network Providers

To the extent non-network Medicare payment provisions apply to the Contractor for activities, the Contractor shall be advised that for a provider of a Medicare service serving a dual-eligible individual with Original Medicare and MassHealth FFS, the amount such provider would receive would be limited to the MassHealth FFS fee schedule when such fee schedule is less than the applicable Medicare fee schedule.

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:

- **Top of Mind monthly provider newsletter:** Optum Behavioral Health news, regulatory updates, process changes and more delivered right to your inbox each month. Most of the information you need to know will be included in Top of Mind.
- **Massachusetts information** webpage: This webpage contains forms, training, reference guides and other items specific to MassHealth, Mass General Brigham and state-specific Medicaid or Commercial plans.
- **Provider notifications:** Urgent and high-priority updates may occasionally be sent to you throughout the month via email.
- **Contractual notifications:** When required by contract or regulation, we will mail items to the primary address you have on file with us.

Unless required by law or specifically authorized by EOHHS, the organization should make every reasonable effort to:

- Provide providers with written notice at least 30 days before any changes to policies or procedures take effect.
- Maintain a process to educate and train providers on these changes before they are implemented.

The network management, communication, profiling and quality improvement processes described in this Addendum apply to all contracted behavioral health provider types, including but not limited to:

- Individual practitioners
- Facility-based providers
- Community Behavioral Health Centers (CBHCs)
- Specialty and diversionary service providers