CARELON BEHAVIORAL HEALTH

WELLPOINT MA ADDENDUM

Last updated 7/1/2024

Any policies contained in this Provider Handbook Addendum will supersede those policies contained in Carelon Behavioral Health's National Provider Handbook. This Addendum is specific to your state. Providers should refer to their plan-specific section within this Addendum.

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Wellpoint

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Wellpoint's electronic Payer ID is 80314. For information about electronic transaction documents for Wellpoint claims, code sets, electronic remittance advice (ERA) registration, and more, please visit Wellpoint's Filing Electronic Claims at www.wellpoint.com/mass/providers/reimbursement-resources/how-to-file-electronic-claims

Submitting Paper Claims

Submit paper claims to the below address:

Wellpoint
P.O. Box 4095
Woburn, MA 01888-4095
Phone: 800-442-9300 (TTY: 711)
Fax: 978-474-5162

10. UTILIZATION MANAGEMENT

UM Terms and Definitions

Term	Definition
Adverse Determination: Commercial Members	A decision to deny, terminate or modify (an approval of fewer days, units or another level of care other than was requested that the practitioner does not agree with) an admission, continued inpatient stay, or the availability of any other behavioral health care service(s) for: • Failure to meet the requirements for coverage based on medical necessity • appropriateness of health care setting and level-of-care effectiveness • Health plan benefits.
Adverse Action: MassHealth Members	The following actions or inactions by Carelon or the provider organization: • Carelon's denial, in whole or in part, of payment for a service failure to provide covered services in a timely manner in accordance with the waiting time standards • Carelon's denial or limited authorization of a requested service, including the determination that a requested service is not a covered service • Carelon's reduction, suspension, or termination of a previous authorization for a service • Carelon's denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute adverse actions, including but not limited to, denials based on the following: o Failure to follow prior authorization procedures o Failure to follow referral rules o Failure to file a timely claim • Carelon's failure to act within the time frames for making authorization decisions

EMERGENCY SERVICES

Definition

Emergency services are those physician and outpatient hospital services, procedures, and treatments, including psychiatric stabilization and medical detoxification from drugs or alcohol, needed to evaluate or stabilize an emergency medical condition. The definition of an emergency medical condition follows: *"…a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in*

(a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person."

Emergency care will not be denied; however, subsequent days do require pre-service authorization. The facility must notify Carelon as soon as possible and no later than 24 hours after an emergency admission and/or learning that the member is covered by Wellpoint. If a provider fails to notify Carelon of an admission, Carelon may administratively deny any days that are not prior-authorized.

Emergency Screening and Evaluation

MassHealth mandates that Emergency Service Providers (ESPs) perform an emergency screening for all MassHealth enrollees requiring inpatient admission. If there are extenuating circumstances, and the ESP cannot evaluate the member in a timely manner (within one hour from telephone notification or member's arrival to the site), Carelon will allow a qualified clinician from a hospital emergency room or other evaluation site to provide the emergency evaluation for MassHealth members. This process allows members to access emergency services as quickly as possible and at the closest facility or by the closest crisis team. All ESPs are contracted providers for Carelon. After the emergency evaluation is completed, the ESP or facility clinician should call Carelon to complete a clinical review, if admission to a level of care that requires precertification is needed. The ESP is responsible for locating a bed, but may request Carelon's assistance. Carelon may contact an out-of-network facility in cases where there is not a timely or appropriate placement available within the network. In cases where there is no in-network or out-of- network psychiatric facility available, Carelon will authorize boarding the member on a medical unit until an appropriate placement becomes available. For Commercial and Medicare members, it is not mandated that an ESP provide an evaluation for members requiring inpatient admission. However, an ESP may evaluate these members.

Per the Commonwealth of Massachusetts, Executive Office of Health & Human Services contract with contracted Managed Care Organizations, based on 42 CFR Part 438, MassHealth members, member representatives or providers have the right to request an extension for up to 14 calendar days. The determination will be issued as expeditiously as the member's health requires but, no later than the date the extension expires.

When the specified time frames for standard and expedited prior authorization requests expire before Carelon makes a decision, an adverse action notice will go out to the member on the date the time frame expires.

Medicaid and Medicare Decision and Notification Time Frames

REQUEST	TYPE OF DECISION	DETERMINATION	VERBAL NOTIFICATION	WRITTEN NOTIFICATION
Pre- Service	Urgent	Within 72 hours from request	Within 72 hours from request	Within 72 hours from request
	Non-Urgent/ Standard	Within 14 Calendar Days	Within 14 Calendar Days	Within 14 Calendar Days
Concurrent Review	Urgent/ Expedited	Within 72 hours from request	Within 72 hours from request	Within 72 hours from request
	Non-Urgent/ Standard	Within 14 Calendar Days	Within 14 Calendar Days	Within 14 Calendar Days
Post- Service	Non-Urgent/ Standard	Within 30 calendar days	Within 30 calendar days	Within 30 calendar days

Commercial Decision and Notification Time Frames

REQUEST	TYPE OF DECISION	DETERMINATION	VERBAL NOTIFICATION	WRITTEN NOTIFICATION
Pre-Service	Urgent	Within 72 hours	Within 72 hours	Within 72 hours
	Non-Urgent/ Standard	Within 15 calendar days	Within 15 calendar days	Within 15 calendar days
Concurrent Review	Urgent/ Expedited	Within 24 hours	Within 24 hours	Within 24 hours
	Non-Urgent/ Standard	Within 15 calendar days	Within 15 calendar days	Within 15 calendar days
Post- Service	Non-Urgent/ Standard	Within 30 calendar days	Within 30 calendar days	Within 30 calendar days

Appeal of Adverse Determination

Appeal requests can be made by calling Carelon's Appeals Coordinator at 1-844-231-7949 or in writing to:

Carelon Behavioral Health
Att: Appeals Department
P.O. Box 1856
Hicksville, NY 11802

Request for Reconsideration of Adverse Determination

If a member or member's provider disagrees with a utilization review decision issued by Carelon, the member, his/her authorized representative, or the provider may request reconsideration. Call Carelon promptly upon receiving notice of the denial for which reconsideration is requested.

When reconsideration is requested, a physician advisor will review the case based on the information available and will make a determination within one business day. If the member, member representative or provider is not satisfied with the outcome of reconsideration, he or she may file an appeal.

Clinical Appeals

- A MassHealth or Massachusetts Commercial member and/or the member's appeal representative or provider (acting on behalf of the member) may appeal an adverse action/adverse determination. Both clinical and administrative denials may be appealed. Appeals may be filed either verbally, in person, or in writing.

- Appeal policies are made available to members and/or their appeal representatives as enclosures in all denial letters, and upon request. Every appeal receives fair consideration and timely determination by a Carelon employee who is a qualified professional. Carelon conducts a thorough investigation of the circumstances and determination being appealed, including fair consideration of all available documents, records, and other information without regard to whether such information was submitted or considered in the initial determination. Punitive action is never taken against a provider who requests an appeal or who supports a member's request for an appeal.

Expedited Clinical Appeals MassHealth

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
Members, their legal guardian, or their AMR have up to 30 calendar days after receiving notice of an adverse action in which to file an appeal. If the member designates an AMR to act on his/ her behalf, Carelon will attempt to obtain a signed and dated Designation of Appeal Representative Form. Every attempt will be made to have this form completed prior to the deadline for resolving the appeal. All expedited internal appeals will be processed by Carelon even if we have not received the Designation of Appeal Representative Form. The provider may act as the member's AMR. However, the provider must still submit a signed authorized Designation of Appeal Representative Form (AMR) to Carelon as documentation that the member did in fact authorize the provider to file an expedited internal appeal on the member's behalf. However, Carelon may not delay or dismiss an expedited appeal if the signed form is not submitted. A Carelon Physician Advisor, who has not been involved in initial decision, reviews all available information and attempts to speak with the member's attending physician. A decision is made within 72 hours of the initial request.	N/A	Members, their legal guardian, or AMRs who remain aggrieved by an expedited internal appeal decision, have the option to request an external review from the Executive Office of Health and Human Services, Office of Medicaid's Board of Hearings (BOH). Carelon will provide the BOH with all documentation relating to the expedited internal appeal. Members or their AMR must make this request to BOH within 20 days after the expedited internal appeal decision, but within 10 days if they wish to receive continuing services without liability. Members or their AMR must complete the Request for Fair Hearing Form, included with the expedited internal appeal decision notification and submit to BOH. Contact Information Members or their AMR should contact the Carelon Appeals Coordinator for assistance in making the request to BOH at (800) 414-2820.

LEVEL 1 APPEAL	LEVEL 2 APPEAL	EXTERNAL REVIEW
Throughout the course of an appeal, the member shall continue to receive services for concurrent review denials only, without liability for services previously authorized by Carelon, until he/she is notified of the appeal determination. The provider must still submit a signed authorized Designation of Appeal Representative Form (AMR) to Carelon as documentation that the member did in fact authorize the provider to file an expedited internal appeal on the member's behalf. However, Carelon may not delay or dismiss an expedited appeal if the signed form is not submitted. A Carelon physician advisor, who has not been involved in initial decision, reviews all available information and attempts to speak with the member's attending physician. A decision is made within 72 hours of the initial request. Throughout the course of an appeal for services previously authorized by Carelon, the member shall continue to receive services for concurrent review denials only, without liability until notification of the appeal resolution, provided the appeal is filed on a timely basis. **Contact Information** Appeal requests can be made by calling Carelon's Appeals Coordinator at 800.414.2820.	N/A	Members, their legal guardian, or AMRs who remain aggrieved by an expedited internal appeal decision have the option to request an external review from an external review agency (ERA) up to 180 days to file an appeal after notification of Carelon's adverse determination with the Department of Public Health Office of Patient Protection (OPP). Carelon will provide the ERA with all documentation relating to the expedited internal appeal. Members or their AMR must make this request to OPP within 4 months after the expedited internal appeal decision, but within two days if they wish to receive continuing services without liability. **Contact Information** Members or their AMR should contact the Carelon Appeals Coordinator for assistance in making the request to the Office of Patient Protection (OPP) at 800.414.2820. Members or their AMR may also contact OPP directly. Call 800.436.7757 or go to www.mass.gov/orgs/office-of-patient-protection to obtain the forms and additional instructions or the external review. (There is a fee of $25.)

* Please note that providers may act as an Authorized Member Representative.

Standard Clinical Appeals MassHealth and Commercial

Level 1 Appeal	Level 2 Appeal	External Review
Members, their legal guardian, or their AMR have up to 30 calendar days after receiving notice of an adverse action to file an appeal. When the member is designating an appeal representative to appeal on his/her behalf, the member must complete and return a signed and dated Designation of Appeal Representative Form prior to the deadline for resolving the appeal (30 calendar days). The Designation of Appeal Form is required even if the provider is acting as the authorized representative. Failure to do so prior to the appeal due date will result in dismissal of the appeal. However, verbal and written communication can only occur with the member or their legal guardian until such time as the form is received. If an individual other than the member or their legal guardian requests the standard first level appeal, the member must complete and return the Designation of Appeal Representative Form prior to the deadline for resolving the appeal. Failure to do so will result in the dismissal of the appeal and notice of dismissal to the member only. A Carelon physician advisor, not involved in the initial decision, will review available information and attempt to contact the member's attending physician/provider. Resolution and notification will be provided within 20 calendar days of the appeal request.		MassHealth members or their AMR should contact Carelon's appeals coordinator for help for external appeal with BOH. Carelon will provide BOH with all documentation relating to the standard first and/or second level appeal. MassHealth members or their AMR must submit requests to BOH within 30 days from Carelon's standard first or second level appeal decision notification, but within 10 days if they wish to receive continuing services without liability. Members may be held liable to pay back MassHealth for continuing services if the appeal is not resolved in their favor. MassHealth members or their AMR must complete the Request for Fair Hearing Form included with all levels of appeal decisions, and submit to BOH. An external review agency will review the case if the member is not satisfied with the second level hearing.

Level 1 Appeal	Level 2 Appeal	External Review
If the appeal requires review of medical records (post service situations), the member or AMR's signature is required on an Authorization to Release Medical Information Form authorizing the release of medical and treatment information relevant to the appeal. Mass Health members must submit an appeal request within 10 days of the adverse action in order to continue services without liability. The provider must submit the medical chart for review. If the chart is not received within 20 days of the initial letter, a reminder letter is sent, giving an additional 15 days. If the chart is not received, a decision is made based on available information. **Contact Information** Appeal requests can be made by calling Carelon's Appeals Coordinator at 800.414.2820 or in writing: Appeals Coordinator Carelon Health Strategies 500 Unicorn Park Drive Suite 103 Woburn, MA 01801		Contact Information Appeal requests can be made by calling Carelon's Appeals Coordinator at 800.414.2820 or in writing: Appeals Coordinator Carelon Health Strategies 500 Unicorn Park Drive Suite 401 Woburn, MA 01801 Or Board of Hearings Office of Medicaid 100 Hancock Street, 6th Floor Quincy, MA 02171 800.655.0338 or 617.847.1200 Fax: 617.847.1204

Please include in the member appeal representative section of clinical appeals: A MassHealth or Commercial member and/or the member's appeal representative or provider (acting on behalf of the member) may appeal an adverse action/adverse determination. Both clinical and administrative denials may be appealed. Appeals may be filed either verbally, in person, or in writing.

Administrative Appeals

A provider may submit an administrative appeal, when Carelon denies payment based on the provider's failure to follow administrative procedures for authorization. (Note that the provider may not bill the member for any services denied on this basis.)

Providers must submit their appeal concerning administrative operations to the Carelon ombudsperson or appeals coordinator no later than 60 days from the date of their receipt of the administrative denial decision. The ombudsperson or appeals coordinator instructs the provider to submit in writing the nature of the administrative appeal and documentation to support an overturn of Carelon's initial decision. The following information describes the process for first and second level administrative appeals:

- **First Level** administrative appeals for both commercial and Medicaid members should be submitted in writing to the appeals coordinator at Carelon. Provide any supporting documents that may be useful in making a decision. (Do not submit medical records or any clinical information.) An administrative appeals committee reviews the appeal, and a decision is made within 30 calendar days of date of receipt of appeal. A written notification is sent within two business days of the appeal determination.

- **Second Level** administrative appeals for both commercial and Medicaid members should be submitted in writing to the president at Carelon. A decision is made within 30 calendar days of receipt of appeal information, and notification of decision is sent within two business days of appeal determination.

- **Final Appeal Level**

  Requests for an External Appeal:

  If you are not satisfied with the appeal decision, the member or their appeal representative have the right to seek external appeal. An external appeal is a complete reexamination of your case by an independent review organization (IRO). To file an external appeal, the member or their appeal representative must send us a letter within four (4) months of receiving the adverse determination letter and explain the reason for their disagreement with our decision. Members are not required to bear any costs when requesting a case be sent for external review to an IRO. Carelon will forward your letter and the entire case file to the IRO. The IRO will send final written outcome of the appeal within 45 calendar days of the request for the review. All decisions rendered by the IRO are final and binding.

Expedited External Review:

Any request for an expedited external review shall be in writing, from a physician, stating that the delay in providing or continuation of health care services that are the subject of the adverse determination, would pose an immediate threat to the member's health. The member or their appeal representative have the right to request continuation of service throughout the appeal process but must do so within two business days of receipt of the adverse determination letter. The member does not have to complete all levels of internal appeal before requesting an expedited external appeal, this may be done at the same time an internal expedited appeal is requested with Carelon. The external review panel will send final written outcome of an expedited external review within 72 hours of the request for the review.

Member Eligibility Verification

The first step in seeking authorization is to determine the member's eligibility. Since member eligibility changes occur frequently, providers are advised to verify a health plan member's eligibility upon admission to, or initiation of, treatment as well as on each subsequent day or date of service to facilitate reimbursement for services. Member eligibility can change, and possession of a health plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check Carelon's Provider Portal or by calling Carelon at (844) 231-7953 for Wellpoint Medicare and (844) 231-7951 for Wellpoint non-Medicare.

Auth	Authorization Process by Level of Care
Level of Care	**Process**
Inpatient Mental Health	Admitting hospitals are required to notify Carelon within 72 hours of admission (or the next business day on holiday weekends). Hospitals should contact their assigned concurrent reviewer for initial notification and treatment planning. For providers in the Hospital Liaison Program (HLP), contact your HLP clinician for initial notification within 72 hours (or the next business day on holiday weekends.)
CCS	Initial 5 days authorization exempt. Call NE Access Line for Continued Stay requests.
ICBAT/CBAT	Admitting hospitals are required to notify Carelon within 72 hours of admission (or the next business day on holiday weekends). Hospitals should contact their assigned concurrent reviewer for initial notification and treatment planning.
TCU	Call assigned reviewer for Pre-certification and Continued Stay requests.
Partial Hospitalization Program (PHP)	Submit notice of admission on ProviderConnect for 12 units over 21 days. Designated providers must call NE Access Line for Precertification. Call assigned concurrent reviewer for Continued Stay requests.
Intensive Outpatient Program (IOP)	Initial 6 units over 14-day period is authorization exempt. Call concurrent reviewer for Continued Stay requests.
DDAT/EATS	Submit notice of admission (NOA) on ProviderConnect for initial 7 days. Call assigned concurrent reviewer for additional 7 days. Note: Clinical review will not be conducted for the first 14 days of treatment per Massachusetts Chapter 258 of the Acts of 2014
ATS (ASAM Level 3.7/Level 4.0)	Submit notice of admission (NOA) on ProviderConnect. Call assigned concurrent reviewer for additional 7 days. Note: Clinical review will not be conducted for the first 14 days of treatment per Massachusetts Chapter 258 of the Acts of 2014
CSS (ASAM Level 3.5)	Submit notice of admission (NOA) on ProviderConnect for 14 days. Call assigned concurrent reviewer for Continued Stay requests. Note: Clinical review will not be conducted for the first 14 days of treatment per Massachusetts Chapter 258 of the Acts of 2014

Auth	Authorization Process by Level of Care
Level of Care	Process
Structured Outpatient Addiction Program (SOAP)	Initial 20 units over 45 days authorization exempt. Call concurrent reviewer for Continued Stay requests.
rTMS	Complete rTMS request form and return via fax for both Precertification and continued stay requests.
Psych Testing and Neuropsych Testing	No authorization is required for outpatient Psych Testing and Neuro Psych Testing
ECT	For Inpatient ECT call assigned reviewer to complete precertification medical necessity review. No authorization is required for Outpatient ECT.
Community Support Program (CSP)	Obtain authorization on ProviderConnect. Complete concurrent review on ProviderConnect. Select providers are required to call assigned reviewer for continued stay review.
Routine Outpatient	Mental Health and substance use routine outpatient services do not require authorization.
Day Treatment	Complete Outpatient Review Form for Adult Day Treatment and return via ProviderConnect both pre-certification and continued stay review.
Family Support and Training (FS&T)	Call 800-495-0086 to complete Pre-certification and Continued Stay review.
Intensive Care Coordination (ICC)	Call assigned reviewer for Pre-certification and Continued Stay requests.
In-Home Behavioral Services (IHBS)	Call 800-495-0086 to complete Pre-certification and Continued Stay review.
Therapeutic Mentoring Services	Call 800-495-0086 to complete Pre-certification and Continued Stay review.
Family Stabilization Team (FST)/In Home Therapy Commercial (IHT)	Call 800-495-0086 to complete Pre-certification and Continued Stay review.

Authorization Not Required for Initial Encounters (IEs)

MassHealth, SCO and Commercial members do not require prior authorization for routine outpatient services

Other Exemptions from Authorization

- Group therapy (CPT code 90853) does not require authorization and does not count towards the member's IEs.
- Medication Evaluation and Management services do not require authorization for all lines of business..
- Outpatient therapy services with a primary substance use disorder diagnosis do not require authorization.

Office visits for medication-assisted treatment, such as Methadone Maintenance, Suboxone, and Vivitrol administration, do not require authorization.

11. QUALITY MANAGEMENT/QUALITY IMPROVEMENT

See Carelon national handbook

Member Safety

In addition to the Serious Reportable Events and Trending Events noted in the National Carelon Provider handbook, Carelon must also receive a copy of any incident that was reported to Massachusetts Department of Health, Office of Behavioral Health within 24 hours of the incident occurring. Please visit www.mass.gov/how-to/behavioral-health-reporting-adverse-incidents for more information on reporting requirements. A copy of the form can be sent via secure email to Ombuds@carelon.com or fax to 877-335-5452.