CARELON BEHAVIORAL HEALTH

NEW HAMPSHIRE ADDENDUM

Last updated: January 2025

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.*

Table of Contents

WellSense Health Plan

The following chapters referenced below correspond with the chapters found in the Carelon Behavioral Health (Carelon) National Provider Handbook. Information included under each chapter is specific to your Plan.

1. INTRODUCTION

Carelon/WellSense New Hampshire Partnership

WellSense New Hampshire has contracted with Carelon Behavioral Health (Carelon) to manage the delivery of behavioral health and substance use disorder services for WellSense members covered by the following products:

- Medicaid
- Medicare Advantage
- Affordable Care Act (effective 1/1/25)

The Plan delegates the following areas of responsibility to Carelon:

- Claims Processing and Claims Payment
- Member Rights and Responsibilities
- Provider Contracting
- Provider Credentialing and Recredentialing
- Quality Management and Improvement
- Referral and Triage
- Service Accessibility and Availability
- Service Authorization
- Treatment Record Compliance
- Utilization Management/Case Management

Carelon/WellSense Behavioral Health Program

The Carelon/WellSense behavioral health and substance use disorder (BH/SU) program provides members with access to a full continuum of member-centered, covered behavioral health and substance use disorder services, that align with the principles of system of care, recovery and resiliency, through Carelon's network of contracted providers. The primary goal of the program is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings. By ensuring that all plan members receive timely access to clinically appropriate behavioral healthcare services, WellSense and Carelon believe that quality clinical services can achieve improved outcomes for our members.

Unique Populations Covered/Service Offered

WellSense New Hampshire covers New Hampshire Medicaid-eligible members who choose WellSense, which includes the Granite Advantage HealthCare Program members.

Provider Manual Changes

Carelon provides notification to network providers at least 60 days prior to the effective date of any policy or procedural change that impacts a provider, such as modification in payment or covered services. Carelon provides 60 days' notice unless the change is a state or federal mandated requirement.

2. ELECTRONIC RESOURCES

See Carelon national handbook

3. PARTICIPATING PROVIDERS

Network Operations

Carelon's Network Operations Department, with Provider Relations, is responsible for procurement and administrative management of Carelon's behavioral health provider network. As such, their role includes contracting, credentialing, and provider relations functions. Representatives may be reached by emailing provider.relations.nh@carelon.com or by phone between 8:30 a.m. and 6 p.m., Eastern Time (ET) Monday through Thursday, and 8:30 a.m. to 5 p.m., ET on Fridays. Contact Carelon at (855) 834-5655 and choose option #2.

Contracting and Maintaining Network Participation

A "participating provider" is an individual practitioner, private group practice, licensed outpatient agency, or facility that has been credentialed by Carelon and has signed a PSA with Carelon. Participating providers agree to provide behavioral health and/or substance use disorder services to members, to accept reimbursement directly from Carelon according to the rates set forth in the fee schedule attached to each provider's PSA, and to adhere to all other terms in the PSA, including this provider manual. Carelon shall reimburse Substance Use Disorder Provider in accordance with rates that are no less than the equivalent DHHS FFS rates.

Participating providers who maintain approved credentialing status remain active network participants unless the PSA is terminated in accordance with the terms and conditions set forth therein. In cases where a provider is terminated, the provider may notify the member of the termination, but in all cases, Carelon will notify members when their provider has been terminated.

Carelon's Provider Database

Carelon maintains a database of provider information as reported to us by providers. The accuracy of this database is critical to Carelon and WellSense's operations, for such essential functions as:

- Reporting to the Plan for mandatory reporting requirements
- Periodic reporting to the health plan for updating printed provider directories
- Identifying and referring members to providers who are appropriate and offer available services to meet the member's individual needs and preferences
- Network monitoring to ensure member access to a full continuum of services across the entire geographic service area
- Network monitoring to ensure compliance with quality and performance standards, including appointment access standards

Provider-reported hours of operation and availability to accept new members are included in Carelon's provider database, along with specialties, licensure, language capabilities, cultural competency training, addresses and contact information. This information is visible to members on our website and is the primary information source for Carelon staff when assisting members with referrals. In addition to contractual and regulatory requirements pertaining to appointment access, up-to-date practice information is critical to ensuring appropriate referrals are made to available providers.

Required Notification of Practice Changes and Limitations in Appointment Access

Notice to Carelon is required for any material changes in practice, any access limitations, and any temporary or permanent inability to meet the appointment access standards above. All notifications of practice changes and access limitations must be submitted 90 days before the planned effective date or as soon as the provider becomes aware of an unplanned change or limitation. Providers are encouraged to review the database regularly, to ensure that the practice information is up to date. For the following practice changes and access limitations, the provider's obligation to notify Carelon is fulfilled by updating information using the methods outlined in the national provider manual.

4. CREDENTIALING AND RE-CREDENTIALING

Individual Practitioner Credentialing

To be credentialed by Carelon, practitioners must be licensed and/or certified in accordance with state licensure requirements, and the license must be in force and in good standing at the time of credentialing or recredentialing. Providers must be enrolled in NH Medicaid to join the Carelon network in NH.

Practitioners must submit a complete practitioner credentialing application with all required attachments. Incomplete applications cannot be processed. All submitted information is primary-source verified by Carelon; providers are notified of any discrepancies found and any criteria not met.

Providers have the opportunity to submit additional, clarifying information to correct the identified discrepancy. Discrepancies and/or unmet criteria may disqualify the practitioner for network participation.

Once the practitioner has been approved for credentialing and contracted with Carelon as a solo provider, or verified as a staff member of a contracted group practice, Carelon will notify the practitioner or the group practice's credentialing contact of the date on which they may begin to serve members of specified health plans.

Carelon shall process credentialing applications from all types of Providers within prescribed timeframes as follows:

4.13.3.8.1 For PCPs, within thirty (30) calendar days of receipt of clean and complete credentialing applications;

4.13.3.8.2 For specialty care Providers, within forty-five (45) calendar days of receipt of clean and complete credentialing applications;

4.13.3.8.3 For any Provider submitting new or missing information for its credentialing application, Carelon shall act upon the new or updated information within ten (10) business days.

The start time for the approval process begins when Carelon has received a Provider's clean and complete application, and ends on the date of the Provider's written notice of network status.

Organizational credentialing

In order to be credentialed, facilities must be licensed or certified by the state in which they operate, and the license must be in force and in good standing at the time of credentialing or recredentialing. Facilities must be enrolled in NH Medicaid to join the Carelon network in NH. If the facility reports accreditation by The Joint Commission (JCAHO), Council on Accreditation of Services for Family and Children (COA), or Council on Accreditation of Rehabilitation Facilities (CARF), DNV GL HealthCare (DNV), such accreditation must be in force and in good standing at the time of credentialing or recredentialing of the facility. If the facility is not accredited by one of these accreditation organizations, Carelon conducts a site visit prior to rendering a credentialing decision.

The credentialed facility is responsible for credentialing and overseeing its clinical staff, as Carelon does not individually credential facility-based staff. Master's-level behavioral health counselors are approved to function in all contracted hospital-based, agency/clinic-based and other facility services sites. Behavioral health program eligibility criteria include the following:

- Master's degree or above in a behavioral health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university
- An employee or contractor within a hospital or behavioral health clinic licensed in the state of New Hampshire who meets all applicable federal, state, and local laws and regulations; supervised in the provision of services by a licensed independent clinical social worker, a licensed psychologist, a licensed master's-level clinical nurse specialist, or licensed psychiatrist meeting the contractor's credentialing requirements
- State-certified SUD outpatient and SUD comprehensive programs are the only facilities allowed to utilize Licensed Alcohol and Drug Counselors (LADCs) to provide SUD services under the supervision of an MLADC
- Is covered by the hospital or behavioral health/substance use disorder agency's professional liability coverage at a minimum of $1,000,000/$3,000,000
- Absence of Medicare/Medicaid sanctions

Once the facility has been approved for credentialing and contracted with Carelon to serve members of one or more health plans, all licensed or certified behavioral health professionals listed may treat members in the facility setting.

Recredentialing

All practitioners and organizational providers are reviewed for recredentialing within 36 months of their last credentialing approval date. They must continue to meet Carelon's established credentialing criteria and quality-of-care standards for continued participation in Carelon's behavioral health provider network. Failure to comply with recredentialing requirements, including timelines, may result in removal from the network.

Additional Regulations

1. The MCO shall ensure that all clinicians who provide community mental health services meet the requirements in He-M 401 and He-M 426 and are certified in the use of the New Hampshire version of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA).
    a. Clinicians shall be certified in the use of the New Hampshire version of the CANS and the ANSA within 120 days of implementation by the Department of Health and Human Services of a web- based training and certification system.
        i. The CANS and the ANSA assessment shall be completed by the community mental health program no later than the first member annual review following clinician certification to utilize the CANS and the ANSA.
        ii. The community mental health long-term care eligibility tool, specified in He-M 401 and in effect on January 1, 2012, shall continue to be used by a clinician until such time as the Department of Health and Human Services implements the web-based access to the CANS and the ANSA; the clinician is certified in the use of the CANS and the ANSA; and the member annual review date has passed.

    b. The CANS and the ANSA assessment shall be completed at least every 90 calendar days to document progress towards goals and objectives and any continued need for CMH services.

        i. Documentation of the review shall fulfill the quarterly review requirements as defined in He-M 408 and He-M 401.

        ii. The CANS and the ANSA shall be used to assist the clinician and the MCO in developing an individualized, person- centered treatment plan, with measurable outcomes to drive future modifications to the individualized service plan.

2. The MCO shall ensure integrated care coordination by requiring providers to accept all referrals for its members from the MCO that result from a court order or a request from DHHS. The MCO shall be required to pay for these Medicaid state plan services, to include assessment and diagnostic evaluations, for these members. Court ordered treatment services shall be delivered at an appropriate level of care.
3. The aftercare provider is required to conduct a medication reconciliation within 48 business hours of discharge for any member discharged from an acute care setting, including psychiatric hospitalization and residential treatment.
4. Providers in the child and adolescent mental health service delivery system shall collaborate with the adult mental health service delivery system in the transition of members through these systems, through activities such as communicating treatment plans and exchange of information.

5. Prescribers and dispensers shall comply with the NH Prescription Drug Monitoring Program (PDMP) requirements, including but not limited to opioid prescribing guidelines.
6. Providers shall provide to the MCO, to the maximum extent possible, data on substance dispensing to Members prior to releasing such medications to Members.

5. OFFICE PROCEDURES

Access Standards

Table: Service Availability and Hours of Operation

General Appointment Standards

Type of Appointment/Service	Appointment Must Be Offered:
Routine/Non-Urgent Services	Within 10 business days
Urgent Care	Within 48 hours
Emergency Services	Immediately; 24 hours a day, seven days a week

Aftercare Appointment Standards

Inpatient and 24-hour diversionary service must schedule an aftercare *follow-up prior to a member's discharge. Appointments for discharges from NH Hospital must be scheduled within 7 calendar days of discharge.*

Aftercare Appointment Standards	
Type of Appointment/Service	Appointment Must Be Offered:
Non-24-hour Diversionary	Within 2 calendar days
Transitional Healthcare	Within 2 business days
Psychopharmacology Services/Medication Management	Within 7 calendar days
All Other Outpatient Services	Within 7 calendar days
Service Availability	Hours of Operation
On-call	24-hour on-call services for all members in treatment. Ensure that all members in treatment are aware of how to contact the treating or covering provider after hours and during provider vacations

Aftercare Appointment Standards	
Type of Appointment/Service	Appointment Must Be Offered:
Crisis Intervention	Services must be available 24 hours a day, seven days a week. Outpatient facilities, physicians, and practitioners are expected to provide these services during operating hours. After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.
Outpatient Services	Outpatient providers should have services available Monday through Friday, from 9 a.m. to 5 p.m. Evening and/or weekend hours should also be available at least two days per week.
Interpreter Services	Under state and federal law, providers are required to provide interpreter services to communicate with individuals with limited English proficiency.

Substance Use Disorder (SUD) Services

Substance Use Disorder (SUD) Services	
Type Of Appointment/ Service	Appointment Must Be Offered:
Response Time for Agencies under Contract	Agencies under contract with managed care organizations (MCOs) as "SUD Outpatient Programs" and "SUD Comprehensive Programs" respond to inquiries for SUD services from members or referring agencies as soon as possible and no later than two business days following the day the call was first received.
Initial Eligibility Screening for SUD Services	The SUD provider conducts an initial eligibility screening for services as soon as possible, ideally at the time of first contact (direct communication by phone or in-person) with the member or referring agency, but no later than two business days following the date of first contact.

Substance Use Disorder (SUD) Services	
Type Of Appointment/ Service	Appointment Must Be Offered:
Members Screening Positive for SUD Services	Members who have screened positive for SUD services receive an SUD assessment and an American Society for Addiction Medicine (ASAM) level of care (LOC) assessment within two business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM LOC assessment and no later than three business days after admission.
Members Identified for Withdrawal Management, Outpatient, or Intensive Outpatient SUD Services	Members identified for withdrawal management, outpatient, or intensive outpatient services start receiving services within seven business days from the date the ASAM LOC assessment was completed.
Members Identified for Partial Hospitalization or Rehabilitative Residential SUD Services	Members identified for partial hospitalization or rehabilitative residential services start receiving interim services (services at a lower level of care than that identified by the ASAM LOC Assessment) or the identified service type within seven business days from the date the initial assessment was completed. They will start receiving the identified level of care no later than 14 business days from the date the initial assessment was completed.
Services Not Available within 14 Business Days	If the type of service identified in the ASAM Level of Care Assessment is not available from the provider who conducted the initial assessment within 48 hours, the provider must provide interim SUD services until such a time that the member starts receiving the identified level of care. If the type of service is not provided by the ordering provider, than Carelon can assist in making a closed loop referral for that type of service (for the identified level of care) within 14 business days from initial contact and to provide interim SUD services until such a time that the Member is accepted and starts receiving services by the receiving agency. When the level of care identified by the initial assessment becomes available by the receiving agency or the agency of the member's choice, members being provided interim services shall be reassessed for ASAM level of care.

Substance Use Disorder (SUD) Services	
Type Of Appointment/ Service	Appointment Must Be Offered:
Pregnant Women with an ASAM	Pregnant women will be admitted to the identified LOC within 24 hours of the ASAM LOC Assessment. If the contractor is unable to admit a pregnant woman for the needed level of care within 24 hours, the contractor: Assists the pregnant woman with identifying alternative providers and with accessing services with these providers. This assistance includes actively reaching out to identify providers on the behalf of the client; and Provides interim services until the appropriate LOC becomes available at either the contractor agency or an alternative provider. Interim services include: At least one 60-minute individual or group outpatient session per week; Recovery support services as needed by the client; and Daily calls to the client to assess and respond to any emergent needs. Pregnant women seeking treatment shall be provided access to childcare and transportation to aid in treatment participation.

Confidentiality of Member Information

All providers are expected to comply with federal, state, and local laws regarding access to member information. With the enactment of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), members give consent for the release of information regarding treatment, payment, and healthcare operations at the sign-up for health insurance. Treatment, payment, and healthcare operations involve a number of different activities, including but not limited to:

- Submission and payment of claims
- Seeking authorization for extended treatment
- QI initiatives, including information regarding the diagnosis, treatment, and condition of a member in order to ensure compliance with contractual obligations
- Member information reviews in the context of management audits, financial audits, or program evaluations
- Chart reviews to monitor the provision of clinical services and ensure that authorization criteria are applied appropriately.

Member consent

At every intake and admission to treatment, the provider needs to explain the purpose and benefits of communication to the member's PCP and other relevant providers. The behavioral health clinician will request written consent from members to release information to coordinate care regarding mental health services or substance use disorder services or both, and primary care. A sample form is available here (See Provider Tools web page), or providers may use their own form; the form must allow the member to limit the scope of information communicated.

Members can elect to authorize or refuse to authorize release of any information, except as specified in the previous section, for treatment, payment, and operations. Whether consenting or declining, the member's signature is required and should be included in the medical record. If a member refuses to release information, the provider should clearly document the member's reason for refusal in the narrative section on the form. Providers must document all instances in which consent was not given, the reason why consent was not provided, and submit this report to Carelon no later than 60 calendar days following the end of the fiscal year.

Confidentiality of members' HIV-related information

Carelon works in collaboration with the Plan to provide comprehensive health services to members with health conditions that are serious, complex, and involve both medical and behavioral health factors.

Carelon coordinates care with the health plan's medical and disease management programs and accepts referrals for behavioral health case management from the health plan. Information regarding HIV infection, treatment protocols and standards, qualifications of HIV/AIDS treatment specialists, and HIV/AIDS services and resources, medications, counseling and testing is available directly from the health plan.

Carelon will assist behavioral health providers or members interested in obtaining any of this information by referring them to the Plan's case management department. Carelon limits access to all health-related information, including HIV-related information and medical records, to staff trained in confidentiality and the proper management of patient information. Carelon's case management protocols require Carelon to provide any Plan member with assessment and referral to an appropriate treatment source. It is Carelon's policy to follow federal and state information laws and guidelines concerning the confidentiality of HIV-related information.

WellSense Member Eligibility

Member identification cards

WellSense members are issued one card, the plan membership card. The card is not dated, nor is it returned when a member becomes ineligible. Therefore, the presence of a card does not ensure that a person is currently enrolled or eligible with the Plan.

A WellSense member card contains the following information:

- Member's name
- Plan name: WellSense
- Plan identification number
- Member's date of birth
- Member Services Department: (855) 834-5655
- Routine or urgent medical care: Call your primary care physician (PCP)
- Emergency: Seek emergency room care right away or call 911
- Behavioral health services (mental health/substance use disorder): (855) 834-5655
- WellSense Transportation to medical/behavioral health appointments: (844) 909-7433

Information for providers and billing offices

- For medical referral, prior authorization, hospital precertification, or to verify member eligibility, call (855) 834-5655.
- Pharmacies: Submit to EnvisionRx OptionsExpress Scripts using the following data: BIN: 009893003858, PCN: ROIRXMA, RxGrp: WLSNS. For pharmacy questions, call (877) 957-1300.
- For behavioral health services, call (855) 834-5655.

Possession of a health plan member identification card does not guarantee that the member is eligible for benefits. Providers are strongly encouraged to check member eligibility frequently.

Member eligibility changes occur frequently. Confirmation of eligibility process is the responsibility of the provider.

To facilitate reimbursement for services, providers are strongly advised to verify a Plan member's eligibility upon admission to treatment and on each subsequent date of service.

The Carelon Clinical Department may also assist the provider in verifying the member's enrollment in WellSense when authorizing services. Due to the implementation of the Privacy Act, Carelon requires the provider to have ready the specific identifying information regarding the member (provider ID#, member full name and date of birth) to avoid inadvertent disclosure of member-sensitive health information.

Please note: Member eligibility information on eServices is updated nightly. Eligibility information obtained by phone is accurate as of the day and time it is provided by Carelon. Carelon cannot anticipate, and is not responsible for, retroactive changes or disenrollments reported at a later date. Providers are to check eligibility each visit.

Mental Health Parity

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

Parity means that:

- The plan must provide the same level of benefits for any mental health and/or substance use disorder as it would for other medical conditions a Member may have.
- The plan must not impose stricter prior authorization requirements and treatment limitations for mental health and substance use disorder benefits as it does for other medical benefits.
- The plan must provide Members and their providers with the medical necessity criteria used by the plan for prior authorization upon either the Member's request or provider's request.
- The plan must not impose aggregate lifetime or annual dollar limits on mental health or substance use disorder benefits.
- Within a reasonable time frame, the plan must provide the Member the reason for any denial of authorization for mental health and/or substance use disorder services.
- Within a reasonable timeframe, if the plan provides out-of-network coverage for other medical benefits, the plan must provide comparable out-of-network coverage for mental health and/or substance use disorder benefits.

The parity requirement applies to:

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

If you think that the plan is not providing parity as explained above, you or the member have the right to file an appeal or file a grievance (complaint) with WellSense New Hampshire (877-957-1300).

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

6. SERVICES TO MEMBERS

Behavioral Health and Substance Use Disorder Benefits

Carelon provides behavioral health services as outlined below. These services are subject to modification based on federal and state mandates.

Behavioral Health Services

Behavioral Health Services	
Service	**Description**
Inpatient Mental Health and Substance Use Disorder Services	Medically necessary services for the treatment of mental, emotional, or substance use disorders. Medically necessary inpatient admissions for adults and children to acute care hospitals for psychiatric conditions are a benefit of the Medicaid program and are subject to UR requirements. Includes inpatient psychiatric services, ordered by a court of competent jurisdiction, relating to court- ordered commitments to psychiatric facilities. Admissions for chronic diagnoses, such as MR or organic brain syndrome, are not a covered benefit for acute care hospitals without an accompanying medical condition. Medically managed withdrawal management in an acute hospital setting.

Behavioral Health Services	
Service	**Description**
Outpatient Mental Health and Substance Use Disorder Services	Medically necessary services for the treatment of mental, emotional, or substance use disorders Outpatient behavioral health services are limited to 24 initial encounters per child (child is defined up until age 18) and 18 initial encounters for adults, per year. These limits do not apply to services rendered by a Community Mental Health Center (CMHC). Includes outpatient psychiatric services ordered by a court of competent jurisdiction, relating to court- ordered commitments to psychiatric facilities, or placements. Provider types include psychiatrist, psychologist, licensed independent clinical social worker (LICSW), licensed marriage and family therapist (LMFT), licensed clinical mental health counselors (LCMHC), and master's-level licensed alcohol and drug counselors (MLADC). Does not require a primary care provider referral Medication management visits do not count against the outpatient visit limit. Psychological testing is covered for specific diagnosis when medically necessary or when court-ordered. Psychological testing will be limited to 8 hours of testing per client, per calendar year (any provider). Psychological testing does count towards outpatient encounter limits. Substance use disorder screening by behavioral health practitioners. Opioid treatment programs, including methadone and buprenorphine administration.
Professional Services	Services provided by or under the personal supervision of a physician within the physician's scope of practice are covered when reasonable and medically necessary. This includes visits in the office, home, inpatient, or outpatient location under Medicaid guidelines.

Outpatient Benefits

Access

Outpatient behavioral health treatment is an essential component of a comprehensive healthcare delivery system. Plan members may access outpatient behavioral health and substance use disorder services by self- referring to a network provider, by calling Carelon, or by a referral through acute or emergency room encounters. Members may also access outpatient care by referral from their primary care practitioner (PCP); however, a PCP referral is never required for behavioral health services.

Initial encounters

Members are allowed a fixed number of initial therapy sessions without prior authorization. These sessions, called Initial Encounters (IEs), must be provided by contracted in-network providers, and are subject to meeting medical necessity criteria.

To ensure payment for services, providers are strongly encouraged to ask new patients if they have been treated by other therapists. Via eServices, providers can determine the number of IEs that have been billed to Carelon. However, please note, the member may have used additional visits that have not yet been billed. If the member has used some IEs elsewhere, the new provider is encouraged to obtain authorization prior to treatment.

Initial Encounters Table:

Outpatient Psychotherapy	Initial Encounters Per Episode of Care
Psychiatric Diagnostic Evaluation (90791) Psychiatric Diagnostic Evaluation with Medical Services (90792) Psychotherapy, 30 minutes (90832) Psychotherapy, 45 minutes (90834) Psychotherapy, 60 minutes (90837) Psychotherapy, 30 minutes Add On (90833) Psychotherapy, 45 minutes Add On (90836) Psychotherapy, 60 minutes Add On (90838) Family psychotherapy (without the patient) 45-60 min (90846) Family/couple therapy – 60 min (90847)	Count towards initial encounters/additional units requested via eServices
Group therapy (90853) Outpatient substance abuse therapy Medication management (E&M)	No authorization required Methadone received at a methadone clinic shall not require Prior Authorization

7. MEMBER RIGHTS AND RESPONSIBILITIES

Member rights

WellSense and Carelon are firmly committed to ensuring that members are active and informed participants in the planning and treatment phases of their behavioral health and substance use disorder services. We believe that members become empowered through ongoing collaboration with their healthcare providers and that collaboration among providers is critical to achieving positive healthcare outcomes.

Members must be fully informed of their rights to access treatment and to participate in all aspects of treatment planning. All plan members have the following rights:

Right to Receive Information

Members have the right to receive information about Carelon's services, benefits, practitioners, their own rights and responsibilities as well as the clinical guidelines. Members have a right to receive this information in a manner and format that is understandable and appropriate to the member's condition.

Right to Respect and Privacy

Members have the right to respectful treatment as individuals, regardless of race, gender, veteran status, religion, marital status, national origin, physical disabilities, mental disabilities, age, sexual orientation, or ancestry.

Right to Confidentiality

Members have the right to have all communication regarding their health information kept confidential by Carelon staff and all contracted providers, to the extent required by law.

Right to Participate in the Treatment Process

Members and their family members have the right to actively participate in treatment planning and decision- making. The behavioral health provider will provide the member, or legal guardian, with complete current information concerning a diagnosis, treatment, and prognosis in terms the member, or legal guardian, can be expected to understand. All members have the right to review and give informed consent for treatment, termination, and aftercare plans. Treatment planning discussions may include all appropriate and medically necessary treatment options, regardless of benefit design and/or cost implications.

Right to Treatment and Informed Consent

Members have the right to give or refuse consent for treatment and for communication to PCPs and other behavioral health providers.

Right to a Second Opinion

Members are entitled to a second opinion, which is provided at no cost to them.

Right to Clinical/Treatment Information

Members and their legal guardian have the right to, upon submission of a written request, review the member's medical records. Members and their legal guardian may discuss the information with the designated responsible party at the provider site.

Right to Appeal Decisions Made by Carelon

Members and their legal guardian have the right to appeal Carelon's decision to not authorize care at the requested level of care, or Carelon's denial of continued stay at a particular level of care according to the clinical appeals procedures described in Chapter 6. Members and their legal guardians may also request the behavioral health or substance use disorder healthcare provider to appeal on their behalf according to the same procedures.

Right to Submit a Grievance or Concern to Carelon

Members and their legal guardians have the right to file a grievance with Carelon or WellSense regarding any of the following:

- The quality of care delivered to the member by a Carelon-contracted provider
- The Carelon utilization review process
- The Carelon network of services
- The procedure for filing a grievance as described in Chapter 5

Right to Contact Carelon Ombudsperson

Members have the right to contact Carelon's ombudsperson to obtain a copy of Carelon's Member Rights and Responsibilities statement. The Carelon ombudsperson may be contacted at (855) 834-5655 or by TTY at 711.

Right to Make Recommendations about Member Rights and Responsibilities

Members have the right to make recommendations directly to Carelon regarding Carelon's Member Rights and Responsibilities statement. Members should direct all recommendations and comments to Carelon's ombudsperson.

All recommendations will be presented to the appropriate Carelon review committee. The committee will recommend changes to the policies as needed and as appropriate.

If the member declines interpretation services at no cost to the member, the provider must inform the member of the potential consequences of declining the services, with the assistance of a competent interpreter to ensure the member's understanding. The provider must then document that the member declined interpretation services. Interpreter services must be re-offered at every new contact. Every decline of services requires new documentation of the offer and the subsequent decline. Children may not be used for interpretation.

Member responsibilities

Members of the health plan agree to do the following:

- Choose a PCP and site for the coordination of all medical care. Members may change PCPs at any time by contacting their health plan.
- Carry the health plan identification card and show the card whenever treatment is sought.
- In an emergency, seek care at the nearest medical facility and call their PCP within 48 hours. (Please note: the back of the Plan identification card highlights the emergency procedures.)
- Provide clinical information needed for treatment to their behavioral healthcare provider.
- To the extent possible, understand their behavioral health problems and participate in the process of developing mutually agreed-upon treatment goals.
- Follow the treatment plans and instructions for care as mutually developed and agreed upon with their practitioners.

Posting member rights and responsibilities

All contracted providers must display in a highly visible and prominent place a statement of members' rights and responsibilities. This statement must be posted and made available in languages consistent with the demographics of the population(s) served. This statement can either be Carelon's statement or a comparable statement consistent with the provider's New Hampshire license requirements.

Informing members of their rights and responsibilities

Providers are responsible for informing members of their rights and respecting these rights. In addition to a posted statement of member rights, providers are also required to:

- Distribute and review a written copy of Member Rights and Responsibilities at the initiation of every new treatment episode and include in the member's medical record signed documentation of this review
- Inform members that Carelon does not restrict the ability of contracted providers to communicate openly with WellSense members regarding all treatment options available to them including medication treatment regardless of benefit coverage limitations
- Inform members that Carelon does not offer any financial incentives to its contracted provider community for limiting, denying, or not delivering medically necessary treatment to plan members
- Inform members that clinicians working at Carelon do not receive any financial incentives to limit or deny any medically necessary care

8. PARTICIPATING PROVIDER COMPLAINTS AND GRIEVANCES

See Carelon national handbook

Carelon shall send written notice to Members and Participating Providers of any changes to the Grievance recovery System at least thirty (30) calendar days prior to implementation.

9. CLAIMS PROCEDURES

Claim Submission Guidelines

Timely Filing for Community Mental Health Centers is 365 days from the date of service. Timely filing for all other provider types (individual, group, and other facilities) is 120 days from the date of service.

General Claims Policies

Carelon requires that providers adhere to the following policies with regard to claims:

Definition of "clean claim"

A clean claim is defined as one that has no defect and is complete, including required, substantiating documentation of particular circumstance(s) warranting special treatment without which timely payments on the claim would not be possible.

Electronic billing requirements

The required edits, minimum submission standards, signature certification form, authorizing agreement and certification form, and data specifications as outlined in this manual must be fulfilled and maintained by all providers and billing agencies submitting electronic media claims to Carelon.

Provider responsibility

The individual provider is ultimately responsible for accuracy and valid reporting of all claims submitted for payment. A provider using the services of a billing agency must ensure through legal contract (a copy of which must be made available to Carelon upon request) that the responsibility of a billing service to report claim information as directed by the provider is in compliance with all policies stated by Carelon.

Limited use of information

All information supplied by Carelon, or collected internally within the computing and accounting systems of a provider or billing agency (e.g., member files or statistical data), can be used only by the provider in the accurate accounting of claims containing or referencing that information. Any redistributed or dissemination of that information by the provider for any purpose other than the accurate accounting of behavioral health claims is considered an illegal use of confidential information.

Prohibition of billing members

Providers are not permitted to bill health plan members under any circumstances for covered services rendered, excluding co-payments when appropriate. See Chapter 3, Prohibition on Billing Members, for more information.

Carelon's right to reject claims

At any time, Carelon can return, reject or disallow any claim, group of claims, or submission received pending correction or explanation

Recoupments and adjustments by Carelon

Carelon reserves the right to recoup money from providers due to errors in billing and/or payment, at any time. In that event, Carelon applies all recoupments and adjustments to future claims processed and reports such recoupments and adjustments on the EOB with Carelon's record identification number (REC.ID) and the provider's patient account number.

Claim turnaround time

All clean claims will be adjudicated within 30 days from the date on which Carelon receives the claim.

Claims for inpatient services

The date range on an inpatient claim for an entire admission (i.e., not an interim bill) must include the admission date through the discharge date. The discharge date is not a covered day of service but must be included as the "to" date. Refer to authorization notification for correct date ranges.

Carelon accepts claims for interim billing that include the last day to be paid as well as the correct bill

Coding

When submitting claims through eServices, users will be prompted to include appropriate codes in order to complete the submission, and drop-down menus appear for most required codes. Please see Carelon's EDI Transactions – 837 Companion Guide for placement of codes on the 837 file. Please note the following requirements with regard to coding:

- Providers are required to submit HIPAA-compliant coding on all claim submissions; this includes HIPAA-compliant revenue, CPT, HCPCS and ICD-10 codes. Providers may refer to their Exhibit A for a complete listing of contracted, reimbursable procedure codes.
- Carelon accepts only ICD-10 diagnosis codes as listed and approved by CMS and HIPAA. In order to be considered for payment by Carelon, all claims must have a Primary ICD-10 diagnosis in the range of F01-F99. All diagnosis codes submitted on a claim form must be a complete diagnosis code with appropriate check digits.
- Claims for inpatient and institutional services must include the appropriate discharge status code. The table below lists HIPAA-compliant discharge status codes.

Table: Discharge Status Codes

Code	Description
01	Discharged to Home/Self-Care
02	Discharged/Transferred to Another Acute Hospital
03	Discharged/Transferred to Skilled Nursing Facility
04	Discharged/Transferred to Intermediate Care Facility
05	Discharged/Transferred to Another Facility
06	Discharged/Transferred to Home/Home Health Agency
07	Left Against Medical Advice or Discontinued Care
08	Discharged/Transferred Home/IV Therapy
09	Admitted as Inpatient to this Hospital
20	Expired
30	Still a Patient

** All UB04 claims must include the three-digit bill type codes according to the table below:*

Table: Bill Type Codes

Type of Facility - 1st Digit	Bill Classification - 2nd Digit	Frequency - 3rd Digit
1. Hospital	1. Inpatient	1. Admission through Discharge Claim
2. Skilled Nursing Facility	2. Inpatient Professional Component	2. Interim – First Claim
3. Home Health	3. Outpatient	3. Interim – Continuing Claims
4. Religious Nonmedical Hospital	4. Diagnostic Services	4. Interim – Last Claim
5. Religious Nonmedical Extended Care Facility	5. Intermediate Care – Level I	5. Late Charge Only
6. Intermediate Care Facility	6. Intermediate Care – Level II	6-8. Not Valid

Modifiers

Modifiers may reflect the discipline and licensure status of the treating practitioner or are used to make up specific code sets that are applied to identify services for correct payment. Table 7-3 lists HIPAA-compliant modifiers accepted by Carelon. Please see your Exhibit A for Modifiers for which you are contracted.

Table: Modifiers

HIPAA Modifier	Modifier Description	HIPAA Modifier	Modifier Description
AB	Psychiatrist (This modifier required when billing for 90862 provided by a psychiatrist.)	HL	Intern
AH	Clinical psychologist	HM	Less than bachelor's-degree level
AJ	Clinical social worker	HN	Bachelor's-degree level
HA	Child/adolescent program	HO	Master's-degree level
HB	Adult program, non-geriatric	HP	Doctoral level
HC	Adult program, geriatric	HQ	Group setting
HD	Pregnant/parenting women's program	HR	Family/couple with client present
HE	Behavioral health program	HS	Family/couple without client present
HF	Substance use program	HT	Multi-disciplinary team
HG	Opioid addiction treatment program	HU	Funded by child welfare agency
HH	Integrated behavioral health/substance use disorder program	HW	Funded by state behavioral health agency
HI	Integrated behavioral health and mental retardation/developmental disabilities program	HY	Funded by juvenile justice agency
HU	Employee assistance program	SA	Nurse practitioner (this modifier required when billing 90862 performed by a nurse practitioner)
HK	Specialized behavioral health programs for high-risk populations	SE	State and/or federally funded programs/services
TD	Registered nurse	U1	Serious and persistent mental illness (SPMI)
TF	Intermediate level of care	U2	Serious mental illness (SMI)
TG	Complex/high level of care	U3	Psychology intern
TH	Obstetrics	U4	Social work intern

HIPAA Modifier	Modifier Description	HIPAA Modifier	Modifier Description
TJ	Program group, child, and/or adolescent	U5	SMI low utilizer
TR	School-based individualized education program (IEP) services provided outside the public school district responsible for the student	U6	Serious emotional disability (SED)
UK	Service provided on behalf of the client to someone other than the client-collateral relationship	U7	Serious emotional disability (SED) with interagency involvement

Time limits for filing claims

Carelon must receive claims for covered services within the designated filing limit:

- Within 120 days of the dates of service on outpatient claims
- Within 120 days of the date of discharge on inpatient claims

Providers are encouraged to submit claims as soon as possible for prompt adjudication. Claims submitted after the 120-day filing limit will deny unless submitted as a waiver or reconsideration request, as described in this chapter.

Prohibition on Billing Members

Health plan members may not be billed for any covered service or any balance after reimbursement by Carelon. Further, providers may not charge WellSense members for any services that are not deemed medically necessary upon clinical review or that are administratively denied. It is the provider's responsibility to check benefits prior to beginning treatment of this membership and to follow the procedures set forth in this Manual.

7. UTILIZATION MANAGEMENT

Carelon's written Utilization Management policies, procedures, and criteria shall be made available upon request to DHHS, Participating Providers, and Members.

Appeal of Adverse Determinations

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

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

Request for Reconsideration of Adverse Determination WellSense Medicaid:
If a plan member, or member's provider, disagrees with a utilization review decision issued by Carelon, the member, their authorized representative, or the provider may request reconsideration. Please 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, they may file an appeal.

Carelon shall ensure that subcontractors or any other party performing utilization review are licensed in NH.

WellSense Medicare Advantage HMO
If a plan member, or member's provider, disagrees with an organization determination issued by Carelon, the member, their authorized representative, or the provider must request a member appeal through WellSense Medicare Advantage HMO.

Clinical Appeals

WellSense Medicare Advantage HMO Overview

Member appeals for WellSense Medicare Advantage HMO are not delegated to Carelon. Follow the instructions below to file a member appeal on behalf of a member with WellSense Medicare Advantage HMO.

Member appeals must be filed with WellSense Medicare Advantage HMO within 60 calendar days of the date of the adverse organization determination from Carelon. The WellSense Medicare Advantage HMO internal appeals process is inclusive of one level of review for both standard and expedited appeals.

The preferred way for a member or the member's Authorized Representative, including a provider on behalf of a member, to file a member appeal is to put it in writing and send it to WellSense Medicare Advantage HMO by mail or fax. A member appeal may also be filed orally by calling the WellSense Medicare Advantage HMO Member Services Department at 855-833-8128.

Written member appeals should include name, address, WellSense Medicare Advantage HMO ID number, day time telephone number, detailed description of the appeal, and any applicable documents and clinical information that relate to the member appeal. Written member appeals should be faxed to 617-897-0805 or postal mailed to:

WellSense Medicare Advantage HMO Member Appeals Department
529 Main Street, Suite 500
Charlestown, MA 02129

WellSense Medicare Advantage HMO resolves standard member appeals as expeditiously as the member's condition warrants, but no later than 30 calendar days from receipt of request. The Plan will resolve all expedited member appeals within 72 hours from receipt of request.

DHHS SHIP Program

The State Health Insurance Assistance Program, or SHIP, is a federal grant program that helps states enhance and support a network of local programs, staff, and volunteers. Through one-on-one personalized counseling, education, and outreach, this network of resources provides accurate and objective information and assistance to Medicare beneficiaries and their families. These resources allow the recipients to better understand and use their Medicare benefits.

If WellSense determines that a dual-eligible member's appeal is solely related to a Medicare service, the Plan shall refer the member and/or authorized representative to New Hampshire's SHIP program, which is currently administered by ServiceLink Aging and Disability Resource Center. Members and/or authorized representatives will be informed that they may contact the SHIP program toll free at (866) 634-9412 or by accessing its website at www.servicelink.org. Members and/or authorized representatives may also send appeals to:

New Hampshire Department of Health and Human Services Bureau of
Elderly and Adult Services
129 Pleasant Street
Governor Hugh Gallen State Office Park Concord, NH 03301-3857

Administrative Appeals

Carelon shall provide written notice to the provider of any adverse action and include in its notice a description of the basis of the adverse action and the right to appeal the adverse action. Providers shall submit a written request for an appeal to Carelon, together with any evidence or supportive documentation it wishes Carelon to consider, within 30 calendar days of:

1. The date of Carelon's written notice of advising the provider of the adverse action to be taken; or
2. The date on which Carelon should have taken a required action and failed to take such action. Carelon may extend the decision deadline by an additional 30 calendar days to allow the provider to submit evidence or supportive documentation, and for other good cause determined by Carelon.

Carelon shall ensure that all Provider Appeal decisions are determined by an administrative or clinical professional with expertise in the subject matter of the Provider Appeal. Carelon may offer a reconsideration with a peer-to-peer review, with a like clinician or doctor, upon request, for providers who receive an adverse decision from Carelon. Any such reconsideration request should occur in a timely manager and before the provider seeks recourse through the Provider Appeal or state fair hearing process.

Carelon will maintain a log and records of all Provider Appeals, including for all matters handled by delegated entities, for a period not less than 10 years. At a minimum, log records shall include:

1. General description of each appeal;
2. Name of the provider;
3. Date(s) of receipt of the appeal and supporting documentation, decision, and effectuation, as applicable; and
4. Name(s), title(s), and credentials of the reviewer(s) determining the appeal decision.

If Carelon fails to adhere to notice and timing requirements, then the provider is deemed to have exhausted Carelon's Appeals Process and may initiate a state fair hearing.

Carelon shall provide written notice of resolution of the Provider Appeal (Resolution Notice) within 30 calendar days from either the date Carelon receives the appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which the providers evidence is received by Carelon.

The Resolution Notice shall include:
1. Carelon's decision;
2. The reason for Carelon's decision;
3. The provider's right to request a state fair hearing; and
4. For overturned appeals, Carelon shall take all steps to reverse the adverse action within 10 calendar days.

The provider must exhaust Carelon's Provider Appeals Process before pursuing a state fair hearing. Carelon is bound by the state fair hearing determination.

11. QUALITY MANAGEMENT/QUALITY IMPROVEMENT

QM&I Program Overview

Program Description	Program Principles	Program Goals and Objectives
Carelon administers, on behalf of the health plan, a Quality Management and Improvement (QM&I) program whose goal is to continually monitor and improve the quality and effectiveness of behavioral health services delivered to members. Carelon's QM&I Program integrates the principles of continuous quality improvement (CQI) throughout our organization and the provider network.	Continually evaluate the effectiveness of services delivered to health plan members Identify areas for targeted improvements Develop QI action plans to address improvement needs Continually monitor the effectiveness of changes implemented, over time	Improve the healthcare status of members Enhance continuity and coordination among behavioral health care providers and between behavioral health and physical health providers Establish effective and cost-efficient disease management programs, including preventive and screening programs, to decrease incidence and prevalence of behavioral health disorders Ensure members receive timely and satisfactory service from Carelon and network providers Maintain positive and collaborative working relationships with network practitioners and ensure provider satisfaction with Carelon services Responsibly contain healthcare costs

Provider Role

Carelon employs a collaborative model of continuous quality improvement (CQI), in which provider and member participation is actively sought and encouraged. In signing the PSA, all providers agree to cooperate with Carelon and the Plan QI initiatives. Carelon also requires each provider to have its own internal QM&I Program to continually assess quality of care, access to care, and compliance with medical necessity criteria. To participate in Carelon's Provider Advisory Council, email provider.relations.nh@carelon.com. Members who wish to participate in the Member Advisory Council should contact the Member Services Department.

Quality Monitoring

Carelon monitors provider activity and uses the data generated to assess provider performance related to quality initiatives and specific core performance indicators. Findings related to provider compliance, with performance standards and measures, are used in credentialing and recredentialing activities, benchmarking, and to identify individual provider and network-wide improvement initiatives. Carelon's quality monitoring activities include, but are not limited to:

- Site visits
- Treatment record reviews
- Satisfaction surveys
- Internal monitoring of timeliness and accuracy of claims payment
- Provider compliance with performance standards including but not limited to:
    - Timeliness of ambulatory follow-up after behavioral health hospitalization
    - Discharge planning activities
    - Communication with member PCPs, other behavioral health providers, and government and community agencies
    - Tracking of adverse incidents, ADAs and appeals.
- Other quality improvement activities

On a regular basis, Carelon's QM&I Department aggregates and trends all data collected and presents the results to the QI Committee for review. The QI Committee may recommend initiatives at individual provider sites and throughout Carelon's behavioral health network as indicated.

A record of each provider's adverse incidents and any grievances or appeals pertaining to the provider, is maintained by the ombudsperson, and may be used by Carelon in profiling, recredentialing and network (re)procurement activities and decisions.

Treatment Records

Treatment record reviews

Carelon reviews member charts and uses data generated to monitor and measure provider performance in relation to the Treatment Record Standards and specific quality initiatives established each year. The following elements are evaluated:

- Use of screening tools for diagnostic assessment of substance use disorders, adolescent depression, and ADHD
- Continuity and coordination with primary care providers and other treaters
- Explanation of member rights and responsibilities
- Inclusion of applicable required medical record elements as listed below
- Allergies and adverse reactions
- Medications
- Physical exam
- Scores from the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA)
- Instances where members did not grant consent to share information between PCPs and behavioral health providers

Carelon may conduct chart reviews onsite at a provider facility, or may ask a provider to copy and send specified sections of a member's medical record to Carelon. Any questions that a provider may have regarding Carelon's access to the plan member information should be directed to Carelon's privacy officer. Please contact us at (855) 834-5655 and ask to speak to the privacy officer.

HIPAA regulations permit providers to disclose information without patient authorization for the following reasons: "oversight of the healthcare system, including quality assurance activities." Please note that Carelon's chart reviews fall within this area of allowable disclosure.

Treatment record standards

To ensure that the appropriate clinical information is maintained within the member's treatment record, providers must follow the documentation requirements below, based upon NCQA standards. All documentation must be clear and legible.

Table: Treatment Documentation Standards

Member Identification Information	The treatment record contains the following member information: • Member name and health plan ID # on every page • Member's address • Employer or school • Home and work telephone # • Marital/legal status • Appropriate consent forms • Guardianship information, if applicable
Informed Member Consent for Treatment	The treatment record contains signed consents for the following: • Implementation of the proposed treatment plan • Any prescribed medications • Consent forms related to interagency communications • Individual consent forms for release of information to the member's PCP and other behavioral health providers, if applicable; each release of information to a new party (other than Carelon or the Plan) requires its own signed consent form. • Consent to release information to the payer or MCO (In doing so, the provider is communicating to the member that treatment progress and attendance will be shared with the payer.) • For adolescents, ages 12–17, the treatment record contains consent to discuss behavioral health issues with their parents. • Signed document indicating review of patient's rights and responsibilities If a member does not consent to share information among PCPs and behavioral health providers: • All instances in which consent was not granted needs to be documented along with the reason for refusal, if possible and submitted to Carelon.

Medication Information	Treatment records contain medication logs clearly documenting the following: • All medications prescribed • Dosage of each medication • Dates of initial prescriptions • Information regarding allergies and adverse reactions are clearly noted Lack of known allergies and sensitivities to substances are clearly noted.
Substance Use Disorder Information	Documentation for any member 12 years and older of past and present use of the following: • Cigarettes • Alcohol • Illicit, prescribed, and over-the-counter drugs
Adolescent Depression Information	Documentation for any member 13-18 years who was screened for depression • If yes, was a suicide assessment conducted? • Was the family involved with treatment?
ADHD Information	Documentation that members aged 6-12 were assessed for ADHD • Was family involved with treatment? • Is there evidence of the member receiving psychopharmacological treatment?

Diagnostic Information	• Risk management issues (e.g., imminent risk of harm, suicidal ideation/intent, and elopement potential) are prominently documented and updated according to provider procedures.
	• All relevant medical conditions are clearly documented and updated as appropriate.
	• Member's presenting problems and the psychological and social conditions that affect their medical and psychiatric status, including housing status and legal status.
	• A complete mental status evaluation is included in the treatment record, which documents the member's:
	  o Affect
	  o Speech
	  o Mood
	  o Thought control, including memory
	  o Judgment
	  o Insight
	  o Attention/concentration
	  o Impulse control
	  o Initial diagnostic evaluation and DSM diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information
	  o Diagnoses updated at least quarterly basis

Treatment Planning	The treatment record contains clear documentation of the following: • Initial and updated treatment plans consistent with the member's diagnoses, goals, and progress • Objective and measurable goals with clearly defined time frames for achieving goals or resolving the identified problems • Treatment interventions used and their consistency with stated treatment goals and objectives • Member, family and/or guardian's involvement in treatment planning, treatment plan meetings and discharge planning • Copy of Outpatient Review Form(s) submitted, if applicable
SUD Treatment Planning	• Clinical Evaluation shall be completed in accordance with SAMHSA Technical Assistance Publication (TAP) 21; Addiction Counseling Competencies and shall be completed prior to admission as part of interim services, or within 3 business days following admission. • For members being transferred from or otherwise referred by another provider, the provider shall use the clinical evaluation completed by the licensed behavioral health professional from the referring agency, which may be amended by the receiving facility. • Individualized treatment plan completed within 3 business days of the clinical evaluation that address all ASAM domains and justify LOC. • Individualized treatment goals, objectives, and interventions should be written in terms that are specific, measurable, attainable, realistic, and time relevant (SMART). • Treatment plan shall include member's involvement in identifying, developing, and prioritizing goals, objectives, and interventions. • Treatment plans shall be updated based on any changes in the ASAM domains and no less frequently than every 4 sessions or every 4 weeks, whichever is less frequent. • Treatment plan updates should include documentation to the degree to which member is meeting goals and objectives, any modification to existing goals or addition of new goals, provider's assessment as to whether member needs to move to a different LOC based on ASAM continuing care, transfer, and discharge criteria, and should include the signature of the member and provider agreeing to treatment plan or documentation of member's refusal to sign to the treatment plan.

Treatment Documentation	The treatment record contains clear documentation of the following: • Ongoing progress notes that document the member's progress towards goals, as well as their strengths and limitations in achieving said goals and objectives • Referrals to diversionary levels of care and services if the member requires increased interventions resulting from homicidality, suicidality, or the inability to function on a day-to-day basis • Referrals and/or member participation in preventive and self-help services (e.g., stress management, relapse prevention, Alcoholics Anonymous, etc.) is included in the treatment record • Member's response to medications and somatic therapies
Coordination and Continuity of Care	The treatment record contains clear documentation of the following: • Documentation of communication and coordination between behavioral health providers, primary care physicians, ancillary providers, and health care facilities. (See Behavioral Health – PCP Communication Protocol later in this chapter, and download Behavioral Health – PCP Communication Form) • Dates of follow-up appointments, discharge plans, and referrals to new providers
Additional Information for Outpatient Treatment Records	These elements are required for the outpatient medical record: • Telephone intake/request for treatment • Face-sheet • Termination and/or transfer summary, if applicable • The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan, and updates) should include the following treating clinician information: o Clinician's name o Professional degree o Licensure o NPI or Carelon identification number, if applicable o Clinician signatures with dates
Additional Information for Inpatient and Diversionary Levels of Care	These elements are required for inpatient medical records: • Referral information (ESP evaluation) • Admission history and physical condition • Admission evaluations • Medication records • Consultations • Laboratory and x-ray reports • Discharge summary and Discharge Review Form

Information for Children and Adolescents	A complete developmental history must include the following information: • Physical, including immunizations • Psychological • Social • Intellectual • Academic • Prenatal and perinatal events are noted

Performance Standards and Measures

To ensure a consistent level of care within the provider network and a consistent framework for evaluating the effectiveness of care, Carelon has developed specific provider performance standards and measures. Behavioral health providers are expected to adhere to the performance standards for each level of care they provide to members, which include, but are not limited to:

- Communication with PCPs and other providers treating shared members
- Availability of routine, urgent, and emergent appointments (See Chapter 5-National Manual)
- Use of a trauma-informed care model for community mental health services, as defined by SAMHSA, with a thorough assessment of an individual's trauma history in the initial intake evaluation and subsequent evaluations to inform the development of an individualized service plan
- Behavioral health services shall be recovery and resiliency oriented based on SAMHSA's definition of recovery and resiliency.
- Community Mental Health Services shall be provided in accordance with the Medicaid State Plan and He-M 401.02 and He-M 426. This includes, but is not limited, to ensuring that the full range of Community Mental Health Services are appropriately provided to eligible members.
- The full continuum of SUD services shall be delivered in accordance to 9 criteria and NH Code of Administration Rules, Chapter He-W 500, Part He-W 513.
- SUD providers shall ensure Peer Recovery Support is available to members as both a standalone service (regardless of an assessment), and as part of other treatment and Recovery services.
- Inpatient behavioral health providers, inclusive of SUD providers who provide 24-hour levels of care, shall ensure that the discharge progress note is provided to any treatment provider within seven calendar days of member discharged for at least 98 percent of members discharged.
- Providers are to notify Carelon of any member who is discharged Against Medical Advice (AMA) after an overdose.

Practice Guidelines

Carelon and WellSense promote delivery of behavioral health treatment based on scientifically proven methods. We have researched and adopted evidenced-based guidelines for treating the most prevalent behavioral health diagnoses, including guidelines for ADHD, substance use disorders, and child/adolescent depression. Carelon has posted links to these on our website. We strongly encourage providers to use these guidelines and to consider these guidelines as a tool that may promote positive outcomes for clients. Carelon monitors provider utilization of guidelines through claim, pharmacy, and utilization data.

Carelon welcomes provider comments about the relevance and utility of the guidelines adopted by Carelon, any improved client outcomes as a result of applying the guidelines, and about providers' experience with any other guidelines. To provide feedback, or to request paper copies of the practice guidelines that Carelon adopted, please contact us at (855) 834-5655.

Outcomes Measurement

Carelon and the health plan strongly encourage and support providers in the use of outcomes measurement tools for all members. Outcomes data is used to identify potentially high-risk members who may need intensive behavioral health, medical, and/or social care management interventions.

Carelon and WellSense receive aggregate data by provider, including demographic information and clinical and functional status, without member-specific clinical information.

Communication between Behavioral Health Providers and Other Treaters

Communication Between Outpatient Behavioral Health Providers and PCPS, Other Treaters	Communication Between Inpatient/Diversionary Providers and PCPS, Other Outpatient Treaters

Outpatient behavioral health providers are expected to communicate with the member's PCP and other outpatient behavioral health providers if applicable, as follows:
 	
• Notice of commencement of outpatient treatment within four visits or two weeks, whichever occurs first
• Updates at least quarterly during the course of treatment
• Notice of initiation and any subsequent modification of psychotropic medications
• Notice of treatment termination within two weeks
 	
Behavioral health providers may use Carelon's *Authorization for Behavioral Health Provider and PCP to Share Information Form* and the *Behavioral Health-PCP Communication Form* available for initial communication and subsequent updates, in Appendix B. Providers may also use their own form that includes the following information:
 	
• Presenting problem/reason for admission
• Date of admission
• Admitting diagnosis
• Preliminary treatment plan
• Currently prescribed medications
• Proposed discharge plan
• Behavioral health provider contact name
	With the member's informed consent, acute care facilities are expected to contact the PCP by phone and/or by fax, within 24 hours of a member's admission to treatment.
	
	Inpatient and diversionary providers must also alert the PCP 24 hours prior to a pending discharge, and must fax or mail the following member information to the PCP within three days post-discharge:
	
	• Date of discharge
	• Diagnosis
	• Medications
	• Discharge plan
	• Aftercare services for each type, including:
	  ○ Name of provider
	  ○ Date of first appointment
	  ○ Recommended frequency of appointments
	  ○ Treatment plan
	
	Inpatient and diversionary providers must make every effort to provide the same notifications upon admission and discharge information to the member's outpatient therapist, if there is one.
	
	Acute care providers' communication requirements are addressed during continued stay and discharge reviews documented in Carelon's member record.

Communication Between Outpatient Behavioral Health Providers and PCPS, Other Treaters	Communication Between Inpatient/Diversionary Providers and PCPS, Other Outpatient Treaters
Request for PCP response by fax or mail within three business days of the request to include the following health information: • Status of immunizations • Date of last visit • Dates and reasons for any and all hospitalizations • Ongoing medical illness • Current medications • Adverse medication reactions, including sensitivity and allergies • History of psychopharmacological trials Outpatient providers' compliance with communication standards is monitored through requests for authorization submitted by the provider, and through chart reviews.	(see above)

Communication between Behavioral Health Providers and Other Treaters

If a member transfers from one behavioral health provider to another, the transferring provider must communicate the reason(s) for the transfer along with the information above (as specified for communication from behavioral health provider to PCP), to the receiving provider.

Routine outpatient behavioral health treatment by an out-of-network provider is not an authorized service covered by Carelon. Members may be eligible for transitional care within 30 days after joining the health plan. Transitional care may also be provided to ensure that services are culturally and linguistically sensitive, individualized to meet the specific needs of the member, timely per Carelon's timeliness standards, and/or geographically accessible.

As part of care coordination activities, participating providers should identify all providers/participating providers involved in the medical and/or behavioral healthcare and treatment of a member. Subject to any required consent or authorization from the member, participating providers should coordinate the delivery of care to the member with these providers/participating providers, inclusive of coordination of treatment plans. Providers shall ensure members with physical health and behavioral health needs are appropriately and timely referred to their PCP for treatment of their physical health needs. All coordination, including PCP coordination, should be documented accordingly in the member treatment record. Carelon consent forms are available through the website.

Providers must comply with Carelon and state policies related to transition of care set forth by DHHS and included in the DHHS model Member Handbook.

Reportable Incidents and Events

Carelon requires that all providers report adverse incidents, other reportable incidents, and sentinel events involving WellSense members to Carelon using the NH DHHS Sentinel Event reporting form available on Carelon's website. https://carelonbehavioralhealth.com/providers/forms-and-guides/nh:

Select WellSense- Medicaid and Medicare Advantage Sentinel Event Reporting Form. Providers shall ensure they follow DHHS's Sentinel Events policy when reporting these events, in addition to Carelon's requirements (see Carelon National Handbook).

DHHS policy:
https://www.dhhs.nh.gov/reports-regulations-statistics/program-quality/sentinel-event-reporting

Table: Reportable Incidents and Events – Overview

	Adverse Incidents	Sentinel Events	Other Reportable Incidents
Incident/ Event Description	An adverse incident is an occurrence that represents actual or potential serious harm to the well-being of a health plan member who is currently receiving or has been recently discharged from behavioral health services.	A sentinel event is any situation occurring within or outside of a facility that either results in death of the member or immediately jeopardizes the safety of a health plan member receiving services in any level of care.	An "other reportable incident" is any incident that occurs within a provider site at any level of care, which does not immediately place a health plan member at risk but warrants serious concern.
Incidents/ Events Include the Following	• All member deaths • Any absence without authorization (AWA) involving a member • Any injury while in a 24- hour program that could, or did, result in transportation to an acute care hospital for medical treatment or hospitalization. • Any sexual assault or alleged sexual assault • Any physical assault or alleged physical assault by a staff person or another patient against a member • Any medication error or suicide attempt that requires medical attention beyond general first aid procedures • Any unscheduled event that results in the evacuation of a program or facility (e.g., fire resulting in response by fire department)	• All medico-legal deaths: Any death required to be reported to the medical examiner or in which the medical examiner takes jurisdiction • Any AWA involving a patient involuntarily admitted or committed and/or who is at high risk of harm to self or others • Any serious injury resulting in hospitalization for medical treatment; a serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is subsequently medically admitted. • Any medication error or suicide attempt that requires medical attention beyond general first aid procedures • Any sexual assault or alleged sexual assault	• Any non-medico-legal deaths • Any AWA from a facility involving a member who does not meet the criteria for a sentinel event as described above • Any physical assault or alleged physical assault by or against a member that does not meet the criteria of a sentinel event • Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization; a serious injury is defined as any injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted.

	Adverse Incidents	Sentinel Events	Other Reportable Incidents
		• Any physical assault or alleged physical assault by a staff person against a member • Any unscheduled event that results in the evacuation of a program or facility whereby regular operations will not be in effect by the end of the business day and may result in the need for finding alternative placement options for member	• Any unscheduled event that results in the temporary evacuation of a program or facility, such as a small fire that requires fire department response. Data regarding critical incidents are gathered in the aggregate and trended on a quarterly basis for the purpose of identifying opportunities for quality improvement.
Reporting Method	• Providers are required to fax a copy of *the NH DHHS Sentinel Event Reporting Form* (for adverse and other reportable incidents and sentinel events) to NH DHHS. • Providers are also required to send a copy of the *NH DHHS Sentinel Event Reporting Form to* Carelon's ombudsperson via secure email at ombuds@carelon.com. Providers can also call Carelon's Clinical Department at (781) 994-7642, available 24 hours a day. • Providers must notify NH DHHS and Carelon as soon as they become aware of an incident, regardless of the hour. • Incident and event reports should not be emailed unless the provider is using a secure messaging system. • Providers should direct all such reports to their Carelon clinical manager or UR clinician by phone or secure email.		
Provide the Following	Providers should be prepared to present: • All relevant information related to the nature of the incident • The parties involved (names and telephone numbers) • The member's current condition • Any improvement steps identified to maintain safety and prevent reoccurrence		

Fraud and Abuse

Carelon's policy is to thoroughly investigate suspected member misrepresentation of insurance status and/or provider misrepresentation of services provided. See the national handbook for definitions and reporting any concerns of fraud, waste and abuse.

Carelon continuously monitors potential fraud and abuse by providers and members, as well as member representatives. Carelon reports suspected fraud and abuse to the health plan in order to initiate the appropriate investigation. WellSense will then report suspected fraud or abuse in writing to the correct authorities.

Grievances and Grievance Resolutions

A grievance is any expression of dissatisfaction by a member, member representative, or provider on member's behalf, about any action or inaction by Carelon other than an adverse action. Possible subjects for grievances include, but are not limited to, quality of care or services provided; Carelon's procedures (e.g., utilization review, claims processing); Carelon's network of behavioral health services; member billing; aspects of interpersonal relationships, such as rudeness of a provider or employee of Carelon; or failure to respect the member's rights.

WellSense Medicaid Grievances

Carelon reviews and provides a timely response and resolution of all grievances that are submitted by members, authorized member representative (AMR), and/or providers. Every grievance is thoroughly investigated and receives fair consideration and timely determination.

Providers may register their own grievances and may register grievances on a member's behalf. Members, or their guardian or representative on the member's behalf, may also register grievances. Contact Carelon to register a grievance.

If the grievance is determined to be urgent, written acknowledgment is communicated to the member and/or provider within 24 hours and written resolution within 72 hours of receipt of the grievance. If the grievance is determined to be non-urgent, Carelon's Grievances and Appeals Coordinator will notify the person who filed the grievance of the disposition of their grievance in writing, within 30 calendar days of receipt.

For both urgent and non-urgent grievances, the resolution letter informs the member or member's representative to contact Carelon's Grievances and Appeals Coordinator in the event that they are dissatisfied with Carelon's resolution.

WellSense Medicare Advantage HMO Grievances

All WellSense Medicare Advantage HMO are reviewed and resolved by WellSense. The member grievance process begins upon WellSense's receipt of a verbal or written expression of dissatisfaction. Members can also file quality of care grievances with the QIO as well as WellSense.

The preferred way for a member or the member's Authorized Representative, including a provider on behalf of a member, to file a grievance is to put it in writing and send it to us by mail or fax. A grievance also may be submitted orally by calling the WellSense Member Services Department at (855) 833-8128 or TTY: 711.

Written grievances should include name, address, WellSense Medicare Advantage ID number, daytime telephone number, detailed description of the grievance (including relevant dates and provider names), and any applicable documents that relate to the grievance (such as billing statements). Written grievances should be faxed to WellSense at (617)-897-0805 or postal mailed to:

WellSense Medicare Advantage HMO Member Grievances Department
529 Main Street, Suite 500
Charlestown, MA 02129

Members, or their Authorized Representatives, may also file a Grievance at any time with CMS.

In addition, whenever Carelon disapproves a member or an authorized representative's request for an expedited Organization Determination or extends the times for resolving an Organization Determination, members or their Authorized Representatives can file an expedited grievance. The also applies to WellSense disapproving a member or an authorized representative's request for an expedited appeal or extending the timeframe to resolve a standard appeal.

WellSense resolves standard grievances within 30 calendar days and expedited grievances within 24 hours or as expeditiously as the member's condition warrants. It is the expectation of WellSense that all providers kindly respond in a timely manner to requests for information relating to grievances.

Member and provider concerns about a denial of requested clinical service, adverse utilization management decision including adverse organization determinations, or an adverse action are not handled as grievances. See UM Appeals in Chapter 10 of the national handbook, Utilization Management.

12. ADDITIONAL HELPFUL RESOURCES

Provider Education and Outreach

Summary

In an effort to help providers that may be experiencing claims payment issues, Carelon conducts quarterly reports identifying those providers that may benefit from outreach and education. Providers with low approval rates are contacted and offered support and documentation material to assist in reconciliation of any billing issues that may be having an adverse financial impact and to ensure proper billing practices within Carelon's documented guidelines.

Carelon's goal in this outreach program is to assist providers in as many ways as possible to receive payment in full, based upon contracted rates, for all services delivered to members.

How the program works

A quarterly approval report is generated that lists the percentage of claims paid in relation to the volume of claims submitted.

All providers below a 75 percent approval rate have an additional report generated listing their most common denials and the percentage of claims they reflect.

An outreach is made to the provider's billing director, as well as a report indicating the top denial reasons. For any further questions we advise to contact NPSL Line at 800-397-1630 for further assistance, or to request training.