Please click on the links below to find the section/document you are looking for.

- Credentialing Criteria
- Medical Necessity Criteria
- Performance Specifications

- Chapter 1: Welcome and Introduction
- Chapter 2: Clinical Operations
- Chapter 3: Administrative Operations
- Chapter 4: Quality Management
- Chapter 5: Network Management and Credentialing
## WELCOME AND INTRODUCTION

## MBHP GOALS

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## GLOSSARY OF TERMS

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WELCOME AND INTRODUCTION

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

Under contract with the Commonwealth’s MassHealth Behavioral Health Program, MBHP manages mental health and substance use disorder services for Members in MassHealth’s Primary Care Clinician (PCC) Plan (a Massachusetts Medicaid program), Community Care Cooperative (C3), Partners HealthCare Choice, Steward Health Choice, and the BeHealthy Partnership. In addition, MBHP manages these services for children in the care or custody of the state, including the Departments of Children and Families and Youth Services, and certain children enrolled in MassHealth who have commercial insurance as their primary insurance. Each year, more than 135,000 Members receive services through MBHP-managed programs. MBHP’s network includes more than 1,500 behavioral health providers, including more than 1,300 individual providers, 140 outpatient clinics, 46 group practices, and 48 inpatient mental health facilities. Currently, 74 percent of all child psychiatrists in Massachusetts are practitioners in our network. In addition, we work closely with more than 380 primary care practices across Massachusetts.

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

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

Important Notice

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

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

MBHP GOALS

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

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

- **Continuously improve the quality of care available to MassHealth Members** by monitoring, measuring, and addressing opportunities to improve all aspects of service delivery, including clinical, network, administrative, and quality management services;
- **Meet the behavioral and primary health care needs of MassHealth Members, as they define them**, and incorporate a strong focus on consumer and family involvement, rehabilitation, and recovery in all program aspects;
- **Strengthen the overall integration of the behavioral health service delivery system** across state agencies, community-based organizations, and institutional providers;
- **Improve cost-effectiveness of care delivery** by ensuring the availability and appropriateness of services; and
- **Improve integration of primary care with behavioral health care** through quality-driven network management activities and care management.

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

MBHP SERVICES

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

Principles of Recovery and Rehabilitation

MBHP supports the principles of recovery and rehabilitation as outlined in the 2003 President’s New Freedom Commission on Mental Health report. As the report recommends, MBHP is implementing mental health and substance use disorder services that place consumer and family choice at the center of service planning and treatment decisions. MBHP accomplishes this goal by promoting recovery-oriented performance specifications and managing its provider network to meet these specifications.
MBHP has also developed provider incentives and launched innovative programs that foster greater adoption of rehabilitation and recovery-oriented practices and values.

MBHP is building the recovery and rehabilitation orientation of its provider network by:

1. helping providers move from a focus on symptom management to one on recovery, strengths and wellness;
2. offering consumers more opportunities to learn from others who have mental health and substance use disorders;
3. working with consumers and families through task forces, advisory committees, trainings, and conferences to advance skills and knowledge, develop new recovery-oriented services, and retool existing services to a rehabilitation and recovery focus;
4. managing providers to achieve improved recovery outcomes by requiring the use of outcome measurement tools that assess acquired life skills and completed stages of recovery;
5. promoting programs and treatments proven to be the most effective for individuals with mental health and substance use disorder conditions; and
6. promoting recovery programs and services that are available and offered consistently to consumers throughout the Commonwealth.

**Data-Driven Network and Utilization Management**

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

**Outpatient**

Providers can register many routine services using MBHP’s Interactive Voice Registration (IVR) technology. MBHP grants initial pre-authorizations for longer periods to inpatient providers who have consistently demonstrated the ability to effectively manage utilization. This strategy makes it possible for MBHP to target resources to providers requiring additional support.

The Outpatient Provider Practice Analysis (OPPA) s dashboard is made available to high-volume behavioral health providers and reviewed during site visits by regional network managers (RNMs). The OPPA dashboard gives providers practice management information in several key areas: Member demographics, diagnostic data, utilization data, quality indicators, coordination of care, and integration with primary care providers. The Substance Abuse Provider Practice Analysis (SAPPA) provides data to substance use disorder service providers on Members discharged from their facilities and their follow-up care.

**Emergency Services Program (ESP)**

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

**Inpatient**

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

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

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

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

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

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

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

**Enrollment procedures**
A Member may be referred to the Integrated Care Management program by the Member’s clinician, an MBHP clinician, a state agency, a Member, family, or significant others by calling or faxing referrals using the ICMP numbers below, completing an online referral form, or by calling the regional care management program supervisor in the region in which the Member lives.

ICMP Phone number: (617) 790-4165
ICMP fax number: 1-855-895-9758
Online referral: [https://www.masspartnership.com/provider/apps/ICMP/ICMRForm.aspx](https://www.masspartnership.com/provider/apps/ICMP/ICMRForm.aspx)

Phone numbers for the Regions are:
- Central Region (508) 890-6400
- Metro Boston Region (617) 790-4000
- Northeast Region (978) 716-3350
- Southeast Region (508) 217-3223
- Western Region (413) 858-8600

Fax numbers for the Regions are:
- Central Region (508) 890-6410
- Metro Boston Region (877) 390-2325
- Northeast Region (855) 294-0149
- Southeast Region (888) 980-8975
- Western Region (855) 818-1248

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

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

MBHP works with providers, local stakeholders, and others to develop culturally sensitive, accessible information on services. In total, these initiatives are designed to strengthen and deepen the cultural competency of the MassHealth Behavioral Health Program.

Special Populations

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

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

- **Children and adolescents:** Given the financial and social strain felt by many MBHP families, children and adolescents are considered to be among MBHP’s most high-risk Members. As a coordinator of many services mandated by the Children’s Behavioral Health Initiative, MBHP sponsors various initiatives and prevention, education, and outreach programs for children, adolescents, and their families. MBHP has committed staff resources to support these efforts.

- **Persons with co-occurring disorders:** Members who have multiple disorders, which present with any combination of psychiatric, substance use, medical, and/or intellectual disability diagnoses, represent a significant clinical challenge. MBHP is committed to developing a continuous, comprehensive, and integrated system of care as well as creating programs targeted to this complex population. In collaboration with MassHealth and the Departments of Mental Health, Developmental Services, and Public Health, MBHP has developed programs and protocols intended to address the needs of Members with co-occurring disorders.

- **Members who are homeless:** Homeless individuals, many of whom experience co-occurring mental health and substance use disorders, are often difficult to assess and treat. Many provide a significant challenge to network providers. MBHP is committed to offering services to aid providers in serving people who are experiencing homelessness.
**MBHP CONTACTS**

The Massachusetts Behavioral Partnership (MBHP) has its headquarters at 1000 Washington Street in Boston, with regional offices in Boston, Danvers, Bridgewater, Worcester, and Springfield.

**BOSTON: 1000 WASHINGTON STREET**
**Toll-Free Number:** 1-800-495-0086
**TTY:** 1-877-509-6981

*General Correspondence Address:*
Massachusetts Behavioral Health Partnership
P.O. Box 55871
Boston, MA 02205-5871

*Clinical Access Line*
**Phone:** 1-800-495-0086
**Fax:** (855) 685-5170

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

*Member Engagement Center*
**Phone:** 1-800-495-0086
**Fax:** (877) 334-9615

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

*Network Operations Department*
**MBHPNetworkOperations@beaconhealthoptions.com**

The Network Operations Department manages and maintains the MBHP and Health New England Be Healthy provider network. Key Network Operations Department activities include oversight of the credentialing and recredentialing process, contract management, and monitoring of provider demographics and provider files. MBHP Network Operations strategy emphasizes working with network providers to ensure Member access to appropriate, high-quality care.

*Network Management Department*
The Network Management Department works together with the MBHP and Health New England Be Healthy provider networks. MBHP’s approach integrates network management, utilization management, quality management, and rehabilitation and recovery into all our interactions with the provider network.
The needs and perspectives of our Members and their families are essential in prioritizing our interventions. Each of MBHP’s five regionally based offices works closely with network providers, community programs, state agencies, and consumer and family advocacy organizations to strengthen continuity of care within a community-based, locally integrated service delivery system.

Community Relations
Phone: 1-800-495-0086
Fax: (877) 334-9615
PO Box 55870
Boston, MA 02205-5870

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

Claims
Massachusetts Behavioral Health Partnership
P.O. Box 55871
Boston, MA 02205-5871

Note: Claims sent to regional offices may experience delays in processing.

Departments at the Boston Office:
- Executive Administration
  - Communications
  - Human Resources
- Medical Affairs
  - Utilization Review
  - Clinical Access Line
  - MCPAP/MCPAP for Moms
- Finance
  - Facilities
- Network Management and Recovery Initiatives
  - Child and Adolescent Services Management
  - PCC Plan Support Services Program
  - Substance Use Disorder Services Management
  - Rehabilitation and Recovery
  - Emergency Services Program Management
  - Regional Offices
- Member and Provider Services
  - Claims Operations
- Member Engagement Center
- Community Relations (Customer Service)

- Management Information Systems
  - Informatics and Analytics
  - IT
- Network Operations
  - Provider Credentialing
- Quality Management
  - Fraud and Abuse

**Departments at all Regional Offices:**
- Integrated Care Management Program (ICMP)
- Program Network Management
- Provider Relations
- PCC Plan Support Services Program

**CENTRAL REGIONAL OFFICE**
Massachusetts Behavioral Health Partnership
50 Prescott Street, Suite 3300
Worcester, MA 01605
**Toll-Free Number:** 1-800-495-0086
**Main Number:** (508) 890-6400
**Fax Number:** (508) 890-6410

**METRO BOSTON REGIONAL OFFICE**
Massachusetts Behavioral Health Partnership
1000 Washington Street, Suite 310
Boston, MA 02118-5002
**Toll-Free Number:** 1-800-495-0086
**Main Number:** (617) 790-4000
**Main Fax Number:** (877) 390-2325

**NORTHEAST REGIONAL OFFICE**
Massachusetts Behavioral Health Partnership
222 Rosewood Drive, Suite 1110
Danvers, MA 01923
**Toll-Free Number:** 1-800-495-0086
**Main Number:** (978) 716-3350
**Main Fax Number:** (855) 294-0149
SOUTHEAST REGIONAL OFFICE
Massachusetts Behavioral Health Partnership
One Lakeshore Center, 3rd Floor
Bridgewater, MA 02324
Toll-Free Number: 1-800-495-0086
Main Number: (508) 217-3223
Main Fax Number: (888) 980-8975

WESTERN REGIONAL OFFICE
Massachusetts Behavioral Health Partnership
1259 East Columbus Avenue, Suite 202
Springfield, MA 01105
Toll-Free Number: 1-888-856-6277
Main Number: (413) 858-8600
Main Fax Number: (855) 818-1248
GLOSSARY OF TERMS

Adolescent - An MBHP-eligible person age 13 to 18 years

Adult - An MBHP-eligible person age 19 to 64

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

(1) The failure to provide MassHealth Covered Services in a timely manner in accordance with the waiting time standards in Section 3.1.G.8;

(2) The denial or limited authorization of a requested service, including the determination that a requested service is not a MassHealth Covered Service;

(3) The reduction, suspension, or termination of a previous authorization for a service;

(4) The denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue; provided that procedural denials for requested services do not constitute Adverse Actions, including but not limited to denials based on the following:

- failure to follow prior authorization procedures;
- failure to follow referral rules;
- failure to file a timely Claim; and

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

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

ASAM - American Society of Addictions Medicine

ASAP - Assessment for Safe and Appropriate Placement

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

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

Beacon Health Options – the parent company of MBHP

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

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

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

Behavioral Health Network Provider (or Network Provider) – A provider who has contracted with the Contractor to provide Behavioral Health Covered Services under the BH Program
Behavioral Health Program (BHP) – That portion of the Contract related to the administration, coordination, delivery, and management of the BH Covered Services described in Appendix A-1

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

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

Care Management Program (CMP) – The administration and provision of certain clinical management and support activities to certain Enrollees and Providers, as described in Section 6.2

Care Team – A group of individuals led by the care coordinator or care manager, including the Member, the primary care clinician (PCC), and any other medical or behavioral health provider, case manager from another state agency, and any family member or other individual requested as part of the team by the Member

CBAT - Community-Based Acute Treatment

CCS - Community Crisis Stabilization

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

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

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

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

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

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

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

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

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

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

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

**Clinical Criteria** – The criteria used to determine the most clinically appropriate and necessary level of care and amount, duration, or scope of services, to ensure the provision of Medically Necessary Behavioral Health Covered Services

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

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

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

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

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

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

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

Members – MassHealth Members who are eligible to receive Behavioral Health Covered Services under the BHP, including PCC Plan Enrollees, Children in the Care and/or Custody of the Commonwealth, and children in MassHealth Standard or CommonHealth with other health insurance

Covered Services - Those services MBHP is responsible for providing to Members as defined by MBHP’s contract with MassHealth

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

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

Date of Action – The effective date of an Adverse Action

DBT - Dialectical Behavior Therapy

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

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

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

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

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

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

DMH Case Management – A service operated by DMH that is performed in accordance with DMH regulations for DMH Clients. DMH Case Management includes those services enumerated in 104 CMR 29.00
**DMH Clients** – For purposes of this Contract, individuals whom EOHHS identifies to the Contractor as being eligible for and recipients of DMH services

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

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

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

**DMH Specialty Programs** – Programs the Contractor manages under the Contract on behalf of DMH, including the Emergency Services Program (ESP) for Uninsured Individuals and persons covered by Medicare only, the Massachusetts Child Psychiatry Access Project (MCPAP), and Forensic Evaluations

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

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

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

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

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

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

**Emergency Services Programs (ESPs)** – The network providers, identified in Appendix A-3, that provide ESP services as described in Appendix A-1, Part III in accordance with the requirements of the contract
**Emergency Services** – MassHealth covered services that are furnished to a Member by a provider qualified to furnish such services under Title XIX of the Social Security Act and that are needed to evaluate or stabilize a Member’s emergency medical condition.

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

**Encounter** – A professional contact between a patient and a provider who delivers health care services

**Engagement** – For each ICMP Tier, a minimum number and type of contacts per month per participant

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

**Enrollee** – A person determined eligible for MassHealth who is enrolled in the PCC Plan, either by choice or by assignment by EOHHS

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

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

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

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

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

**Grievance** – Any expression of dissatisfaction by a Member or Appeal Representative about any action or inaction by the Contractor other than an Adverse Action. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee of the Contractor, or failure to respect the Member’s rights.
**Group Practice** - A multi-disciplinary team of individual practitioners contracted as one entity. Each practitioner within the group is credentialed individually. The head of the group practice must be one of the following: a full-time psychiatrist; a master’s-level, advance-practice registered nurse, board-certified in adult or child psychiatric nursing under the supervision of a licensed psychiatrist; a licensed psychologist (including PhD, EdD, and PsyD); an LICSW; or an LMHC. MBHP/HNE BH will only consider the following licensure levels for group contracting: MD, APRN-BC, LICSW/LCSW, LMHC, or licensed psychologist (including PhD, EdD, and PsyD).

**Health Care Acquired Conditions (HCACs)** – Conditions occurring in an inpatient hospital setting, which Medicare designates as hospital-acquired conditions (HACs) pursuant to Section 1886 (d)(4)(D)(iv) of the Social Security Act (SSA)(as described in Section 1886(d)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT)/pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients

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

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

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

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

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

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

**Interactive Voice Registration (IVR)** - MBHP’s IVR system enables eligible providers to obtain authorization for designated levels of care.

**Intensive Outpatient Program (IOP)** - Provides comprehensive, behaviorally oriented treatment services that are significantly more structured than traditional outpatient therapy, yet significantly less structured than a traditional inpatient hospital program.
**Internal Appeal** – A request by a Member or Appeal Representative made to the Contractor for review of an Adverse Action

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

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

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

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

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

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

**MassHealth** – The Medicaid program of the Commonwealth of Massachusetts, administered by EOHHS pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and other applicable laws and waivers thereto

**MassHealth CommonHealth** – The MassHealth Coverage Type for individuals who are determined by EOHHS to meet the requirements of 130 CMR 505.004

**MassHealth Covered Services** – Medical and behavioral health services or related care provided to Members, in accordance with the lists of covered services associated with the MassHealth Coverage Type specified in 130 CMR 505.001 through 505.009

**MassHealth Family Assistance** – The MassHealth coverage type that includes those individuals determined by EOHHS to meet the requirements of 130 CMR 505.006

**MassHealth Provider** – A participating individual, facility, agency, institution, organization, or other entity that has appropriate credentials and licensure and has entered into an agreement with EOHHS for the delivery of MassHealth covered services to MassHealth Members

**MassHealth Managed Care** – The provision of primary care, behavioral health, and other medical services through a contracted Managed Care Organization or the PCC Plan, in accordance with the provisions of 130 CMR 450.117 et seq. and 130 CMR 508.000 et seq

**MassHealth Member (“Member”)** – Any individual determined by EOHHS to meet the requirements of 130 CMR 505.002 or 130 CMR 505.005
MassHealth Standard – The MassHealth Coverage Type for individuals who are determined by EOHHS to meet the requirements of 130 CMR 505.002

MBHP – Massachusetts Behavioral Health Partnership

Medicaid – See MassHealth

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

Medical Necessity Criteria - The factors/conditions used to determine the most clinically appropriate level of care and amount, duration, or scope of services as set forth in MBHP Clinical Criteria to ensure the provision of Medically Necessary Covered Services

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

1. it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and

2. there is no other medical service or site of service, comparable in effect, available, and suitable for the Member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior authorization request, to be available to the Member through sources described in 130 CMR 450.317(C), 503.007, or 517.007. See, 130 CMR 450.204.

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

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

Member Appeal - A request by a Member or his/her authorized representative for the reconsideration of any adverse action by MBHP that impacts the Member’s treatment

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

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

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

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

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

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

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

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

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

**Outpatient Provider Practice Analysis (OPPA)** – Dashboard made available to high-volume behavioral health providers and reviewed during site visits by Regional Network Managers (RNMs). The OPPA dashboard gives providers practice management information in several key areas: Member demographics, diagnostic data, utilization data, quality indicators, coordination of care, and integration with primary care providers.

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

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

For each of a. through c., above, the term “surgical or other invasive procedure” is defined in CMS Medicare guidance on NCDs.
2. Additional Other Provider Preventable Conditions (Additional OPPCs) – Additional OPPCs are state-defined OPPCs that meet the requirements of 42 C.F.R. 447.26(b). EOHHS has designated certain conditions as “Additional OPPCs.”

**Participant** – An Enrollee who has agreed to care management interventions offered by the Contractor and who meets the definition of Engaged for the particular Tier the Enrollee is assigned to.

**Patient-Centered Medical Home Initiative (PCMHI) Clinical Care Management Services** – Services provided by a licensed nurse care manager employed by an EOHHS PCMHI participating practice. The services include stratification of the practice patient population, having contact with patients identified as high-risk no less frequently than every 30 days, case review and planning, including completing, analyzing, and updating as necessary medical bio-psychosocial support and self-management support assessments, and providing intensive medical and medication management.

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

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

**Plan Type** – An identifier used by MassHealth’s MMIS to identify the Rating Category in which a Member is enrolled in the Behavioral Health Program.

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

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

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

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

- Authorize the treatment based on medical necessity;
- Suggest an alternate level of care; or
- Determine that certification is not appropriate.
Prevalent Languages – Those languages spoken by a significant percentage of Members in the Commonwealth, as determined by EOHHS. Currently, EOHHS has determined that English and Spanish are Prevalent Languages.

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

Primary Care – All health care services and laboratory services customarily furnished by or through a family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or nurse practitioner, to the extent the furnishing of those services is legally authorized by the Commonwealth, as further described in 130 CMR 450.101

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

PCC Plan Hotline – The toll-free telephone line maintained by the Contractor to answer or refer PCC or other PCC Plan provider inquiries. Such inquiries may include, but are not limited to, questions about: the Contractor’s responsibilities related to the PCC Plan, including reporting, quality management, operations, PCCs participating in PCMHI, the PCC Provider Contract (see Appendix C-2), and other topics as directed by EOHHS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Rating Category (RC)** – A specific group of Members for which a discrete BH Covered Services Capitation Rate applies, as described in Section 10.2

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

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

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

**Substance Abuse Provider Practice Analysis (SAPPA)** – Provides data to substance use disorder service providers on Members discharged from their facilities and their follow-up care

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

**Serious Mental Illness** – A substantial disorder of thought, mood, perception, orientation, or memory in an adult, which: significantly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life; has lasted or is expected to last at least one year; has resulted in functional impairment that substantially interferes with or limits the performance of one or more major life activities; meets diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) American Psychiatric Association, Washington, DC (2000), as currently
drafted and subsequently amended; and is not based on symptoms primarily caused by substance use, mental retardation, or organic disorders

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

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

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

**Structured Outpatient Addictions Programs (SOAP)** - SOAP consist of clinically intensive, structured day and/or evening substance use disorder services. Some SOAPs offer Motivational Interviewing or enhanced services for adolescents and adults who are homeless.

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

**Tier** – A division or category within the Integrated Care Management Program’s system of stratification

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

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

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

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

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

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

**Youth** - An MBHP-eligible Member age 18 years and younger
# CLINICAL OPERATIONS

## INTRODUCTION TO MEDICAL NECESSITY CRITERIA AND UTILIZATION MANAGEMENT

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## BEHAVIORAL HEALTH ACCESS PROTOCOL FOR DYS AND MBHP

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## MEMBER APPEALS

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INTRODUCTION TO MEDICAL NECESSITY CRITERIA AND UTILIZATION MANAGEMENT

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

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

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

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

Clinical Philosophy

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

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

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

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

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

**Definition of Medical Necessity**

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

1. The proposed service must be *reasonably calculated to prevent, diagnose, alleviate, correct, prevent the worsening of*, or cure conditions in the Member that:
   a. endanger life;
   b. cause suffering or pain;
   c. cause physical deformity or malfunction; and
   d. threaten to cause or aggravate a handicap or result in illness or infirmity.

2. There is *no other medical service or site of service comparable* in effect and available or suitable for the Member requesting the service that is more conservative or less costly.

3. The service *meets professionally recognized standards of health care* and is substantiated by records, including evidence of such medical necessity and quality.

**Determining the Appropriate Level of Care**

Three concepts underlie determinations of the appropriate level of care:

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

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

For example, a diagnosis alone does not determine the necessity of treatment at a given level. Individuals with the same diagnosis or even one individual over time may exhibit a wide range of severity of symptoms or psychosocial needs. The applicability of these criteria to individual circumstances will depend on information obtained by the MBHP care manager from the Member, behavioral health and medical providers, family members, and caregivers.

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

Severity of Condition

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

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

Intensity of Service

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

Cultural, Ethnic, and Linguistic Assessment Considerations

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

Evaluating Medical Necessity for Continued Care

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

- Progress in relation to specific symptoms or impairments is clearly evident, and the maximum
level of functioning has not been obtained;

- **Active evaluation and treatment appropriate for the condition are occurring** with cooperation of the individual and his or her family or other support system, and timely relief of symptoms is either evident or reasonably expected;

- **Treatment goals are realistic** and established within an appropriate time frame for the current level of treatment;

- **Psychosocial, cultural, and linguistic issues are addressed** through timely referral to and coordination with community and psychosocial rehabilitation resources (e.g., culturally specific treatment modalities, social service agencies, peer support, recovery/self-help groups, legal aid, credit counseling, assertive community treatment, and clubhouse programs); and

- **All services, resources, and treatment modalities are carefully structured** to achieve maximum results with the greatest efficiency, which allows the individual to be treated at the least-intensive level of care appropriate for the condition and the desired results (e.g., move to less intensive level of care or reunification of the family).

**Discharge Criteria**

MBHP’s discharge criteria describe the circumstances under which an individual qualifies for transition to a different level of care.

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

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

**Clinical Criteria Development**

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

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

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

Proposed revisions to the clinical criteria are presented to the MBHP Behavioral Health Clinical Advisory Committee, a quality committee that meets quarterly. Its membership includes a broad representation of clinical specialties and licensure levels. The Utilization Management Committee also reviews the clinical criterion. Final approval is the responsibility of the MBHP Quality Management Operations Committee. The MBHP Chief Medical Officer conducts a comprehensive review of the criterion annually.

**Clinical Review Information Requirements**

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

**Commonly Requested Information**

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

1. Presenting problem/reason for admission, including precipitant
2. Diagnostic profile - mental health diagnosis including personality disorders, developmental disabilities and substance use disorders; medical diagnoses that are also the focus of treatment or help explain the need for treatment
3. What are the current symptoms being treated that meet level of care (specific symptoms, e.g., She appears depressed as evidenced by crying, staying in room, doesn't want to tend to ADLs)?
   a. Why does the Member require this current level of care?
   b. Could the Member receive treatment in a less restrictive environment? If not, why?
4. What are the interventions taking place? Measurable goals? Each discipline should have
some targeted interventions (for each level of care these interventions should be specific to the level of care and comply with medical necessity criteria for that level of care). Could these interventions be performed in a less-restrictive environment?

5. Medication management regime - dose, frequency and outcome (What is the rationale for the medications, and how do they correspond to the diagnosis?) Has it been effective, have symptoms been alleviated, is Member taking meds?

6. Is the Member been making progress? Please describe in objective and specific terms. What is the Member's baseline functioning? Is the Member still experiencing any acute symptoms that cannot be treated at a lower level of care or put the Member at risk? Is there reasonable expectation of progress with continuation at current level of care?

7. What is the discharge plan for ongoing therapeutic services and living/housing situation? Have referrals been made, and when is the service to begin? Is the service going to work with family and acute setting through this admission?

8. What are the barriers to the Member making progress, if any? What are the barriers to discharge? Has treatment been adjusted to account for barriers? Have the appropriate resources been contacted in a timely manner to decrease barriers and enhance treatment needs?

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

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

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

When it is anticipated that the Member's discharge plan will include DMH Continuing Care Services and/or other state agencies, the DMH Continuing Care Services or other state agency management staff should be included during treatment team meetings. Family members should be included in the treatment/discharge planning process for all Members, and only with consent for Members age 19+.

**AUTHORIZATION REVIEW**

**Clinical Access Line**

The MBHP Clinical Access Line is staffed by licensed clinical care managers 24 hours a day, seven days a week, 365 days a year. Routine calls (non-urgent or non-emergency) should be made during business hours, 8:30 a.m. to 5 p.m., Monday through Friday.
MBHP requires providers to request pre-authorization for admission of eligible Members into the following levels of care (see table at the end of this section):

- All Psychiatric Inpatient Services including Developmental and Eating Disorders
- Assessment/Observation/Holding Beds - 24 hours
- Medically Managed Detoxification Services (Level IV)
- Enhanced Acute Treatment Services (E-ATS)
- Medically Monitored Detoxification Services for Adolescents
- Clinical Support Services (CSS) for Substance Abuse for Individuals Under Age 21
- Community-Based Acute Treatment (CBAT) for Children and Adolescents

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

Members seeking admission to the above levels of care, with the exception of E-ATS and Level IV Medically Managed Detoxification Services, must be evaluated by an MBHP-contracted ESP before admission. Requesting providers should contact the closest ESP directly. MBHP Clinical Access Line clinicians are available 24 hours a day, seven days per week to provide information regarding ESP locations. After completing the evaluation, the ESP will contact MBHP to obtain authorization of services.

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

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

### Decision time table

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<th>Type of Service</th>
<th>Timeframe</th>
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<td>For non-urgent pre-service decisions</td>
<td>15 days of receipt of the request</td>
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<tr>
<td>For urgent pre-service decisions</td>
<td>72 hours of receipt of the request</td>
</tr>
<tr>
<td>For urgent concurrent review</td>
<td>24 hours of receipt of the request</td>
</tr>
<tr>
<td>For post-service decisions</td>
<td>30 calendar days of the receipt of the request</td>
</tr>
</tbody>
</table>

### Reviewer availability policy

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

Routine calls (regarding non-urgent or non-emergency care) should be made during normal
business hours, 8:30 a.m. – 5 p.m., Monday through Friday. Peer Advisors are available for consultations during normal business hours.

If a denial has been issued and the provider would like to discuss this denial with an MBHP Peer Advisor, they should call the Medical Affairs Department within three calendar days of the date on the Notice of Adverse Action at 1-800-495-0086 (press 3, then press 2) to request a reconsideration of the decision. Any reconsideration requests received after three calendar days of the adverse determination letter will be considered an Appeal. Internal Member Appeals need to be requested by either the Member or the Member’s authorized representative.

**Authorization Approvals Only Available Online**

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

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

Electronic authorization letters provide several advantages over paper letters:

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

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

- request and view authorizations;
- submit claims and view status;
- access Provider Summary Vouchers;
- submit customer service inquiries; and
- submit updates to provider demographic information

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

**Referral Process/Assistance**

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

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

**Emergency Services**

Emergency Services Programs (ESPs) are the primary mechanism through which MBHP Members access emergency and acute care services.

ESPs evaluate Members for admission to all acute care services or for referral to a non-acute or diversionary level of care. If an acute care service is needed, the ESP is required to obtain pre-authorization from the Clinical Access Line (with the exception of Crisis Stabilization Services, which do not require pre-authorization). Clinical Access Line clinicians are also available for assistance with and consultation regarding determination of the appropriate level of care for a Member.

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

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

**Emergency Admissions without Pre-Certification**

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

Emergency admissions may also occur without an ESP intervention when the admission is required for provider compliance with the Emergency Medical Treatment and Labor Act (EMTALA). Any hospital with an emergency department must provide medical screening examinations to an individual who comes to the emergency department to determine if the individual is suffering from an emergency medical condition. An “emergency medical condition” is a medical condition with acute symptoms of sufficient severity (including severe pain) that if not immediately treated could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any organ or body part. If the individual requires stabilizing treatment, the hospital must provide such treatment, including an emergency admission if necessary, or, if the hospital lacks the capability or capacity to provide stabilizing treatment, conduct appropriate transfers.
When an emergency admission has occurred without ESP involvement, authorization for the inpatient care must be requested as soon as possible after the placement of the Member, and in all cases within 24 hours. MBHP reserves the right to authorize individual exceptions to this policy as indicated by clinical or best practice considerations.

**Authorization Requests from the Courts/Evaluations by Court Psychologists**

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

**Mandated treatment**

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

**Treatment that is not mandated**

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

**Concurrent Review**

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

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

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

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

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

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

Authorization Process by Level of Care

Authorization request process is dependent on level of care, type of request (continued stay dates or an increase in intensity and frequency of service) and provider eligibility in administrative efficiency programs. Requests are made via phone contact with a Care Manager, through our automated IVR telephone system, various web based forms, or fax forms.

Please note all requests (regardless of format) are subject to possible live clinical review with a care manager.

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<th>ESP Evaluation Required</th>
<th>Telephone Pre-certification via Clinical Access Line</th>
<th>Telephone Non-Access Line</th>
<th>Authorization Exempt</th>
<th>IVR</th>
<th>Web Request</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>Psychiatric Inpatient Services</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>Web form (MBHP website) for certain requests for eligible providers</td>
<td>For Continued Stay requests call CCR Dept at Ext. 455620 or the assigned Care Manager</td>
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<tr>
<td>Level IV Medically Managed Detoxification Services</td>
<td>X</td>
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<td>For Continued Stay requests call CCR Dept at Ext. 455620 or the assigned Care Manager</td>
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<tr>
<td>Acute Treatment Services for Substance Use Disorders (ATS)</td>
<td>X</td>
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<td>Web request on ProviderConnect website.</td>
<td></td>
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<tr>
<td>Enhanced Acute Treatment Services for Substance Use Disorders (E-ATS)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>Web form (MBHP website) for certain requests</td>
<td>For Continued Stay requests call CCR Dept at Ext. 455620 or the assigned Care Manager</td>
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<tr>
<td>Level of Care</td>
<td>ESP Evaluation Required</td>
<td>Telephone Pre-certification via Clinical Access Line</td>
<td>Telephone Non-Access Line</td>
<td>Authorization Exempt</td>
<td>IVR</td>
<td>Web Request</td>
<td>Comments</td>
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<td>Clinical Support Services for Substance Abuse (CSS)</td>
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<td>Web request on ProviderConnect website.</td>
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<tr>
<td>Community Based Acute Treatment for Youth (CBAT or ICBAT)</td>
<td>X</td>
<td></td>
<td>X</td>
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<td>For Continued Stay requests call CCR Dept at Ext. 455620 or the assigned Care Manager</td>
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<td>Partial Hospitalization Program (PHP)</td>
<td></td>
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<td>X</td>
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<td>For Continued Stay requests call CCR Dept at Ext. 455620 or the assigned Care Manager</td>
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<tr>
<td>Structured OP Addiction Services (SOAP)</td>
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<td>Web request on ProviderConnect website.</td>
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<td>Acupuncture Substance Abuse Treatment Services</td>
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<td>Methadone Maintenance</td>
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<td>Refer to IVR manual for details</td>
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<td>Community Support Services (CSP)</td>
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<td>Inpatient/Outpatient ECT</td>
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<td>Subject to medical record review to verify medical necessity</td>
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<td>Bridge Consult</td>
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<tr>
<td>ASAP (Assessment for Safe and Appropriate Placement)/FSSO (Firesetters, Sexual Offenders)</td>
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<td>Web request on ProviderConnect website.</td>
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<td>Crisis Stabilization (CCS)</td>
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<td>Continued stay requests via the Clinical Access Line</td>
</tr>
<tr>
<td>Level of Care</td>
<td>ESP Evaluation Required</td>
<td>Telephone Pre-certification via Clinical Access Line</td>
<td>Telephone Non-Access Line</td>
<td>Authorization Exempt</td>
<td>IVR</td>
<td>Web Request</td>
<td>Comments</td>
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<td>Outpatient Services (therapy or medication management)</td>
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<td>X</td>
<td></td>
<td>Web Form (MBHP website) for additional units/ frequency within current authorization date range</td>
<td>Refer to IVR Manual for instruction on web form vs IVR</td>
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<tr>
<td>Collateral Contact</td>
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<td>X</td>
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<td>Subject to health record review to verify medical necessity</td>
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<td>Family Consultation</td>
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<td>Case Consultation</td>
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<td>X</td>
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<td>Subject to health record review to verify medical necessity</td>
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<td>Dialectical Behavior Therapy (DBT)</td>
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<td>Psychological Testing</td>
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<td>X</td>
<td></td>
<td>Web request on Provider Connect website</td>
<td>Fax PER form. Refer to IVR manual for details.</td>
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<tr>
<td>Intensive Care Coordination (ICC)</td>
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<td>Web request on Provider Connect website</td>
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<td>Therapeutic Mentoring (TM)</td>
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<td>Fax form for additional units/ frequency within current authorization date range</td>
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<tr>
<td>In-Home Behavioral Services (IHBS)</td>
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<td>Fax form for additional units/ frequency within current authorization date range</td>
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<td>Family Support and Training (FS&amp;T)</td>
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<td>Fax form for additional units/ frequency within current authorization date range</td>
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<td>In-Home Therapy (IHT)</td>
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<td>Fax form for additional units/ frequency within current authorization date range</td>
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<td>Level of Care</td>
<td>ESP Evaluation Required</td>
<td>Telephone Pre-certification via Clinical Access Line</td>
<td>Telephone Non-Access Line</td>
<td>Authorization Exempt</td>
<td>IVR</td>
<td>Web Request</td>
<td>Comments</td>
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<td>CSPECH – Community Support Program for People Experiencing Chronic Homelessness</td>
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<tr>
<td>PACT – Program for Assertive Community Treatment</td>
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<td>Web request on Provider Connect website</td>
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<td>Psychiatric Day Treatment</td>
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<td>X</td>
<td>Web form for some requests.</td>
<td>Refer to IVR manual for details.</td>
</tr>
</tbody>
</table>

**THE INTERACTIVE VOICE REGISTRATION (IVR) SYSTEM**

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

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

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

Providers can access the IVR Manual via [www.masspartnership.com](http://www.masspartnership.com).

Please note that all contracted providers are required to register to use password-protected sections of the MBHP website via submission of the Provider Website Registration form. The form is located in the “Administrative Operations” section of this Provider Manual and also on the MBHP website at [www.masspartnership.com](http://www.masspartnership.com). The completed form can be faxed, mailed or emailed to MBHP’s Provider Relations Department. Notices and a corresponding link to the website will be sent to the e-mail address provided on the registration form(s). Once registered on the website, providers will have access to their restricted provider information, such as confidential reporting data, Alerts, and for certain levels of care and eligible providers, access to web forms for authorization requests. For additional information or instructions, please contact the MBHP Community Relations Department at 1-800-495-0086.
Outpatient Services (Therapy or Medication Visits)

For new authorizations once an authorization end date has expired, please use the IVR. For additional units beyond the max amount allowed by the IVR for a particular authorization period, use the Outpatient Treatment Screen on the MBHP website. You may locate and submit the form by going to https://www.masspartnership.com.

SOAP and CSS

For continued stay in SOAP or CSS, please use the Substance Use Extension Form on the MBHP website. You may locate and submit the form by going to https://www.masspartnership.com.

CBHI Services: IHT, IHBS, TM, and FS&T

For new authorizations once an authorization end date has expired, please use the IVR. For additional units beyond the max amount allowed by the IVR for a particular authorization period, use Additional Units Request Form. You may locate and download the form by going to https://www.masspartnership.com. Please fax this form to the number indicated on the form.

Psychological Testing

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

CBHI Service: ICC

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

Psychiatric Inpatient, ATS, and E-ATS

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

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

For continued stay for ATS or E-ATS, all ATS and E-ATS providers may use the expedited Concurrent Review Form if parameters are met. Parameters are outlined in the instructions section of the form.

All Expedited Forms may be accessed through this address: https://www.masspartnership.com/provider/m/expedited.aspx

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

**INFORMATION ON WEB REQUEST FORMS FOR AUTHORIZATION PROCEDURES FOR SOAP, CSS, OUTPATIENT SERVICES, AND DAY TREATMENT**

Electronic forms for web-based submissions are intended to simplify the authorization process, accelerate response times to your requests, and decrease time spent in telephonic review.*

**Substance Use Extension Form (All SOAP and CSS Providers)**

Initial SOAP or CSS authorizations are obtained via IVR. Web forms are for requesting continued stay at the current level of care.

To request changes to an existing authorization expiration date and/or number of treatment units, use this web-based form rather than calling an outpatient reviewer directly. Requesting providers should still be prepared to participate in telephonic clinical reviews, whenever deemed necessary by the outpatient department. You may locate and submit this form by going to [www.masspartnership.com](http://www.masspartnership.com).

This form must be submitted **no later than three business days** prior to the last covered day of the existing authorization to avoid loss of reimbursement for days not authorized.

**The Outpatient Request Form is for all contracted outpatients service providers for therapy or medication management.**

**Note Regarding Website Registration**

Please note that all contracted providers are required to complete a Provider Website Registration form. The form is located in the “Administrative Operations” section of this Provider Manual and also on the MBHP website at [www.masspartnership.com](http://www.masspartnership.com), under “Provider Log In.” The completed form can be faxed, mailed or emailed to MBHP’s Provider Relations Department. Notices and a corresponding link to the website will be sent to the e-mail address provided on the registration form(s). Once registered on the website, providers will have access to restricted provider information, such as confidential reporting data, Alerts, for certain levels of care and eligible providers, access to web forms for authorization requests.

**BEHAVIORAL HEALTH CARE ACCESS PROTOCOL FOR DYS AND MBHP**

To ensure safety, access, and quality of care for DYS youths needing Massachusetts Behavioral Health Partnership (MBHP) behavioral health services, network providers as well as DYS and MBHP staff should adhere to the following protocol.

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

A. Discharge Planning Policy for DYS and MBHP

B. DYS Release of Medical Information Statement
Communication and Collaboration

Within MBHP, two departments will provide assistance with access to behavioral health services. Those departments are the Clinical Access Line and the Regional Office. The Clinical Access Line is available 24 hours a day, providing authorizations for inpatient/ICBAT/CBAT levels of care, and assisting the ESP with bed availability. The Regional Offices assist in resolving access issues for Members, and are the lead contact for state agency personnel to consult on Member level or facility matters.

The need for timely and thorough communication and collaboration are central to the issues outlined above, which are summarized below and further addressed throughout this protocol. Managing the service access needs and quality of care for DYS youths can best be accomplished at a local or regional level. The following chain of communication should be followed throughout the processes delineated in this protocol. Please refer to Attachment A for contact lists.

- Whenever concerns arise, the DYS regional clinical coordinator (or designee) should first contact the MBHP network provider involved, and both should make every effort to resolve any issues.
- If the DYS regional clinical coordinator needs further assistance, he/she should contact the MBHP Regional Network Managers (RNMs) with any clinical issues relating to accessing behavioral health services, or quality of care once a youth is admitted to an acute service.
- If the DYS regional office needs further assistance, or for more complicated clinical or systemic access issues, the DYS Regional Director should contact the MBHP Regional Director.
- If these issues cannot be resolved at the regional level, the DYS Director of Clinical Services will contact the MBHP Assistant Vice President for Network Management and Recovery Initiatives and/or the Interagency Network Manager.

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

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

Procedures

Crisis Intervention and Management Strategies

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

**To avoid multiple admissions** to different hospitals, a primary hospital provider should be identified in the Member’s MBHP Risk Management Safety Plan. Identifying a primary hospital provider does not preclude a Member from being admitted to another appropriate hospital provider if the primary facility is not available.

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

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

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

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

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

**Interventions**

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

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

For interventions taking place in the Emergency Department (ED) of a hospital:

- DYS staff will make appropriate staffing arrangements in order to facilitate a timely intervention.
- When medically necessary, MBHP will authorize one-to-one “specialing” on a case-by-case basis with MBHP supervisory approval and according to MBHP protocols for the authorization of this service.

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

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

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

- DYS, in collaboration with the ESP, ED staff, and MBHP, will make a determination as to where and how a youth will be maintained in safety and security until a bed is located and transport arranged. All parties agree to remain actively engaged in the case until resolution is reached.
- If the DYS Regional Directors or Regional Clinical Coordinators have concerns about this process, the MBHP Regional Network Manager or Regional Director will be contacted (i.e., between 8:00 a.m. to 5:00 p.m.), or the MBHP Clinical Access Line after business hours.

Care Management

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

INTERNAL MEMBER APPEALS AND BOARD OF HEARING APPEALS

Definitions

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

1) The failure to provide MCO Covered Services in a timely manner in accordance with the accessibility standards established by MBHP;

2) The denial or limited authorization of a requested service, including the determination that a requested service is not an MCO covered service;

3) The reduction, suspension, or termination or a previous authorization by MBHP for a service;

4) The denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute
Adverse Actions, including but not limited to denials based on the following:

i. Failure to follow prior authorization procedures

ii. Failure to follow referral rules

iii. Failure to file a timely claim

5) The failure to act within the timeframes for making authorization decisions; and

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

**Appeal representative** - Any individual that MBHP can document has been authorized by the Member in writing to act on the Member’s behalf with respect to all aspects of an Internal Member Appeal or Board of Hearing (BOH) Appeal. MBHP must allow a Member to give a standing authorization to an Appeal Representative to act on his/her behalf for all Internal Member Appeals. Such standing authorization must be done in writing according to MBHP’s procedures and may be revoked by the Member at any time. When a minor is able, under law, to consent to a medical procedure, that minor can request an appeal of the denial of such treatment without parental/guardian consent and appoint an Appeal Representative without the consent of a parent/guardian.

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

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

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

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

**Internal Member Appeal** - A request by a Member or the Member’s Appeal Representative made to MBHP for review of an Adverse Action

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

**General Policies**

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

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

All notices pertaining to Adverse Actions, Internal Member Appeals, and BOH Appeals must be
made available to the Member in either English or Spanish, as appropriate. Notices must be written in a manner, format, and language that is easily understood by a Member, including written at no higher than a sixth-grade level. Notices must also be available in a format that takes into consideration the special needs of those Members who are visually limited or have limited reading proficiency.

Members or their Appeal Representatives have the right to request Internal Member Appeals either orally or in writing within 90 calendar days of the date on the Notice of Adverse Action. If a Member submits an appeal more than 90 days after the date on the Notice of Adverse Action, MBHP may dismiss the appeal.

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

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

When an Adverse Action is overturned through the Internal Member Appeal or BOH Appeal process, MBHP will authorize the appealed services as promptly as required by the Member’s condition. If the services are Continuing Services, MBHP shall pay for those services provided during the Internal Member Appeal and/or BOH Appeal.

MBHP shall not take punitive action against providers who request an Expedited Internal Member Appeal or support a Member’s Internal Member Appeal or BOH Appeal.

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

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

**Member Rights Concerning the Internal Appeal Process**

**Members have the right to:**

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

Members have the right to designate, in writing, an Appeal Representative. The notice must indicate the name of the Appeal Representative and must be signed and dated by the Member; no specific format is required. MBHP will work to resolve the Internal Member Appeal pending receipt of such notice from a Member.

Time Limits for MBHP to Resolve Internal Member Appeals

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

Standard Internal Member Appeals

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

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

Members or their Appeal Representatives may waive their right for a Level II Internal Member Appeal and appeal to the BOH.

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

1. The Member or his/her Appeal Representative requests the extension; or
2. MBHP believes that there is a need for additional information and that the extension is in the Member’s best interest and MBHP can justify the extension to EOHHS upon request. If MBHP chooses to implement an extension, it shall notify the Member in writing of the reason for the extension and inform the Member of his/her right to file a grievance should s/he disagree with that decision.

MBHP’s failure to resolve an Internal Member Appeal within these timeframes is considered an Adverse Action, and Members can immediately request an appeal with MassHealth’s BOH.

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

If the subject of the Internal Member Appeal involves the reduction, suspension, or termination of a previously authorized service and the request for the Internal Member Appeal is received by MBHP within 10 calendar days of the date on the Notice of Adverse Action, MBHP shall ensure that the Member receives Continuing Services while an Internal Member Appeal is pending unless the Member indicates s/he does not want to receive such services or the Member withdraws the Internal Member Appeal.
The Provision of Continuing Services While a BOH Appeal Is Pending

If the subject of the BOH Appeal involves the reduction, suspension, or termination of a previously authorized service, and the request for the BOH Appeal is within 10 calendar days of the date on the Internal Member Appeal notice by MBHP, MBHP shall ensure that the Member receives Continuing Services while the BOH Appeal is pending unless the Member indicates s/he does not want to receive such services or the Member withdraws the BOH Appeal.

Procedure for Filing Internal Member Appeals

A Member or his/her Appeal Representative can request an Internal Appeal by calling MBHP’s Clinical Access Line at 1-800-495-0086 (press 1 for English or 2 for Spanish, then option 4, then option 2), or by writing to the following address:

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

Procedures for Filing a Board of Hearing Appeal

A Member or his/her Appeal Representative may request a Fair Hearing before MassHealth’s BOH only after they have exhausted MBHP’s Internal Member Appeal process. For any Internal Member Appeal that is resolved not wholly in favor of the Member, MBHP will provide the Member or his/her Appeal Representative an Internal Member Appeal determination notice and a copy of this notice along with MassHealth’s “Fair Hearing Request” form.

The “Fair Hearing Request” form and the copy of MBHP’s Internal Member Appeal determination notice should be mailed to the following address:
Board of Hearings
Office of Medicaid
100 Hancock Street, 6th Floor
Quincy, MA 02171
The Member or his/her Appeal Representative may fax the “Fair Hearing Request” form and the copy of MBHP’s Internal Member Appeal determination notice to the BOH at (617) 847-1204.

The Member or his/her Appeal Representative may request that MBHP assist with facilitating this process by calling MBHP’s Member Appeals Coordinator at 1-800-495-0086 (press 1 for English or 2 for Spanish, then option 2, then Ext. 454087).

PRIMARY CARE CLINICIAN (PCC) PLAN INTEGRATED CARE MANAGEMENT PROGRAM (ICMP)

The ICMP is designed to support medical and behavioral health care providers by providing services to Members to better manage their complex conditions and improve their health. It is staffed with nurse and behavioral health care managers who are regionally based throughout the state. The ICMP is a voluntary service provided to eligible Members of all ages who have complex health conditions.
Member Eligibility and Identification

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

How it Works

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

For PCCs with one or more Members in the ICMP, the program will mail monthly correspondence listing their enrolled Member(s). Additionally after each Member completes his or her care management assessment, the program will send the Member’s summary care plan information to the PCC. A Physician Alert (fax) and or a phone call by ICMP staff will also be directed to providers for urgent or emergent situations.

Referrals and Information

To refer Members (children, youth, and adults), to request a copy of the clinical guidelines the program follows, or to learn more about this program please contact the ICMP at 1-800-495-0086 Ext. 454165 or go to www.masspartnership.com for our online referral form and additional information about the program.

Enhanced Care Coordination (ECC)

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

- Psychological Evaluation Request (PER) form
- Integrated Care Management Program Referral form
MBHP CLINICAL OPERATIONS APPENDICES

- Attachment A: Medical Necessity Criteria
- Attachment B: DYS Discharge Planning Protocols
APPENDIX B.

DYS DISCHARGE PLANNING PROTOCOLS

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

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

C. Disagreement about Readiness for Discharge
   1. At any time during the discharge process, DYS may disagree regarding the readiness for a DYS youth to be discharged.
   2. If the DYS Regional Clinical Coordinator (or designee) believes that resources to meet the youth’s needs are not available at a DYS facility, then he/she must contact the DYS Director of Clinical Services (or the DYS Assistant Commissioner for Program Services, if the DYS Director of Clinical Services is not available).
   3. The DYS Director of Clinical Services will contact the MBHP Regional Director to discuss the youth and jointly decide a plan of action. The existing protocol for Administratively Necessary Days will be utilized while a disposition plan is being addressed.

D. Aftercare Planning Including Medications
   1. An aftercare plan, as well as a written letter from the hospital psychiatrist stating that the youth has reached a level of stabilization that no longer requires ongoing hospitalization for psychiatric reasons and can be safely managed in the community or the setting for which the youth is returning, is provided to the DYS Regional Clinical Coordinator (designee) by fax or in person prior to the youth leaving the hospital.
      a. The aftercare plan includes a written record of any new or significant medication changes made during the hospitalization.
      b. The written record will outline how the provider received the guardian’s permission for medication changes (i.e., “parent/guardian gave verbal permission to Dr. Smith for dosage increase of Prozac on 1/5/12”).
         i. If the hospital is unable to reach the parent/guardian, the DYS Regional clinical coordinator should be contacted prior to discharge.
   2. The hospital is responsible for providing a prescription (not the actual medications) for at least 14 days for any and all current medications prescribed for the youth during the inpatient stay.
a. Paper prescriptions should be provided to the DYS staff who picks up the youth upon discharge or phoned into the designated pharmacy for which DYS will provide a phone # if requested prior to discharge. DYS cannot provide PRN medication to DYS youth.

b. As referenced in the MBHP Inpatient performance specifications, providers will keep abreast of state agency regulations regarding the provision of certain medications and provide appropriate documentation to DYS.

3. DYS does not have the ability to accommodate a Rogers Order if it has been obtained during the course of the hospitalization.

4. The aftercare plan must be discussed with the DYS Regional Clinical Coordinator (or his/her designee) prior to the discharge-planning meeting at the hospital.

   a. The hospital should first attempt to reach the DYS Regional Clinical Coordinator and then the DYS Regional Director.

   b. If the hospital is unable to reach the DYS Regional Clinical Coordinator or the DYS Regional Director within 24 hours of the call to discuss discharge, hospital staff should call the CIC at (617) 960-3333. CIC staff will ensure appropriate follow up from a senior manager at DYS.

E. Discharge Day

1. Hospitals should inform DYS in advance of discharge

   a. if a youth was chemically restrained on the day of discharge; or

   b. if a youth made suicidal threats on the day of discharge.

2. To avoid possible aggressive behavior or other difficulties at time of discharge, it is recommended that the hospital inform the youth of his/her discharge date once it is determined and not at the time of discharge.

F. Transportation

1. DYS plans transportation a day in advance and not on the weekends. As such, they require at least 24-hour advanced notification regarding discharges.

2. DYS requires a letter from the hospital noting that the youth has reached a level of stabilization that no longer requires ongoing hospitalization for psychiatric reasons and can be safely managed in the community or the setting for which the youth is returning. The DYS transportation staff cannot transport youth without that letter. The letter needs to include verification that the hospital obtained consent for all the medications they are discharging the youth on. The letter should be signed by the hospital psychiatrist and faxed to the DYS program from which the youth was admitted either the day before or the day of discharge.

3. Discharge instructions and prescriptions should also be given by the hospital to the driver.

4. Typically it’s the drivers who pick up the youth, not case managers or clinical or program staff. As such, communication between the hospital and clinical or program DYS staff should be done in advance by phone or in person.

G. Inpatient Provider Responsibilities

1. For all youth under age 21, the provider will ensure a smooth transition for the return to home or discharge location by

   a. linking to necessary services and making appropriate referrals, including CBHI services, if indicated;

   b. documenting all efforts related to these activities, including DYS, the Member’s, and the families/guardian/caregivers’ active participation in discharge planning;
c. reviewing and updating the Safety Plan in collaboration with the youth, family, and ICC provider if enrolled in ICC, and if indicated with the youth’s ESP/MCI provider, sending a copy to those providers with consent; and

d. if the youth is being discharged to the community, the parent/guardian should be educated regarding use of the ESP/MCI service if needed in the future, including access to their community-based services.

H. DYS Responsibilities

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

## ADMINISTRATIVE OVERVIEW

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ADMINISTRATIVE OPERATIONS OVERVIEW

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

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

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

HOW TO GET A CLAIM PAID

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

Verifying an MBHP Member’s Eligibility

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

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

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

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

Submitting a Complete and Accurate Claim Form

Claims Mailing Address:

MBHP Claims
P.O. Box 55871
Boston, MA 02205-5871
The second step in getting a claim paid is to submit a complete and accurate claim. Please refer to our Online Benefit Grid at www.masspartnership.com.

This grid explains which codes and modifiers should be used with which services, as well as whether a service requires an authorization.

Click here for information on submitting electronic claims.

**Service Facility Address Required on All Claims**

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

For Places of Service 12 (Home) and 03 (School), please use the contracted facility address where the provider of the service normally provides the service when not at a Member’s home or school.

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

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

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

**Third Party Liability (TPL) Claims**

Effective for dates of service on and after 2/1/2013, for all services for which an Explanation of Benefits (EOB) is required and a denial has been issued by the primary insurer, providers must exhaust all levels of internal and external appeals with the primary insurer before MBHP will pay claims.

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

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

To determine if a service requires an EOB or not, please refer to the MBHP Benefit Services Grid located www.masspartnership.com. Column “O” will let you know if an EOB is required.
Providers must exhaust all avenues of other insurance coverage and payment prior to billing MBHP. If a Member indicates that he or she is covered by a third party insurer and EVS indicates they are enrolled in MBHP, it is the provider's responsibility to obtain reimbursement from the third party insurer and notify MBHP of the active third party coverage by completing the Third Party Liability form located in the forms section of this Provider Manual.

Please mail this form to:

MBHP-TPL Unit
P. O. Box 55871
Boston, MA 02205-5871

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

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

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

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

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

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

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

*Retroactive Member Eligibility:*

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

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

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

**Provider name**
Enter the name of the provider that rendered the service and is seeking reimbursement.

**Provider number**
Enter the provider’s Medicaid number.

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

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

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

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

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

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

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

**Date**
Indicate the date that the form is completed.
Send the completed Timely Filing Waiver form and completed claim forms along with any supporting documentation to justify the waiver of the 90-day time limit to:

MBHP -Timely Filing Waiver Unit  
P. O. Box 55871  
Boston, MA 02205-5871

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

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

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

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

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

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

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

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

Instructions for completing the Adjustment/Reversal form are:

*Provider information*

Enter the name, number, and address of the provider to whom the payment was made.
Member information
Enter the Member’s name and number as it appears on the Summary Voucher.

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

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

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

A copy of the corrected claim form and a copy of the Summary Remittance Voucher page on which the original claim appears must be included with the Adjustment/Reversal form. It is not necessary to attach a refund check to the Adjustment/Reversal form. Any reduction or increase in payment will be applied to the weekly payment cycle following processing. The Adjustments/Reversals will appear as negative claim amounts regardless of whether a refund check is submitted. If submitted, the refund check will appear as an applied amount at the end of the Summary Remittance Voucher detailing the claims that were adjusted/reversed. The check number of the provider’s refund check will appear as the transaction reference number on an MBHP Summary Remittance Voucher.

Please mail completed forms and claims to:
MBHP
Attn. Adjustments/Reversals
P. O. Box 55871
Boston, MA 02205-5871

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

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

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

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

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

This information should be mailed to:

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

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

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

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

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THE BEHAVIORAL HEALTH QUALITY MANAGEMENT PROGRAM

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

The QM Program includes the following basic tenets:

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

The behavioral health quality management process is structured to:

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

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

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

- Data collected from monitoring mechanisms is carefully examined. These mechanisms include routine reports, health record audits, and ad hoc analyses.
- As data and experience indicate a need for quality improvement, project teams are formed.
- These teams assess the process to be improved and identify root causes of the problem.
- The team proposes solutions with stakeholder input and management review.
- From this input, the team develops a Work Plan.
• The team collects indicator data and evaluates the results of the interventions.
• Based on this evaluation, the Work Plan is revised.

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

**MBHP Quality Management Work Plan**

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

**Annual evaluation of the MBHP Quality Management Work Plan**

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

**Role of Providers in the Behavioral Health Quality Management Program**

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

• Review, evaluate, and make recommendations for credentialing and recredentialing decisions;
• Participate in the development or review of clinical practice guidelines that are distributed to providers;
• Provide peer review and feedback on proposed best practice guidelines, clinical quality indicators, and any critical issues regarding policies and procedures;
• Participate in the planning, design, implementation, and review of the QM Program;
• Review quality improvement program initiatives and activities and make recommendations for plans to improve quality of clinical care and service; and
• Review proposals to conduct clinical data evaluations and develop profile reports that identify best practices and aid in development of initiatives that will result in improved treatment and improved systems of care.

Providers interested in participating in one of our Quality Committees or who want to learn more about our QM Program should contact MBHP’s Quality Management Department at **1-800-495-0086**.
**Provider Involvement in Behavioral Health Quality Review of Network Services**

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

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

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

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

**Member Rights and Confidentiality**

Providers are expected to cooperate with MBHP in its education efforts to improve understanding about Member rights and responsibilities, both those mandated by statute and those defined by MBHP. It is the policy of MBHP to ensure that Members are treated in a manner that respects their rights and responsibilities as Members. The MBHP Member Rights and Responsibilities Statement can be copied and posted or distributed to Members at their initial visit by providers.

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

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

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

Confidential information may include but is not be limited to:

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

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

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

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

**Concerns and Grievances**

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

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

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

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

**Policy Statement on Behavioral Health Standardized Assessments**

The quality of behavioral health treatment services is enhanced when providers use standardized assessment instruments, ones that have good psychometric properties, to supplement the clinical judgments of the clinician. For both acute 24-hour services and community-based services, MBHP regards the use of clinical information gathered through a standardized assessment to be an important resource for care management, treatment, and discharge planning. Therefore, MBHP requires that all providers use a standardized assessment instrument to inform:

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

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

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

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

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

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

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

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

Definitions of Key Terms

<table>
<thead>
<tr>
<th>Behavioral Health Care</th>
<th>This term includes all treatment and support services related to mental health disorders, mental illnesses, and substance use disorders, as these disorders are referenced in the Diagnostic and Statistical Manual IV.</th>
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<tr>
<td>Standardized Assessment Instrument</td>
<td>A standardized assessment instrument is one that measures behavioral health needs, and may include life-functioning needs. The instrument can be clinician-administered or self-administered by the Member. The instrument is developed through research on the validity and reliability of the assessment items. Some instruments are broad measures of clinical and life-functioning domains, while others are narrow (e.g., an assessment of depression only). The essential feature is that the assessment items are research-validated indicators of the measurement construct.</td>
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<td>Change in Clinical Status</td>
<td>To measure a change in a Member’s clinical status, the clinician must administer a standardized instrument at some point in the treatment process (typically, upon intake) and then re-administer the same instrument at a second point-in-time (typically, prior to a review of the treatment plan). The difference in the Member’s evaluation between the first assessment and subsequent assessment is the measure of “clinical change.” Many standardized instruments characterize this change in the form of a score related to level of disability. While summary scores are useful for documenting change, clinicians are advised to review a Member’s response to individual assessment items to learn about the personal content of the change, and not just focus on change scores.</td>
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Treatment Outcome

The term “treatment outcome” is equivalent to the term “change in clinical status.” Typically, outcomes are measured by changes in scored measured of severity. As noted above, clinicians should focus not only on numeric scores, but also on the content of assessment items in which the Member has changed between evaluations.

Data-Informed Service Planning

The numeric and content information (data) gathered from a standardized assessment and reassessment must be incorporated into a Member’s service plan. That is, if the assessment instrument indicates an elevated concern about depression that was not otherwise noted by the clinician’s own assessment, the clinician should explore the question of depression with the Member during the intake or review process. Based on this review of the standardized assessment with the Member, the results of this review should be incorporated into the treatment goals and interventions included in the service plan. If a standardized assessment points to a clinical concern that is not confirmed with the Member, then the clinician must document in the Member’s medical record that a concern was identified but not substantiated through further discussion with the Member.

Behavioral Health Profile Management Services

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

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

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

MBHP’s provider profile reports include:

**Inpatient Hospital Provider Profile Reports:** MBHP has a structured inpatient quality and utilization management strategy that is implemented by Regional Network Management (RNM) staff and our Medical Affairs Department. RNMs provide inpatient mental health providers with standard, authorization-based data reports on a monthly basis, and conduct in-person site visits, often in collaboration with Medical Affairs, to review this data. The site visits occur monthly, bimonthly, or quarterly, depending on provider performance. The profile reports are based on a risk adjustment methodology and provide facility specific data and statewide comparative data. Some of the core measurements used to monitor inpatient provider performance and identify opportunities for improvement through these reports are length of stay and both 7- and 30-day readmission rates.
Outpatient Provider Practice Analysis Report: The Outpatient Provider Practice Analysis (OPPA) report is available on a dashboard which is updated quarterly. These reports present data on the Members assigned to each provider as their “primary” outpatient provider, using an algorithm MBHP developed. This practice of assigning responsibility for a Member’s care to a specific BH provider mirrors the logic used in the primary care arena and serves to promote continuity of care. This “assignment” method has been very well received by BH providers who have embraced the responsibility for coordinating care not only with other BH providers, but also with primary care and other providers. Based on the number of Members assigned to their practices, providers are divided into small (50-199), medium (200-499), and large (500+) provider groups. Practice data is benchmarked against similar-sized providers. Some of the core measurements used to monitor outpatient provider performance through these reports, and enable to manage their practices, include:

- Number and list of Members receiving diagnostic evaluations with no billed follow up
- Percentile related to utilization of various treatment modalities
- Number and list of Members who required ESP or inpatient care (i.e., “step-ups”)
- Number of Members receiving medication only
- Percent and list of youth without the required number of well-child care visits
- Number and list of Members with diabetes

Substance Abuse Provider Practice Analysis Report: Substance Abuse Provider Practice Analysis (SAPPA) reports are distributed to providers by RNMs on a semi-annual basis through on-site provider visits. Like the OPPAs, the SAPPAs include provider-level and statewide-level data, including the following addiction treatment levels of care: Acute Treatment Services (ATS), including Enhanced Acute Treatment Services (E-ATS) for adults and adolescents, and Inpatient Level IV and Structured Outpatient Addiction Program (SOAP). The core measurement used to monitor substance use disorder provider performance through these reports is data about the next billed service following discharge from the given level of care. These data indicate readmissions, step-ups and step-downs, and those with no billed services post discharge. The goal is to work with providers around engaging Members with substance use disorder conditions in continuous treatment.

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

Provider Quality Improvement (QI) Programs and Plans

Network providers are required to have internal processes, policies, procedures, programs, and/or activities aimed at monitoring and improving quality of care. Providers are expected to identify a manager responsible for the provider’s quality improvement process. Providers work collaboratively with MBHP staff in developing, implementing and monitoring quality improvement plans in response to adverse incidents, concerns and grievances, or such quality initiatives as provider profiles, health record review, etc. Providers engage Members, families, and other relevant stakeholders in their quality management activities.
Providers are expected to demonstrate a commitment to continuously improve the quality of care they provide. This can be done by participation in a variety of activities that include, but are not limited to, the following:

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

**Behavioral Health Quality Management Initiatives and Conferences**

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

**Cultural competency**

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

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

**Continuity and coordination of care**

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

- Member requires a change in level of care, necessitating the Member’s need for a new provider;
- There are multiple providers involved in treatment simultaneously (e.g., psychiatrist for medication management, therapist for on-going treatment);
- Change in health plans or benefit plans;
- Termination of an existing Beacon Health Options provider; or
- Member is being treated for several (co-morbid) conditions simultaneously with multiple providers (both behavioral health provider(s) and a PCP or medical specialist).
As an MBHP provider, you will be expected to provide coordination of care as appropriate, sharing information with a Member's other provider(s) within the context of providing quality care and the guidelines of protecting a Member's privacy. The company has mechanisms in place to monitor continuity of care and coordination with general medical care and to evaluate the use of psychopharmacological medications.

Integration of Care with Primary Care Providers

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

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

MBHP Members have the following rights and responsibilities:

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

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

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

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

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

Additionally, MBHP acknowledges its own responsibilities to comply with applicable federal and state laws including, but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; Titles II and III of the Americans with Disabilities Act; Section 542 of the Public Health Service Act; and Title 45 Part 46 of the Code of
Federal Regulations pertaining to research involving human subjects.

**Confidentiality of Member Health Care Information**

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

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

**Restraint and Seclusion**

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

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

MBHP monitors provider compliance with the requirements of these laws and regulations and works with providers in their efforts to achieve compliance. Additional information on these principles is available from MBHP’s quality coordinator for incidents at 1-800-495-0086.

All providers, as applicable, are required to submit a copy of their restraint and seclusion policy and procedure during the re-credentialing process, or as otherwise indicated by MBHP.

**Exchange of Information with Primary Care Providers**

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

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

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

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

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

Provider/Member relationship

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

Members’ Right to Access Interpreter Services

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

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

Member Grievances

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

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

Quality Coordinator
Quality Management Department
Massachusetts Behavioral Health Partnership
1000 Washington St., Suite 310
Boston, MA 02118-5002
Phone: (800) 495-0086
Fax: (877) 335-5452

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

Provider Concerns

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

Quality Coordinator
Quality Management Department
Massachusetts Behavioral Health Partnership
1000 Washington St., Suite 310
Boston, MA 02118-5002
Phone: (800) 495-0086
Fax: (877) 335-5452

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

INCIDENT REPORTING

Adverse Incident Reporting

MBHP has expanded upon the Department of Mental Health’s protocol and categories for adverse incident reporting. All 24-hour level of care providers (e.g., inpatient psychiatric units and acute treatment services for substance use disorders) must report each occurrence that represents actual or potential serious harm to the well-being of a Member or to others by the actions of a Member. Reporting requirements for providers of non-24-hour levels of care are limited to Member deaths, serious injuries requiring urgent or emergent treatment that occurred while a Member was receiving
services from the providers of MBHP Members, and any serious attempted suicides that occur during the time span that a Member is receiving services from the provider, during and outside a treatment session. Incidents must be reported to MBHP by fax at (877) 335-5452 within 24 hours of their occurrence. Examples of Reportable Adverse Incidents are provided below.

Examples of Reportable Adverse Incidents

Death: all deaths of Members, regardless of cause

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

Absence without Authorization (AWA): Please file an Incident Report for individuals who are AWA or absent beyond authorized leave who are in the following circumstances:
- Are Members who are committable or are under the age of 18;
- Have been admitted or committed to a facility pursuant to M.G.L. chapter 123, §§ 7-8, 10-11, or 12, and who are a danger to self or others;
- Are considered “dangerous persons” and have been voluntarily committed or committed under statutes involving the commitment, retention, and emergency restraint of dangerous persons; or
- Have been admitted under M.G.L. chapter 123, §§ 15, 16, 17, or 18, which includes competency to stand trial and the hospitalization of mentally ill prisoners.
*Note: AWA incidents differ from a discharge that occurs Against Medical Advice (AMA).

Sexual Assault: Any sexual assault or alleged sexual assault where the Member is either the alleged perpetrator or the alleged victim. This involves any assault that is sexual in nature, such as:
- any touching or fondling that is physically forceful;
- forced penetration;
- sexual contact between patients, whether consensual or not, when at least one of the patients is a Member; or
- sexual contact between staff and Members, whether consensual or not.

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

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

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

Absence without Authorization (Members who are not committable and are over the age of 18): any Members who do not meet the criteria in Category I and are determined through their clinical presentation to be AWA, or absent beyond authorized leave; Also, any Member who has not returned to the facility by the midnight census, unless otherwise indicated by his or her treatment plan
* Note: AWA incidents differ from a discharge that is Against Medical Advice (AMA).
Any physical assault or alleged physical assault to or by Members: physical aggression to or by Members either directed at, or exhibited by, another patient that exceeds normative clinical behavior addressed in the treatment plan. This includes hitting, kicking, and/or use of a weapon, as well as staff mistreatment of Members, and any physical aggression that produces tissue damage.

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

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

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

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

General Guidelines for Adverse Incident Reporting

All incidents must be reported to MBHP by fax (877-335-5452) within 24 hours of their occurrence.

The incident reporting form is available on the website www.masspartnership.com. It is also available in the Quality Management section of this Provider Manual under “Forms.” A PDF version is available, as well as a Microsoft Word version for providers who prefer to type the incident information into the form.

Proper Format and Submission

The incident report must be either printed legibly or typed. Reports that are illegible due to either poor handwriting or fax quality will not be accepted. Please contact the MBHP Quality Specialist for assistance with submission of adverse incidents at 1-800-495-0086 or for questions regarding the incident reporting process. **This form cannot be emailed. It must be printed and then faxed to MBHP.**

Adverse Incident Report Form Requirements

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

**Member information:** Fill in the name of the Member, his or her social security number, date of birth, age, and gender.

**Facility information:** Include the name of the facility, the unit on which the event occurred, the city or town in which the facility is located, and the level of care provided by the facility.
**Date and time of incident:** Include both the time (as well as it can be ascertained) and the date the incident was discovered by staff.

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

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

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

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

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

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

**Person reporting the incident:** Print the name of the person reporting the incident as well as his or her telephone number, and sign and date the form.

**MBHP RECORD REVIEW AND AUDIT PROGRAM**

Providers are required to ensure that all health records and clinical files are maintained in accordance with applicable state and federal law, including but not limited to those contained in: M.G.L. chapter 66A; M.G.L. chapter 123; DMA regulations 130 CMR 433.409 and 450.250; and DMH regulations 104 CMR 2.07 and 15.03(9), and related amendments.

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

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

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

In-office, retrospective health record reviews are conducted; copies of provider records sent by the provider to MBHP. MBHP will notify the provider via mail and will include a list of Member names and dates of service. The provider has 10 days to submit copies of the records to MBHP. If missing documentation of paid services is noted, the provider has one business day to submit missing documentation. Any missing documentation after one business day will be subject to recovery of payment.

Routine or ad hoc, on-site retrospective health record reviews are typically scheduled within a two-week notice to providers of such review. When the MBHP reviewer arrives at the provider’s office, the reviewer presents a list of Member names to the provider on the day of the review, and the provider selects available records from the list. If a provider maintains health records off-site from where the review is being conducted, the provider should inform the MBHP review team at the beginning of the review.

All records reviewed by MBHP must include any and all documentation submitted to the record review staff at the time of the review or not later than 5 p.m. on the date of the review via fax to MBHP. No documentation will be accepted after 5 p.m., and failure to timely submit documentation will be subject to recovery of payment.

Upon completion of an on-site health record review, the MBHP reviewer will give verbal feedback to the provider regarding the preliminary findings of the review. MBHP will send a final written report to the provider, ordinarily within 30 days. If documentation deficiencies are noted in the report, the provider will be required to submit an acceptable written plan of correction to MBHP’s Health Record Review Manager. Outpatient providers are expected to score a minimum of 76 percent across all domains, and inpatient providers are expected to score a minimum of 80 percent across all domains. MBHP may conduct follow-up reviews to verify the implementation of a quality improvement plan.

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

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

- **Standard One**: Comprehensive Assessment
- **Standard Five**: Progress Notes, Medical Necessity Criteria
- **Standard Seven**: Documentation of Paid Services

See standards below for additional information concerning recovery of payment.
Requests for reconsideration of documentation deficiency determination
The provider may submit a written request to MBHP for a reconsideration of documentation deficiency determinations within 30 days of a deficiency notification. The provider will be notified of a decision of reconsideration within 30 days. All administrative decisions made by MBHP regarding claims recovery are final.

Provider’s reconsideration requests should be sent to:

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

Online availability of standardized clinical forms
Under the leadership of the Association for Behavioral Healthcare (ABH), a set of standardized clinical forms is now available for behavioral health documentation. These forms were created with an extensive review of regulatory, accrediting body, and payer requirements over a two-year period by clinical staff representing various levels of care and by payer representatives. The use of these forms is not required by MBHP, but is available for those providers who would like access to quality clinical documentation forms. They are available free of charge at https://www.abhmass.org/msdp/forms-and-manuals/forms-and-manuals-by-program-type.html.
## PROVIDER PEFORMANCE SPECIFICATIONS:
### ASSESSMENT-INFORMED SERVICE PLANNING
#### USING STANDARDIZED INSTRUMENTS

### Section 1: Selecting the Standardized Assessment Instrument

<table>
<thead>
<tr>
<th>1.A</th>
<th>Assessment Instruments</th>
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<tbody>
<tr>
<td>MBHP recommends the following standardized assessment instruments for use in its Clinical Outcomes Measurement Protocol. Some MBHP services require certain instruments; for a description of required instruments by service, refer to Section 1.F.</td>
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<tr>
<td>- Adolescent Treatment Outcomes Module (ATOM)</td>
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<tr>
<td>- Behavioral and Symptom Identification Scale (BASIS-32)</td>
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<tr>
<td>- Behavioral and Emotional Rating Scale (BERS)</td>
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<tr>
<td>- Brief Psychiatric Rating Scale (BPRS – adult and child)</td>
<td></td>
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<tr>
<td>- Brief Symptom Inventory (BSI)</td>
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<tr>
<td>- Child-Adolescent Functional Assessment Scale (CAFAS/PECFAS)</td>
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<tr>
<td>- Child and Adolescent Needs and Strengths (CANS) – See Section 1.B</td>
<td></td>
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<tr>
<td>- Child Behavior Checklist (CBCL)</td>
<td></td>
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<tr>
<td>- Connor’s Rating Scales – Revised (CRS-R)</td>
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<tr>
<td>- Current Evaluation of Risk and Functioning – Revised (CERF-R)</td>
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<tr>
<td>- Global Appraisal of Individual Needs (GAIN)</td>
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<tr>
<td>- Methadone Treatment Quality Assurance System (MTQAS)</td>
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<tr>
<td>- Personal Experience Inventory (PEI and PEI-Adult)</td>
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<tr>
<td>- Quality of Life Inventory (QOLI)</td>
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<td>- SF8, 12, 36</td>
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<td>- SOCRATES</td>
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<td>- Symptom Checklist-90-Revised (SCL-90-R)</td>
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<tr>
<td>- Treatment Outcome Package (TOP, TOP-SA)</td>
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<tr>
<td>- Youth Outcome Questionnaire (YOQ)</td>
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</table>

This list may be supplemented from time-to-time with the addition of instruments with good psychometric properties for outcomes assessment.

### 1.B Specifications for the Use of the Child and Adolescent Needs and Strengths (CANS) tool

**For Members under the age of 21**, the CANS tool is the required instrument as part of an initial behavioral health assessment for the following services and must be updated at least every 90 days when the treatment plan is reviewed:

- Outpatient Therapy (diagnostic evaluations and individual, family, and group therapy)
- Intensive Care Coordination (ICC)
- In-Home Therapy (IHT)

The **CANS must also be completed** as part of a discharge planning process in the following 24-hour level of care services:

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

For additional information on the CANS, please refer to the following resource:
### 1.C 24-Hour Acute Services (Psychiatric or Detoxification)

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

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

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

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

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Assessment Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Therapy (diagnostic evaluations and individual, family, and group therapy)</td>
<td>CANS</td>
</tr>
<tr>
<td>Intensive Care Coordination (ICC)</td>
<td>CANS</td>
</tr>
<tr>
<td>In-Home Therapy (IHT)</td>
<td>CANS</td>
</tr>
<tr>
<td>Community-Based Acute Treatment (CBAT)</td>
<td>CANS (discharge)</td>
</tr>
<tr>
<td>Transitional Care Units (TCU)</td>
<td>CANS (discharge)</td>
</tr>
<tr>
<td>Psychiatric inpatient hospitalization</td>
<td>CANS (discharge)</td>
</tr>
<tr>
<td>Emergency Services Provider (ESP) evaluations</td>
<td>Any instrument</td>
</tr>
<tr>
<td>Community Support Program (CSP)</td>
<td>Any instrument</td>
</tr>
<tr>
<td>Acute treatment services for substance abuse (ATS, E-ATS, Level IV detox)</td>
<td>Any instrument (discharge)</td>
</tr>
<tr>
<td>Community Support Services (CSS) for Substance Use Disorders</td>
<td>Any instrument</td>
</tr>
<tr>
<td>Structured Outpatient Addiction Program (SOAP)</td>
<td>Any instrument</td>
</tr>
<tr>
<td>Psychiatric Day Treatment</td>
<td>Any instrument</td>
</tr>
<tr>
<td>Partial hospitalization</td>
<td>Any instrument</td>
</tr>
<tr>
<td>Psychopharmacology evaluations</td>
<td>Exempt</td>
</tr>
<tr>
<td>Psychological/neuropsychological testing</td>
<td>Exempt</td>
</tr>
<tr>
<td>Ongoing medication management</td>
<td>Exempt</td>
</tr>
<tr>
<td>Family consultation</td>
<td>Exempt</td>
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<tr>
<td>Case consultation</td>
<td>Exempt</td>
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<tr>
<td>Inpatient-outpatient bridge</td>
<td>Exempt</td>
</tr>
<tr>
<td>ASAP</td>
<td>Exempt</td>
</tr>
<tr>
<td>Collateral Contact</td>
<td>Exempt</td>
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<tr>
<td>Specialing</td>
<td>Exempt</td>
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<tr>
<td>IM injections</td>
<td>Exempt</td>
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**Section 2: Administering the Standardized Assessment Instrument**

**2.A Members to be Included in the Standardized Assessment Process**

All Members shall be included in the standardized assessment process, as specified in this protocol. MassHealth Members are defined as those who are eligible to receive Covered Services under the Office of Medicaid, Office for Behavioral Health, including MBHP enrollees.

To comply with the MBHP standardized assessment policy, the provider must select an
2.B **MBHP Covered Services Exempted from Standardized Assessments**

With the exception of the services listed below, all behavioral health services covered by MBHP will be evaluated through this outcomes protocol. The services (with their associated CPT codes) that are exempt from this protocol are:

**Medication Evaluation Services**
- Simple and complex medication visit (90862)
- Medication diagnostic visit (99404)
- 60-minute medication evaluation groups (90857)
- Psychiatric consultation on a medical floor (99251, 99252, 99253, 99254, 99255)

**Mental Health and Substance Abuse Outpatient Services**
- Family consultation (90887)
- Case consultation (90882)
- Inpatient-outpatient bridge (H0032)
- Collateral contact (H0046)
- Psychological testing (96101, 96111, 96116, 96118, 96119, 96120, 99402)
- IM injections (90772)

**Other Services**
- Specialing (T1004)
- Assessment for Safe and Appropriate Placement (ASAP) (H2028)

2.C **Intake/Baseline Assessments and Periodic Reassessments for Outpatient and Other Non-24-Hour Services**

The assessment process shall include the administration of the assessment instrument by the clinician, or self-administration by the Member, at the time of the Member’s intake for treatment (baseline assessment), with additional administrations (reassessments) given at least every 90 days (required for youth under the age of 21 (see below, this section) and recommended for adults). If there is a specified end to treatment or the time of discharge is known, the standardized assessment should also be administered at discharge.

In the case of a clinician administering the evaluation instrument, the clinician can bill MBHP for the evaluation session within the regular parameters of direct Member contact for that session.

The CANS is required to be updated every 90 days for services outlined in Section 1.B above.

2.D **Special Considerations Regarding Assessments**

**Clinical contraindications:** If a Member’s individual practitioner or treatment team decides that the administration of a standardized assessment instrument is not clinically indicated, or the Member refuses to complete the assessment, then the Member can be exempt from the assessment.

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1 The exemption for medical evaluation services is made on the assumption that Members for whom psychotropic medications are being prescribed by a network psychiatrist are also receiving psychotherapy or other treatment services and that such Members are receiving outcomes evaluations through these other services. Generally, MBHP recommends against Members receiving medication services only, without receiving other psychosocial treatment in addition to the medication treatment.
These instances should be exceptional and must be justified in the Member’s medical record by the clinician.

**Multiple services:** Members ages 21 and older, receiving multiple concurrent services at a single LOC, do not need to have multiple assessments. *If a Member is receiving services from multiple practitioners, it is the responsibility of the practitioners to jointly identify a lead practitioner who would be responsible for a single outcomes assessment protocol and for the communication of outcome results to subordinate clinicians.*

For example, if a Member is receiving outpatient services and day treatment services, the provider of the core ongoing psychotherapeutic service should take the lead in conducting the assessments.

If outpatient psychotherapy is provided by a clinician and medication management is provided by a psychiatrist, the psychotherapist would in most instances be the provider responsible for the outcome measurement. It would be important that the psychotherapist communicate the results of the outcome measurements to the psychiatrist.

*For Members under age 21, the CANS is an integral, requisite part of the behavioral health assessment process. When a Member is treated by more than one provider, each provider is required to perform their own behavioral health assessment, which must include the CANS.*

**Family therapy:** When an entire family is being treated through family therapy sessions, it may not be feasible to administer an assessment to every member of the family. Many times, one or more members of the family are concurrently receiving individual therapy.

In such cases, the *routine outcomes assessment completed for the Member of the family who is receiving individual therapy will suffice.* That is, the family members not seen individually do not need to be included in the outcomes assessment, unless the provider otherwise decides to assess each family member or the family as a unit.

If a family is being seen as a unit with no other services being provided to individual family members, then the administration of an assessment instrument for the family is at the discretion of the clinician.

**Group therapy:** Each Member involved in group therapy is expected to have an assessment as part of the Member’s intake assessment and revision of the Member’s treatment plan.
## Section 3: Incorporating Result of Standardized Assessments into Treatment Plans

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

### Helpful references:


### CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) TOOL

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

The CANS tool, developed by John S. Lyons, PhD, is a document that organizes clinical information collected during a behavioral health assessment in a consistent manner to improve communication among those involved in planning care for a child or adolescent. The CANS tool is also used as a decision-support tool to guide care planning and track changing strengths and needs over time. The CANS tool is used in child-serving systems in more than 30 states across the country.
There are two forms of the Massachusetts CANS tool: “CANS Birth through Four” and “CANS Five through Twenty.” In addition, the CANS tool assessment form includes a determination of whether a child meets the criteria for Serious Emotional Disturbance (SED).

CANS action checklist for network providers
Network providers need to take the following steps to meet their obligations concerning the CANS tool:

[ ] Ensure that all clinical staff members who are required to use the CANS tool are CANS-trained and certified. Information on CANS certification and training can be found on the web at https://masscans.ehs.state.ma.us/login.aspx?ReturnUrl=%2fDefault.aspx. This website includes an online training course, online certification exam, and more. For more information on training, contact the Massachusetts CANS Training Center by calling (508) 856-1016, ext. 61016, or sending an email to Mass.Cans@umassmed.edu.

[ ] Ensure that your organization is enrolled with the Virtual Gateway (VG). This enrollment is necessary to access the web-based CANS application. *Enrollment with the VG for other business applications (such as STARS, EIM/EIS, etc.) does not satisfy this requirement.* For information on how to enroll, email the VG customer service group at VirtualGatewayCBHI@state.ma.us. If technical assistance is needed with the VG, please contact the VG Customer Service group at 1-800-421-0938, ext. 5.

[ ] When a provider organization terminates employment of a CANS-certified employee, the provider organization must submit a request to the Virtual Gateway to have the staff person deactivated as soon as access to the Virtual Gateway is no longer required by the provider organization. For more information about using the CANS application on the Virtual Gateway, please refer to http://www.mass.gov/eohhs/consumer/insurance/cbhi/cans/using-the-cans-application-on-the-virtual-gateway.html. Additionally, a copy of the completed CANS must be filed in the Member’s medical record.

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

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

The CANS requirement applies to behavioral health clinicians with the following credentials
The following types of clinicians are required to pass the online CANS certification examination and use the CANS tool:

- Psychologists
- LICSWs
- LMHCs
• LMFTs
• LCSWs
• Unlicensed, master’s-level clinicians working under the supervision of a licensed clinician
• Master’s-level clinical interns in psychology and social work working under the supervision of a licensed clinician
• Bachelor’s-level Intensive Care Coordinators

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

Non-24-hour level of care services that require use of the CANS tool
The use of the CANS tool is required to be completed and entered into the Virtual Gateway as part of an initial behavioral health assessment for the following service for Members under the age of 21 and must be updated and entered into the Virtual Gateway at least every 90 days thereafter

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

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

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

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

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

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

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

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

The CANS tool is not required in the following circumstances:

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

**CANS in other EOHHS Agencies**

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

**CANS as an Outcome Instrument in Relation to MBHP’s Policy Statement on Behavioral Health Standardized Assessments**

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

Inpatient providers can use the CANS tool as part of the discharge planning process in lieu of the Brief Psychiatric Rating Scale (BPRS). A provider still has the option of using additional standardized assessment instruments for its own clinical or quality improvement purposes.
Billing for CANS
Billing is permitted, and reimbursement will be provided for 90791-HA when the CANS tool is used as part of the initial outpatient comprehensive assessment for eligible Members under the age of 21. Outpatient individual, family, and group therapists are required to complete the CANS and enter it into the Virtual Gateway as part of the initial comprehensive assessment and every 90 days thereafter. If the Member leaves treatment and subsequently returns to the provider for a new course of treatment, the provider must perform a new initial assessment inclusive of the CANS tool, enter it into the Virtual Gateway, and may bill a 90791-HA. Outpatient billing and reimbursement are not permitted for use of the CANS tool during the 90-day updates. Currently, MBHP does not allow doctoral student/master’s-level clinical interns to bill for 90791 or 90791-HA. Doctoral student/master’s-level clinical interns can however bill for ongoing therapy when the CANS is updated as part of the treatment plan every 90 days thereafter.

Billing is permitted, and reimbursement will be provided for T1017-HO and T1017-HN when the initial CANS tool and reassessment CANS tool is completed by master’s- and bachelor’s-level providers of Intensive Care Coordination (ICC).

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

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

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

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

MBHP Clinical Practice Guidelines
*New Guideline for 2017
Psychiatric Evaluation of Adults
MBHP has adopted the American Psychiatric Association (APA) guideline titled Practice Guidelines for the Psychiatric Evaluation of Adults. For more information and to access this guideline, please visit: http://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760
Continuing Guidelines

Opioid-Related Disorders
MBHP has adopted the Substance Abuse and Mental Health Services Administration (SAMHSA) guideline titled Treatment Improvement Protocol (TIP) 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. For more information and to access this guideline, please visit: http://www.ncbi.nlm.nih.gov/books/NBK64164/pdf/TOC.pdf.

Assessment and Treatment of Children and Adolescents with Depressive Disorders MBHP has adopted the American Academy of Child and Adolescent Psychiatry guideline titled Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders. For more information and to access this guideline, please visit: http://www.jaacap.com/article/S0890-8567(09)62053-0/pdf.

MBHP asks providers to consider including these guidelines with their scientifically based reference materials for clinical staff. MBHP also asks providers and their clinicians to consider these guidelines whenever they think the guidelines may promote positive outcomes for clients.

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

BEHAVIORAL HEALTH SCREENING

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

As part of our preventive health programming, MBHP offers services such as:

- **Educational Materials** on relevant behavioral health topics such as depression, consumer information guides, and articles in our Member newsletter;
- **Specialized Care Management Services** targeted to the specific needs of Members with mental illness and substance use disorders, including Targeted Outreach, Care Coordination, and Intensive Clinical Management (ICM); and
- **The Children’s Behavioral Health Initiative (CBHI)**, which is helping make it easier for families to find and access appropriate services and to ensure that families feel welcome, respected, and receive services that meet their needs.

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

MBHP has developed and supports two new screening programs:
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications

MBHP aims to improve integration and support its Members with comorbidities by promoting the importance of screening.

- Screenings allow timely diagnosis and treatment of diabetes for Members identified as susceptible to metabolic syndrome.
- Proper pharmacy, nutritional counseling, and integrated care can improve health outcomes.
- Promoting Universal Screening for Substance Misuse by Outpatient Mental Health Providers- MBHP will create recommended screening protocols that can be disseminated across the provider network.
- Training sessions focusing on strategies for integrating universal screening into intake and assessment procedures and utilizing the screening process to engage Members in conversation regarding substance use may be conducted at regional or statewide level of care meetings, depending on the identified needs of the provider network.

Screening for Risky Alcohol Use in Adults Presenting for Outpatient Treatment of Depression

MBHP is initiating a screening program to identify risky alcohol use in adults presenting for outpatient treatment of depression, to improve clinical hand-offs and follow-up visits at different levels of care or with different providers. This may result in the under-reporting of AOD diagnoses when that diagnosis is not carried over when working with a Member with a primary mental health diagnosis. As a result, there is a risk that the Member’s problematic alcohol use may not be identified or effectively treated.

Unhealthy alcohol use is among the most common causes of preventable morbidity and mortality in the United States and can complicate treatment for other chronic conditions, including mental health disorders such as depression:

- Nearly one-third of people with major depression also have an alcohol problem.
- Binge drinking can lead to symptoms of depression and can exacerbate existing depressive symptoms.
- Many symptoms of intoxication and withdrawal from alcohol resemble the symptoms of depression.
- Heavy alcohol use can make treatment with antidepressant medication less effective.

Universal screening for risky alcohol use among adults seeking outpatient treatment for depression is key to effective differential diagnoses and ensuring that treatment interventions are effective. Screening provides an opportunity to initiate a discussion with Members regarding their alcohol use and to provide intervention as needed that focuses on education and increasing motivation to reduce risky behavior. All provider organizations contracted with MBHP for adult outpatient mental health services are strongly encouraged to screen all MBHP-managed Members age 18 and older with depression as a presenting complaint or diagnosis for risky alcohol use at intake, and at least annually thereafter, using a validated screening tool and standardized screening procedures. MBHP is recommending that providers who are not currently using a validated screening tool use the AUDIT-C as a “pre-screening” instrument to identify alcohol use patterns for all adult Members with depression as a presenting complaint or diagnosis. When a “pre-screen” is positive, MBHP is recommending that the provider complete the full AUDIT with the
Member to determine if a brief intervention or a referral to specialty treatment is indicated. Both the AUDIT-C and the AUDIT can be completed by the Member as a self-administered questionnaire or completed as part of the clinical interview. The results of the screening and any subsequent conversations should be documented in the Member record, and any alcohol related diagnosis should be included on submitted claims.

**Using the CRAFFT Screening Tool with Adolescents Who are at Risk for Substance Use Disorders**

Adolescents are at significant risk for developing alcohol and other substance use disorders. Research has shown that screening is an important component in identifying and treating substance use disorders for this age group. The CRAFFT is the most frequently used substance use disorder screening tool in Massachusetts for teens. The CRAFFT is a mnemonic acronym made up of the first letters of key words used in the six screening questions, and it is used to screen for high-risk alcohol and other drug use disorders simultaneously. Currently, CRAFFT is one of the MassHealth-approved behavioral health screening tools mandated for use by primary care clinicians. MBHP has developed a preventive health initiative that focuses on expanding the use of the CRAFFT to a behavioral health venue. MBHP recommends that Members who are between the ages of 14-21 and have CBHI or outpatient services be screened for alcohol and other drug use using the CRAFFT Screening Tool. The results of the screening tool may be used by these providers to facilitate a referral to appropriate treatment.

**Relapse Prevention for Members with Substance Use Disorders**

It is widely recognized that Members who are discharged from inpatient detoxification services (e.g., Acute Treatment Services (ATS)) are at high risk for relapse. MBHP is committed to helping these Members get linked with aftercare services that will help them maintain their sobriety and prevent relapse. MBHP has implemented a quality improvement program that connects Members being discharged from ATS with a Community Support Provider (CSP) who is available to help them successfully transition back to the community. CSPs can provide transportation to aftercare appointments, facilitate attendance at 12-step meetings, and connect Members to other community-based resources. MBHP has developed a preventive health brochure that educates Members about the signs and symptoms that can lead to a relapse and encourages Members to seek support if they believe that their sobriety is in jeopardy. ATS programs will provide this brochure to all Members at the time of discharge and CSPs will refer to the brochure during their work with Members.
MBHP QUALITY MANAGEMENT FORMS

- Adverse Incident Reporting Form
- Behavioral Health Provider/Primary Care Clinician Two-Way Communication Form
MBHP QUALITY MANAGEMENT APPENDICES

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

104 CMR 27.00: LICENSING AND OPERATIONAL STANDARDS FOR MENTAL HEALTH FACILITIES

Section

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27.01: Legal Authority to Issue

104 CMR 27.00 is promulgated under the authority of M.G.L. c. 19, §§ 1, 7, 8, 18 and 19 and M.G.L. c. 123.

27.2: Scope

Unless the contrary is specified in a particular section, the provisions of 104 CMR 27.00 apply to all facilities that are licensed, contracted for, or operated by the Department.

SUBPART A: LICENSING
27.3: Licensing; Generally

(1) All private, county or municipal mental health facilities are subject to licensing by the Department pursuant to M.G.L. c. 19, § 19.

(2) Types of Licenses. Licensed mental health facilities shall be issued a single license which may incorporate one or more of the following classes:
   (a) Class II License to provide diagnosis and treatment of adults on voluntary admission status under M.G.L. c. 123, § 10.
   (b) Class III License to provide diagnosis and treatment of adults on conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntary committed status under M.G.L. c. 123, §§ 7 and 8, and to use restraint and seclusion.
   (c) Class IV License to provide diagnosis and treatment of adults on involuntary committed status under M.G.L. c. 123, § 12, and to use restraint and seclusion.
   (d) Class V License to provide evaluation, diagnosis and treatment of patients committed by order of a criminal court to determine competency to stand trial or criminal responsibility or for treatment under M.G.L. c. 123, §§ 15, 16, 17 and 18, and to use restraint and seclusion.
   (e) Class VI License to provide diagnosis and treatment of minors on voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntary committed status under M.G.L. c. 123, §§ 7, 8 and 12, and to use restraint and seclusion.
27.03: continued

(f) **Limited Class VI.** License to provide diagnosis and treatment of minors age 16 and 17 on adult units on voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§ 7, 8 and 12, and to use restraint and seclusion.

(g) **Class VII.** License to provide diagnosis and treatment of adolescents in an Intensive Residential Treatment Program (IRTP) on conditional voluntary or conditional voluntary admission status under M.G.L. c. 123, §§ 10 and 11, and on involuntarily committed status under M.G.L. c. 123, §§ 7 and 8, and to use restraint and seclusion.

(h) **Class VIII.** License to administer electroconvulsive treatment.

(3) Every licensed facility shall maintain complete records for each patient in accordance with the provisions of M.G.L. 23, § 36 and 104 CMR 27.17.

(4) **Duration of License.** Licenses issued under 104 CMR 27.03 shall be valid for a term of two years and may be renewed for like terms, subject to limitation, suspension or revocation for cause. Licenses are not transferable from one licensee to another individual or agency or from one location to another.

(5) **Requirements for License or Renewal.**

(a) Every applicant for a license or for a subsequent renewal of such license shall use the forms prescribed by the Department and shall submit the fee established by the Department. A schedule of licensing fees may be obtained from the Department.

(b) A hospital, clinic or nursing home licensed by the Department of Public Health under M.G.L. c. 111 which admits mentally ill persons only on voluntary admission status pursuant to 104 CMR 27.06, need not be licensed by the Department of Mental Health as Class II. All other hospitals licensed by the Department of Public Health which admit mentally ill persons on any admission status other than, or in addition to, voluntary status shall also be licensed by the Department of Mental Health.

(c) Every facility seeking a license or a renewal of such license shall meet all applicable fire, health, building and safety codes, and shall make available upon request copies of all required licenses, permits, certificates of inspection and/or occupancy necessary for the operation of the facility in the location where it is situated.

(d) Every facility seeking a license or a renewal of such license shall demonstrate compliance with the standards of the American Institute of Architecture, or other nationally recognized standards, for facilities of the type licensed.

(e) Every facility seeking a license shall submit a statement of ownership, a plan showing the extent of the property, location and plans of existing buildings, and any plans and specifications of buildings to be erected. Notice shall be given to the Department by the applicant or licensee of any changes in these matters.

(f) Every facility seeking a license shall submit written plans describing:

1. its plan for delivery and supervision of clinical services. All clinical services, as well as the supervision of such services, shall be performed by personnel qualified by license or experience in the field in which they are performing.

2. its plan for assuring adequate and appropriate staffing to meet the needs of the patient population at all times.

3. its program of orientation and continuing in-service education for all personnel, both professional and non-professional, who provide care and treatment to patients.

(6) **Staffing.**

(a) The director of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, shall hold an advanced degree from an accredited college or university in a discipline appropriate to the care and treatment of the mentally ill. If the director of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof is not a fully licensed physician, there shall be a director of psychiatric or medical services for such facility who is a physician fully licensed to practice medicine under Massachusetts law, and who is certified or eligible to be certified by the American Board of Psychiatry and Neurology in psychiatry; provided that in the discretion of the Department, experience and expertise may be considered in lieu of Board certification or eligibility.
27.03: continued

(b) Facilities licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, shall have a physician, under full or limited licensure as defined by Massachusetts law, on the premises at all times.

c) The director or chief of nursing of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, shall hold an advanced degree in psychiatric nursing and be licensed to practice professional nursing. If such director or chief of nursing does not hold such a degree, the facility shall provide for a person with such a degree and license to oversee in-service training for its nursing personnel.

d) The director or chief of nursing of a facility licensed as Class II, III, IV, V, VI, Limited VI, VIII or any combination thereof, shall hold an advanced degree in psychiatric nursing and be licensed to practice professional nursing. If such director or chief of nursing does not hold such a degree, the facility shall provide for a person with such a degree and license to oversee in-service training for its nursing personnel.

e) The nursing personnel of every facility subject to licensure shall be adequately prepared by education, training and experience to provide care and treatment for patients with mental illness. The facility shall maintain such nursing force at levels deemed adequate by the Department

(7) Additional Requirements for Class VI, Limited VI, and VII Facilities. In addition to complying with all applicable standards in this title, a facility licensed as Class VI, Limited VI, or VII shall comply with the following requirements:

(a) In its application for a license, or for renewal of a license, the facility shall include a detailed description of its physical facilities as well as its plan for providing age appropriate programming and services. This plan and description shall be subject to approval by the Commissioner or designee. The plan shall include but not be limited to psychiatric, medical, nursing, social work and psychological services, family-focused treatment, occupational therapy, physical therapy if any, educational programs, recreational activities and equipment, and outdoor facilities.

(b) A child and adolescent psychiatrist certified or eligible to be certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology or the American Board of Adolescent Psychiatry shall provide on-site supervision of the care and treatment of patients in Class VI and VII facilities and shall be available for consultation and case supervision as needed for patients in Limited Class VI facilities.

(c) The facility shall have on its staff, or as consultants, a pediatrician and a pediatric neurologist, both of whom shall be fully licensed to practice medicine under Massachusetts law.

(d) If the facility employs behavioral management, it must meet the requirements of 104 CMR 27.10(7)

(8) Additional requirements for Class VIII Facilities. In addition to complying with all applicable standards in this title, a facility licensed as Class VIII shall comply with the following requirements:

(a) The facility shall establish a written plan for the administration of electroconvulsive treatment in compliance with the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and with current practice guidelines established by the American Psychiatric Association.

(b) Monthly Reports. All facilities administering electroconvulsive treatment (ECT) to inpatients or outpatients shall maintain aggregate data, which shall be available to the Department for inspection upon request.

(9) Additional Requirements for Class III through VII Facilities. In addition to complying with all applicable standards in this title, a facility to be licensed as Class III through VII shall include the following in its application for a license or renewal of a license:

(a) the facility's plan to reduce and, wherever possible, eliminate restraint and seclusion as required by 104 CMR 27.12(1);

(b) a comprehensive statement of the facility's policies and procedures for the utilization and monitoring of restraint and seclusion, including a listing of all types of mechanical restraints used by the facility, a statistical analysis of the facility's actual use of such restraint and
seclusion, and a certification by the facility of its ability and intent to comply with all applicable statutes and regulations, including 104 CMR 27.12, regarding physical space, staff training, staff authorization, record keeping, monitoring and other requirements for the use of restraint and seclusion.

(10) Accreditation.
(a) A facility seeking a license as Class II, III, IV, V, VI, Limited VI, VIII, or any combination thereof, or a renewal of such license, shall be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other nationally recognized accreditation agency approved by the Commissioner utilizing the applicable standards as promulgated by said Joint Commission or agency. Facilities that have not yet attained accreditation shall be in substantial compliance with those standards, and must submit a plan for obtaining accreditation within a reasonable period of time.
(b) A facility seeking a license as Class VII, or a renewal of such license shall be accredited as a residential treatment program by JCAHO or other nationally recognized accreditation agency approved by the Commissioner. Facilities that have not yet attained accreditation must be in substantial compliance with the standards for residential treatment programs set forth by said Joint Commission or agency, and must submit a plan for obtaining accreditation within a reasonable period of time.

(11) Deemed Status. In addition to the Departmental action on license applications as set forth below, and any additional requirements for Class VII facilities set forth in 104 CMR 27.04, the Department may approve licensure of accredited facilities in accordance with the following requirements for deemed status.
(a) A facility requesting deemed status shall provide to the Department a copy of the facility’s current accreditation letter and the accrediting agency’s explanation of its survey findings.
(b) A facility requesting deemed status shall submit for Department review and approval written plans for compliance with Department regulations governing restraint and seclusion, human rights, and investigation of complaints.
(c) A facility which has been granted deemed status shall notify the Department of the time and place of the summation conferences scheduled at the completion of an accreditation, and shall permit Department observers to attend such conferences.
(d) The Department may at any time require a facility which has been granted deemed status to demonstrate its compliance with applicable law, accreditation standards, Department regulations, or implementation of any recommendations for corrections or deficiencies, by submitting such documentation or reports or permitting such inspection as may be requested by the Department. The Department may require a validation survey of an accredited facility to verify such compliance.
(e) A facility which has been granted deemed status shall immediately notify the Department of any change in its accreditation status.
(f) The Commissioner or designee may revoke the deemed status of an accredited facility if:
1. The facility loses its accreditation;
2. The facility fails to cooperate with the Department’s validation survey or requests for documentation or reports;
3. The facility fails to cooperate with a Department investigation in accordance with 104 CMR 32.00;
4. The facility is out of compliance with applicable accreditation standards and a significant deficiency is determined to exist;
5. The facility is out of conformity with its plans for compliance with Department regulations on restraint and seclusion, human rights, and investigation of complaints.
6. The facility is out of compliance with other applicable Department regulations.
(g) A facility whose deemed status has been revoked may be subject to a licensing review or full survey pursuant to 104 CMR 27.00.
(h) A facility may request an informal administrative review of a decision to deny or revoke deemed status. The facility must request an informal administrative review in writing within 15 days of the date it receives notice of the denial or revocation of its deemed status by the Commissioner or designee. The request shall state the reasons why the facility considers the
denial or revocation of deemed status incorrect. The written request shall be accompanied by any supporting evidence or arguments.

(i) The Commissioner or designee shall notify the facility, in writing, of the results of the informal administrative review within 20 days of receipt of the request for review. Failure of the Commissioner or designee to respond within that time shall be considered confirmation of the denial or revocation of deemed status.

(12) If a facility is not yet accredited by JCAHO or if an accredited facility chooses not to apply for deemed status, it shall be subject to a full survey for licensure by the Department.

(13) Provisional License. A provisional license shall be used for facilities not currently in operation or for which compliance cannot fully be determined without an evaluation of the facility in operation. After the granting of a provisional license or the initial provision of services by the facility, the Department shall conduct a timely evaluation of the facility to determine what action regarding licensure should be taken.

(14) Departmental Action on License Application. Upon receipt and review of all required documentation, and after any site visit, the Department may take one of the following actions:

(a) Approve the facility for licensure, if no deficiencies are outstanding;
(b) Approve the facility for licensure, subject to demonstrated progress by the program applicant in implementing a plan of correction approved by Department;
(c) Disapprove the facility for licensure until such time as deficiencies are corrected.
(d) Approve the facility for a provisional license subject to such conditions as the Department deems necessary.

(15) Departmental Inspection.

(a) Notwithstanding a facility’s deemed status, the Department may conduct random, periodic surveys or inspections of any facility licensed hereunder to determine compliance with accreditation standards or the provisions of 104 CMR. Such random survey need not pertain to any actual or suspected deficiency in compliance with accreditation standards or 104 CMR 27.00. Refusal to permit inspection shall be sufficient cause for revocation of a facility’s license.
(b) Without limiting the generality of the foregoing, the Department shall conduct annual inspections of facilities granted deemed status to determine their compliance with Department regulations governing restraint and seclusion, human rights, investigation of complaints, and interpreter services.
(c) Licensed facilities shall immediately notify the Department of any substantial change in its physical plant, staffing or services, and shall submit documentation of such changes as may be requested by the Department.
(d) The scope of the Department's inspections shall include any aspect of the operation of the facility, and may include, but is not limited to, confidential interviews with patients and staff, and examination and review of all records, including those of current and discharged patients.
(e) The Department shall provide a copy of the inspection report to the facility director.

(16) Revocation or Limitation of License. Failure to comply with the requirements for licensure as set forth in 104 CMR 27.00 may constitute sufficient cause for the Department to refuse to grant, suspend, revoke, limit or restrict the applicability of, or refuse to renew one or more classes of licenses pursuant to the procedural requirements and provisions of M.G.L. c. 30A. The Department, under the authority of M.G.L. c. 19, § 19, may take reasonable action, including, but not limited to, temporarily suspending a license prior to a hearing in cases of emergency if it deems that such action would be in the public interest; provided, however, that upon request of an aggrieved party, a hearing pursuant to M.G.L. c. 30A, § 13 shall be held after such action is taken.

(17) In restricting or limiting the applicability of one or more classes of licenses, the Department may issue deficiency orders, reprimands or other appropriate orders to obtain compliance with 104 CMR 27.00; provided that such actions may be subject to the procedural requirements and provisions of M.G.L. c. 30A.
27.3 : continued

(18) **Waiver.**
   (a) The requirements of 104 CMR 27.03 through 27.17 shall be strictly enforced, and shall not be subject to waiver, except as specifically authorized by the Commissioner or designee in accordance with the provisions of 104 CMR 27.03(18).
   (b) No waiver may be granted by the Commissioner or designee without a determination by the Commissioner or designee that:
       1. The health, safety, or welfare of neither patients nor staff may be adversely affected by granting the waiver; and that
       2. In justification of the waiver, a substitute provision or alternative standard has been stated and is found by the Department to result in comparable services to the patients, and to which the facility will be held accountable to the same degree and manner as any provision of 104 CMR 27.00.
   (c) Waivers may be granted for the duration of a facility’s license, or for such other period of time as the Department may determine, and may be renewable.
   (d) The granting of a waiver for any single facility or period of time shall not require or signify the granting of a waiver for any other facility or period of time.

27.4 : Licensing: Intensive Residential Treatment Programs

(1) **Adolescent Intensive Residential Treatment Program.** An adolescent intensive residential treatment program (IRTP) is a residential mental health program which provides comprehensive treatment and education in a secure setting to mentally ill adolescents and which has the capacity to admit such adolescents on an involuntary basis pursuant to the provisions of M.G.L. c. 123 §§ 3, 7, 8, 10 and 11. IRTPs are not authorized to administer electroconvulsive treatment.

(2) **Eligibility.** Only individuals who meet the following criteria may be eligible for admission to an IRTP:
   (a) The individual shall be from 13 through 18 years of age. An individual already admitted to an IRTP who becomes 19 years of age may remain there to complete his or her course of treatment; and
   (b) The individual has been determined to require long-term (i.e., typically, at least three months or longer) treatment in a secure residential setting; and
   (c) Treatment in a less restrictive setting has been determined to be inappropriate for the individual; and
   (d) Failure to place the individual in a secure treatment setting would create a likelihood of serious harm by reason of mental illness.

(3) **Admission.** Individuals who meet the IRTP eligibility criteria may be admitted to and retained in an IRTP only in accordance with the provisions of M.G.L. c. 123, §§ 3, 10 & 11 or 7 and 8, and the regulations promulgated thereunder. For IRTPs operated by or under contract with the Department, individuals may only be admitted upon approval of the Department. Referrals for admission shall be made through an admissions process, as designated by the Department, and shall contain such clinical information and documentation as the Department may require.

(4) **Location.** If an IRTP is located on the grounds of a state hospital or in the same building as an adult inpatient mental health unit or an adolescent continuing care inpatient unit, it shall have program, kitchen and eating facilities separate from those of the state hospital or inpatient unit.

(5) **Staffing.** Each IRTP shall be staffed at a level sufficient to meet the clinical needs of the patients, as well as the administrative and ancillary services necessary to the operation of the program, consistent with the requirements of JCAHO or other accreditation agency approved by the Commissioner. Among the clinical staff shall be persons qualified to provide services in appropriate disciplines, including, but not limited to: psychiatric and psychological intervention; individual, group and family therapy; milieu management; medication administration; discharge planning; education; vocational training; and recreation.
   (a) Each IRTP shall have sufficient full-time senior management to provide adequate oversight of program, clinical and psychiatric operations. Senior managers with responsibility for clinical matters shall be mental health professionals, licensed as
management shall be a licensed mental health professional who is, by training or experience, a specialist in the treatment of adolescents.

(b) Each IRTP shall have a psychiatrist, board certified (or eligible) in child and adolescent psychiatry, available for consultation and shall have a psychiatrist on site or on call, 24 hours a day, for psychiatric emergencies, including but not limited to seclusion and restraint.

(c) Each IRTP shall have sufficient qualified nursing staff for the administration of regularly prescribed medications, as well as for administration of PRN and emergency medication and conducting examinations pursuant to 104 CMR 27.12.

(d) Each IRTP shall have a sufficient number of independently licensed mental health professionals such that the primary individual and family therapist for each patient shall be so licensed.

(e) Provision shall be made to ensure that sufficient back-up personnel are available to respond within a reasonable time in emergency situations.

(6) General Physical Requirements.

(a) Each program shall provide space that is safe, comfortable, well-lighted, well-ventilated, adequate in size and of sufficient quality to be utilized in a manner consistent with the overall philosophy and treatment goals of the program.

(b) Each program shall provide sufficient security features to enable the staff to prevent physical harm to patients and to staff and to prevent escape from the program, including the capacity to lock the program to prevent unauthorized access to the community.

SUBPART B: OPERATIONAL STANDARDS FOR MENTAL HEALTH FACILITIES

27.5 General Admission Procedures

(1) For the purpose of involuntary commitment, mental illness is defined as a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but shall not include alcoholism or substance abuse which is defined in M.G.L. c. 123, § 35.

(2) For the purposes of voluntary or conditional voluntary admission to mental health facilities in the Commonwealth, any degree of severity of a mental disorder including alcoholism may qualify a person for admission to a mental health facility at the discretion of the facility director or designee when it is determined that such admission is necessary and appropriate.

(3) Admission Examination. Upon admission, each person shall receive a mental status examination and, within 24 hours of admission, a complete psychiatric and physical examination. In the case of admissions to an IRTP, such physical examination shall occur within seven calendar days of admission. As part of the admission examination, staff shall seek to determine from the patient, the patient's record, the patient's legally authorized representative or, if appropriate and authorized, from other sources, whether the patient has a history of trauma, including but not limited to physical or sexual abuse or witnessing violence. At the completion of each admission examination, the physician shall make an admission diagnosis, and shall enter the findings of such admission examination in the patient's medical record.

(4) Admission Examination for Persons under the Age of 22.

(a) In addition to the requirements above, the admission examination for persons under the age of 22 shall include a determination as to whether the individual has special educational needs.

(b) If the individual has special educational needs, the facility director shall seek written authorization to provide necessary clinical information to the patient's Local Education Authority (LEA) in order that an educational program can be jointly developed for such patient by the LEA and the facility.

(5) Notice to Family or Others.

(a) Admission of Individuals Age 16 or Over. Within 48 hours after admission of any patient, including a patient age 16 or 17 who has applied for admission himself or herself, the
director of the facility, or designee, shall notify the patient’s legally authorized representative

27.05: continued

and, unless requested not to do so, the nearest relative regarding the admission of such patient to the facility. In the alternative, a competent patient over the age of 18 may designate any two persons to receive such notification. Notice may be given by telephone, telegram, letter or other appropriate means.

(b) Admission of all other minors. Except in an emergency, or pursuant to court order, no minor, except a 16 or 17 year old who has applied for admission himself or herself, shall be admitted to a facility without notice to and consent of the minor’s legally authorized representative. In an emergency or pursuant to a court order (including application for admission pursuant to M.G.L. c. 123, § 12 with or without the consent of the legally authorized representative), the legally authorized representative shall be notified forthwith upon receipt of the minor at the facility.

(6) Denial of Admission. Applicants for voluntary or conditional voluntary admission to mental health facilities shall not be denied admission without an explanation of the basis for such refusal, and alternatives shall be offered or recommended by the admitting physician where feasible.

(7) Prohibition of Admission of Individuals under the Age of 19 to Adult Inpatient Units; Exceptions. Except as provided in 104 CMR 27.05(7), no individual under the age of 19 years shall be admitted to an adult unit of a Department facility.

(a) The Department may place an individual age 17 or 18 on such an adult inpatient unit where a judge of a court of competent jurisdiction has issued an order for the commitment of the individual to a mental health facility pursuant to the provisions of M.G.L. c. 123, §§ 15, 16, 17, or 18, or where the individual has been committed to the Department of Youth Services, and the Commissioner or designee has determined that one or both of the following factors exist:
   1. placement of the individual on an adolescent inpatient unit would create a likelihood of serious harm to the individual or others; or
   2. the individual is in need of stricter security than is available on an adolescent inpatient unit.

(b) The factors to be considered in the above determinations include, but are not limited to the following:
   1. the nature, circumstances and seriousness of the offense with which the individual has been charged;
   2. the individual’s court and delinquency record;
   3. the individual’s maturity;
   4. the individual’s history of mental illness;
   5. the individual’s social history;
   6. the risk of harm presented by the individual’s placement on an adolescent inpatient unit;
   7. the individual’s history of victimizing others;
   8. the mental health treatment most suitable for the individual

(c) The statewide specialty Deaf Unit at Westborough State Hospital and the Commonwealth Research and Evaluation Unit at Erich Lindemann Mental Health Center may admit individuals under the age of 19 provided that the Units ensure appropriate separate physical space and programmatic services for them, as approved by the Commissioner.

(8) Computation of Time. Unless otherwise specified, all computation of days within 104 CMR 27.00 SUBPART B shall be in accordance with the following:

(a) when the time period is less than 7 calendar days, Saturdays, Sundays, and legal holidays are not counted;
(b) when the time period is 7 calendar days or longer, the time is counted in calendar days, except when the last day is a Saturday, Sunday, or legal holiday, in which case the final day counted is the next business day;
(c) the day on which action or event is initiated is not counted.
27.6: Voluntary and Conditional Voluntary Admission

(1) Eligibility for Voluntary or Conditional Voluntary Admission.
   (a) A person may be admitted on a voluntary or conditional voluntary admission status to a
       facility upon written application, provided that in the opinion of the facility director, or
       designee, such person is in need of care and treatment and that the admitting facility is suitable
       for such care and treatment.
   (b) In order to be admitted on voluntary or conditional voluntary admission status, a person
       must be competent to apply for such admission, and desirous of receiving treatment.
   (c) A person’s application for voluntary or conditional voluntary status shall only be accepted
       upon a determination by the admitting or treating physician that the person has attained the age
       of 16 and is competent to apply for such status, or, if application is made on behalf of the person
       by a guardian, that the guardian has specific authority to do so. An application made on behalf
       of a minor by the minor’s parent or guardian may be accepted upon a determination by the
       admitting or treating physician that the person making such application is in fact the minor’s
       legally authorized representative.
   (d) For purposes of 104 CMR 27.06, competent means:
       1. that a patient admitted on a voluntary status understands that he or she is in a facility
          for treatment and that he or she may leave the facility at any time.
       2. that a patient admitted on a conditional voluntary status understands that he or she
          is in a facility for treatment, understands the three-day notice provisions, and
          understands the facility director’s right to file a petition for commitment and thereby
          retain him or her at the facility.

(2) Prior to admission such person shall be afforded the opportunity for consultation with an
      attorney, or with a person who is working under the supervision of an attorney, concerning the
      legal effect of the admission.

(3) Upon admission the patient and his or her legally authorized representative shall receive
      information concerning the legal and human rights which he or she retains after admission to the
      facility.

(4) Voluntary admission status shall be totally voluntary, and may be terminated by the patient or
      facility director at any time without notice.

(5) A patient on conditional voluntary admission status, or any parent or guardian who applied
      for the admission of such person, may be required to give three days prior written notice to the
      facility director of his or her intention to leave such facility or to withdraw such person from the
      facility. Such three day notice may only be retracted by written notice to the facility director. Such
      three day notice and any retraction thereof shall become part of the patient’s record. The form and
      content of such three day notice or retraction thereof shall be deemed sufficient so long as it
      conveys the patient’s intention, without requirement that it be on any particular form of the facility.

(6) Prior to admitting a person on conditional voluntary admission status, the admitting
      personnel shall inform such person of the three day notice requirements established in M.G.L. c.
      123, § 11, and of the facility director’s right to file a petition for commitment upon notice that
      the patient wishes to leave, pursuant to M.G.L. c. 123, § 11.

(7) A person who is 16 or 17, or during the course of hospitalization attains the age of 16, and
      who has been admitted to a facility as a voluntary or conditional voluntary patient by application
      of a legally authorized representative shall have the same rights as those persons 16 or over who
      have applied and been admitted on their own behalf, including the right to leave the facility upon
      submission of a three day notice of intent to do so, and the right to remain at the facility, upon
      written application, despite notice by a legally authorized representative of intention to withdraw
      such patient.

(8) Application for conditional voluntary admission shall be made only upon such form as the
      Commissioner may prescribe.
27.7 : Three Day Involuntary Commitment

(1) No person shall be admitted to a facility upon application for involuntary hospitalization pursuant to M.G.L. c. 123, § 12 unless the person, his or her legal guardian with authority to admit to a facility or, if a minor, his or her legally authorized representative, has been given the opportunity by the facility to apply for admission under M.G.L. c. 123, §§10 and 11. For a patient aged 16 or 17 this opportunity must be given to both the patient and his or her legally authorized representative. The right to convert to voluntary or conditional voluntary admission status may be exercised by a patient, his or her legal guardian with specific authority to admit to a facility, or, if a minor, by his or her legally authorized representative at any time within the three day period. A mental health professional responsible for the patient shall again inform the patient or legally authorized representative in the patient’s record.

(2) Examination Prior to Admission. Persons for whom application has been made for three day involuntary hospitalization by the appropriate party pursuant to M.G.L. c. 123, § 12, and who have not been examined by a designated physician prior to reception at the admitting facility, shall receive such examination immediately after reception at such facility. For the purposes of this paragraph, “immediately” shall mean within two hours and before the person has been classified as a patient or has been assigned to a bed or ward by the admitting staff. In the event that the designated physician on call at the facility is engaged in an emergency situation elsewhere, he or she shall conduct such an examination as soon as such emergency no longer requires his or her attention.

(3) Upon admission of a person to a facility pursuant to M.G.L. c. 123, § 12(b), the facility shall inform the person and his or her legally authorized representative that it shall, upon request, notify the Committee for Public Counsel Services of the person’s name and location, upon which notice the Committee will appoint an attorney to meet with the person.

(4) Emergency Hearing. The facility shall inform a person admitted pursuant to M.G.L. c. 123, § 12(b) and his or her legally authorized representative of the right to request an emergency court hearing if he or she or his or her legally authorized representative has reason to believe that the admission is the result of an abuse or misuse of the provisions of M.G.L. c. 123, §12(b). The facility shall, upon request, provide the person and his or her legally authorized representative with the form that may be used to request such a hearing and shall take steps to transmit any such completed forms to the court in accordance with the requirements of the court with jurisdiction over the facility.

27.8 : Transfer of Patients

(1) For the purposes of 104 CMR 27.08, "emergency" shall mean those medical, surgical and psychiatric crises which in the opinion of the facility director threaten the safety, health or life of the patient or others, and which could not be appropriately treated in the transferring facility.

(2) Permitted Transfers; Exceptions. Any persons admitted to inpatient treatment status may be transferred from any facility to any other facility, provided that except in an emergency:

(a) Patients on voluntary admission status under 104 CMR 27.06 shall not be subject to transfer without their written consent; and

(b) Patients on conditional voluntary admission status under 104 CMR 27.06 may refuse transfer. Such refusal may be considered equivalent to submission of the patient’s three day written notice of their intention to leave or withdraw from the facility.

(3) Absent an emergency, and except for a patient under the age of 16 or under a guardianship with authority to admit to a psychiatric facility, a patient on conditional voluntary admission status may not be transferred against his or her will unless a court of competent jurisdiction enters a commitment order pursuant to M.G.L. c. 123, §§ 7 and 8.
27.8: continued

(4) Absent an emergency, a patient under the age of 16 or under a guardianship with authority to admit to a psychiatric facility, who has been admitted pursuant to his or her legally authorized representative’s authority, may not be transferred over the objection of the legally authorized representative unless a court of competent jurisdiction enters a commitment order pursuant to M.G.L. c. 123, §§ 7 and 8.

(5) In no event shall an order of commitment for observation pursuant to M.G.L. c. 123, § 12 be issued in order to transfer a patient in lieu of compliance with the requirements of M.G.L. c. 123, § 3, or 104 CMR 27.08.

(6) Transfer of a patient committed pursuant to M.G.L. c. 123, § 12 shall not extend the period of such hospitalization.

(7) Transfer Procedures.
   (a) The approval of the director of the receiving facility shall be obtained by the transferring facility.
   (b) The director of the transferring facility shall give six days written notice to the patient to be transferred and to his or her nearest relative, unless the patient knowingly objects, or his or her legally authorized representative; provided, however, that if such transfer must be made immediately because of an emergency, notice shall be given within 24 hours after the transfer pursuant to M.G.L. c. 123, § 3. The notice shall be provided in a form prescribed by the Commissioner.
   (c) A patient, legally authorized representative of a patient under the age of 18, or a duly appointed guardian with authority to admit the ward to a psychiatric facility may, but shall not be required to, waive the six days notice requirement.
   (d) A copy of the Notice of Transfer, along with a copy of the patient’s underlying admission status documentation shall accompany the patient to the receiving facility, and the underlying status shall remain valid upon admission to the receiving facility.

27.9: Discharge

(1) Discharge Procedures.
   (a) A facility shall arrange for necessary post-discharge support and clinical services. Such measures shall be documented in the medical record.
   (b) A facility shall make every effort to avoid discharge to a shelter or the street. The facility shall take steps to identify and offer alternative options to a patient and shall document such measures, including the competent refusal of alternative options by a patient, in the medical record. In the case of such discharge, the facility shall nonetheless arrange for, in the case of a competent refusal, identify post-discharge support and clinical services. The facility shall keep a record of all discharges to a shelter or the street in a form approved by the Department and submit such information to the Department on a quarterly basis.
   (c) When a patient in a facility operated by or under contract to the Department is a client of the Department pursuant to 104 CMR 29.00, the service planning process outlined in 104 CMR 29.00 shall be undertaken prior to discharge.
   (d) A facility shall keep a record of all patients discharged therefrom, and shall provide such information to the Department upon request.

(2) Voluntary Admission Status. A patient voluntarily admitted to a facility under 104 CMR 27.06 shall be discharged without a requirement of a three day notice upon his or her request.

(3) Discharge Initiated by Facility Director. The facility director may discharge any patient admitted as a voluntary or conditional voluntary patient at any time he or she deems such discharge in the best interest of such patient; provided, however, that if a legally authorized representative made the application for admission, 14 days notice shall be given to such legally authorized representative prior to such discharge, in accordance with M.G.L. c. 123, § 10(a). With the consent of such legally authorized representative, the superintendent may discharge a patient under the age of 16 years at any time.
27.9: continued

(4) Conditional Voluntary Admission Status. A patient admitted to a facility on conditional voluntary admission status under 104 CMR 27.06 shall be discharged by the facility upon his or her request, but he or she shall give three days written notice to the facility director. The facility director may require an examination of such patient to be conducted to determine his or her clinical progress and suitability for discharge, including such factors as legal competency and family, home or community situation. Such persons may be retained at the facility beyond the expiration of the three day notice period if, prior to the expiration of the said three day notice period, the facility director files with the district court a petition for the commitment of such person at the said facility.

(5) Discharge at Request of Parent or Guardian. Hospitalization of a person under the age of 16 may be terminated at the request of his or her legally authorized representative in the same manner as any other patient.

(6) Patients Aged 16 or 17. A person who is 16 or 17 years old, or who becomes 16 during the course of hospitalization, and who has been admitted to a facility as a voluntary or conditional voluntary patient by application of a legally authorized representative shall have the same rights pertaining to release, withdrawal and discharge as those persons over the age of 16 who have applied and been voluntarily admitted to the facility on their own behalf.

(7) Involuntary Commitment Status.
   (a) Three day commitment. A person admitted to a facility under M.G.L. c. 123, § 12, may be discharged by the facility director at any time during such period of hospitalization if the facility director determines that such person is not in need of care and treatment in the facility. The three day hospitalization period authorized under M.G.L. c. 123, § 12 shall not be extended, and, at the end of such period, a person so hospitalized shall be discharged by the facility unless, prior to expiration, such person has applied for voluntary admission to the facility, or the facility director has filed a petition for an order of commitment.
   (b) Prolonged Commitment. A person committed to a facility by order of a court of competent jurisdiction shall be discharged by the facility at the expiration of the time period established by the order, unless the commitment order is renewed under the procedures established in M.G.L. c. 123, §§ 7 and 8.
   (c) At any time during the period of hospitalization, the facility director may discharge such person if he or she determines that such person is no longer in need of care and treatment.

(8) Forensic Commitment Status.
   (a) A person committed to facility under M.G.L. c. 123, § 15 shall not be discharged except to the committing court, or upon other court order.
   (b) A person committed to a facility under M.G.L. c. 123, § 16 shall not be discharged unless appropriate notice has been given by the facility director to the court exercising jurisdiction over such person and to the district attorney of the district within which the alleged crime or crimes occurred. If within 30 days of the receipt of such communication the district attorney has not filed a petition for further commitment of such person, the person may be discharged. If such a petition is filed, a hearing shall take place pursuant to M.G.L. c. 123, § 16(c).
   (c) In the event the facility director intends to remove or modify any court ordered restrictions on such a person’s movements, he or she shall communicate the intention to remove or modify such restriction in writing to the court. If within 14 days the court does not make written objection thereto, such restrictions may be removed or modified.
   (d) A person hospitalized at a facility pursuant to M.G.L. c. 123, § 18, shall not be discharged except to prison, a correctional facility, or the court, unless such person’s sentence has expired.
27.10: Treatment

(1) Consent to Treatment.
(a) Upon admission to a facility for care and treatment, a person shall, upon giving informed consent, receive treatment and rehabilitation in accordance with accepted therapeutic practice, including oral, subcutaneous and intramuscular medication when appropriate and when ordered by a physician. Informed consent means the knowing consent, voluntarily given by the patient, or his or her legally authorized representative, who can understand and weigh the risks and benefits of the particular treatment being proposed.
(b) Treatment with antipsychotic medication, Electroconvulsive Treatment (ECT), psychosurgery, involuntary sterilization or abortion, and other highly intrusive or high risk interventions may not be administered or performed without the patient’s specific informed consent. In the case of a patient incapable of giving informed consent, such interventions may not be administered or performed without prior review and approval by a court of competent jurisdiction or the consent of his or her legally authorized representative.
(c) Prior to an adjudication of incompetence, and court approval of a treatment plan, a patient retains the right to accept or refuse treatment as prescribed.
(d) For a patient who is believed to be incompetent to give informed consent to treatment with antipsychotic medication, the right to refuse such medication may be overridden prior to an adjudication of incompetence and court approval of a treatment plan only in rare circumstances to prevent an immediate, substantial and irreversible deterioration of the patient’s mental illness. If treatment is to be continued over the patient's objection, and the patient remains incompetent, then an adjudication of incompetence and court approval of a treatment plan must be sought.
(e) Chemical restraints may be used only in an emergency situation pursuant to 104 CMR 27.12.

(2) Electroconvulsive Treatment for Patients under the Age of 16.
(a) Electroconvulsive treatment shall not be administered to any patient under the age of 16 unless the Commissioner or designee concurs.
(b) The approval of the administration of electroconvulsive treatments to patients under 16 shall be based on such written recommendations and independent consultations as the Commissioner or designee deems appropriate under the circumstances of the individual case.
(c) The Commissioner or designee’s approval, and the basis therefor, shall become a permanent part of the patient’s record.

(3) Routine and Preventive Treatment. A patient shall be informed upon admission and at each periodic review of the routine and preventive treatment that is ordinarily performed at, or arranged by, the facility. Routine and preventive treatment includes standard medical examinations, clinical tests, standard immunizations, and treatment for minor illnesses and injuries. A patient who is capable of giving informed consent regarding routine and preventive treatment has the right to refuse such treatment, except that such refusal may be overridden by the facility director, without special court authorization, when the treatment consists of:
(a) a complete physical examination, and associated routine laboratory tests, required by law to be conducted upon admission and at least annually thereafter.
(b) immunizations or treatment required by law or necessary to prevent the spread of infection or disease.

(5) Written Treatment Plan. As part of the treatment of a patient in a facility, there shall be a written assessment of the needs and strengths of the individual and a written, multi-disciplinary treatment plan, which shall be developed with the maximum possible participation of the patient or the patient's legally authorized representative. The treatment plan, upon acceptance by the patient or his or her legally authorized representative, shall be implemented by the facility staff in good faith within the limits of available resources. There shall be a periodic written assessment of treatment progress, and significant modifications of the treatment plan and the rationale for such modifications shall be recorded by the responsible clinicians.
27.10: continued

(6) **Additional Requirements for Patients Eligible for Public School Education.**
   (a) Treatment plans for patients who are "children with special needs," as defined in M.G.L. c. 71B shall, where appropriate, take into account the plan for providing special education services developed in accordance with regulations of the Department of Education.
   (b) Treatment plans for patients who are eligible for public school education but who are not "children with special needs" as defined in M.G.L. c. 71B, § 1, shall, if appropriate, and in addition to all other requirements for treatment plans, reflect such patient’s educational needs.

(7) **Behavior management as defined in 104 CMR 27.10 may only be used in facilities licensed as Class VI, Limited VI or VII or in units of Department facilities that admit patients under 19. Each facility that employs behavior management techniques shall submit a behavior management plan, which shall be subject to Department approval. The plan shall outline the facility's philosophy, policy and procedures for behavior management whereby behavior management interventions are used as an educational process by which staff assist the patients in developing the experience and self control necessary to assume responsibilities, make daily living choices, and learn to live in reasonable conformity with accepted levels of social behavior. The plan shall include a description of acceptable and unacceptable behavior for the patients, as well as the sanctions that will result from unacceptable behavior. The plan shall be submitted to the Human Rights Officer and, where applicable, to the Human Rights Committee, for review.
   (a) No behavior modification techniques which involve corporal punishment, infliction of pain or physical discomfort, or deprivation of food or sleep shall be used for behavior management.
   (b) Seclusion and restraint, as defined in these regulations, may not be used for behavior management, but may only be used in accordance with 104 CMR 27.12.
   (c) The treatment plan for each patient for whom behavior management will be employed shall contain specific, individualized behavior management interventions, consistent with the program’s behavior management plan. The treatment plan including behavior management interventions may not be instituted without the consent of the patient or his or her legally authorized representative.
   (d) Each behavior management plan shall describe behavior management interventions that may be used. These may include but are not limited to the following:
   1. level/point systems of privileges, including procedures for the patient’s progress in the program;
   2. the type and range of restrictions a staff member can authorize for misbehavior of a patient;
   3. the use of the practice of separating a patient from a group or facility activity.
   (e) When feasible and appropriate, patients shall participate in the establishment of rules, policies and procedures for behavior management.
   (f) Upon admission, the facility shall provide patients and their legally authorized representatives with a copy of the facility’s behavior management plan.
   (g) Any behavior management plan which provides that a patient may be separated from the group or facility activities shall include, but not be limited to, the following:
   1. guidelines for staff in the utilization of such procedures;
   2. persons responsible for implementing such procedures;
   3. the duration of such procedures, including provisions for approval by the facility director or his or her designee of a period longer than 30 minutes;
   4. a requirement that patients shall be observable at all times and that staff shall be in close proximity at all times;
   5. a procedure for staff to directly observe the patient every 15 minutes;
   6. a means of documenting the use of such procedures if used for a period longer than 30 minutes including, at a minimum, length of time, reasons for this intervention, who approved the procedure, and who directly observed the patient at least every 15 minutes.
   (h) A time out room shall not be locked.
   (i) Any room or space used for the practice of separation must be physically safe.
27.11: Periodic Review

(1) Schedule of Periodic Reviews. Every facility shall conduct a periodic review of each inpatient upon admission, and for patients whose hospitalizations are expected to be at least 90 days, during the first three months, during the second three months, and annually thereafter until discharge, except that for facilities licensed as Class VI, Limited Class VI and VII and for units of Department facilities that admit patients under 19, such periodic reviews shall be conducted quarterly.

(2) Notice to Patient and Family. Prior to the periodic review, the facility director or designee shall give reasonable advance written notice to each patient and his or her legally authorized representative and, unless the patient knowingly objects, to the nearest relative, giving the date of such review and requesting their participation in such review.

(3) Thorough Clinical Examination. Each periodic review shall include a thorough clinical examination, which shall consist of: a mental status examination; a review of the patient's clinical history, including a review of the treatment plan, of response to treatment, and of medications administered; and an evaluation of general behavior and social interaction by clinical personnel from the various disciplines providing treatment. At least once in every 12 month period, a thorough clinical examination shall also include a physical examination.

(4) Evaluation of Competency. For each periodic review, the legal competency of a patient shall be evaluated by the senior reviewing clinician in terms of whether he or she is competent to remain on, or to apply for, conditional voluntary admission status, to render informed consent to customary and usual medical care or extraordinary treatment, including administration of antipsychotic medications, or to manage his or her own funds in accordance with the requirements of 104 CMR 30.01(3).

(a) If a patient is on voluntary or conditional voluntary admission status, and the patient is believed no longer to be competent, and the patient remains in need of continued hospitalization, then the facility director shall take reasonable steps to obtain alternate authority for continued hospitalization either by seeking an order of commitment pursuant to M.G.L. c. 123, §§ 7 and 8, or a guardianship with authority to admit the ward to a psychiatric facility.

(b) If the question of a patient's competency is raised by a periodic review or if the facility director has reason to believe that a patient who has been under the care of the facility, who is not under guardianship or conservatorship, is unable to care for his or her property, he or she shall promptly take reasonable steps to initiate the process for the appointment of a guardian or conservator.

(5) Consideration of Alternatives to Hospital. For each periodic review the alternatives to hospitalization should be evaluated, with consideration being given to specific and available resources in the community which the patient could utilize.

(6) Results of the Periodic Review.

(a) Upon completion of every periodic review subsequent to admission, the person in charge of conducting the review shall prepare a full and complete record of all information presented at such review, including medical evidence or information, the reasons for a determination that a patient requires continued care and treatment at the facility, and the consideration given to alternatives to continued hospitalization. This written record of each periodic review shall become part of the patient's permanent medical record.

(b) If upon completion of the periodic review, it is determined that the patient is in need of further care and treatment, facility director or designee shall notify the patient and his or her legally authorized representative, or, if there is no such legally authorized representative and the patient does not knowingly object, his or her nearest relative, of that determination, and of the right to leave the facility if he or she was not committed under a court order. If said patient is not committed under a court order and does not choose further treatment as an inpatient, within 14 days of said notification the patient shall be discharged or shall be made the subject of a petition for a court ordered commitment. Following any review under the provisions of 104 CMR 27.11, or at any other time, any patient who is no longer in need of care as an inpatient shall be discharged.
27.12: Prevention of Restraint and Seclusion and Requirements When Used

(1) **Prevention/Minimal Use of Restraint and Seclusion.** A facility licensed as Class III through VII shall develop and implement a plan to reduce and, wherever possible, eliminate the use of restraint and seclusion. The facility's plan shall include, at a minimum, the following:

(a) a posted statement of the facility's commitment to the prevention and minimal use of restraint and seclusion;
(b) policies and procedures that support the prevention and minimal use of restraint and seclusion;
(c) staff training that focuses on crisis prevention, de-escalation and alternatives to restraint and seclusion;
(d) programming and milieu that are consistent with the prevention and minimal use of restraint and seclusion;
(e) the development and use of sensory interventions and therapies designed to calm and comfort patients that utilize sight, touch, sound, taste, smell, pressure, weight or physical activity;
(f) the development and use of an individual crisis prevention plan for each patient;
(g) assessment of the impact of trauma experience and the potential for retraumatization;
(h) the regular use of debriefing activities;
(i) the process for addressing patient concerns and complaints about the use of restraint or seclusion;
(j) the use of data to monitor and improve quality and prevent and minimize the use of restraint and seclusion, such as identifying times or shifts with a high incidence of restraint or seclusion.

(2) **Staff Training.**

(a) A facility shall ensure that all unit staff and other staff who may be involved in restraint and seclusion receive training in the prevention and minimal use of restraint and seclusion during orientation, which shall be no later than one month after hire, and receive annual training thereafter. Training shall include, at a minimum, the following:

1. the harmful emotional and physical effects of restraint and seclusion on patients and staff;
2. the impact of trauma, including sexual and physical abuse and witnessing of violence, on individuals;
3. the impact of restraint or seclusion on individuals with a history of trauma, including the potential for retraumatization;
4. crisis prevention approaches and de-escalation strategies;
5. the use of the individual crisis prevention plan.

(b) In addition to the training in 104 CMR 27.12(2)(a), staff who may be directly involved in authorizing, ordering, administering or applying, monitoring, or assessing for release from restraint or seclusion shall receive additional training, and annual retraining thereafter. No staff shall be permitted to participate in any restraint or seclusion prior to receiving such additional training. Such training shall include, at a minimum, the following:

1. applicable legal and clinical requirements for restraint and seclusion;
2. the safe and appropriate initiation of physical contact and application and monitoring of restraint and seclusion;
3. approaches to facilitate the earliest possible release from restraint or seclusion.

(c) Following initial training and each annual retraining, a facility shall require each staff member to demonstrate competencies in all areas of training. A facility shall maintain documentation of staff training and competencies.

(3) **Individual Crisis Prevention Planning.** A facility shall develop an individual crisis prevention plan for each patient.

(a) **Definition.** An individual crisis prevention plan is an age and developmentally appropriate, patient-specific plan that identifies triggers that may signal or lead to agitation or distress in the patient and strategies to help the patient and staff intervene with de-escalation techniques to reduce such agitation and distress and avoid the use of restraint and seclusion.

(b) **Development of the Individual Crisis Prevention Plan.** As soon as possible after admission, facility staff shall collaborate with each patient and his or her legally authorized representative, if any, and, where appropriate, with other sources, such as family members, caregivers, and the patient's health care proxy, to complete and implement an individual crisis
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prevention plan. If the patient refuses or is unable to participate in the initial development of the plan, staff shall develop a plan using available information and shall make continuing efforts to include the patient's participation in review and revision of the plan. Relevant clinical data, including medical risk factors, physical, learning, or cognitive disability, and the patient's history of trauma shall inform the development of the plan. The plan shall include, at a minimum, the following elements:

1. identification of triggers that signal or lead to agitation or distress in the patient and, if not addressed, may result in the use of restraint or seclusion;
2. identification of the particular approaches and strategies that are most helpful to the patient in reducing agitation or distress, such as environmental supports, physical activity, and sensory interventions;
3. in order to minimize trauma or retraumatization if restraint or seclusion is used, identification of the patient's preferences, such as type of intervention and positioning, gender of staff who administer and monitor the restraint or seclusion, and supportive interventions that may have a calming effect on the patient.

(c) Update and Revision of Plan. The plan shall be updated as necessary to reflect changes in such triggers and strategies and shall be reviewed at each treatment plan review.

(d) Access to Plan. A facility shall ensure that all staff on all shifts are aware of and have ready access to the individual crisis prevention plans for the patients in their care. A copy of the individual crisis prevention plan and any revisions thereto shall be placed in the patient record.

(4) Debriefing Activities. A facility shall develop procedures to ensure that debriefing activities occur after each episode of restraint or seclusion in order to determine what led to the incident, what might have prevented or curtailed it, and how to prevent future incidents. Debriefing activities shall be documented and used in treatment planning, revision of the individual crisis prevention plan, and ongoing facility-wide restraint and seclusion prevention efforts.

(a) Staff Debriefing. As soon as possible following each episode of restraint or seclusion, supervisory staff and staff involved in the episode shall convene a debriefing. The debriefing shall, at a minimum, include the following:

1. identification of what led to the incident;
2. determination of whether the individual crisis prevention plan was used;
3. assessment of alternative interventions that may have avoided the use of restraint or seclusion;
4. determination of whether the patient's physical and psychological needs and right to privacy were appropriately addressed;
5. consideration of counseling or medical evaluation and treatment for the involved patient and staff for any emotional or physical trauma that may have resulted from the incident;
6. consideration of whether other patients and staff who may have witnessed or otherwise been affected by the incident should be involved in debriefing activities or offered counseling;
7. consideration of whether the legally authorized representative, if any, family members, or others should be notified of and/or involved in debriefing activities;
8. consideration of whether additional supervision or training should be provided to staff involved in the incident;
9. determination of whether the incident should be referred for senior administrative review because it meets one or more of the criteria outlined in 104 CMR 27.12(4)(c)1. through 6. or otherwise warrants such review.

(b) Patient Debriefing. Within 24 hours after a patient's release from restraint or seclusion, the patient shall be asked to debrief and provide comment on the episode, including the circumstances leading to the episode, staff or patient actions that may have helped to prevent it, the type of restraint or seclusion used, and any physical or psychological effects he or she may be experiencing from the restraint or seclusion. Whenever possible and appropriate, the staff person providing the patient with the opportunity to comment shall not
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have been involved in the episode of restraint or seclusion. As part of the debriefing, the patient shall be provided with a copy of the restraint and seclusion order form required pursuant to 104 CMR 27.12(5)(i) 1., with an attached patient debriefing and comment form approved by the Commissioner and shall be offered the opportunity to provide comment in writing. The staff person shall provide the patient with any necessary assistance in completing the patient debriefing and comment form. If the patient does not complete the form, but provides verbal or other response to the episode, the staff person shall document such response on the form. If the patient provides verbal or other response to the episode at any other time, the staff person witnessing the response shall document it in writing. The patient debriefing and comment form or other documentation shall be attached to the restraint and seclusion order form and included in the patient record and copies of the form shall promptly be forwarded to the treatment team and the human rights officer. The patient shall also be notified of the availability of the complaint procedure outlined in 104 CMR 32.00. The human rights officer shall meet with a patient who has expressed a response to an episode of restraint or seclusion that suggests a possible rights violation or other harmful consequence.

(c) Senior Administrative Review. The facility director shall ensure that senior administrative and clinical staff who are empowered to make recommendations and decisions about the need for expert consultation, training, performance improvement activities, change in policy, or other appropriate measures conduct regular reviews of all incidents of restraint and seclusion. In addition, such staff shall conduct a specific review of an episode of restraint or seclusion by the next business day if any of the following apply:

1. A patient or staff member experienced significant emotional or physical injury as a result of the episode.
2. The episode of restraint or seclusion exceeded six hours or episodes of restraint and/or seclusion for a patient exceeded 12 hours in the aggregate in any 48-hour period.
3. An exception to the restrictions on mechanical restraint of minors has occurred pursuant to 104 CMR 27.12(5)(g)5.
4. The episode appears to be part of a pattern warranting review.
5. The episode is marked by unusual circumstances.
6. The episode resulted in a complaint or reportable incident pursuant to 104 CMR 32.00.
7. The staff involved in the episode requested such a review pursuant to 104 CMR 27.12(4)(a)9.

(5) Requirements for the Use of Restraint and Seclusion.

(a) Definitions. For purposes of 104 CMR 27.12, the following definitions shall apply:

1. Authorized Physician. An authorized physician is any physician who has been authorized by the facility director to order medication restraint, mechanical restraint, physical restraint or seclusion, to examine patients in such restraint or seclusion, and to assess for readiness for release and order release from restraint or seclusion.
2. Authorized Staff Person. An authorized staff person is any member of the licensed clinical staff at a facility who has been authorized by the facility director to initiate or renew mechanical restraint, physical restraint or seclusion pursuant to 104 CMR 27.12(5)(e)2. or (01., and to assess for readiness for release and order release from restraint or seclusion.
3. Restraint. Restraint, for purposes of 104 CMR 27.00, means behavioral restraint, including medication restraint, mechanical restraint and physical restraint. Restraint means bodily physical restriction, mechanical devices, or medication that unreasonably limit freedom of movement. Restraint does not include the use of restraint in association with acute medical or surgical care, adaptive support in response to the patient's assessed physical needs, or standard practices including limitation of mobility related to medical, dental, diagnostic, or surgical procedures and related post-procedure care.

a. Medication Restraint. Medication restraint occurs when a patient is given medication involuntarily for the purpose of restraining the patient. Medication restraint shall not include:
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i. involuntary administrations of medication when administered in an emergency to prevent immediate, substantial and irreversible deterioration of serious mental illness, provided that the requirements of 104 CMR 27.10(1)(d) are complied with; or

ii. for other treatment purposes when administered pursuant to a court approved substituted judgment treatment plan.

b. Mechanical Restraint. Mechanical restraint occurs when a physical device or devices are used to restrain a person by restricting the movement of a patient or the movement or normal function of a portion of his or her body.

c. Physical Restraint. Physical restraint occurs when a manual method is used to restrain a person by restricting a patient's freedom of movement or normal access to his or her body. Physical restraint may only include bodily holding of a patient with no more force than is necessary to limit the patient's movement. Physical restraint shall not include:

i. non-forcible guiding or escorting of a patient to another area of the facility;

ii. taking reasonable steps to prevent a patient at imminent risk of entering a dangerous situation from doing so with a limited response to avert injury, such as blocking a blow, breaking up a fight, or preventing a fall, a jump, or a run into danger;

4. Seclusion.

a. Seclusion occurs when a patient is involuntarily confined in a room and is prevented from leaving, or reasonably believes that he or she will be prevented from leaving, by means that include, but are not limited to, the following:

i. manually, mechanically, or electrically locked doors, or "one-way doors," that, when closed and unlocked, cannot be opened from the inside;

ii. physical intervention of staff;

iii. coercive measures, such as the threat of restraint, sanctions, or the loss of privileges that the patient would otherwise have, used for the purpose of keeping the patient from leaving the room.

b. Seclusion shall not include voluntary, collaborative separation from a group or activity for the purpose of calming a patient.
(b) Emergency Basis for Medication Restraint, Mechanical Restraint, Physical Restraint or Seclusion. Medication restraint, mechanical restraint, physical restraint or seclusion may be used only in an emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide. Such emergencies shall only include situations where there is a substantial risk of, or the occurrence of, serious self-destructive behavior, or a substantial risk of, or the occurrence of, serious physical assault. As used in the previous sentence, a substantial risk includes only the serious, imminent threat of bodily harm, where there is the present ability to effect such harm.

1. Restriction on Medication Restraint, Mechanical Restraint, Physical Restraint or Seclusion: Use of Individual Crisis Prevention Plan. Medication restraint, mechanical restraint, physical restraint or seclusion may be used only after the failure of less restrictive alternatives, including strategies identified in the individual crisis prevention plan, or after a determination that such alternatives would be inappropriate or ineffective. Under the circumstances, and may be used only for the purpose of preventing the continuation or renewal of such emergency condition. The preferences in the patient's individual crisis prevention plan, such as type of restraint or seclusion and gender of staff, shall be considered in ordering or initiating restraint or seclusion.

2. Duration of Medication Restraint, Mechanical Restraint, Physical Restraint, or Seclusion. Medication restraint, mechanical restraint, physical restraint or seclusion may only be used for the period of time necessary to accomplish its purpose but in no event beyond the periods established in 104 CMR 27.12(5)(e), (f) and (g).

3. PRN Orders Prohibited. No "PRN" or "as required" authorization of medication restraint, mechanical restraint, physical restraint or seclusion may be written.

4. Seclusion Used with Mechanical Restraint Prohibited. No patient shall be placed in seclusion while in mechanical restraints.

5. Other Requirements. When an emergency condition exists justifying the use of medication restraint, mechanical restraint, physical restraint or seclusion, such use must conform to all applicable requirements of 104 CMR 27.12.

(c) Physical and Mechanical Restraint or Seclusion - Physical Conditions.

1. Position in Physical or Mechanical Restraint. A patient shall be placed in a position that allows airway access and does not compromise respiration. A face-down position shall not be used, unless:
   a. there is a specified patient preference and no psychological or medical contra-indication to its use; or
   b. there is an overriding psychological or medical justification for its use, which shall be documented.

2. Personal Needs and Comfort. Provision shall be made for appropriate attention to the personal needs of the patient, including access to food and drink and toileting facilities, by staff escort or otherwise, and for the patient's physical and mental comfort.

3. Personal Dignity. Patients in restraints or seclusion shall be fully clothed, limited only by patient safety considerations related to the type of intervention used, and the restraint devices used shall afford patients maximum personal dignity.

4. Physical Environment. The physical environment shall be as conducive as possible to facilitating early release, with attention to calming the patient with sensory interventions where possible and appropriate.

5. Seclusion - Observation. Any room used to confine a patient in seclusion must provide for complete visual observation of the patient so confined.

6. Mechanical Restraint - Locks Prohibited. No locked mechanical restraint devices requiring the use of a key for their release may be used.

(d) Medication Restraint - Order. A patient may be given medication restraint only on the order of an authorized physician who has determined, either while present at the time of (i.e., at any time during the course of) the emergency justifying the use of the restraint or after telephone consultation with a physician, registered nurse or certified physician assistant who is present at the time and site of the emergency and who has personally examined the patient, and using all relevant information available regarding the patient, that such medication restraint is the least restrictive, most appropriate alternative available.

1. Such order along with the reasons for its issuance shall be recorded in writing at the time of its issuance.

2. Such order shall be signed at the time of its issuance by such authorized physician if present at the time of the emergency.

3. Such order, if authorized by telephone, shall be transcribed and signed at the time of its issuance by the physician, registered nurse or physician assistant who is present at the time of its issuance.
4. An authorized physician shall conduct a face-to-face evaluation of the patient as soon as possible but no later than within one hour of the initiation of the restraint if the restraint was authorized by telephone.

(e) Initiation of Mechanical Restraint, Physical Restraint or Seclusion.
1. The order that a patient be placed in mechanical restraint, physical restraint, or seclusion shall be made by an authorized physician who is present when an emergency as defined in 104 CMR 27.12(5)(b) occurs, except as provided in 104 CMR 27.12(5)(e)2.

a. Such order along with the reasons for its issuance and criteria for release shall be recorded in writing and signed at the time of its issuance by such physician.
b. Such order shall authorize use of mechanical restraint, physical restraint or seclusion for no more than two hours, subject to the additional restrictions in 104 CMR 27.12(5)(g).
c. Such order shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(5)(h).

2. If an authorized physician is not present when an emergency justifying the use of mechanical restraint, physical restraint or seclusion occurs, a patient may be placed in mechanical restraint, physical restraint or seclusion at the initiation of an authorized staff person, subject to the following conditions and limitations: a. Such initiation shall be subject to the additional restrictions in 104 CMR 27.12(5)(g).

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b. Such initiation along with the reasons for its issuance shall be recorded in writing and signed at the time of the incident by such authorized staff person.
c. Such initiation shall authorize use of mechanical restraint, physical restraint or seclusion for no more than one hour, subject to the additional restrictions in 104 CMR 27.12(5)(g).
d. An authorized physician shall examine the patient as soon as possible but no later than one hour of such initiation of mechanical restraint, physical restraint, or seclusion.

3. At the time of initiation of restraint, an authorized staff person or authorized physician shall observe and make written note of the patient's physical status, including respiratory functioning, skin color and condition, and the presence of undue pressure to any part of the body.

(f) Mechanical Restraint, Physical Restraint or Seclusion - Renewals to Continue Use.
1. Continuation for a Second Hour of Mechanical Restraint, Physical Restraint or Seclusion Initiated by an Authorized Staff Person - Exceptional Circumstances. In exceptional circumstances, where an authorized physician has not examined the patient within the first hour of initiation of restraint or seclusion as required by 104 CMR 27.12(5)(e)2.d., an authorized staff person may issue a single renewal for a second one hour period, subject to the following conditions and limitations:

a. Such renewal shall be subject to the additional restrictions in 104 CMR 27.12(5)(g).
b. Such renewal may only be issued if such authorized staff person determines that such restraint or seclusion is necessary to prevent the continuation or renewal of an emergency condition or conditions as defined in 104 CMR 27.12(5)(b).
c. Such renewal shall authorize use of mechanical restraint, physical restraint or seclusion for no more than one hour, shall terminate whenever a release decision is made pursuant to 104 CMR 27.12(5)(h)8., and shall be subject to the monitoring, examination and release provisions of 104 CMR 27.12(5)(h).
d. An authorized physician shall examine the patient as soon as possible but no later than within one hour of such initiation of mechanical restraint, physical restraint or seclusion, and may order the restraint to continue for no more than two hours from the initiation of the restraint or seclusion by the authorized staff person, subject to the additional restrictions in 104 CMR 27.12(5)(g).

2. Continuation of Mechanical Restraint or Seclusion for Additional Two-Hour Periods. Subsequent orders for renewals of mechanical restraint or seclusion may be made for up to two-hour periods only if an authorized physician has examined the patient and ordered such renewal prior to the expiration of the preceding order, subject to the following conditions and limitations.
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4. No minor age nine through 17 shall be in seclusion for more than two hours in any 24-hour period.
5. No minor under age 13 may be placed in mechanical restraint, except under the following conditions:
   a. The facility medical director is notified prior to the use of such restraint or immediately after the initiation of the restraint, if an emergency as defined in 104 CMR 27.12(5)(b) occurs. The facility medical director shall inquire about the circumstances warranting the use of such restraint, the efforts made to de-escalate the situation, the alternatives to such restraint considered and tried, any preferences indicated in the individual crisis prevention plan, and whether other measures or resources might be helpful in avoiding the use of mechanical restraint or in facilitating early release.
   b. The facility director shall also be immediately informed of the use of such restraint and shall report it in writing to the Commissioner or designee by the next business day.
   c. All other applicable provisions of 104 CMR 27.12 shall be complied with.
6. Mechanical Restraint or Seclusion Exceeding Six Hours or Multiple Episodes. If an episode of mechanical restraint or seclusion has exceeded five hours and it is expected that a new order will be issued to extend the episode beyond six hours or if there are two or more episodes of any restraint or seclusion for a patient in any 12 hour period, the facility director and facility medical director shall be notified. The facility medical director shall inquire about the circumstances of the episode(s) of restraint or seclusion, the efforts made to facilitate release, and the impediments to such release, and help to identify additional measures or resources that might be beneficial in facilitating release or preventing additional episodes.
7. Mechanical Restraint or Seclusion Exceeding 12 Hours or Total Episodes Exceeding 12 Hours in a 48-Hour Period. If an episode of mechanical restraint or seclusion has exceeded 11 hours and it is expected that a new order will be issued to extend the episode beyond 12 hours, or if episodes of restraint and/or seclusion for a patient have exceeded 12 hours in the aggregate in any 48-hour period, the following shall occur:
   a. The patient shall receive a medical assessment.
   b. The facility director and facility medical director shall be notified. The facility medical director shall inquire about the outcome of the measures identified pursuant to 104 CMR 27.12(5)(g)6., in the case of a continuous episode, and about the circumstances that resulted in the continued or multiple use of restraint or seclusion. The facility medical director shall take steps, including consultation with appropriate parties, to identify and implement strategies to facilitate release as soon as possible and/or eliminate the use of multiple episodes, such as psychopharmacological reevaluation or other consultation, assistance with communication, including interpreter services, and consideration of involving family members or other trusted individuals.
   c. The episode(s) shall be reported to the Commissioner or designee by the next business day.
8. Release Prior to Expiration of Order. If a patient is released from restraint or seclusion prior to the expiration of an order and an emergency as defined in 104 CMR 27.12(5)(b) occurs prior to such order's expiration, but no later than one-half hour after release, the

patient may be returned by an authorized staff person to restraint or seclusion without a new order for the time remaining in the order. Such return to restraint or seclusion shall be documented in the record. If the time permitted by the order or one-half hour has elapsed at the time of such emergency, the procedures for ordering or initiating restraint or seclusion pursuant to 104 CMR 27.12(5)(e) shall be followed.

(h) Monitoring and Assessment of Patients in Mechanical Restraint, Physical Restraint or Seclusion; Release.

1. One-on-One Staff Monitoring. Whenever a patient is in physical or mechanical restraint or seclusion, a staff person shall be specifically assigned to monitor such person one-on-one.

2. The staff person conducting such monitoring may be immediately outside a space in which a patient is being secluded without mechanical restraint provided that the following conditions are met:
   a. The staff person must be in full view of the patient (e.g., the patient may approach the seclusion door and see the staff person through a window in the door if he or she wishes to do so); and
   b. The staff person must be able at all times to observe the patient.

3. The staff person shall monitor a patient in mechanical or physical restraint by being situated so that the staff person is able to hear and be heard by the patient and visually observe the patient at all times. It is not necessary for a staff person monitoring a patient in mechanical or physical restraint to be in full view of the patient, although if such visibility has been expressed as a preference by the patient, consideration shall be given to honoring such preference.

4. Staff who monitor a patient in physical or mechanical restraint or seclusion shall continually assist and support the patient, including monitoring physical and psychological status and comfort, body alignment, and circulation, taking vital signs when indicated, and monitoring for readiness for release pursuant to 104 CMR 27.12(5)(h)(6). Such monitoring activities shall be documented every 15 minutes.

5. Staff who monitor a patient in restraint or seclusion shall continue appropriate interventions designed to calm the patient throughout the episode of restraint or seclusion and shall ensure that the patient has access to a means of marking the passage of time, either visually or verbally.

   a. Staff conducting monitoring shall continually consider whether a patient in mechanical restraint, physical restraint or seclusion appears ready to be released. If the staff person believes that the patient may be ready to be released from such restraint or seclusion either because the criteria for release have been met or an emergency condition or conditions as defined in 104 CMR 27.12(5)(b) no longer exists, he or she shall immediately notify an authorized physician or authorized staff person, who shall promptly assess the patient for readiness to be released.
   b. If a patient falls asleep while in mechanical restraint, staff conducting monitoring shall notify an authorized physician or authorized staff person, who shall release the patient from the restraint or seclusion, unless such efforts are reasonably expected to re-agitate the patient.
   c. If, at any time during mechanical restraint, physical restraint, or seclusion, a patient is briefly released from such restraint or seclusion to attend to personal needs pursuant to 104 CMR 27.12(5)(c)(2) or for other purpose, staff conducting monitoring shall consider the patient's readiness to be permanently released, rather than returned to the restraint or seclusion, and notify an authorized staff person if the patient appears ready to be released.

7. Assessment. An authorized staff person or authorized physician shall assess a patient in mechanical or physical restraint or seclusion for physical and psychological comfort, including vital signs, and readiness to be released at least every 30 minutes and at any other time that it appears that the patient is ready to be released. Such assessments shall be documented in the record.

8. Permanent Release. A patient shall be released from mechanical restraint, physical restraint or seclusion as soon as an authorized physician or authorized staff person determines after examination of the patient or consultation with staff that such mechanical restraint, physical restraint, or seclusion is no longer needed to prevent the continuation or renewal of an emergency condition or conditions as defined in 104 CMR 27.12(5)(b) and, in no event, no later than the expiration of an initial or renewed order for such mechanical restraint or seclusion, unless such order is renewed in accordance with the requirements or 104 CMR 27.12(5)(f). The circumstances...
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(i) Documentation Requirements.
1. The Restraint and Seclusion Order Form. Each facility subject to these regulations shall ensure that a restraint and seclusion order form is maintained and completed on each occasion when a patient is placed and maintained in restraint or seclusion. The restraint and seclusion order form shall conform to the following requirements:
   a. The restraint and seclusion order form must be in a form approved by the Commissioner.
   b. The restraint and seclusion order form shall be completed in triplicate, one copy of which shall be placed in the patient's record, one copy of which shall be used for the patient's comments pursuant to 104 CMR 27.12(4)(b), and one copy of which shall be used for the review by the Commissioner or designee pursuant to 104 CMR 27.12(5)(i)2.
   c. Any attachments required by 104 CMR 27.12 shall be attached to each copy of the restraint and seclusion order form.

2. Submission to the Commissioner; Review. At the end of each month, a facility shall submit to the Commissioner or designee copies of all restraint and seclusion forms with attachments, if any, required by 104 CMR 27.12 and an aggregate report for each facility unit, on a form approved by the Commissioner, containing statistical data on the episodes of restraint and seclusion for the month. The Commissioner or designee shall review such aggregate reports and review a sample of restraint and seclusion forms, and shall maintain statistical records of all uses of restraint or seclusion, organized by facility and unit.

3. Human Rights Committee/Human Rights Officer Review. At the end of each month, copies of all restraint and seclusion order forms and attachments, if any, sent to the Commissioner or designee pursuant to 104 CMR 27.12(5)(i)2. shall be sent to the human rights committee of the facility, if operated by or under contract to the Department, and otherwise to the human rights officer, which shall review the use of all restraints by the facility or program. The committee or human rights officer shall have the authority to:
   a. review all pertinent data concerning the behavior that necessitated restraint or seclusion;
   b. obtain information about the patient's needs from appropriate staff, relatives and other persons with direct contact or special knowledge of the patient;
   c. monitor the use of the individual crisis prevention plan and consider all less restrictive alternatives to restraint and seclusion in meeting the patient's needs;
   d. review and refer to the person in charge for action in accordance with 104 CMR 32.00 all complaints that the rights of a patient are being abridged by the use of restraint or seclusion; and
   e. generally monitor the use of restraint and seclusion in the facility.

27.13: Human Rights

(1) No right protected by the Constitutions or laws of the United States and the Commonwealth of Massachusetts shall be abridged solely on the basis of a patient’s admission or commitment to a facility, except insofar as the exercise of such rights have been limited by a court of competent jurisdiction. Furthermore, no person shall be deprived of the right to manage his or her affairs, to contract, to hold professional, occupational or vehicle operator's licenses, to make a will, to marry, to hold or convey property or to vote in local, state, or federal elections solely by reason of his or her admission or commitment to a facility.

(2) In cases where there has been an adjudication that a person is incompetent, or when a conservator or guardian has been appointed for such person, such person’s human rights may be limited only to the extent of the guardian or conservator's adjudicated responsibility. If at any time during a patient’s treatment, the clinical team believes the patient to be incompetent to make treatment or other personal or financial decisions, the director or designee shall notify the patient that a recommendation has been made that there be an adjudication or other determination of the competency of such patient.

27.13: continued

(3) Right to Treatment. Each patient admitted to a facility shall, subject to his or her giving informed consent, receive treatment suited to his or her needs which shall be administered skillfully, safely, and humanely with full respect for dignity and personal integrity.
(5) In addition to the foregoing, a patient of a facility:

(a) shall have reasonable access to a telephone to make and receive confidential telephone calls and to assistance, when desired and necessary to implement this right, provided that such calls do not constitute a criminal act or represent an unreasonable infringement of other persons’ right to make and receive phone calls;

(b) shall have the right to send and receive sealed, unopened, uncensored mail, provided, however, that the facility director or designee may direct, for good cause and with documentation of specific facts in the patient’s record, that a particular patient’s mail be opened and inspected in front of the patient, without it being read by staff, for the sole purpose of preventing the transmission of contraband. Writing materials and postage stamps in reasonable quantities shall be made available for use by patients. Reasonable assistance shall be provided to patients in writing, addressing and posting letters and other documents upon request;

(c) shall have the right to receive visitors of such patient’s own choosing daily and in private, at reasonable times. Hours during which visitors may be received may be limited only to protect the privacy of other patients and to avoid serious disruptions in the normal functioning of the facility and shall be sufficiently flexible as to accommodate individual needs and desires of such patients and their visitors;

(d) shall have the right to a humane psychological and physical environment. Each such patient shall be provided living quarters and accommodations which afford privacy and security in resting, sleeping, dressing, bathing and personal hygiene, reading and writing, and in toileting. 104 CMR 27.13 shall not be interpreted as requiring individual sleeping quarters;

(e) shall have the right to receive, or refuse, visits and telephone calls from his or her attorney or legal advocate, physician, psychologist, clergy or social worker at any reasonable time, regardless of whether the patient initiated or requested the visit or telephone call;

(f) shall, upon admission and upon request at any time thereafter, be provided with the name, address, and telephone number of the Mental Health Legal Advisors Committee, Committee for Public Counsel Services, and authorized Protection and Advocacy organizations, and shall be provided with reasonable assistance in contacting and receiving visits or telephone calls from attorneys or paralegals from such organizations; provided, further, that the facility shall designate reasonable times for unsolicited visits and for the dissemination of educational materials to patients by such attorneys or paralegals;

(f) shall have the right to file complaints and to have complaints responded to in accordance with 104 CMR 32.00.

(6) Any rights set forth in 104 CMR 27.13(5)(a) and (c) may be temporarily suspended, but only by the facility director or designee upon concluding that based on the experience of the patient’s exercise of such right, such further exercise of it in the immediate future would present a substantial risk of serious harm to said patient or others and that less restrictive alternatives have either been tried or failed or would be futile to attempt. The suspension shall last no longer than the time necessary to prevent the harm, and its imposition shall be documented with specific facts in the patient’s record.

(7) Patients have the right to be free from unreasonable searches of their person or property.

(8) Right of Habeas Corpus. Any patient involuntarily committed to any facility who believes or has reason to believe he or she should no longer be retained may make written application to the superior court for a judicial determination of the necessity of continued commitment pursuant to M.G.L. c. 123, § 9(b).

27.13: continued

(9) Rights at Court Hearing. Whenever a court hearing is held under the provisions of M.G.L. c. 123 for the commitment or further retention of a person in a facility, such person shall have the right to a timely hearing and representation by counsel as provided by law.

(10) Rights of Aliens. Aliens shall have the same rights under the provisions of M.G.L. c. 123 as citizens of the United States.

(11) Human Rights Information to Each Patient on Admission. A member of the admitting staff shall give each patient, and, if applicable, his or her legally authorized representative, at the time of admission a copy of the rights set forth in 104 CMR 27.13, or other materials explaining his or
(12) **Copies of Rights Posted and Available in Facilities.** Each facility shall post a copy of the rights set forth in 104 CMR 27.13 in the admitting room of the facility, in each unit, and in other appropriate and conspicuous places in the facility, and shall make copies available upon request.

### 27.14: Human Rights Officer; Human Rights Committee

(1) **Human Rights Officer.** Each facility shall have a person or person employed by or affiliated with the facility appointed to serve as the human rights officer and to undertake the following responsibilities:

   (a) To participate in training programs for human rights officers offered by the Department;
   (b) To inform, train and assist patients in the exercise of their rights;
   (c) To assist patients in obtaining legal information, advice and representation through appropriate means, including referral to attorneys or legal advocates when appropriate;
   (d) In the case of Department facilities, to serve as staff to the facility’s human rights committee.

   In the case of Department facilities, the Commissioner or designee shall appoint the human rights officer. Otherwise, the facility director shall make such appointment.

(2) **Human Rights Committee.** For each facility operated by, or under contract to the Department, the Commissioner or designee shall establish, impanel and empower a human rights committee in accordance with the provisions of 104 CMR 27.14. Such a human rights committee may be established jointly with other programs in an Area; provided, however, that the number, geographical separateness or programmatic diversity of the programs is not so great as to limit the effectiveness of the committee in meeting the requirements of 104 CMR 27.14.

(3) Each such human rights committee shall be composed of a minimum of five members, a majority of whom shall be consumers of mental health services, family members of consumers, or advocates; provided, however, that no member shall have any direct or indirect financial or administrative interest in the facility or the Department.

(4) The general responsibility of each such human rights committee shall be to monitor the activities of the facility with regard to the human rights of the patients in the facility. The specific duties of the committee shall include:

   (a) Reviewing and making inquiry into complaints and allegations of patient mistreatment, harm or violation of patient's rights and referral of such complaints for investigation in accordance with the requirements of 104 CMR 32.00;
   (b) Reviewing and monitoring the use of restraint, seclusion and other physical limitations on movement;
   (c) Reviewing and monitoring the methods utilized by the facility to inform patients and staff of the patient's rights, to train patients served by the program in the exercise of their rights, and to provide patients with opportunities to exercise their rights to the fullest extent of their capabilities and interests;
   (d) Making recommendations to the facility to improve the degree to which the human rights of patients served by the facility are understood and enforced;
   (e) Visiting the facility with prior notice or without prior notice provided good cause exits.

### 27.15: Visit

(5) Each such human rights committee shall meet as often as necessary upon call of the chairpersons, or upon request of any two members, but no less often than quarterly. Minutes of all committee meetings shall be kept and shall be available for inspection by the Department upon request. The committee shall develop operating rules and procedures, as necessary.

(1) A visit is a temporary release of any patient, with the exception of those patients committed pursuant to M.G.L. c. 123, §§ 15, 17 and 18, to the community for a period of not more than 30 days.

(2) A patient committed pursuant to M.G.L. c. 123, § 16 may be released on visit only if not restricted by court order, and upon authorization by the facility director after review by senior clinical staff.

(3) **Readmission to Facility.** A patient on visit may be readmitted to the facility at any time within 30 days from the day of release without new admission procedures. In the case of persons involuntarily committed, the original commitment order shall remain in effect. Readmission to the
(4) Every facility shall maintain a record of the names of all patients on visit status.

27.16: Absence Without Authorization

(1) Classification as AWA. Any patient admitted or committed to a Department facility pursuant to M.G.L. c. 123, §§ 7 & 8, 10 & 11, 12, 15, 16, 17, or 18, who leaves the facility grounds or an off-grounds program or activity without permission and fails to return within a reasonable time, or any patient who, having left the facility with permission, fails to return at the designated time or within a reasonable time thereafter, shall be classified by the facility director as “absent without authorization.” (AWA).

(2) Classification as AWA: Action to Be Taken.
   (a) Immediate classification: A patient who is admitted or committed pursuant to M.G.L. c. 123, §§ 7 & 8, 10 & 11, or 12 and who is at a high risk of harm to self or others or a patient who is committed pursuant to M.G.L. c. 123, §§ 15, 16, 17, or 18 shall be immediately classified as AWA.
   (b) Classification by midnight census: A patient who does not meet the criteria of 104 CMR 27.16(2)(a) shall be classified as AWA if he or she has not returned within a reasonable time based on clinical judgment or by the midnight census, whichever is earlier.
   (c) The facility shall take prompt and vigorous measures to secure the patient’s return.
   (d) When a patient is classified as AWA, the facility director or designee shall immediately notify the following parties:
      1. local and state police. The police shall be provided with the patient’s description, other information that would assist the police in locating the patient, and information of the patient’s tendencies to be assaultive, homicidal, suicidal or to use weapons;
      2. the district attorney of the county in which the facility is located;
      3. the patient’s next of kin;
      4. the patient’s legally authorized representative;
      5. any person known to be placed at risk because the patient has left the facility;
      6. designated individuals within the Department.
      If such notification is made by telephone, it shall be followed by written notification.

(3) Return from AWA: Action to Be Taken.
   (a) A patient may return or be returned to the facility under the original patient status within six months of being classified as AWA.
   (b) All parties who were notified at the time of a patient’s classification as AWA, shall be notified of the patient’s return to the facility by the facility director or designee.

27.16: continued

(4) Discharge of Patients on AWA: Action to Be Taken.
   (a) Six months after being classified as AWA, a patient on AWA who is not committed pursuant to M.G.L. c. 123, §§ 15, 16, 17, or 18 may be discharged from the facility upon authorization by the facility director after review by senior clinical staff. After such six month period, subsequent hospitalization of patients discharged while on AWA status shall require new admission proceedings. However, under specific circumstances, the facility director, in consultation with senior clinical staff, may discharge a patient on AWA status at an earlier date.
   (b) There shall be no such discharge after a six month period for persons committed to a Department facility pursuant to M.G.L. c. 123, §§ 15, 16, 17 or 18.
   (c) All parties who were notified at the time of a patient’s classification as AWA, shall be notified of the facility’s decision to discharge the patient pursuant to 104 CMR 27.16(4)(a).

(5) All incidents of AWA shall receive clinical review and such other review as may be determined by the Commissioner.

27.17: Records

(1) "Individual record" shall refer to the medical and psychiatric record of a patient admitted to a facility providing care and treatment, and shall not include any financial, statistical or bookkeeping records of the facility.

(2) Contents of Individual Record. The facility shall maintain a permanent individual record containing all significant clinical information for each person admitted to the facility. Such record
shall include:

(a) identification data, including patient's admission status;
(b) admission information, including admission diagnosis;
(c) health care proxies and advance directives;
(d) history and results of physical examination and psychiatric examination or mental status;
(e) consent forms;
(f) social service and nurses' notes, and psychological reports;
(g) reports of clinical laboratory examinations and X-rays, if any;
(h) reports of diagnostic and therapeutic procedures;
(i) diagnoses recorded in accordance with the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association;
(j) progress notes;
(k) reports of periodic reviews;
(l) conclusions, including primary and secondary final diagnoses and clinical resume;
(m) all restraint and seclusion orders, including comment forms;
(n) commitment orders and records of transfer, including notice of transfer;
(o) records of all placements;
(p) reports of treatment for accidents, injuries or severe illnesses while the patient is in the care of the facility;
(q) requests for and consents to disclosure of information from such individual patient record;
(r) discharge information; and
(s) any other information deemed necessary and significant to the care and treatment of the patient.

(3) Maintenance of Records for 30 Years. Each facility providing care and treatment shall maintain individual patient records for at least 30 years after closing of the record due to discharge, death, or last contact.

(4) Microfilmed or Electronic Storage of Records. Facilities may put on microfilm or other form of electronic storage an individual case record after ten years have elapsed from the last contact with such patient. However, such microfilmed records shall be maintained for at least 20 years after being microfilmed. Any form of electronic storage system shall have adequate backup and security provisions to safeguard against data loss, as well as against unauthorized access.

27.17: continued

(5) Reporting Patient Data to the Department. Each facility shall maintain and make available to the Department such statistical and diagnostic data as may be required by the department.

(6) Confidentiality of and Access to Records. Except as provided in 104 CMR 27.17, all records relating to any persons admitted to or treated by a facility shall be private and not open to public inspection.

(a) Records of patients shall be open to inspection upon proper judicial order, whether or not such order is made in connection with pending judicial proceedings. For the purposes of 104 CMR 27.17(6), the term “proper judicial order” shall mean an order signed by a justice or special justice of a court of competent jurisdiction as defined from time to time by the General Laws, or a clerk or assistant clerk of such a court acting upon instruction of such a justice. A subpoena shall not be deemed a “proper judicial order.” Wherever possible, a patient’s legally authorized representative, if any, shall be informed of a court order commanding production of the patient’s record.

(b) The Commissioner or designee shall permit the attorney of a patient to inspect the records of said patient upon the request of the patient or attorney. For the purposes of 104 CMR 27.17(6), the Commissioner or designee may require that the request be in writing and may further require appropriate verification of the attorney-client relationship.

(c) A patient and the patient’s legally authorized representative shall be permitted to inspect the patient’s records, absent a determination by the Commissioner or designee, provided that the individual making the determination must be a licensed health care professional, that: inspection by the patient is reasonably likely to endanger the life or physical safety of the patient or another person; the record makes reference to another person (other than a health care provider) and inspection is reasonably likely to cause substantial harm to such other person; or inspection by the legally authorized representative is reasonably likely to cause substantial harm to the patient or another person. The facility director may require the legally authorized

representative’s consent before permitting a patient under the age of 18 to inspect his or her own records, provided that a patient who is 16 or 17 years old and admitted himself or herself pursuant to G.L. c. 123, §§ 10 & 11, may inspect records of the admittance without such consent. The records of emergency medical or dental treatment of a patient under 18 who consented to such care in accordance with G.L. c. 112, § 12F shall be confidential between the minor and physician or dentist and shall not be released except upon the written consent of the patient under 18 or a proper judicial order. Clinical staff may offer to read or interpret the record when necessary for the understanding of the patient or his or her legally authorized representative. In no circumstance may an individual be denied access to a record solely because he or she declines the offer of clinical staff to read or interpret the record. If access to a record is denied based on the criteria in 104 CMR 27.17(f)(c), the patient or legally authorized representative shall be informed of the right to appeal. The individual making a determination on appeal must be a licensed health care professional, and such determination shall be final.

(d) Records or parts thereof shall be open to inspection by other third parties, upon the written informed consent of the individual or legally authorized representative, provided that such written informed consent shall meet the requirements for authorization set forth in 45 CFR 164.508.

(e) Records may be disclosed as required by law. In addition to the laws and regulations of the Department, such laws include, but are not limited to:
1. M.G.L. c. 6, §§ 178C through 178O (the Sex Offender Registry Law - Department only);
2. M.G.L. c. 19, § 15 (Department of Elder Affairs - abuse of elderly persons, age 60 or over);
3. M.G.L. c. 19C, § 10 (Disabled Persons Protection Commission – abuse of disabled persons ages 18 to 59);
4. M.G.L. c. 119, § 51A (Department of Social Services – abuse or neglect of children under 18);
5. 42 U.S.C. 10806 (Protection and Advocacy for Mentally Ill Individuals);
6. M.G.L. c. 221, § 34E (Mental Health Legal Advisors Committee).

27.17: continued

(f) The Commissioner or designee may in his or her discretion permit inspection or disclosure of the records of a patient where the Commissioner or designee has made a determination that such inspection or disclosure would be in the best interest of the patient and that such disclosure is permitted by the privacy regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR Parts 160 and 164. Prior to authorizing any release of records under 104 CMR 27.17, other than by court order or to the attorney for a patient, the Commissioner or designee shall have made a determination that it is not possible or practicable to obtain the informed written consent of the patient, if competent, or the patient’s legally authorized representative.

(g) Without limiting the discretionary authority of the Commissioner or designee to identify other situations where inspection or disclosure is in the patient's best interest, if it is not possible or practicable to obtain the informed written consent of the patient, if competent, or

the patient’s legally authorized representative, such inspection or disclosure may be made in the patient's best interest in the following cases:
1. from a sending facility to a receiving facility for purposes of transfer pursuant to M.G.L. c. 123, § 3;
2. to a physician or other health care provider who requires such records for the treatment of a medical or psychiatric emergency; provided however that the patient is given notice of the access as soon as possible;
3. to a medical or psychiatric facility currently caring for the patient, when the disclosure is necessary for the safe and appropriate treatment and discharge of the patient;
4. where the patient has provided consent for a particular treatment or service, to those persons involved in such treatment or service;
5. between the Department and a contracted vendor regarding individuals being served by the vendor for purposes related to services provided under the contract;
6. to persons authorized by the Department to monitor the quality of services being provided to the individual;
7. to enable the patient, or someone acting on his or her behalf, to obtain benefits, protective services, or third party payment for services rendered to such patient;
8. to persons conducting an investigation involving the patient pursuant to 104 CMR 32.00;
9. to persons engaged in research if such access is approved by the Department pursuant
27.18: Interpreter Services

(1) For the purposes of 104 CMR 27.18, the following words shall have the following meanings:
   (a) Competent interpreter services means interpreter services performed by a person who is fluent in English and in the language of a non-English speaker, who is trained and proficient in the skill and ethics of interpreting and who is knowledgeable about the specialized terms and concepts that need to be interpreted for purposes of receiving care or treatment.
   (b) Facility shall mean a Department-operated hospital, community mental health center with inpatient unit, or psychiatric unit within a public health hospital; a Department-licensed psychiatric hospital; or a Department-licensed psychiatric unit within a general hospital.
   (c) Non-English speaker means a person who cannot speak or understand, or has difficulty with speaking or understanding, the English language because the speaker primarily or only uses a spoken language other than English.

(2) Each facility shall in connection with the delivery of inpatient services, if an appropriate bilingual clinician is not available, provide competent interpreter services to every non-English speaker who is a patient.

(3) Based on the volume and diversity of non-English-speaking patients served by the facility, the facility shall use reasonable judgment as to whether to employ, or to contract for, the on-call use of one or more interpreters for particular languages when needed, or to use competent telephonic or televiewing interpreter services; provided that such facility shall only use competent telephonic or televiewing interpreter services in situations where either:
   (a) there is no reasonable way to anticipate the need for employed or contracted interpreters for a particular language; or
   (b) there occurs, in a particular instance, an inability to provide competent services by an employed or contracted interpreter.

(4) Interpreter services shall be available 24 hours a day and seven days a week.

(5) The facility shall not require, suggest, or encourage the use of family members or friends of patients as interpreters and shall not, except in exceptional circumstances, use minor children as interpreters.

(6) The facility shall post signs and provide written notification of the right to and availability of interpreter services to patients in their primary language.

(7) The facility shall develop written policies and procedures that are consistent with 104 CMR 27.18 and that assist staff and patients in accessing interpreter services.
REGULATORY AUTHORITY

104 CMR 27.00: M.G.L. c. 19, §§ 1 and 18; c. 123, § 2.
SUMMARY:
This interim final rule with comment period establishes a definition of a “psychiatric residential treatment facility” that is not a hospital and that may furnish covered Medicaid inpatient psychiatric services for individuals under age 21. This rule also sets forth a Condition of Participation (CoP) that psychiatric residential treatment facilities that are not hospitals must meet to provide, or to continue to provide, the Medicaid inpatient psychiatric services benefit to individuals under age 21. Specifically, this rule establishes standards for the use of restraint or seclusion that psychiatric residential treatment facilities must have in place to protect the health and safety of residents. This CoP acknowledges a resident's right to be free from restraint or seclusion except in emergency safety situations. We are requiring psychiatric residential treatment facilities to notify a resident (and, in the case of a minor, his or her parent(s) or legal guardian(s)) of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that occurs while the resident is in the program. We believe these added requirements will protect residents against the inappropriate use of restraint or seclusion.

Effective Date: These regulations are effective on March 23, 2001.

For the reasons set forth in the preamble, 42 CFR chapter IV is amended as follows:

PART 441—SERVICES:
REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES
A. Part 441 is amended as set forth below:

1. The authority citation for part 441 continues to read as follows: Authority:
   Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 441.151 is revised to read as follows: Sec.
   441.151 General requirements.

   a) Inpatient psychiatric services for individuals under age 21 must be:
      1) Provided under the direction of a physician;
      2) Provided by--
         (i) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited
             by the Joint Commission on Accreditation of Healthcare Organizations; or
A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State.

(3) Provided before the individual reaches age 21, or, if the individual was receiving the services immediately before he or she reached age 21, before the earlier of the following--

(i) The date the individual no longer requires the services; or

(ii) The date the individual reaches 22; and

(4) Certified in writing to be necessary in the setting in which the services will be provided (or are being provided in emergency circumstances) in accordance with Sec. 441.152.

(b) Inpatient psychiatric services furnished in a psychiatric residential treatment facility as defined in Sec. 483.352 of this chapter, must satisfy all requirements in subpart G of part 483 of this chapter governing the use of restraint and seclusion.

PART 483: REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

B. Part 483 is amended as set forth below:

1. The authority citation for part 483 continues to read as follows:

   Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. A new subpart G, consisting of Secs. 483.350 through 483.376, is added to part 483 to read as follows:

Subpart G--Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21

Sec. 483.350 Basis and scope.

Sec. 483.352 Definitions.

Sec. 483.354 General requirements for psychiatric residential treatment facilities.

Sec. 483.356 Protection of residents.

Sec. 483.358 Orders for the use of restraint or seclusion.

Sec. 483.360 Consultation with treatment team physician.

Sec. 483.362 Monitoring of the resident in and immediately after restraint.

Sec. 483.364 Monitoring of the resident in and immediately after seclusion.

Sec. 483.366 Notification of parent(s) or legal guardian(s).

Sec. 483.368 Application of time out.

Sec. 483.370 Postintervention debriefings.

Sec. 483.372 Medical treatment for injuries resulting from an emergency safety intervention.

Sec. 483.374 Facility reporting.

Sec. 483.376 Education and training.

Subpart G--Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21

Sec. 483.350 Basis and scope.

(a) Statutory basis. Sections 1905(a)(16) and (h) of the Act provide that inpatient psychiatric services for
individuals under age 21 include only inpatient services that are provided in an institution (or distinct part thereof) that is a psychiatric hospital as defined in section 1861(f) of the Act or in another inpatient setting that the Secretary has specified in regulations. Additionally, the Children's Health Act of 2000 (Pub. L. 106-310) imposes procedural reporting and training requirements regarding the use of restraints and involuntary seclusion in facilities, specifically including facilities that provide inpatient psychiatric services for children under the age of 21 as defined by sections 1905(a)(16) and (h) of the Act.

(b) Scope. This subpart imposes requirements regarding the use of restraint or seclusion in psychiatric residential treatment facilities, that are not hospitals, providing inpatient psychiatric services to individuals under age 21.

Sec. 483.352 Definitions.
For purposes of this subpart, the following definitions apply: Drug used as a restraint means any drug that--
(1) Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;
(2) Has the temporary effect of restricting the resident's freedom of movement; and
(3) Is not a standard treatment for the resident's medical or psychiatric condition.
Emergency safety intervention means the use of restraint or seclusion as an immediate response to an emergency safety situation.
Emergency safety situation means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.
Mechanical restraint means any device attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.
Minor means a minor as defined under State law and, for the purpose of this subpart, includes a resident who has been declared legally incompetent by the applicable State court.
Personal restraint means the application of physical force without the use of any device, for the purpose of restricting the free movement of a resident's body.
Psychiatric Residential Treatment Facility means a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting.
Restraint means a ``personal restraint,'' ``mechanical restraint,'' or ``drug used as a restraint'' as defined in this section.
Seclusion means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.
Serious injury means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self- inflicted or inflicted by someone else.
Staff means those individuals with responsibility for managing a resident's health or participating in an emergency safety intervention and who are employed by the facility on a full-time, part-time, or contract basis.
Time out means the restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.

Sec. 483.354 General requirements for psychiatric residential treatment facilities.
A psychiatric residential treatment facility must meet the requirements in Sec. 441.151 through Sec. 441.182 of this chapter.

Sec. 483.356 Protection of residents.
(1) Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.
(2) An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.
(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only-
   (i) To ensure the safety of the resident or others during an emergency safety situation; and
   (ii) Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.
(4) Restraint and seclusion must not be used simultaneously.
   (b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).
   (c) Notification of facility policy. At admission, the facility must--
      (1) Inform both the incoming resident and, in the case of a minor, the resident's parent(s) or legal guardian(s) of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program;
      (2) Communicate its restraint and seclusion policy in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators;
      (3) Obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and
      (4) Provide a copy of the facility policy to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s).
   (d) Contact information. The facility's policy must provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization.

Sec. 483.358 Orders for the use of restraint or seclusion.
(a) Only a board-certified psychiatrist, or a physician licensed to practice medicine with specialized training and experience in the diagnosis and treatment of mental diseases, may order the use of restraint or seclusion.
(b) If the resident's treatment team physician is available, only he or she can order restraint or seclusion. If the resident's treatment team physician is unavailable, the physician covering for the treatment team
physician can order restraint or seclusion. The covering physician must meet the same requirements for training and experience described in paragraph (a) of this section.

(c) The physician must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

(d) If the physician is not available to order the use of restraint or seclusion, the physician's verbal order must be obtained by a registered nurse at the time the emergency safety intervention is initiated by staff and the physician's verbal order must be followed with the physician's signature verifying the verbal order. The ordering physician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(e) Each order for restraint or seclusion must:

(1) Be limited to no longer than the duration of the emergency safety situation; and
(2) Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9.

(f) Within 1 hour of the initiation of the emergency safety intervention, a physician or clinically qualified registered nurse trained in the use of emergency safety interventions must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to--

(1) The resident's physical and psychological status;
(2) The resident's behavior;
(3) The appropriateness of the intervention measures; and
(4) Any complications resulting from the intervention.

(g) Each order for restraint or seclusion must include--

(1) The ordering physician's name;
(2) The date and time the order was obtained; and
(3) The emergency safety intervention ordered, including the length of time for which the physician authorized its use.

(h) Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:
(1) Each order for restraint or seclusion as required in paragraph (g) of this section.
(2) The time the emergency safety intervention actually began and ended.
(3) The time and results of the 1-hour assessment required in paragraph (f) of this section.
(4) The emergency safety situation that required the resident to be restrained or put in seclusion.
(5) The name of staff involved in the emergency safety intervention.
(i) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.
(j) The physician ordering the restraint or seclusion must sign the order in the resident's record as soon as possible.

Sec. 483.360 Consultation with treatment team physician.
If the physician ordering the use of restraint or seclusion is not the resident's treatment team physician, the ordering physician or registered nurse must--

(a) Consult with the resident's treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained or placed in seclusion; and

(b) Document in the resident's record the date and time the team physician was consulted.

Sec. 483.362 Monitoring of the resident in and immediately after restraint.
(a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention.

(b) If the emergency safety situation continues beyond the time limit of the physician's order for the use of restraint, a registered nurse must immediately contact the ordering physician in order to receive further instructions.

(c) A physician, or a registered nurse trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed.

Sec. 483.364 Monitoring of the resident in and immediately after seclusion.
(a) Clinical staff, trained in the use of emergency safety interventions, must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not meet this requirement.

(b) A room used for seclusion must--

(1) Allow staff full view of the resident in all areas of the room; and
(2) Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

(c) If the emergency safety situation continues beyond the time limit of the physician's order for the use of seclusion, a registered nurse must immediately contact the ordering physician in order to receive further instructions.

(d) A physician, or a registered nurse trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.
Sec. 483.366 Notification of parent(s) or legal guardian(s).
If the resident is a minor as defined in this subpart:

(a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

(b) The facility must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

Sec. 483.368 Application of time out.
(a) A resident in time out must never be physically prevented from leaving the time out area.

(b) Time out may take place away from the area of activity or from other residents, such as in the resident's room (exclusionary), or in the area of activity or other residents (inclusionary).

(c) Staff must monitor the resident while he or she is in time out.

Sec. 483.370 Postintervention debriefings.
(a) Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion.

(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of--

(1) The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;
(2) Alternative techniques that might have prevented the use of the restraint or seclusion;
(3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and
(4) The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

(c) Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.

Sec. 483.372 Medical treatment for injuries resulting from an emergency safety intervention.
(a) Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

(b) The psychiatric residential treatment facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that
reasonably ensure that--

(1) A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;

(2) Medical and other information needed for care of the resident in light of such a transfer, will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and

(3) Services are available to each resident 24 hours a day, 7 days a week.

(c) Staff must document in the resident's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.

(d) Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

Sec. 483.374 Facility reporting.

(a) Attestation of facility compliance. Each psychiatric residential treatment facility that provides inpatient psychiatric services to individuals under age 21 must attest, in writing, that the facility is in compliance with HCFA's standards governing the use of restraint and seclusion. This attestation must be signed by the facility director.

(1) A facility with a current provider agreement with the Medicaid agency must provide its attestation to the State Medicaid agency by July 21, 2001.

(2) A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency.

(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State-designated Protection and Advocacy system. Serious occurrences that must be reported include a resident's death, a serious injury to a resident as defined in Sec. 483.352 of this part, and a resident's suicide attempt.

(1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State-designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include the name of the resident involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility.

(2) In the case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

(3) Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and the State-designated Protection and Advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.

Sec. 483.376 Education and training.

(a) The facility must require staff to have ongoing education, training, and demonstrated knowledge of--

(1) Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;
(2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and

(3) The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.

(b) Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.

(c) Individuals who are qualified by education, training, and experience must provide staff training.

(d) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

(e) Staff must be trained and demonstrate competency before participating in an emergency safety intervention.

(f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis.

(g) The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.

(h) All training programs and materials used by the facility must be available for review by HCFA, the State Medicaid agency, and the State survey agency.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Robert A. Berenson, Acting Deputy Administrator, Health Care Financing Administration.

Donna E. Shalala, Secretary.
DMH Policy #96-3R
Informed Consent for Psychiatric Medications, Electroconvulsive Treatment, or Psychosurgery

Date of Issue: 2/16/96 Revised
Date: 8/22/96 Effective Date: 9/1/96

I. PURPOSE
To establish a statewide system for assuring informed consent for psychiatric medications, electroconvulsive treatment and/or psychosurgery and related treatment information.

II. SCOPE
This policy applies to any entity, be it an individual, program or facility (or any of their staff) that is operated or funded by the Department of Mental Health and the clients (child, adolescent or adult) who receive treatment from them. This policy also applies to any private program or facility that agrees by contract (or other agreement to comply with this policy.

For clients under the age of 16, it must be understood that each time the policy references “client,” it is the parent or legal guardian of the minor client who must be consulted for the purposes of giving informed consent unless the client has been determined to be an emancipated minor (see IV A5). This does not, however, preclude the necessity of involving the minor client in discussions regarding the implications of any recommended treatment.

III. DEFINITIONS
A. Emancipated Minor: A client under the age of 18 may give consent for medical or dental care if he/she is: married, widowed or divorced; the parent of a child; pregnant or believes herself to be pregnant; a member of the armed forces; living separate and apart from parent or legal guardian and managing his/her own financial affairs.

B. Authorized Prescribing Clinician: For the purposes of this document, includes licensed physicians, licensed physician’s assistants of licensed clinical nurse specialists practicing in the expanded role, who are authorized under Massachusetts law to prescribe certain kinds of treatment.

C. Roger’s Order: The judicial review and approval required to treat individuals with antipsychotic medications, electroconvulsive treatment or psychosurgery who are unable to give informed consent.

D. Treatment: For the purposes of this document, includes use of psychiatric medications, electroconvulsive treatment and/or psychosurgery.

E. Competence: Ability to understand the nature of the illness; the risks, benefits and side effects of the proposed treatments and capable of rationally manipulating the information to arrive at an informed decision.
IV. INTRODUCTION

Although this policy is limited to programs that are operated or funded by DMH, under Massachusetts law, the doctrine of informed consent is applicable to all Authorized Prescribing Clinicians. However, the doctrine of informed consent only extends to clients able to make informed decisions. For those clients incapable of making an informed decision to accept or forego certain forms of treatment, the law provides an alternative means to protect their interests, i.e., appointment of a guardian and application of the doctrine of substituted judgment. In any event, clients who are not able to consent to or refuse treatment shall nevertheless be informed of the purpose, risks, benefits and side effects of the proposed treatment (as provided under this policy) to the extent possible, consistent with the client’s ability to understand this information.

There are other circumstances where an incompetent client’s right to refuse medication may be overridden to prevent an immediate, substantial and irreversible deterioration of the client’s mental illness. Similarly, chemical restraint may be used in an emergency situation pursuant to applicable Department regulations.

A. Consistent with Massachusetts law, the following principles are established with regard to informed consent:

1. For consent to treatment to be informed, it must be voluntary, (i.e., free of coercion), knowing, and competently given. Individuals are presumed competent to make informed decisions.

2. The Authorized Prescribing Clinician owes to the client the duty to disclose, in a reasonable manner, all significant medical information that the Authorized Prescribing Clinician possesses or reasonably should possess that is material to an informed decision by the client as to whether or not to undergo a proposed treatment.

3. Knowing exercise of the right to accept or forego treatment requires knowledge of the available options and risks attendant on each.

4. Competent adults have the right to forego treatment, or even cure, if it entails what, for them are unacceptable consequences or risks, however unwise their decision may be in the eyes of the medical profession or others.

5. An “emancipated minor” has the same right as an adult to consent to or refuse medical treatment.

6. It is the Department’s policy that parents and other legal guardians (for example, DSS if it has custody) of 16 and 17 year old clients should play a central role in the development of the client’s treatment plan. The parent(s) or legal guardian(s) should be given the opportunity to be involved in the decision-making and to co-sign the treatment plan unless it is not in the best interests of the 16 or 17 year old client to do so. However, because 16 or 17 years old clients are authorized by law to sign themselves into and out of inpatient mental health facilities, it is the Department’s policy to afford these 16 and 17 year old clients the right to consent to and refuse treatment. In order to give informed consent, the 16 or 17 year old client must be capable of understanding the nature of his or her illness and the risks and benefits of the proposed treatment.

In cases where the 16 or 17 year old client refuses treatment, court approval must be obtained before beginning treatment.
Whenever questions arise as to the specific rights of minors, their parent(s) or legal guardian(s), the appropriate DMH legal office should be contacted for clarification.

B. Consistent with acceptable health care practices, facilities and programs covered by this policy shall adhere to standards regarding informed consent established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and identified in its Accreditation Manual for Hospitals, Accreditation Manual for Health Care Networks, and Mental Health Manual.

V. AUTHORIZED PRESCRIBING CLINICIAN RESPONSIBILITIES

A. Introduction
Providing information necessary for informed consent is the responsibility of the Authorized Prescribing Clinician. This information shall be provided in the client’s own language, in terms the client can understand. The Authorized Prescribing Clinician will discuss the nature of the illness and the need for medication with the client, describing the type of treatment, its risks and benefits, probability of side effects, alternative treatments, and the prognosis with and without any treatment. Further discussion then shall proceed in response to questions that the client has about specific issues of possible side effects, for example, tardive dyskinesia or certain dystonic reactions from neuroleptic medications. The Authorized Prescribing Clinician assesses the client’s ability to understand and process the information and documents this discussion in the medical record.

B. Obtaining Valid Informed Consent
Informed consent must include the following elements:

1. An assessment of the competency/ability of the client to understand that there may be something wrong, that there is a treatment that might help and that the client has the capacity to recognize and report side effects.
2. A description of the condition being treated;
3. An explanation of the proposed treatment;
4. An explanation of the risks, side effects and benefits of the proposed treatment;
5. A set of materials provided to the client that are written in common, everyday language describing the benefits, risks, and side effects of the prescribed medication;
6. An explanation of alternatives to the proposed treatment, including not having treatment and the risks, benefits and side effects of the alternatives to the proposed treatment;
7. An explanation of the right to freely consent to or refuse the treatment without coercion, retaliation or punishment. Loss of privileges, threat/use of restraints, discharge, guardianship, Roger’s orders or any form of retaliation and/or coercion shall never be used as punishment when a client freely exercises his/her right to refuse/accept treatment. Such interventions may only be utilized in accordance with applicable legal and clinical standards. In cases where a competent client refuses a recommended treatment, alternative, clinically appropriate treatment acceptable to the client, including no treatment, shall be explored and offered where possible.
8. An explanation of the right to withdraw one’s consent to treatment, orally or in writing, at any time.

C. Ongoing Communication and Review
When initiating or making substantial changes in treatment for inpatients or outpatients, the discussion of informed consent shall be documented early in the treatment process and periodically as continuing dialogue about it occurs. For stable outpatients, documentation at annual intervals is sufficient, unless there are changes in the treatment or the client’s mental and/or physical status. For long stay inpatients, informed consent issues will be documented as part of the periodic review process, at three and six month intervals, and then annually unless there are changes in the treatment or in the client’s mental and/or physical status.

Obtaining informed consent is an ongoing process rather than a one-time event. Discussions about informed consent, in particular regarding psychiatric medications, do not stop with the initial consent but continue through the course of treatment as the client experiences the medication and its benefits and side effects and especially when the care of the client is transferred to a new Authorized Prescribing Clinician. If at any point in time a client decides to stop taking the treatment or experiences side effects that were not previously discussed, such discussions shall then take place and be subsequently documented in the medical record as part of the informed consent process.

A continuing assessment of the capability of making informed decisions must also occur, particularly when the Authorized Prescribing Clinician has reason to believe that the client’s ability to understand and process the information has changed.

D. Documentation of Informed Consent
Documentation of informed consent in the medical record shall include:

1. An assessment of the client’s capacity to understand and process the information;
2. an indication that the client has been provided information including risks, benefits and side effects;
3. A notation that the client has assented to, or refused treatment;
4. A signed copy of a consent form, or an indication of the oral consent on the form. These forms shall be duplicate carbonless forms. The client shall be given a signed copy of his or her consent form.
5. A description of any questions and comments offered by the client and the Authorized Prescribing Clinician’s response;
6. An ongoing review of the efficacy of treatment, the side effects of medications; alternative treatments and continuing competency; this review should include appropriate diagnostic tests. Discussion of all of these shall occur on a regular basis and shall be documented in the medical record.

E. Incompetency, Guardianship or an Order for Psychiatric Treatment under Chapter 123 s. 8B
1. If after conversations between an Authorized Prescribing Clinician and a client, the Authorized Prescribing Clinician has reason to believe that a client is not capable of giving
informed consent, this is documented in the medical record describing the specific facts upon which this conclusion is based. The client should be fully and honestly informed of the pursuit of the guardianship, in a manner appropriate to his or her needs. A discussion regarding the process of obtaining guardianship or a court order for treatment in accordance with MGL c. 123 s. 8B shall be initiated with legal counsel. Legal counsel will work with the Authorized Prescribing Clinician to determine whether a petition will be filed, and in which forum, based upon relevant criteria such as the standards set for in DMH Policy #83-50, an assessments of the merits of the case, resources of the legal office, and other considerations. In addition, if the Authorized Prescribing Clinician has reason to believe that a client under guardianship has been restored to competency, s/he should contact legal counsel for advice.

2. If the client has a legal guardian with responsibility for treatment decision, the above procedures for informed consent shall be followed with the guardian. It should be noted that if antipsychotic medications, electroconvulsive treatment or psychosurgery are to be given, information should be shared with the guardian, but only the court can give consent to this treatment.

3. Clients who are not able to consent to or refused treatment shall nevertheless to be informed of the purpose, risks and benefits of the proposed treatment (as provided under this policy) to the extent possible, consistent with the client’s ability to understand this information.

4. It is the parent or legal guardian or a client under the age of 16 who has the authority to make treatment decisions on behalf of the client, unless the client is an Emancipated Minor. Additionally, see Section IV. A.6 of this policy regarding 16 and 17 year olds.

VI. TREATMENT TEAM RESPONSIBILITIES

A. Treatment Teams in conjunction with the client shall assess the best method to provide ongoing information about treatment.

B. Written materials that supply current and accurate explanations of treatment in common, everyday language shall be made available to clients for review and discussion. A copy of these materials shall be given to the client and client’s guardian if s/he has one, and a copy shall be placed in the medical record. At the client’s request, a copy will be given to the client’s family or significant others designated by the client.

VII. ADMINISTRATIVE RESPONSIBILITIES

A. On inpatient units and in 24-hour resident facilities, a human rights officer shall introduce himself/herself to a client as soon as possible and preferably within 72 hours of admission to inform the client of his/her human rights, including informed consent, and the right to refuse treatment, accept treatment, or request alternative treatments. The human rights officer will also answer any questions or provide additional information if requested to do so.

B. A blank copy of the consent form shall be posted in patient areas of outpatient services and on inpatient units. Information from the most recent edition of the PDR Family Guide to Prescription Drugs, unless at such time another standardized, regularly updated set of fact sheets are adopted by the Department, shall be available at the place of service. These fact sheets shall be translated into languages spoken by the clients, where possible.
C. Settings that prescribe and/or administer medications shall have methods appropriate client needs to provide ongoing information and education about medication including, but not limited to medication groups.

D. A separate document on Informed Consent Rights shall be posted in patient areas. This posting shall reflect the values and principles embodied in this policy and shall convey that clients have the right to freely consent to or refuse recommended treatment without coercion, retaliation or punishment unless a court has ordered said treatment or in an emergency situation.

The posted document shall read as follows: You are an active partner in your treatment.

You have the right to know the benefits, risks and side effects of the proposed treatment, alternative treatments and what is likely to occur if you go untreated. This information should be discussed with you and given to you in the form of a consent form. Information sheets for each prescribed medication also will be given to you.

You are entitled to an explanation of your right to freely consent to or refuse treatment without coercion, retaliation, or punishment. Loss of privileges, threat/use of restraints, discharge, guardianship, Roger’s orders or any form of retaliation and/or coercion shall never be used as punishment when you freely exercise your right to refuse/accept treatment. Such interventions may only be utilized in accordance with applicable legal and clinical standards. When you are competent and refuse a recommended treatment, alternative clinically appropriate treatment acceptable to you, including no treatment, shall be explored and offered where possible.

You have the right to freely consent to or refuse recommended treatment unless a court has ordered said treatment. (In emergency situation, medication may be given without your consent.)

If you have not received adequate information about your treatment rights, believe that your rights are being violated, or that you are being coerced into treatment, you may contact: The Human Rights Office, Mental Health Legal Advisors Committee or other Mental Health Protection and Advocacy agency, etc. (include local methods of access of each).

When an inpatient is under guardianship with a Roger’s order from a Probate Court, the order should be sent to the treating outpatient psychiatrist upon discharge along with a copy of the discharge summary. Similarly, when an outpatient under guardianship with a Roger’s order from a Probate Court is admitted to a hospital, a copy of the order should be sent to the inpatient treatment facility. The release of client records and information must be consistent with confidentiality requirements.

VIII. TRAINING AND EVALUATION

A. The process of informed consent is reviewed at least annually as part of each facility’s quality improvement plan.

B. Annually, all Authorized Prescribing Clinicians credentialed to provide services at each facility will be trained regarding the requirements of informed consent. Furthermore, all staff involved in medication delivery, dispensing and education, as well as human rights officers, will also receive this training annually.
IX. IMPLEMENTATION RESPONSIBILITY
Implementation of this policy, including training and evaluation, shall be the responsibility of the person in charge of each facility or program included under Part II (scope).

X. REVIEW
This policy shall be reviewed annually.

References:
The following statutes, regulations, and policies are applicable to this policy and may be referenced:

MGL c. 111, s. 70E; MGL c. 123, ss. 4, 23, 24 and 25; MGL c. 201; 104 CMR 3.08; 104 CMR 15.06; 104 CMR 3.12; 104 CMR 16.00; DMH Policy #83-50
CHAPTER 123. MENTAL HEALTH.

Chapter 123: Section 23. Telephone access rights; mail rights; visitation rights; legal and civil rights; suspension of rights; notice of rights.

This section sets forth the statutory rights of all persons regardless of age receiving services from any program or facility, or part thereof, operated by, licensed by or contracting with the department of mental health, including persons who are in state hospitals or community mental health centers or who are in residential programs or inpatient facilities operated by, licensed by or contracting with said department. Such persons may exercise the rights described in this section without harassment or reprisal, including reprisal in the form of denial of appropriate, available treatment. The rights contained herein shall be in addition to and not in derogation of any other statutory or constitutional rights accorded such persons.

Any such person shall have the following rights:

(a) reasonable access to a telephone to make and receive confidential telephone calls and to assistance when desired and necessary to implement such right; provided, that such calls do not constitute a criminal act or represent an unreasonable infringement of another person's right to make and receive telephone calls;

(b) to send and receive sealed, unopened, uncensored mail; provided, however, that the superintendent or director or designee of an inpatient facility may direct, for good cause and with documentation of specific facts in such person's record, that a particular person's mail be opened and inspected in front of such person, without it being read by staff, for the sole purpose of preventing the transmission of contraband. Writing materials and postage stamps in reasonable quantities shall be made available for use by such person. Reasonable assistance shall be provided to such person in writing, addressing and posting letters and other documents upon request;

(c) to receive visitors of such person's own choosing daily and in private, at reasonable times. Hours during which visitors may be received may be limited only to protect the privacy of other persons and to avoid serious disruptions in the normal functioning of the facility or program and shall be sufficiently flexible as to accommodate individual needs and desires of such person and the visitors of such person.

(d) to a humane psychological and physical environment. Each such person shall be provided living quarters and accommodations which afford privacy and security in resting, sleeping, dressing, bathing and personal hygiene, reading and writing and in toileting. Nothing in this section shall be construed to require individual sleeping quarters.
(e) to receive at any reasonable time as defined in department regulations, or refuse to receive, visits and telephone calls from a client's attorney or legal advocate, physician, psychologist, clergy member or social worker, even if not during normal visiting hours and regardless of whether such person initiated or requested the visit or telephone call. An attorney or legal advocate working under an attorney's supervision and who represents a client shall have access to the client and, with such client's consent, the client's record, the hospital staff responsible for the client's care and treatment and any meetings concerning treatment planning or discharge planning where the client would be or has the right to be present. Any program or facility, or part thereof, operated by, licensed by or contracting with the department shall ensure reasonable access by attorneys and legal advocates of the Massachusetts Mental Health Protection and Advocacy Project, the Mental Health Legal Advisors Committee, the committee for public counsel services and any other legal service agencies funded by the Massachusetts Legal Assistance Corporation under the provisions of chapter 221A, to provide free legal services. Upon admission, and upon request at any time thereafter, persons shall be provided with the name, address and telephone number of such organizations and shall be provided with reasonable assistance in contacting and receiving visits or telephone calls from attorneys or legal advocates from such organizations; provided, however, that the facility shall designate reasonable times for unsolicited visits and for the dissemination of educational materials to persons by such attorneys or legal advocates. The department shall promulgate rules and regulations further defining such access. Nothing in this paragraph shall be construed to limit the ability of attorneys or legal advocates to access clients records or staff as provided by any other state or federal law.

Any dispute or disagreement concerning the exercise of the aforementioned rights in clauses (a) to (e), inclusive, and the reasons therefor shall be documented with specific facts in the client's record and subject to timely appeal.

Any right set forth in clauses (a) and (c) may be temporarily suspended, but only for a person in an inpatient facility and only by the superintendent, director, acting superintendent or acting director of such facility upon such person; concluding, pursuant to standards and procedures set forth in department regulations that, based on experience of such person's exercise of such right, further such exercise of it in the immediate future would present a substantial risk of serious harm to such person or others and that less restrictive alternatives have either been tried and failed or would be futile to attempt. The suspension shall last no longer than the time necessary to prevent the harm and its imposition shall be documented with specific facts in such person's record.

A notice of the rights provided in this section shall be posted in appropriate and conspicuous places in the program or facility and shall be available to any such person upon request. The notice shall be in language understandable by such persons and translated for any such person who cannot read or understand English.

The department, after notice and public hearing pursuant to section 2 of chapter 30A, shall promulgate regulations to implement the provisions of this section.

In addition to the rights specified above and any other rights guaranteed by law, a mentally ill person in the care of the department shall have the following legal and civil rights: to wear his own clothes, to keep and use his own personal possessions including toilet articles, to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases, to have access to individual storage space for his private use, to refuse shock treatment, to refuse lobotomy, and any other rights specified in the regulations of the department; provided, however, that any of these rights may be denied for good cause by the superintendent or his designee and a statement of the reasons for any such denial entered in the treatment record of such person.
# NETWORK MANAGEMENT AND CREDENTIALING

## NETWORK MANAGEMENT

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NETWORK MANAGEMENT

MBHP manages a Behavioral Health Provider Network to meet the Behavioral Health needs of Covered Individuals. We work with this provider network to assure timely access for all Covered Individuals to the full range of BH Covered Services including outpatient, inpatient, 24-hour Diversionary, community Diversionary, and Emergency Services.

MBHP adheres to the following key principles of Behavioral Health Provider Network management:

- The use of data in decision-making
- Adherence to a continuous quality improvement that focuses on access, quality, value, and outcomes
- Promoting collaboration and alignment with state and federally funded services and programs and support of state agency missions
- Recognizing the capacity of Covered Individuals and their families to access their strengths as part of their treatment and eventual recovery
- Supporting and incorporating EOHHS health care reform initiatives, including PCMHI and those associated with payment reform
- Improving the ability of the Behavioral Health Provider Network to meet all of the health needs of Covered Individuals through strengthened collaboration with PCCs, emergency departments, specialty medical providers, pharmacies, and inpatient hospital providers
- Reducing health disparities
- Identifying and disseminating best practices

MBHP’s network management strategy is integrated with utilization management, quality management, and rehabilitation and recovery initiatives to ensure the delivery and management of quality services. Our established statewide regional network management structure engages providers of all levels of care in the use of robust provider/regional/statewide data to manage utilization, improve quality and outcomes, and ensure access, quality, Member satisfaction, provider accountability, and cost containment. MBHP works closely with not only network providers but also state agencies, consumer, family and advocacy organizations, and other stakeholders to strengthen continuity of care within a community-based, locally integrated service delivery system.

MBHP employs a multi-pronged, data-driven system for monitoring the performance of our provider network across all levels of care and covered services. We manage compliance with established standards and contractual requirements as delineated in our provider contracts and encompassing medical necessity criteria, performance specifications, per diem definitions and all policies and procedures in the Provider Manual. We also have many other measures of provider performance including utilization indicators. Regional network management staff actively monitors contract compliance and provider performance, intervene when lack of compliance or poor performance is identified, and work with providers to mitigate barriers, ensure accountability and improve compliance and performance.

Network Management Approach

MBHP is committed to partnering with our provider network in a collaborative manner to achieve our network management, quality management and utilization management goals, by forging productive working relationships to which MBHP offers:
• a value-driven managed care organization that shares common values with providers, including recovery orientation, good clinical care, and mutual respect;
• an accessible and responsive managed care organization, not only during the initial process of joining the network but also in an ongoing fashion as procedures and requirements change, challenges arise, and the provider or the Members they serve need assistance of any kind;
• clear initial and ongoing communication;
• clear, easy and swift credentialing and contracting processes;
• user-friendly clinical, authorization, administrative and financial systems;
• good faith efforts by the managed care organization to ensure fair and equitable rates as well as accurate and timely claims payment;
• a comprehensive continuum of care and high quality care management services, to give providers the tools and supports they need to provide good care for the Members they serve;
• a network management approach that simultaneously maintains both collaboration and accountability and balances statewide consistency with appropriate local variance; and
• a utilization management approach that prioritizes providing the right care for each Member while collaborating with providers to improve quality, increase efficiency, and contain cost.

Regional Offices and Representatives for Network Providers

MBHP maintains five regional offices in order to ensure accessibility to our Members and providers in their local communities. They include:

• MetroBoston Regional Office- located in Boston
• Northeast Regional Office- located in Danvers
• Southeast Regional Office- located in Bridgewater
• Central Regional Office- located in Worcester
• Western Regional Office- located in Springfield

The regional director is the primary representative for the provider network in each region. Contact information for the MBHP regional directors can be found at www.masspartnership.com. Additionally, the regional director assigns a regional network manager to provide day-to-day network management and be available to each network provider.

Provider Performance Specifications

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

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

In accordance with MBHP’s mission and values, particular emphasis has been placed in the General performance specifications on recovery, wellness, and resilience; cultural competence in serving our Members; and integration of physical and behavioral health. Also of note, the General performance specifications reiterate the responsibility of providers to immediately notify MBHP of revocation, limitation, suspension, or other conditions placed on the license, certification, or accreditation, in compliance with all applicable state and federal laws, regulations, licensing, policies, and accreditation requirements, as well as any proposed changes in location of services for which the provider is contracted. The General performance specifications articulate providers’ responsibility to meet with MBHP staff for the purposes of care management, network management, quality management, and/or utilization management.

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

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

Provider Responsibilities

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

This representative shall be responsible for:

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

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

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

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

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

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

**Operating Hours:** Every provider shall maintain hours of operation for Members in the same manner as maintained for all other populations who utilize the provider’s services. In addition, all outpatient providers are expected to provide emergency services 24 hours per day, seven days per week to all Members enrolled in the outpatient program/clinic/practice. These services are intended to be the first level of crisis intervention whenever needed by the Member. During operating hours, these services are provided by phone and face-to-face through emergency appointments as warranted by the Member’s clinical presentation. After hours, the program provides an emergency phone number that accesses a clinician either directly or via an answering service. Any call that is identified as an emergency by the caller is immediately triaged to a clinician. A clinician must respond to emergency calls within 15 minutes. This clinician provides a brief assessment and intervention minimally by phone. Based upon these emergency services conducted by the provider both during operating hours and after hours, the provider may refer the Member, if needed, to an ESP for an emergency behavioral health evaluation. Maintenance of an answering machine or answering service directing callers to call 911 or the ESP, or to go to a hospital emergency department, is not sufficient.

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

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

All providers shall manage services to eliminate the necessity of maintaining waiting lists. Providers who are not able to offer access that comply with the MBHP access standards outlined below must refer Members to
another MBHP provider to ensure that Members receive services in a timely manner. Providers will contact the MBHP clinical access line or regional office for assistance with making referrals as needed.

**Inpatient Facility Compliance with “No Reject” Requirements**

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

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

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

**Notification of Change in Status:** Providers must notify MBHP in writing within 24 hours upon the occurrence of the following:

- Any legal or governmental action initiated against provider and/or the members of its clinical staff whenever the existence or outcome of such action could materially affect the performance of provider and/or the members of its clinical staff;
- Any action taken against the licensure or Drug Enforcement Agency (DEA) authorization of provider and/or the members of its clinical staff;
- Any action causing a loss of admitting privileges of provider and/or the members of its clinical staff with a participating provider or any other hospital, provider, or program;
• Any action by an insurance carrier indicating that it will lower coverage, cancel, or non-renew the insurance coverage required to be carried by provider and/or the members of its clinical staff;
• Any malpractice litigation in which provider and/or the members of its clinical staff are named as defendants and the plaintiff is asking for damages in excess of $25,000;
• Any action or event known to provider and/or the members of its clinical staff which could materially impair the performance of provider and/or the members of its clinical staff; or
• Any action through which provider and/or the members of its clinical staff are excluded from participation as a Medicaid or Medicare provider, or are excluded from any private payer network or plan.

Notification of Inability to Provide Services: Providers must also notify MBHP:
• immediately of their inability to provide emergency care by contacting the Clinical Access Line at 1-800-495-0086 (press 3 and then 1 to skip prompts);
• within 24 hours of their inability to deliver urgent care also by contacting the Clinical Access Line at 1-800-495-0086 (press 3 and then 1 to skip prompts); or
• within seven days of their inability to provide routine care by faxing notice to the Clinical Access Line fax number at 1-855-685-5170.

Delegation of Subcontractor Agreements

In the event that a provider wishes to engage any subcontractors to assist with its obligations to provide Covered Services, the provider must:
• Complete the MBHP Organizational Providers Subcontracting Application and provide a written description of any subcontracted relationships to the MBHP Network Operations Department no later than 60 days prior to the agreement;
• Maintain all subcontracts or agreements in writing;
• Monitor the quality of care provided to Members under the MBHP agreement and any subcontract;
• Remain fully responsible for meeting all of the terms and requirements of the provider agreement. No provider agreement or subcontract agreement will relieve the provider of its legal responsibilities under the provider agreement; and
• Submit claims for the delivery of all services in accordance with MBHP’s claims policies and procedures. Claims must contain the name and tax ID number of the provider who has the contract with MBHP. MBHP reserves the right to determine approval or denial of all subcontractor agreements.

Information can be submitted in writing by e-mailing to MBHPNetworkManagement@valueoptions.com, faxing to 1-877-390-2324, or mailing to:

Garland Russell, Director Network Operations
Massachusetts Behavioral Health Partnership
Network Operations
1000 Washington Street, Suite 310
Boston, MA 02218-5002
Performance Evaluation/Audits

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

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

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

Provider Appeals Related to Credentialing, Sanctions, or Terminations

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

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

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

Fair Hearing Process
Providers may request a second level of appeal or a Fair Hearing when the PAC denies credentialing or re-credentialing, issues a sanction, or dis-enrolls a provider from the network based on issues related to competence or professional conduct. A request for a Fair Hearing must be made within 30 calendar days of the date of the PAC’s notification. The provider will receive written notice of the place, time, and date of the Fair Hearing, which shall not be less than 90 calendar days after the date that the request for appeal was received from the provider.
Additionally, the provider will receive an explanation of the hearing procedures and a list of witnesses, if any, expected to testify on behalf of ValueOptions. The chair of the PAC will identify peer reviewers who will participate as the Fair Hearing panel, assuring representation of the discipline of the provider requesting the appeal. These peers will not have any economic interest adverse to the provider, nor will they have participated in the prior decisions of the PAC or NCC. One member of the Fair Hearing panel will be selected to act as the hearing officer and will preside over the Fair Hearing. Both ValueOptions and the provider will make reasonable efforts to establish a mutually agreed upon date for the hearing. Both ValueOptions and the provider have the right to legal representation at the Fair Hearing. The provider will receive a written recommendation from the panel within 15 business days after the Fair Hearing. The Fair Hearing process as set forth above is subject to applicable state and federal laws and regulations.

**Provider Sanctions**

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

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

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

2. **Immediate Termination**
   
   MBHP may immediately terminate a provider’s agreement upon the occurrence of any of the following events:
   
   a. End of Contract with MassHealth: MBHP’s contract with the MassHealth program terminates.
   b. Insolvency or Dissolution: The provider, group, or facility of which the provider is employed becomes insolvent, or the subject of a bankruptcy, receivership, reorganization, dissolution, liquidation, or other similar proceeding.
   c. Loss of License: The provider license issued by the Commonwealth of Massachusetts is revoked, suspended, surrendered, or not renewed.
   d. Conviction of Fraud
   e. Limited Ability to Practice: Final disciplinary action by a governmental agency or licensing board that impairs the professional’s ability to practice
   f. Death: The death of the provider
      
      i. **Immediate Termination:** We may immediately terminate this Agreement upon the occurrence of any one of the events set forth in this Section 4.1. In cases of immediate termination, an appeal is not available. In addition, in cases of immediate termination, we will provide written notice to
Members of your termination from the network within thirty (30) days of the date of the termination notice provided to you.

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

We reserve the right also to terminate this Agreement immediately upon verbal notice if we determine that you are endangering the health and wellbeing of a Member in any way. The verbal notice will be confirmed in writing within five (5) business days.

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

Finally, you are required to notify us if you have reason to be considering insolvency or are otherwise financially unsound. We are required to notify EOHHS within one (1) business day of receipt of such financial notification. We may immediately terminate this Agreement if you become insolvent or are the subject of bankruptcy, receivership, reorganization, dissolution, liquidation, or other similar proceeding.

**Non-Renewal of Provider Agreement**

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

**Inspection Authority**

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

**Fraud and Abuse Management**

Although MBHP is confident in the capacity of its provider network to maintain industry standards with regard to business practices and billing and collection procedures, it is necessary to maintain a fully developed fraud and abuse management program to identify and manage situations of suspected improper billing and/or fraud. MBHP’s compliance unit is responsible for thoroughly addressing situations of suspected fraud, determining the provider’s culpability, developing an appropriate response from MBHP, and coordinating MBHP’s approach with MassHealth BHP and Commonwealth departments as restitution and/or prosecution is sought. When
conducting audits of administrative and billing records, MBHP will follow MassHealth Regulation 130 CMR 450.235 regarding the limitation of payment calculation of overpayment by sampling. Please note, MBHP will recoup from providers monies paid inappropriately or incorrectly.
The most common causes/forms of incorrect payments, improper billing practices, and fraud arise from:

- Billing for services not rendered;
- Misrepresentation of fees, dates of service, diagnosis, or other clinical or billing information to substantiate services (i.e., incorrect or incomplete documentation);
- Unbundling of services that were contracted under the same per diem or unit charge;
- Undocumented/poorly documented services; or
- Claims for non-medically necessary services.

**Address Changes, Mergers, Acquisitions, and New Sites**

MBHP requires providers to notify the director of Network Operations of an address change or any mergers, acquisitions, changes or transfers of control or ownership, as well as any requests to add and/or remove a practice site, in writing thirty (30) days before such events occur. MBHP, at its sole discretion, shall determine whether such changes may require reapplication depending on the nature and scope of the change. Providers should not assume that satellite offices or facilities acquired or operated as a result of such transactions will be covered under the provider’s original provider application. The addition of a satellite office or facility may require a separate application and may not receive approval as a contracted site. It is not deemed approved until you receive an Exhibit A (contracted sites) or notification in writing from the Director of Network Operations.

Information can be submitted in writing by e-mailing to MBHPNetworkManagement@valueoptions.com, faxing to 1-877-390-2324, or mailing to:

Massachusetts Behavioral Health Partnership  
Network Operations  
1000 Washington Street, Suite 310  
Boston, MA 02218-5002

Failure to notify Network Management and/or Network Operations of changes may result in delay in payment of claims or change in the provider’s network status to include suspension or termination from the network. In addition, if your MassHealth number changes due to a merger, acquisition, or any other legal change, you must notify MBHP in writing within thirty (30) days of the change. Failure to provide proper notice will result in the denial of claims on the remittance advice.

Please send changes regarding MassHealth number changes to the following address:

Massachusetts Behavioral Health Partnership  
Network Operations  
1000 Washington Street, Suite 310  
Boston, MA 02218-5002

or fax to 1-877-390-2324 or e-mail to MBHPNetworkManagement@valueoptions.com

All changes must have an effective date for the change as per the MassHealth Provider Enrollment Unit.
MBHP Obligations

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

- Member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the Member needs in order to decide among all relevant treatment options;
- Risks, benefits, and consequences of treatment or non-treatment; and
- Member’s right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

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

Affirmative Statement Regarding Incentives

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

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

CREDENTIALING

In this section you will find information regarding the following:

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

MBHP’s LCC determines the contract status of present and future practitioners. All potential practitioners, groups of individual practitioners, and organizational providers who submit a complete application and are approved by MBHP staff for contracting must be reviewed by the LCC to determine participation status. LCC considerations include, but are not limited to, pending lawsuits, malpractice history, insufficient professional liability coverage, access in a particular area, clinical availability of less than 20 hours per week, and all credentialing waiver requests. All LCC recommendations and decisions are forwarded to the MBHP/ValueOptions NCC for final review and/or approval. Once the NCC makes a decision regarding network participation status, a letter is sent to the practitioner, group of individual practitioners, or organizational provider by MBHP.

The LCC meets the second and fourth Tuesday of each month. Emergency meetings are scheduled as needed.

Initial Credentialing Process

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

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

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

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

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

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

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

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

MBHP will only consider the following licensure levels for individuals in a group contracting setting: MD, DO, PNMHCS, LICSW, LCSW, LMHC, LMFT, licensed psychologist (including, PhD, EdD, and PsyD) and certificate levels: Board Certified Behavioral Analyst or Behavioral Management Monitor.

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

Re-credentialing Process

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

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

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

If you are an individual practitioner or group of individual practitioners*, MBHP completes a PSV on the following information:
- Licenses
- Highest level of education
- Educational Commission for Foreign Medical Graduates certificate (MDs/DOs)
- History of actions by licensing boards
- Federal and State DEA certificates (MDs/DOs/PNMHCSs only)
- Malpractice history through the NPDB
- American Board certification (MDs/DOs)
- American Nurses Credentialing Center certification (PNMHCS only)
- Sanctions from Medicare or Medicaid (Office of Inspector General)
- Admitting privileges, as applicable
- CANS Certification (practitioners who treat MBHP Members under the age of 21)
- Grievance and complaint letters from MBHP’s QM Department
- Claims history

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

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

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

MBHP will only consider the following licensure levels for individuals in a group contracting setting: MD, DO, PNMHCS, LICSW, LCSW, LMHC, LMFT, licensed psychologist (including, PhD, EdD, and PsyD) and certificate levels: Board Certified Behavioral Analyst or Behavioral Management Monitor.

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

**Confidentiality and Accuracy of Credentialing Information**

Network practitioners have the right to:
- review information submitted to support the credentialing application;
- correct erroneous information collected during the credentialing process;
- be informed of the status of the credentialing or re-credentialing application; and
- be notified of these rights.
Network practitioners have the right to review the credentialing and re-credentialing information MBHP uses to evaluate provider applications. The information includes information obtained from malpractice insurance carriers, state licensing boards, OIG, and/or the NPBD. A practitioner may not, however, review references, recommendations, or other information that is peer-review protected. MBHP does not release data to external entities in any form that would allow the identification of practitioners by name. Items of a confidential nature in the credentialing and re-credentialing process include, but are not limited to: license, professional liability insurance, degree, American Board certification, American Nurses Credentialing Center certification, federal and state DEA certificates, and information gained from the NPDB and OIG. Adverse findings that may impact a credentialing or re-credentialing decision will only be released to the practitioner if requested in writing by the practitioner.

A credentialing specialist will notify a practitioner if the information MBHP receives from outside sources differs substantially from the information given to MBHP by the practitioner. The practitioner will have the opportunity to correct erroneous information. Please contact the credentialing specialists at 1-800-495-0086 or e-mail at MBHPNetworkManagement@valueoptions.com for information on the process for viewing practitioner credentialing and re-credentialing files or for information on the status of a credentialing or re-credentialing application.

**Requesting a Waiver of the Credentialing Criteria**

Credentialing criteria were developed to reflect issues of access, performance, quality, liability, experience, and licensure. Only those practitioners who meet the MBHP credentialing criteria may provide behavioral health services to MBHP Members. Although these criteria were developed to ensure that all services provided to Members reflect the best practice of the professional field, it is understood that there may be certain situations where MBHP chooses to waive a specific item for a practitioner. Examples include waivers of a staff member’s license, training, or education, or waiver of an organizational provider’s physical plant requirements. The LCC will review a request for a credentialing waiver.

Circumstances for which a waiver may be approved include, but are not limited to, the following:
- Ensuring Member access;
- Meeting Member’s linguistic or cultural needs; and
- Meeting Member’s need for specialized care.

Please note that individually contracted practitioners may not request a waiver to bill for services provided by another practitioner.

If you want to request a waiver, please submit a written request that details the following:
- The criteria you want waived;
- The rationale underlying your request (e.g., specific need that the waiver will meet); and
- Documentation that a need exists.

If the waiver pertains to a staff member’s qualifications, the waiver request must include the following:
- How this staff can address this need;
- Copy of the staff member’s resume (month/year format)
- Official transcripts from the highest level of education;
• A copy of his/her license or certification, if applicable; and
• Two letters of reference from behavioral health practitioners who are familiar with the staff member’s work. The letters may be submitted via fax to the attention of Director, Network Operations at 1-877-390-2324, by e-mail to MBHPNetworkManagement@valueoptions.com, or sent by U.S. mail to the following address:

Massachusetts Behavioral Health Partnership
Attn: Director, Network Operations
1000 Washington Street, Suite 310
Boston, MA 02118-5002

MBHP maintains the right to offer credentialing waivers based on the overall mission of MBHP. Practitioners will be notified in writing of the outcome of the LCC and NCC recommendations and decisions regarding each waiver request.

**Site Visits**

MBHP staff may conduct site visits at practitioners’ offices to assess the appearance and adequacy of waiting and treatment room space, availability of appointments, accessibility, and record-keeping practices (if applicable).

MBHP may conduct a structured site visit to practitioners' offices for all practitioners with two or more documented Member complaints in a six-month time frame relating to physical accessibility, physical appearance, adequacy of waiting/examining room space, availability of appointments, adequacy of treatment recordkeeping, or quality of care issues. This visit includes an evaluation using the MBHP site and operations standards and an evaluation of the practitioner's clinical recordkeeping practices to ensure conformity with MBHP standards.

Organizational providers (facilities) must be evaluated at credentialing and re-credentialing. Those who are accredited by an accrediting body accepted by MBHP (currently The Joint Commission, CARF, COA, or another recognized accreditation service, as applicable for behavioral health care) must have their accreditation status verified. In addition, non-accredited organizational providers must undergo a structured site visit to confirm that they meet all MBHP standards. Standing with state and federal authorities and programs will be verified. MBHP will not reimburse an organizational provider if a service is a non-credentialed and/or non-contracted, non-Covered Benefit.
MBHP NETWORK MANAGEMENT APPENDICES

- Appendix A: Credentialing Criteria
- Appendix B: Regional Zip Code Listing
- Appendix C: Performance Specifications
## APPENDIX B – REGIONAL ZIP CODE LIST

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MBHP NETWORK MANAGEMENT APPENDICES

- Appendix A: Credentialing Criteria
- Appendix B: Regional Zip Code Listing
- Appendix C: Performance Specifications
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