



Commonwealth Care Alliance Massachusetts
CCA Health Rhode Island

Medicare Advantage Plans Provider Manual | 2024



In Massachusetts: CCA Medicare Preferred (PPO) and CCA Medicare Value (PPO):

In Rhode Island: CCA Medicare Preferred (PPO), CCA Medicare Value (PPO) and CCA Medicare Maximum (HMO D-SNP)

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Welcome Letter

Dear Commonwealth Care Alliance Provider:

Welcome to the Commonwealth Care Alliance (CCA) provider manual. This manual includes information about how providers can do business with CCA, as well as information about our CCA Medicare Preferred (PPO) and CCA Medicare Value (PPO) health plans in Massachusetts and Rhode Island, our CCA Medicare Maximum (HMO D-SNP) plan in Rhode Island, and our new CCA Medicare Premier (PPO) plan in Massachusetts.

CCA is committed to partnering with providers to ensure our members receive the highest-quality coordinated care possible, and we have designed this administrative resource to provide you with comprehensive information about our programs and plans. In addition to detailed CCA program information, you will find our policies and procedures, referral and claim information, and other useful reference materials. We hope providing these materials will make working with CCA staff and members as seamless as possible.

CCA members are encouraged to be active participants in their healthcare. When members enroll in a CCA plan, they receive a Member Handbook, which outlines the terms of benefits. Copies of the handbook may be obtained by contacting our Member Services department:

- For Massachusetts, please call 866-610-2273
- For Rhode Island, please call 833-346-9222

If you have any questions regarding the information in this Provider Manual, please email Provider Relations at providerrelations@commonwealthcare.org.

We look forward to working with you to provide the best care possible **for** the members we so proudly serve.

SECTION 1: Key Contact Information

SECTION 1: Key Contact Information

Contact	Telephone	Fax	Email	Website/Portal
Claims – Medical, Non-routine Vision, and Non-routine Hearing				
<p>For Dates of Service: Through March 31, 2023</p> <p>Claims Customer Service</p> <ul style="list-style-type: none"> • Refunds and escalations • Corrected claims • Claims status • Claim receipt • Check run <p>New providers, contracting and billing.</p> <p>TTY Massachusetts / Rhode Island Relay Service</p> <p>Note: Acupuncture claims are processed and handled by American Specialty Health (ASH). Reference Acupuncture contact information below for details</p>	866-420-9332			
<p>For Dates of Service: April 1, 2023 - Onward</p> <p>Claims Customer Service</p> <ul style="list-style-type: none"> • Refunds and escalations • Corrected claims • Claims status, receipt <p>New providers, contracting, and EDI, electronic billing setup or problems (Availity)</p>	<p>866-420-9332</p> <p>800-Availity (800-282-4548)</p>	855-865-1814	<p>E-ticketing: Availity Essentials Provider Portal - Select Help & Training > Availity Support Submit an online support request or chat online.</p>	<p>Portal: apps.availity.com/web/welcome/#/edi</p> <p>Registering (1st time): availity.com/Essentials-Portal-Registration</p>

SECTION 1: Key Contact Information

Contact	Telephone	Fax	Email	Website/Portal
Member Services				
General questions <ul style="list-style-type: none"> • Initial contact Member appeals <ul style="list-style-type: none"> • Service denials (process; how to respond) Member benefits <ul style="list-style-type: none"> • Member information; coverage 	866-610-2273 (MA) 833-346-9222 (RI)		Email: memberservices@commonwealthcare.org	
Member Appeals and Grievances				
Member appeals Member grievances	866-610-2273(MA) 833-346-9222 (RI)		Email: agdepartment@commonwealthcare.org	
Member Enrollment				
Outreach and marketing <ul style="list-style-type: none"> • Referrals for potential members 	866-610-2273	617-830-0534	Email: marketdevelopment@commonwealthcare.org	
Clinical Operations				
Prior authorization <ul style="list-style-type: none"> • Benefit and service authorizations Transitions of Care team and facility inpatient authorization	866-420-9332 857-246-8822	855-341-0720 855-811-3467		
Acupuncture Benefit Administrator: American Specialty Health (ASH)				
For Rhode Island Plans Only <ul style="list-style-type: none"> • Claims processing • Member eligibility • Prior authorization submission • Provider Relations • Clinical guidelines 	800 972-4226	877-248-2746		Portal: www.ashlink.com

SECTION 1: Key Contact Information

Contact	Telephone	Fax	Email	Website/Portal
Dental Benefit Administrator: SKYGEN				
<ul style="list-style-type: none"> • Claims processing • Member eligibility • Prior authorization submission • Provider Relations • Dental Provider Manual located in the Dental Provider Portal 	855-434-9243		Email providerservices@skygenusa.com	Portal: https://pwp.sciodontal.com
Hearing Benefit Administrator: NationsHearing				
<ul style="list-style-type: none"> • Claims processing • Member eligibility • Provider Relations • Hearing Provider Manual <p>NationsBenefits® Attention: Claims 1801 NW 66th Avenue, Suite 100 Plantation, FL 33313</p>	800-921-4559			Portal: https://providers.nationshearing.com
Contact	Telephone	Fax	Email	Website/Portal
Pharmacy				
General questions	866-420-9332		Email: providerservices@commonwealthcare.org	
Pharmacy coverage determinations (e.g., prior authorization)	866-270-3877	855-668-8552		
<ul style="list-style-type: none"> • Electronic prior authorizations – Pharmacy 	866-610-2273 (MA)	857-453-4517		
Pharmacy redeterminations (appeals)	833-346-9222 (RI)			



SECTION 1: Key Contact Information

Contact	Telephone	Fax	Email	Website/Portal
Vision Benefit Administrator: VSP				
<ul style="list-style-type: none"> • Claims processing • Member eligibility • Covered services • Provider Services • Appeals and grievances • Vision Provider Manual <p><u>In-network providers</u> Vision Service Plan Attention: Claim Services PO Box 495907 Cincinnati, OH 45249-5907</p> <p><u>Out-of-network providers</u> Vision Service Plan Attention: Claim Services PO Box 595918 Cincinnati, OH 45249-5918</p> <p><u>In-network providers</u> Vision Service Plan Attention: Claim Services PO Box 495907 Cincinnati, OH 45249-5907</p> <p><u>Out-of-network providers</u> Vision Service Plan Attention: Claim Services PO Box 595918 Cincinnati, OH 45249-5918</p>	800-615-1883			Portal: http://www.vspproviderhub.com/
Compliance				
Concerns and reporting <ul style="list-style-type: none"> • Fraud, waste, and abuse and compliance concerns 	866-457-4953 Compliance Hotline **anonymous**			CCA Electronic submission form



SECTION 1: Key Contact Information

Contact	Telephone	Fax	Email	Website/Portal
Third-Party Liability				
COB, third party, Q&A	617-426-0600 Ext. 5-1221		Email: tplcoordinator@commonwealthcare.org	
Interpreter Services				
<p>Providers may contact the CCA Provider Services department, along with the member, and they will be connected to the appropriate interpreter telephonically.</p> <p>Please have the member's name and ID number available.</p> <p>Provider Services is available during the hours of 8 am to 6 pm, Monday–Friday. For assistance after business hours and weekends, please call CCA Member Services.</p> <p>Member Services is available during the hours of 8 am to 8 pm, Monday–Friday, and 8 am to 6 pm, Saturday and Sunday, to assist members with interpreter services.</p>	<p>Provider Services: 866-420-9332</p> <p>Member Services: 866-610-2273 (MA) 833-346-9222 (RI)</p>		Email: providerservices@commonwealthcare.org	

SECTION 1: Key Contact Information

Fitness Benefit Administrator: Silver & Fit				
<ul style="list-style-type: none"> • Provider Relations • Claims processing • Member eligibility • Provider Relations • Gym Assignment <p>American Specialty Health Fitness, Inc. PO Box 509117 San Diego, CA 92150-9117</p>	877-329-2746		Email: fitness@ashn.com (Claims)	

SECTION 2: Introduction to Commonwealth Care Alliance

This section introduces Commonwealth Care Alliance and describes its mission, vision, and approach to giving the highest-quality healthcare to its members.

What is Commonwealth Care Alliance?

Commonwealth Care Alliance® (CCA) is a mission-driven healthcare services organization that offers high-quality health plans and care delivery programs designed for individuals with the most significant needs. CCA delivers comprehensive, integrated, and person-centered care by coordinating the services of local staff, provider partners, and community organizations. CCA's unique model of *uncommon care*® has achieved an unparalleled track record of improved health and quality outcomes and lower costs of care.

Our Mission

Our mission is to improve the health and well-being of people with the most significant needs by innovating, coordinating, and providing the highest-quality, individualized care.

Our Vision

Our vision is to lead the way in transforming the nation's healthcare for individuals with the most significant needs.

Our Approach

Although the characteristics of the varied populations served by Commonwealth Care Alliance are quite different, experience has demonstrated common care system principles that are key to improving care and managing costs. These principles include:

- A "top to bottom" clear exclusive mission to serve people with complex needs
- Specialized administrative and clinical programmatic expertise
- New approaches to care management and care coordination that support primary care clinicians through a team approach involving nurse practitioners, nurses, behavioral health clinicians, and/or non-professional peer counselors
- 24/7 personalized continuity in all care settings
- Selective comprehensive primary care networks and selective networks of physician specialists, healthcare facilities, human service agencies, and community-based organizations
- Flexible benefit designs
- Promotion of member empowerment and self-management strategies
- Integration of medical and behavioral health services
- State-of-the-art clinical information technology support for the care delivery and payment system

SECTION 3: Member Eligibility, Appeals & Grievances

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Eligibility

Eligible potential members include people with Medicare who want to join a Medicare Advantage plan, including Medicare Prescription Drug coverage.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan’s service area

Important: To join a Medicare Advantage plan, you must have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

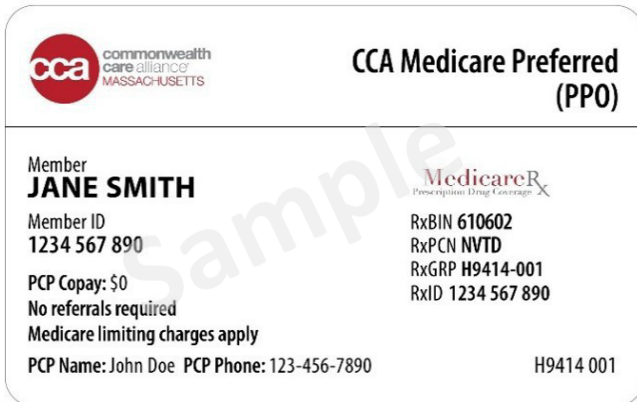
To join the D-SNP program:

- In addition to the Medicare Advantage requirements above, a dual Medicaid eligibility is also required

Member Identification Card*

Each member receives a Commonwealth Care Alliance identification card to be used for services covered by Commonwealth Care Alliance and prescription drug coverage at network pharmacies.

CCA Medicare Preferred (PPO) – Massachusetts



cca commonwealth care alliance MASSACHUSETTS

CCA Medicare Preferred (PPO)

Member **JANE SMITH**

Member ID **1234 567 890**

PCP Copay: \$0
No referrals required
Medicare limiting charges apply

PCP Name: John Doe PCP Phone: 123-456-7890

MedicareRx
Prescription Drug Coverage

RxBIN **610602**
RxPCN **NVTD**
RxGRP **H9414-001**
RxID **1234 567 890**

H9414 001

See evidence of coverage for benefit information.

Member Services: 866-610-2273 (TTY 711)
Vision (VSP): 855-492-9028 (TTY 711)
Provider Services: 866-420-9332
Provider Pharmacy Services: 866-270-3877

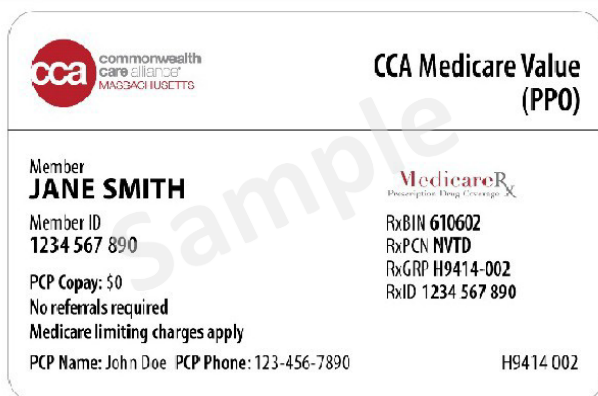
Submit dental claims to:
pwp.sciondental.com/PWP
855-434-9243

Submit claims to:
Commonwealth Care Alliance Claims
P.O. Box 3085
Scranton, PA 18505

Submit vision claims to:
Eyefinity.com
800-615-1883

ccama.org/members

CCA Medicare Value (PPO) – Massachusetts



cca commonwealth care alliance MASSACHUSETTS

CCA Medicare Value (PPO)

Member **JANE SMITH**

Member ID **1234 567 890**

PCP Copay: \$0
No referrals required
Medicare limiting charges apply

PCP Name: John Doe PCP Phone: 123-456-7890

MedicareRx
Prescription Drug Coverage

RxBIN **610602**
RxPCN **NVTD**
RxGRP **H9414-002**
RxID **1234 567 890**

H9414 002

See evidence of coverage for benefit information.

Member Services: 866-610-2273 (TTY 711)
Vision (VSP): 855-492-9028 (TTY 711)
Provider Services: 866-420-9332
Provider Pharmacy Services: 866-270-3877

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800-615-1883

ccama.org/members

SECTION 3: Member Eligibility, Appeals & Grievances

CCA Medicare Preferred (PPO) – Rhode Island



CCA Medicare Preferred (PPO)

Member
John Q Sample

Member ID
99999999

PCP Copay: \$0
No referrals required
Medicare limiting charges apply

PCP Name: DoctorButcher PCP Phone: H9876-001

Medicare^{Rx}
Prescription Drug Coverage

RxBIN 610602
RxPCN NVTD
RxGrp PRI
RxID 99999999

See evidence of coverage for benefit information.

Member Services: 833-346-9222 (TTY 711)

Vision (VSP): 855-492-9028

Provider Services: 866-420-9332

Provider Pharmacy Services: 866-270-3877


Submit dental claims to:
pwp.sciondental.com/PWP
855-434-9243

Submit claims to:
Commonwealth Care Alliance Claims
P.O. Box 3085
Scranton, PA 18505

Submit vision claims to:
Eyefinity.com
800-615-1883

ccari.org/members

CCA Medicare Value (PPO)– Rhode Island



CCA Medicare Value (PPO)

Member
John Q Sample

Member ID
99999999

PCP Copay: \$0
No referrals required
Medicare limiting charges apply

PCP Name: DoctorButcher PCP Phone: H9876-002

Medicare^{Rx}
Prescription Drug Coverage

RxBIN 610602
RxPCN NVTD
RxGrp VRI
RxID 99999999

See evidence of coverage for benefit information.

Member Services: 833-346-9222 (TTY 711)

Vision (VSP): 855-492-9028

Provider Services: 866-420-9332

Provider Pharmacy Services: 866-270-3877


Submit dental claims to:
pwp.sciondental.com/PWP
855-434-9243

Submit claims to:
Commonwealth Care Alliance Claims
P.O. Box 3085
Scranton, PA 18505

Submit vision claims to:
Eyefinity.com
800-615-1883

ccari.org/members

CCA Medicare Maximum (HMO) (D-SNP) Rhode Island



CCA Medicare Maximum (HMO D-SNP)

Member
John Q Sample

Member ID
99999999

PCP Copay: \$0
No referrals required
Medicare limiting charges apply

PCP Name: DoctorButcher PCP Phone: H0876-001

Medicare^{Rx}
Prescription Drug Coverage

RxBIN 610602
RxPCN NVTD
RxGrp MRI
RxID 99999999

See evidence of coverage for benefit information.

Member Services: 833-346-9222 (TTY 711)

Vision (VSP): 855-492-9028

Provider Services: 866-420-9332

Provider Pharmacy Services: 866-270-3877

Submit dental claims to:
pwp.sciondental.com/PWP
855-434-9243

Submit claims to:
Commonwealth Care Alliance Claims
P.O. Box 3085
Scranton, PA 18505

Submit vision claims to:
Eyefinity.com
800-615-1883

ccari.org/members

SECTION 3: Member Eligibility, Appeals & Grievances

Interpreter Services

Commonwealth Care Alliance providers must ensure that members have access to medical interpreters, signers, and TDD/TTY services to facilitate communication, without cost to members.

If the member speaks a language that is not prevalent in the community or the provider does not have access to interpretation, CCA will provide telephonic language assistance services.

Providers, along with the member, may contact the CCA Provider Services department at 866-420-9332 and they will be connected to the appropriate interpreter telephonically.

- Please have the member's name and CCA ID number available.

Provider Services is available during the hours of 8 am to 6 pm, Monday–Friday. For assistance after hours and weekends, please call CCA Member Services:

- For Massachusetts, please call 866-610-2273
- For Rhode Island, please call 833-346-9222

Member Services is available during the hours of 8 am to 8 pm, Monday–Friday, and 8 am to 6 pm, Saturday and Sunday, to assist members with interpreter services.

Member Rights and Responsibilities

Commonwealth Care Alliance members deserve the best service and health care possible. CCA is committed to maintaining a mutually respectful relationship with its members.

Clearly outlined member rights and responsibilities help foster cooperation among members, practitioners and CCA. Member rights and responsibilities are updated annually. You can find the most up to date versions of the member rights and responsibilities by following the links below.

- Massachusetts - Medicare Advantage Member Rights and Responsibilities
 - CCA [Medicare Preferred \(PPO\)](#)
 - CCA [Medicare Value \(PPO\)](#)
- Rhode Island - Medicare Advantage and HMO D-SNP Member Rights and Responsibilities
 - CCA [Medicare Preferred \(PPO\)](#)
 - CCA [Medicare Value \(PPO\)](#)
 - CCA [Medicare Maximum \(HMO D-SNP\)](#)

Prevent Discrimination

Commonwealth Care Alliance complies with applicable federal civil rights laws and does not discriminate on the basis of medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence. Commonwealth Care Alliance does not exclude people or treat them differently because of medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color religion, creed, public assistance, or place of residence.

All CCA providers must:

- Make covered health services available to all members

SECTION 3: Member Eligibility, Appeals & Grievances

- Accept and treat members without discrimination in comparison to such services rendered to your other patients and without discriminating based upon source of payment, sex, age, race, color, religion, national origin, health status, or disability
- Help our non-English-speaking members get interpreter services if necessary (providers can call Provider Services for translation services at 866-420-9332)

Office Access Parity

Commonwealth Care Alliance (CCA) providers will ensure that CCA members have equal access or parity to providers as commercial members of other health plans, or as individuals eligible to receive services through government health plans. This parity may include hours of office operations, after-hours care, and provider coverage.

Office Access and Availability

Commonwealth Care Alliance is committed to providing provider access and availability to its members in a timely manner. In addition to this commitment, the Center for Medicare & Medicaid Services (CMS) have provided time frame requirements that the Commonwealth Care Alliance provider network needs to adhere to support each member's needs.

The time frame requirements are as follows:

Primary Care Office Visits

Primary care office visits must be available within 10 calendar days, and specialty care office visits must be available within 30 days of the member's request for non-urgent symptomatic care.

Urgent Care and Symptomatic Office Visits

All urgent care and symptomatic office visits must be available to members within 48 hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention. Examples include recurrent headaches or fatigue.

Non-symptomatic Office Visits

All non-symptomatic office visits must be available to members within 30 calendar days. Examples of non-symptomatic office visits include, but are not limited to, well and preventive care visits for covered services, such as annual physical examinations or immunizations.

Behavioral health providers' access and availability timeframes can be found in Section 11 of this Provider Manual.

SECTION 3: Member Eligibility, Appeals & Grievances

Member Appeals and Grievances

Filing an Appeal or Grievance on Behalf of a Member

Providers may file an appeal or grievance on behalf of a member using the procedures described below. An Appointment of Representative form (AOR) is required to file post-service member appeals and grievances on behalf of a member. A pre-service appeal will not be delayed for receipt of the AOR from a provider only; others will need to submit the AOR, prior to beginning a member appeal or grievance.

An AOR form can be printed from the following link: [cms.gov/medicare/cms-forms/cms-forms/downloads/cms1696.pdf](https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1696.pdf). The form must be completed and signed by the member and the provider within 44 days of receipt of the appeal request.

Return the completed form to CCA via fax at 857-453-4517 or by mail at the following address:

Commonwealth Care Alliance
 Attn: Appeals and Grievances
 30 Winter Street
 Boston, MA 02108

Member Appeals

Appeals are procedures that deal with the review of adverse initial determinations made by CCA regarding healthcare services or medication. Appeals processed by CCA are called Level 1 appeals. Medicare requires that CCA automatically send medical service appeal denials to their Independent Review Entity (IRE) for a Level 2 review. If the IRE does not decide in the members favor, there are additional levels of appeals, including Administrative Law Judge, Medicare Appeal Counsel, and Federal Court.

Instructions for filing a Level 1 appeal with CCA are listed on the initial denial notification and include both standard and expedited options for pre-service requests. Providers may file a pre-service appeal on a member's behalf within 60 days of the denial by calling Provider Services at 866-420-9332, by sending a fax to the Appeals and Grievances department at 857-453-4517, or via mail at the address listed above.

A participating provider does not need to be the representative to initiate a pre-service appeal but is required to submit an Appointment of Representative form (AOR) for post-service member appeals prior to the end of the appeal time frame. CCA includes as parties to the appeal the member and the appeal representative or legal representative of a deceased member's estate. Participating providers filing a dispute regarding how a claim was processed must utilize the Provider Payment Disputes and Appeals process found in Section 6.

Non-contracted providers may file appeal requests within 60 days of the original payment or denial date as indicated on the EOP if the appeal includes a signed Waiver of Liability (WOL) form. Non-contracted provider appeals without the WOL will be dismissed if the WOL is not received within 60 days of the appeal request.

Appeal Resolution Time Frames			
Appeal Type	Part C	Part B	Part D
Standard pre-service*	30 days	7 days	7 days
Expedited	72 hours	72 hours	72 hours
Post-service	60 days	60 days	14 days

SECTION 3: Member Eligibility, Appeals & Grievances

*Pre-service appeal requests that are not entirely pre-service will be split, addressing pre-service appeals and post-service claim appeals separately. If an appeal request is post-service but pre-claim, this request will be dismissed until the claim organization determination has been made for the date of service (e.g., claim is processed). Participating providers filing a dispute regarding how a claim was processed must utilize the Provider Payment Disputes and Appeals process found in Section 6.

Pre-service appeals can be submitted as expedited (also called a “fast appeal”) or standard. If the provider indicates that applying the standard timeframe could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function (the physician does not have to use these exact words), the plan will process the appeal as expedited.

In some cases, CCA may extend these timeframes up to 14 calendar days if the member requests the extension or if CCA justifies the need for additional information and how the extension will benefit the member.

Appeals decided by a medical director during the utilization review will be reviewed on appeal by another medical director who has not been involved in the initial level of review and does not report to the individual who made the initial determination. Appeals will be reviewed by a physician with the same or similar specialty as the appealing provider. Providers and members may submit supporting evidence for the appeal at any time during the appeal timeframe. Upon decision, the member and provider are notified in writing. For expedited appeals, the member and provider will also receive verbal notification of the decision.

If an appeal is approved, authorization will be entered within the appeal time frame. If an appeal is denied, there are additional levels of review available. CCA requires that members and their appeal representative exhaust the CCA Internal Appeals process before filing a Level 2 (external) appeal.

Any denial for a Medicare covered Part B or C service is automatically sent to the Medicare IRE for a second-level review. For Part D appeals, a second-level review must be requested in writing to the IRE as directed on the denial letter.

External Appeals

CCA ensures that members have access to all Medicare Appeal processes.

Level	Type	Entity
1	Internal	CCA
2	External	The Independent Review Entity (IRE) (Medicare)
3	External	Administrative Law Judge (ALJ)
4	External	Medicare Appeals Council (MAC)
5	External	Federal District Court

SECTION 3: Member Eligibility, Appeals & Grievances

Grievances

Grievances are defined as an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of healthcare items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.

If a member expresses a grievance to a provider, the provider should encourage the member to contact CCA directly. If a provider wishes to file a grievance on a member's behalf, they must be the member's appointed representative.

Grievances are accepted orally and in writing at any time. CCA sends written acknowledgment of the receipt of each grievance to the member or representative and then a resolution notification within 30 days. When a grievance is received, the issue is investigated internally or with our vendors or providers and tracked for quality and reporting. CCA ensures that the decision-makers on quality-of-care grievances have the appropriate clinical expertise.

A resolution of the grievance is relayed to the member or representative. Resolution can be oral for grievances that are received orally, and all other cases are responded to in writing. Oral grievances are responded to in writing upon request. Grievances about quality of care are always responded to in writing.

Grievance Resolution Time Frames	
Standard	30 days, plus extension up to 14 days, when applicable
Expedited	24 hours

Grievances are handled according to the standard time frame unless the dissatisfaction is about the refusal to expedite an initial or appeal review, or the request to take an extension on an appeal or grievance. In those instances, the case is reviewed and responded to within 24 hours and a new determination is made on the expedited review or extension.

It is the responsibility of all network providers to participate in our grievance review process. Providers are expected to respond to a request for information from CCA within five business days. This turnaround time is to ensure that the plan meets its regulatory and accreditation requirements to the member and remains compliant with all state and federal requirements. A finding letter is sent to the provider and member at the end of the investigation.

SECTION 4: Prior Authorization Requirements

Table of Authorization Requirements

In accordance with the member's Evidence of Coverage, certain services performed by contracted providers require prior authorization before being rendered. The Commonwealth Care Alliance Authorization and Utilization Management department is responsible for reviewing prior authorization service requests from providers. All requests, except behavioral health and inpatient/observation admissions—must be faxed to **855-341-0720** using the Standardized Prior Authorization Request form along with the necessary clinical documentation to support the request. Use the [Standard Prior Authorization Form](#)

- Behavioral health prior authorization service requests must be faxed to 855-341-0720 using the appropriate form for the service requested along with the necessary clinical documentation to support the request.
- Inpatient/observation admissions authorization service requests must be faxed to 855-811-3467 using the standard authorization request form for the service requested along with the necessary clinical documentation to support the request.
 - Please use CCA's standard prior authorization form when making authorization requests.
 - Massachusetts – [View and download forms](#)
 - Rhode Island – [View and download forms](#)
 - Admission notification is required within 24 to 48 hours of facility admission.
- CCA Massachusetts utilizes Patient Ping, a secure, third-party admission and discharge notification software system.
 - CCA Massachusetts will create the admission authorization once notified of the member's admission for facilities who contract and participate in the use of Patient Ping, preventing late authorizations.
 - If you do not contract with patient ping, admission notification is required within 24-48 hours of facility admission
- CCA Massachusetts does not require submission of clinical information for those facilities which have granted electronic medical record (EMR) access to CCA staff for medical necessity (MN) review (except for members who have restricted EMR access. Clinical submission is still required for these members.)
 - Providers must review their contracts to determine EMR agreements.
 - All facilities which have not granted CCA EMR access are required to submit clinical information timely for MN review.
- Please go to CCA's provider portal to check the status of your authorization request; [CCA Provider Portal](#).
 - For more information, please refer to section six, claims and billing procedures.

Services requiring prior authorization by CCA are listed below. If a requested service or item is not listed below, please call Commonwealth Care Alliance at **866-420-9332** for clarification.

- Massachusetts – [Prior Authorization Requirements Table PDF](#)
- Rhode Island – [Prior Authorization Requirements Table PDF](#)

SECTION 5: Centralized Enrollee Record

Durable Medical Equipment (DME)

For a code-specific list of durable medical equipment (DME) and other services requiring prior authorization (PA) for Commonwealth Care Alliance Medicare Advantage plans, please see the following links.

- Massachusetts – [Durable Medical Equipment \(DME\) List PDF](#)
- Rhode Island – [Durable Medical Equipment \(DME\) List PDF](#)

Utilization Determination Time Frames

CCA will review and make utilization management decisions in keeping with the time frames referenced in the table below. To meet these time frames, we ask that providers submit all relevant information and documentation in a timely manner. In the event that CCA needs to request an extension, we will communicate clearly why we need additional time and adhere to CMS rules.

Expedited organization determinations (prior authorization requests) are made when the member or their physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. Expedited requests must be indicated on the prior authorization form.

Category of utilization management decision	Review and determination time frame
Standard	Determination and notification within 14 calendar days after receipt of request, and as quickly as needed based on the member's health condition
Standard Extension	Up to 14 additional calendar days (not to exceed 28 calendar days) after receipt of the original request
Expedited	Determination and notification as quickly as the member's health condition requires, but no later than 72 hours after receipt of the request
Expedited Extension	Up to 14 additional calendar days (not to exceed 17 calendar days) after receipt of the original request
Concurrent	Determination and notification as soon as medically indicated; usually within 72 hours of request
Medicare Part B Standard request	Determinations are made no later than 72 hours of request
Medicare Part B Expedited request	Determinations are made within 24 hours of request

CCA Utilization Management decision making is based only on appropriateness of care and service and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage. There are no financial incentives for CCA Utilization Management decision makers.

Clinical Decision Making

CCA uses criteria based on CMS requirements defined in CMS national coverage determinations (NCDs), relevant local coverage determinations (LCDs), generally accepted criteria such as InterQual®, in addition to our Medical Necessity Guidelines (MNG's).

We use InterQual® criteria to review certain services (such as imaging, DME, and inpatient). We make these criteria available, upon request, to members and providers impacted by a denial decision.

SECTION 5: Centralized Enrollee Record

All Medical Necessity Guidelines can be located on the Commonwealth Care Alliance website, under the Medical Guidelines section of the Provider Page. Please [click here](#) for more information.

Please note: Failure to obtain the required prior authorization may result in a claim being denied or in a reduction in payment. CCA members cannot be billed for services that require prior authorization and are delivered without a prior authorization.

About Medical Criteria Request

Commonwealth Care Alliance uses written criteria based on sound clinical evidence to evaluate the medical appropriateness of healthcare services. These criteria are objective and based on current clinical and medical evidence and applied with consideration of individual needs and characteristics (e.g., age, comorbidities, prior treatment, and complications) and the availability of services within the local delivery system. For a hard copy of these policies/criteria, please contact Provider Services at 866-420-9332.

Discharge Notification and Planning

We believe it is critical that the member or member's authorized representative, CCA, the admitting provider, and the PCP are all in agreement about the treatment plan and next steps by the time the member is to be discharged from a facility.

The facility or admitting physician is required to contact CCA and provide clinical information to support discharge decisions for:

- Requests for facility stay extensions (Note: Contact must be made prior to the expiration of the approved days)
- Requests to move members to a different level of care
- Discharge plans that include any of the following:
 - Home health services or specialized durable medical equipment
 - Multiple medications
 - Programs for lifestyle changes like weight management, nutrition, smoking cessation, exercise, diabetes education, or stress management
- Facilities are requested to submit all discharge documentation within 24 hours of members discharge; including medication list, after visit summary, and completed discharge summary if available to the Transitions of Care Department via fax 855-811-3467.

Member Notices

- Contracted acute care facilities of CMS are required to issue the Medicare Outpatient Observation Notice (MOON), Form CMS10611-MOON to CCA members who receive hospital outpatient observation services.

SECTION 5: Centralized Enrollee Record

- Cost share may apply, please refer to the members benefit plan for cost share amounts for any observation or inpatient billing.
- Providers may access instructions and the MOON forms (English and Spanish) on the CMS website at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON>.

Emergency Medical Treatment and Labor Act

As defined by the Emergency Medical Treatment and Labor Act (EMTALA 42 CFR 489.24), the Commonwealth Care Alliance provider network will provide proper medical screenings and examinations by qualified hospital personnel for all individuals who seek care in a provider's emergency department. A provider will either provide stabilizing treatment for that individual or arrange appropriate transfer to another qualified provider to do so. Nothing shall impede or obstruct a provider from rendering emergency medical care to an individual.

SECTION 5: Centralized Enrollee Record

SECTION 5: Centralized Enrollee Record

Commonwealth Care Alliance utilizes Altruista Health as its electronic member record.

In order to ensure the highest-quality, most effective healthcare to members, all providers are reminded to review their provider agreement with Commonwealth Care Alliance for provider obligations regarding their documentation in all Commonwealth Care Alliance member clinical records and the obligation to share clinical information with Commonwealth Care Alliance primary care teams and interdisciplinary care teams.



SECTION 6: Claims and Billing Procedures

SECTION 6: Claims and Billing Procedures

This section is intended for Commonwealth Care Alliance providers. The information here enables providers to comply with the policies and procedures governing Commonwealth Care Alliance managed care plans. Updates or changes to this section are made in the form of provider bulletins that Commonwealth Care Alliance provides to you by mail, facsimile, or the Commonwealth Care Alliance website.

Commonwealth Care Alliance pays clean claims submitted for covered services provided to eligible Commonwealth Care Alliance members. In most cases, Commonwealth Care Alliance pays clean claims within 30 days of receipt. The receipt date is the day that Commonwealth Care Alliance receives the claim. Claim turnaround timelines are based on the claim receipt date. Filing limits are strictly adhered to and are specified in your contract.

Please note that contracted and non-contracted providers must file claims no later than 90 days after the date the services were furnished, unless the filing limit is stipulated otherwise in contract.

Commonwealth Care Alliance accepts both electronic and paper claims with industry-standard diagnosis and procedure codes that comply with the Health Information Portability and Accountability Act (HIPAA) Transaction Set Standards. For detailed instructions for completing both the CMS HCFA 1500 and UB-04 claim forms, please use the links below.

- [CMS HCFA 1500](#)
- [CMS UB-04 claim](#)

If CCA has returned a rejected paper or electronic claim due to missing or incomplete information, please make the necessary correction as indicated in the rejection letter and resend the claim following the standard billing practice for clean claims submission within the required timely filing limit.

Providers are responsible for obtaining prior authorization from Commonwealth Care Alliance before providing services. Please consult your contract manager, Section 4 of this manual, or contact the Commonwealth Care Alliance Provider Services department to determine if prior authorization is needed. In the event of a contradiction, the most restrictive requirement applies, except for emergency services.

Commonwealth Care Alliance (CCA) partnered with Cognizant to implement the Facets claims platform, which went into effect on April 1, 2023. We have modified this section to include pre- and post- implementation guidance for ease of access.

Contact Information

Contact Information for Provider Claims, Billing Support, and EDI Support	
For Dates of Service: Through March 31, 2023	For Dates of Service: April 1, 2023 – Onward
CCA Provider Services at 866-420-9332 Available M–F, 8 am – 6 pm	CCA Provider Services at 866-420-9332 Available M–F, 8 am – 6 pm
	EDI Support: Availity Client Services at 800-Availity (800-282-4548) M–F, 8 am – 8 pm
	Availity Essentials Provider Portal To register click on the registration button in the upper right corner and follow the instructions.

SECTION 6: Claims and Billing Procedures

Billing Members

Commonwealth Care Alliance members are responsible for copayments and co-insurance. Providers may collect copayments at the time of service. The member's financial liability will be listed on the Explanation of Payment following claim submission and processing.

Providers cannot bill members for covered services beyond their normal cost-sharing.

Providers cannot:

- Bill
- Charge
- Collect a deposit
- Seek compensation
- Seek remuneration
- Seek reimbursement
- Have recourse against our members, or their representative, or the Medicare Advantage organization

Additional Fees for Covered Services

You may not charge additional fees for:

- Covered services beyond members' copayments or co-insurance
- Concierge or boutique practice fees
- Retainers, membership, or administrative fees
- Denied services/claims because you failed to follow our protocols and/or reimbursement policies
- Reductions applied to services/claims resulting from our protocols and/or reimbursement policies

You may charge members for:

- Missed appointments
 - CMS does not allow you to charge Medicare Advantage members for missed appointments unless the member was aware of that policy

Providers are responsible for obtaining prior authorization from Commonwealth Care Alliance before providing services. Please consult your contract or Section 4 of this manual or contact the Commonwealth Care Alliance Provider Services department to determine if prior authorization is needed. In the event of a contradiction, the most restrictive requirement applies, except for emergency services.

Members that are dually eligible are individuals who are enrolled in both Medicare and Medicaid. The Qualified Medicare Beneficiary (QMB) program is for individuals who are enrolled in Medicare Part A and/or Part B and receive full Medicaid benefits and/or assistance with Medicare premiums or cost sharing. Providers are prohibited from billing QMB individuals for all Medicare cost share (except Part D). All Medicare and Medicaid payments received for services rendered to QMB individuals are considered payment in full. Providers are subject to sanctions if they bill a QMB individual for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing).

For more information visit: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1128.pdf>

SECTION 6: Claims and Billing Procedures

Eligibility

Providers are required to confirm member eligibility on a regular basis prior to rendering services, even if a prior authorization covers a long period.

Eligibility may be confirmed by:	
For Dates of Service: Through March 31, 2023	For Dates of Service: April 1, 2023 – Onward
Logging in to the CCA Provider Portal	Using the Avality Essentials Provider Portal *
Using the NEHEN Provider Portal *	Logging in to the CCA Provider Portal
Contacting CCA Provider Services at 866-420-9332	Using the NEHEN Provider Portal *
	Contacting CCA Provider Services at 866-420-9332

*Supports batch Eligibility transactions

SECTION 6: Claims and Billing Procedures

Claims Submission

For dates of service after April 1, 2023, Commonwealth Care Alliance accepts submissions of properly coded claims from providers by means of Electronic Data Interchange (EDI), or industry-standard paper claims. The provider acknowledges and agrees that each claim submitted for reimbursement reflects the performance of a covered service that is fully and accurately documented in the member's medical record prior to the initial submission of any claim. No reimbursement or compensation is due should there be a failure in such documentation. Providers shall hold all members harmless, regardless of payment or denial.

For dates of service prior to April 1, 2023, Commonwealth Care Alliance accepts only industry-standard paper claims submitted directly to CCA. Please note: Receipt of claims does not guarantee payment.

Providers are responsible for obtaining prior authorization from Commonwealth Care Alliance before providing services. Please consult your contract or Section 4 of this manual or contact the Commonwealth Care Alliance Member Services department to determine if prior authorization is needed. In the event of a contradiction, the most restrictive requirement applies, except for emergency services.

Providers may collect payment for services not covered under a member's benefit plan only with the CCA Medicare Advantage member's written consent. The member must sign and date the consent before the service is done. Keep a copy of this in the member's medical record. If you know or have reason to suspect the member's benefits do not cover the service, the consent must include:

- An estimate of the charges for that service
- A statement of reason for your belief the service may not be covered
- When we determine the planned services are not covered services, a statement that we have determined the service is not covered and that the member knows our determination and agrees to be responsible for those charges

For Medicare Advantage members, in addition to obtaining the member's written consent before the service is done, you must do the following:

- If you know or have reason to believe that a service or item you are providing or referring may not be covered, request a pre-service determination from us prior to rendering services.
- If we determine the service or item is not covered, we issue an Integrated Denial Notice (IDN) to the member and to you. The IDN gives the member their cost for the non-covered service or item and appeal rights. You must make sure the member has received the IDN prior to rendering or referring for non-covered services or items to collect payment. Per CMS requirements, for you to hold a Medicare Advantage member financially liable for the non-covered service or item, the member must first have an IDN, unless the Evidence of Coverage (EOC) or other related materials clearly exclude the item or service.
- A pre-service organization determination is not required to collect payment from a Medicare Advantage member where the EOC or other related materials are clear that a service or item is not covered.

If you followed this protocol and requested a pre-service organization determination and an IDN was issued before the non-covered service was rendered, you must include the GA modifier on your claim for the non-covered service. Including the GA modifier on your claim helps ensure your claim for the non-covered service is appropriately adjudicated as member liability.

Do not bill the member for non-covered services in cases where you do not follow this protocol. If you do not follow the terms of this protocol (such as requesting a pre-service organization determination for a Medicare Advantage member or rendering the service to a Medicare Advantage member before CCA issues the pre-service organization determination), you may receive an administrative claim denial. Providers cannot bill the member for administratively denied claims.

SECTION 6: Claims and Billing Procedures

Electronic Data Interchange Claims

For dates of services after April 1, 2023, Commonwealth Care Alliance accepts electronic claims through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to Commonwealth Care Alliance must be in the ANSI ASC X12N format, version 5010A, or its successor version

Claims submitted via EDI must comply with HIPAA transaction requirements. EDI claims are sent via modem or via a clearinghouse. The claim transaction is automatically uploaded into the claims processing system. Commonwealth Care Alliance has a Companion Guide and Training Manual that further explains the requirements and operations.

Minimum Requirements for EDI Claims:

- Member first and last name
- Date of birth
- Member ID
- Rendering provider
- Rendering provider NPI
- Pay-to name
- Pay-to tax ID
- Place of service
- Diagnosis code
- Procedure code
- Modifiers
- Billed amount
- Quantit

For Dates of Service: Through March 31, 2023	For Dates of Service: April 1, 2023 – Onward
CCA no longer accepts EDI files for dates of service through March 31, 2023	Companion Guide and Training Manual
	<p>Initial EDI Setup</p> <p>In order to view member eligibility, claims status and submit claims electronically to Commonwealth Care Alliance, providers must register with the Availity Essentials Provider Portal</p> <p>To register with the Availity Essentials Provider Portal, click on the registration button in the upper right corner and follow the instructions.</p> <p>If you have additional questions or need assistance, please contact Availity Client Services at 800-Availity (800-282-4548), M–F, 8 am – 8 pm ET.</p> <p>For more information on EDI implementation, refer to the Medicare Billing Fact Sheet.</p>

Three EDI Options

Commonwealth Care Alliance offers three options for submitting EDI claims. With the appropriate option in place for your electronic workflow, electronic billing results in fewer errors, lower costs, and increased efficiency for businesses on both ends of the transaction. These options are detailed below:

Option One

Clearinghouse Submitters

Standard 837 file submissions through a clearinghouse using the Commonwealth Care Alliance payer ID number, **A2793**. This PIN is the identifier at the Clearinghouse to route claims directly to the Claims Operation department.

Option Two

Direct Submitters

This option is for those entities that choose to create their own 837 file and submit that file directly to the [Availity Essentials Provider Portal](#) with the CCA payer ID **A2793**. Commonwealth Care Alliance offers a secure web portal where providers can obtain access to claim status, member eligibility, and multiple claim submission options.

The easy-to-navigate web portal requires authorized billers and providers to register to access information. Once you are a registered user, please [click here](#) to access the Availity Essentials Provider Portal.

Option Three

Single Claims Submitters

Single claims submissions are for industry standard claim forms. Providers are required to register with the Availity Essentials Provider Portal for claims submission and to validate member eligibility and claim status.

Please note: Options Two and Three allow vendors to use our automated secure web portal interface to transmit HIPAA-compliant claims for processing and the ability to view member and provider data and claim processing status, per level of authorization.

Providers using electronic submission must submit clean claims to Commonwealth Care Alliance or its designee, as applicable, using the HIPAA-compliant 837 electronic format or a CMS-1500/UB-04, or their successors, as applicable.

Reprocessing EDI Claims

Providers may submit corrected claims electronically or by mailing a corrected paper claim to correct a claim that was previously submitted and paid or denied. Corrected claim submissions do not apply to an original or first-time submission. Please [click here](#) to obtain the Request for Claim Review form.

Mail corrected paper claims to:

Commonwealth Care Alliance,
Claims
P.O. Box 3085
Scranton, PA 18505

SECTION 6: Claims and Billing Procedures

Electronic Funds Transfer (EFT) for All Dates of Service

Commonwealth Care Alliance (in partnership with Payspan) has implemented an enhanced online provider registration process for electronic funds transfer and electronic remittance advice (ERA) services.

Once a provider has registered, this no-cost secure service offers a number of options for viewing and receiving remittance details. ERAs can be imported directly into a practice management or patient accounting system, eliminating the need to rekey remittance data.

Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts.

Providers will no longer receive paper Explanation of Payments (EOPs). EOPs can be viewed and/or downloaded and printed from Payspan's website, once registration is completed. Providers can register using Payspan's enhanced provider registration process at payspanhealth.com.

Payspan Health Support can be reached via email at providersupport@payspanhealth.com, by phone at 877-331-7154 (Option #1), or online at payspanhealth.com.

EFT Advantages:

- By using EFT, you eliminate the risks associated with lost, stolen, or misdirected checks
- With EFT, you will save yourself and your company valuable time
- EFT eliminates excess paper and helps you automate your office
- EFT is HIPAA compliant (ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard)

The Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Department of Health and Human Services (HHS) to establish national standards for electronic healthcare transactions for health plans and providers. The 835 X12N Implementation Guides were implemented as the standard documents to be used in order to comply with claims transaction compliance for Electronic Data Interchange in healthcare.

Explanation of Payment (EOP) Statements

Commonwealth Care Alliance, in partnership with Payspan, provides online access to EOPs. Payspan delivers remittance information and electronic payment information to CCA providers, replacing the paper delivery of EOP statements. This service offers providers online access to current EOP statements. EOPs can be printed from the Payspan website, and ANSI 835 electronic remittance advice (ERAs) are also available for download. The website has tools and workflow management options to manage your payments and remittances.

To get started, providers can register using Payspan's enhanced provider registration process at payspanhealth.com. Payspan Health Support can be reached via email at providersupport@payspanhealth.com, by phone at 877-331-7154 (Option #1), or online at payspanhealth.com.

SECTION 6: Claims and Billing Procedures

Paper Claims

All providers are encouraged to submit claims to Commonwealth Care Alliance electronically for dates of service April 1, 2023, onward. Commonwealth Care Alliance does recognize, however, that some providers may choose to submit for reimbursement using industry-standard paper claim forms. If a provider does submit paper claim forms, the following forms are acceptable.

- CMS-1500
- CMS-1450 (UB-04)

All information must be typed and aligned within the data fields. Please do not stamp, handwrite, or use correction fluid. For detailed instructions for completing both the CMS HCFA 1500 and UB-04 claim forms, please use the links below.

- [CMS HCFA 1500](#)
- [CMS UB-04 claim](#)

[Click here](#) for more information about Medicare Billing: 837-P and Form CMS-1500.

For Dates of Service: Through March 31, 2023	For Dates of Service: April 1, 2023 – Onward
<p>Mail all paper claims to:</p> <p>Commonwealth Care Alliance Attn: Claims 2 Avenue de Lafayette Boston, MA 02111</p>	<p>Mail all paper claims to:</p> <p>Commonwealth Care Alliance, Claims P.O. Box 3085 Scranton, PA 18505</p>
<p>Please note: As of May 17, 2024, Commonwealth Care Alliance will not accept electronic claims for dates of service prior to April 1, 2023.</p>	<p>Please note: While Commonwealth Care Alliance accepts paper claim submissions, electronic billing and electronic funds transfer are preferred.</p> <p>Please register with the Availity Essentials Provider Portal. If providers utilize billing agencies to manage their account receivables, please grant them access to Payspan.</p>

Use of Invoices

Providers are encouraged to submit invoices with single paper claim submissions when appropriate (prescription, manufacturer's invoice, supplier's invoice, etc.).

Use of Modifiers

Commonwealth Care Alliance follows CMS guidelines regarding modifier usage. Pricing modifier(s) should be placed in the first position(s) of the claim form.

SECTION 6: Claims and Billing Procedures

Timely Claims Submission

Unless otherwise stated in the Agreement, providers must submit clean claims, initial, and corrected, to Commonwealth Care Alliance. The start date for determining the timely filing period is the “from” date reported on a CMS-1500 or 837-P for professional claims or the “through” date used on the UB-04 or 837-I for institutional claims.

Unless prohibited by federal law or CMS, Commonwealth Care Alliance may deny payment of any claim that fails to meet Commonwealth Care Alliance submission requirements for clean claims or failure to timely submit a clean claim to Commonwealth Care Alliance.

Please note that contracted/non-contracted providers must file original claims no later than **90 days** from the date the service was provided, unless the filing limit is stipulated otherwise in the contract.

The following items are accepted as proof that a claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by Commonwealth Care Alliance; and
- A provider’s electronic submission sheet that contains all the following identifiers:
 - Patient name
 - Provider name
 - Date of service to match Explanation of Payment (EOP)/claim(s) in question
 - Prior submission bill dates
 - Commonwealth Care Alliance product name or line of business

For Dates of Service: Through March 31, 2023	For Dates of Service: April 1, 2023 – Onward
<p>Checking Claim Status</p> <p>Providers requesting information on the status of a claim, including clarification of any Explanation of Payment may call CCA Provider Services at 866-420-9332, Monday through Friday 8:00 am to 6:00 pm</p>	<p>Checking Claim Status</p> <p>Once you are a registered user, providers may check claims status, member eligibility, and provider status through the Availity Essentials Provider Portal.</p> <p>All other providers requesting information on the status of a claim, including clarification of any Explanation of Payment may call CCA Provider Services at 866-420-9332.</p>
	<p>Web Portal</p> <p>Commonwealth Care Alliance offers <u>two</u> secure web portals where providers can obtain access to claim status, member eligibility, and other options.</p> <p>CCA Provider Portal: CCA offers a secure Provider Portal, where active and participating providers, provider groups, hospitals, and ancillaries may register to obtain access to member eligibility and authorization status; to access and download CCA documentation, forms, and templates; to access the claims portal; and to access Explanation of Payments.</p>

SECTION 6: Claims and Billing Procedures

For Dates of Service: Through March 31, 2023	For Dates of Service: April 1, 2023 – Onward
	<p>To access the CCA Provider Portal, you will need to create a new account. Be sure to have the most recent CCA Explanation of Payment (EOP) available, along with check number and corresponding “payment amount” to assist in the validation process.</p> <p>Please click the CCA Provider Portal and follow the additional steps required for access.</p> <p>Availity Essentials Provider Portal: The easy-to-navigate claims Availity Essentials Provider Portal requires authorized billers and providers to register.</p> <p>If providers utilize billing agencies to manage their account receivables, please grant them access to Payspan.</p>

SECTION 6: Claims and Billing Procedures

Corrected Claims

Corrected Claims To modify a claim that was originally submitted on paper or via EDI submission and paid or denied, providers may submit a corrected claim via paper or 837 submissions. If the corrected claim requires the inclusion of additional information, invoice, prescription, etc., the submission must be paper.

How to Submit a Corrected Claim for Dates of Service April 1, 2023, and Onward

A provider may submit a corrected paper claim to modify a claim that was previously submitted and paid or denied (e.g., changing units, dates of service, bill type, etc.).

~~(06/2021)~~ Corrected Claim Submission Requirements:

1. The original claim number MUST be listed
2. Any necessary modifications from the original claim
3. Any required supporting documentation
4. CMS HCFA 1500 or UB-04 paper claim form with corrections MUST NOT contain any of the following:
 - No handwritten changes
 - No correction fluid on form

For detailed instructions for completing both the CMS HCFA 1500 and UB-04 claim forms, please use the links below.

- [CMS HCFA 1500](#)
- [CMS UB-04 claim](#)

Submission Requirements

The provider may submit a paper corrected claim accompanied by the required documentation stated above. Whenever possible, corrected claims may be submitted electronically. Corrected claim requests will be considered when received from contracting providers within 180 days, or for/ non-contracting providers within **90 days from the original payment or denial date** as indicated on the EOP and accompanied by supporting documentation when applicable. CCA reviews all corrected claim requests within 60 calendar days from receipt date.

For Dates of Service: Through March 31, 2023	For Dates of Service: April 1, 2023 – Onward
<p>Provider must submit their paper corrected claim requests to the address below:</p> <p>Commonwealth Care Alliance Attn: Claims 2 Avenue de Lafayette Boston, MA 02111</p>	<p>Provider must submit their paper corrected claim requests to the address below:</p> <p>Commonwealth Care Alliance, Claims P.O. Box 3085 Scranton, PA 18505</p>
<p>Rejected Claims</p> <p>If Commonwealth Care Alliance returns/rejects a claim due to missing or incomplete information, it is the provider's responsibility to resubmit a clean claim within original filing limits.</p>	<p>Rejected Claims</p> <p>If Commonwealth Care Alliance returns/rejects a claim due to missing or incomplete information, it is the provider's responsibility to resubmit a clean claim within original filing limits.</p> <p>Mail paper claims to:</p>

SECTION 6: Claims and Billing Procedures

<p>Mail all paper claims to:</p> <p>Commonwealth Care Alliance Attn: Claims 2 Avenue de Lafayette Boston, MA 02111</p>	<p>Mail all paper claims to:</p> <p>Commonwealth Care Alliance Attn: Claims P.O. Box 3085 Scranton, PA 18505</p>
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Provider Payment Disputes and Appeals

If a provider disagrees with CCA's decision of denial or reimbursement of a claim, the provider can file a payment dispute for reconsideration. All provider payment disputes must be received in writing. Examples of why a provider might submit a payment dispute for a claim decision may include:

- Denials due to timely filing
- Claims believed to be adjusted incorrectly
- Disputing a request for recovery of overpayments

Provider Payment Disputes Do Not Include:

- Seeking resolution of a contractual issue payment disputes, wherein the provider believes, CCA is paying an amount different than was contractually agreed. Please direct these concerns to ccacontracting@commonwealthcare.org.
- An appeal made by a provider on behalf of a specific member. These should be directed to the CCA Provider Services department at 866-420-9332.
- Incomplete or incorrect claims. If CCA returns a claim due to missing or incomplete information, the claim may be resubmitted using the Request for Claim Review form.
 - Massachusetts – [Download Request for Claim Review form](#)
 - Rhode Island – [Download Request for Claims Review form](#)

All Provider Payment Disputes Must Include:

- Request for Claim Review form
- Provider's tax identification number
- Provider's contact information
- A clear identification of the disputed item
- A concise explanation for which the provider believes the payment amount, request for additional information, or other CCA action is incorrect
- The remittance advice (or the member's name, date of service, CPT or HCPC codes, original claim number)
- Copy of the authorization (if authorization was required)
- An explanation for good cause if attempting to dispute a timely filing denial

If a provider dispute does not include all required information listed above, a request for additional information may be issued to the requesting provider. If the request for additional information is not returned with the required information by the 60th day from the initial payment dispute receipt, the payment dispute will be dismissed.

SECTION 6: Claims and Billing Procedures

Payment Dispute Submission Requirements for Contracted Providers

A payment dispute from a contracted provider must be made in writing, accompanied by the required documentation stated above. Payment dispute requests will be considered when received within **90 days from the original payment or denial date**, as indicated on the EOP, with supporting documentation.

Commonwealth Care Alliance reviews all payment disputes within 60 calendar days. Commonwealth Care Alliance will review all supporting documentation submitted with a payment dispute to make a determination.

SECTION 6: Claims and Billing Procedures

Appeal Submission Requirements for Non-contracted Providers

The claim appeal by a non-contracted provider must be made in writing accompanied by required documentation stated above. Appeal requests will be considered when received within 60 days from the original payment or denial date as indicated on the EOP, per CMS Regulations.

Waiver of Liability (WOL): Non-contracted providers **must** include a signed [Waiver of Liability](#) form holding the member harmless regardless of the outcome of the appeal. This form must be accompanied with the claim appeal. If a signed WOL is not received with the appeal request, the provider will be issued a letter requesting the documentation accompanied by a blank WOL. If a signed WOL is not received within the appeal time period, the appeal will be dismissed.

Commonwealth Care Alliance reviews all appeals within 60 calendar days. Commonwealth Care Alliance will review all supporting documentation submitted with the appeal to make a determination.

For Dates of Service: Through March 31, 2023	For Dates of Service: April 1, 2023 – Onward
<p>Provider Payment Disputes and Appeals:</p> <p>Contracted and non-contracted providers must submit their request to the address below:</p> <p>Commonwealth Care Alliance Attn: Claims 2 Avenue de Lafayette Boston, MA 02111</p> <p>For additional questions on provider payment disputes or appeals, please contact the CCA Provider Services department at 866-420- 9332</p>	<p>Provider Payment Disputes and Appeals:</p> <p>Contracted and non-contracted providers must submit their request to the address below:</p> <p>Commonwealth Care Alliance Attn: Payment Disputes and Appeals P.O. Box 3566 Scranton, PA 18505</p> <p>For additional questions on provider payment disputes or appeals, please contact the CCA Provider Services department at 866-420- 9332</p>

SECTION 6: Claims and Billing Procedures

Hospice

Services rendered to CCA Medicare Advantage members who have elected hospice should be billed directly to Medicare.

Payment Policy

CCA has developed a payment policy program to provide guidance to providers on current coding and billing practices set by CCA. All payment policies are designed to assist providers with claim submission. All payment policies assist in helping CCA make determinations on plan coverage and reimbursement. Payment policies will be consistently updated to ensure accurate coding and billing following Medicare guidelines. CCA will follow additional guidance as deemed necessary in the development of all payment policies. References to policy guidance are provided within all payment policies. Payment policies are located on the provider website under Provider Resources:

- Massachusetts – [Provider Payment Policies](#)
- Rhode Island – [Provider Payment Policies](#)

Extended Care Facility Billing Information

Extended care facilities are required to submit claims with the appropriate codes for services rendered to Commonwealth Care Alliance members. Please refer to Section 4, Prior Authorization Requirements, for authorization requirements.

Behavioral Health Billing Information

Licensure and Modifiers

Claims for behavioral health outpatient services must include the appropriate modifier for the license of the clinician who provided the service. The table below shows licensures accepted by Commonwealth Care Alliance, the corresponding modifiers, and Commonwealth Care Alliance policy regarding reimbursement. Please refer to Section 4, Prior Authorization Requirements, for authorization requirements.

Degree	License	Modifier	Commonwealth Care Alliance Policy
Physician	MD, DO	U6	May provide/bill for direct services
Psychologist: Ph.D., Psy.D., Ed.D.	LP	AH	May provide/bill for direct services
Advanced Practice Nurse; Clinical Nurse Specialist	APRN, RNCS	SA	May provide/bill for direct services
Licensed Independent Clinical Social Worker	LICSW	AJ	May provide/bill for direct services
Licensed Mental Health Counselor	LMHC	TBD	May provide/bill for direct services
Licensed Marriage and Family Therapist	LMFT	TBD	May provide/bill for direct services
Registered Nurse	RN	TD	May provide/bill for direct service medical services

Per CMS Section 4121 of Division FF of Consolidation Appropriations Act, 2023, establishes a new Medicare benefit category for Licensed Mental Health Counselors (LMHCs) and Licensed Marriage and Family Therapists (LMFTs) furnished by and directly billed by LMHCs and LMFTs. Payment for LMHC and LMFT services under Part B of the Medicare program will begin on January 1, 2024.

SECTION 6: Claims and Billing Procedures

Significant Events with Reimbursement Impact

Serious Reportable Events

According to the National Quality Forum (NQF), serious reportable adverse events (SREs)—commonly referred to as "never events"—are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a healthcare facility. In an effort to reduce or eliminate the occurrence of SREs, Commonwealth Care Alliance will not provide reimbursement or allow hospitals to retain reimbursement for any care directly related to a "never event." Commonwealth Care Alliance has adopted the list of serious adverse events in accordance with CMS.

Commonwealth Care Alliance will require all participating providers to report SREs by populating present-on-admission (POA) indicators on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims, where applicable. Otherwise, Commonwealth Care Alliance will follow CMS guidelines for the billing of "never events." In the instance that the "never event" has not been reported, Commonwealth Care Alliance will use any means available to determine if any charges filed with Commonwealth Care Alliance meet the criteria, as outlined by the NQF, and adopted by CMS, as a serious reportable adverse event.

In the circumstance that a payment has been made for an SRE, Commonwealth Care Alliance reserves the right to recoup the payment from the provider. Commonwealth Care Alliance will require all participating acute care hospitals to hold members harmless for any services related to "never events" in any clinical setting.

Hospital-Acquired Conditions

According to CMS, hospital-acquired conditions (HACs) are selected conditions that were not present at the time of admission but developed during the hospital stay and could have been prevented through the application of evidence-based guidelines. Therefore, in an effort to reduce or eliminate the occurrence of HACs, Commonwealth Care Alliance will not provide reimbursement or allow hospitals to retain reimbursement for any care directly related to the condition. Commonwealth Care Alliance has adopted the list of HACs in accordance with CMS.

Commonwealth Care Alliance will require all participating providers to report present-on-admission information for both primary and secondary diagnoses when submitting claims for discharge. Hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present. Commonwealth Care Alliance will require all participating acute care hospitals to hold members harmless for any services related to HACs in any clinical setting.

Provider Preventable Conditions

A provider preventable condition (PPC) is a condition that meets the definition of a "health care–acquired condition (HCAC)" or an "other provider preventable condition (OPPC)" as defined by the Centers for Medicare & Medicare Services (CMS) in federal regulations at 42 CFR 447.26(b).

No payment shall be made by Commonwealth Care Alliance to the provider for a PPC. As a condition of payment from Commonwealth Care Alliance, the provider must comply with reporting requirements on PPC as described at 42 C.F.R. sec. 447.26(d).

Commonwealth Care Alliance reserves the right to apply regulations and guidelines promulgated by CMS that relate to PPCs to support Commonwealth Care Alliance actions in the application of state-specific determinations.

SECTION 7: Clinical Documentation and Medicare Risk Adjustment

Clinical Documentation Processes

The Centers for Medicare & Medicaid Services (CMS) use a risk-adjustment system to account for medical expenses and care coordination costs for beneficiaries with special needs. As part of that system, CMS requires providers to support all diagnoses billed with “substantive documentation” in the provider’s medical record. Commonwealth Care Alliance and CMS may audit providers at any point for compliance with documentation standards.

The definition of “substantive documentation” is that each diagnosis billed must be supported by three items in the medical record:

1. An **evaluation** for each diagnosis
 - Assesses of relevant symptoms and physical examination findings at time of visit
 - Only contains diagnoses that are active or chronic (which must be identified as such)
 - Lists and addresses all past and recent diagnosis if they are active and of medical significance
2. A **status** for each diagnosis to indicate progress or lack thereof, for example:
 - Stable, progressing or worsening, improving
 - Not responding to treatment or intervention
3. A **treatment plan** for each diagnosis; for example:
 - Observation or monitoring for exacerbation, responses to treatment, etc.
 - Referrals to specialists or services (e.g., cardiologist or PT)
 - Continuations or changes to any related medications

Coding Compliance

Commonwealth Care Alliance encourages providers to code to the most appropriate level of specificity as a general standard of practice (CPT, ICD10). All medications should have an associated diagnosis identified on the problem list that correlates to their usage. Commonwealth Care Alliance and/or CMS may audit the provider at any point for over-coding and/or similar billing practices related to fraud, waste, and abuse.

Educational Resources

Providers are encouraged to contact the Commonwealth Care Alliance Clinical Documentation team to request education about coding and documentation compliance. Please email: rahub@commonwealthcare.org.

Behavioral Health Screening Compliance

Commonwealth Care Alliance encourages all of its contracted primary care providers (PCPs) to screen and assess each member for behavioral health needs. The early identification of behavioral health needs can lead to successful referrals, intervention, and integrated treatment in a timely manner.

The behavioral health screening tool and how to evaluate results can be found in Section 17, Forms, in this Provider Manual. How to make a behavioral health specialty care referral can be found in Section 13, Provider Credentialing.

CCA recommends the use of the PHQ--9 depression assessment tool to assess patients for depression. The tool is a diagnostic measure to assess for major depression as well as other depressive disorders. The PHQ--9 can be administered repeatedly to reflect improvement or worsening of symptoms. CCA recommends the use of the AUDIT screening tool to assess the use of alcohol and other drug abuse and dependence. The tool is not diagnostic but can identify the existence

SECTION 7: Clinical Documentation and Medicare Risk Adjustment

of alcohol or other drug problems. In addition, CCA recommends that providers conduct a mental status exam to further evaluate for other behavioral health symptoms.

Medicare Risk Adjustment: General Guidelines and Recommendations

General Medicare Risk Adjustment Guidelines

For the findings and coding of clinical encounters to be accepted by CMS for risk adjustment purposes, a clinical encounter must be in the form of a face-to-face visit by a physician or advanced practice clinician (such as an NP, PA, LICSW, OT, or PT).

Moreover, all active diagnoses must be documented during a face-to-face encounter at least once per calendar year for the diagnoses to count for risk adjustment purposes.

Annual Assessment Process

Commonwealth Care Alliance encourages providers to adopt the practice of an annual comprehensive assessment to ensure that all active conditions are reviewed at least once during the calendar year. The process of reviewing active conditions may be tied to an annual wellness exam or an annual physical exam.

The documentation and coding compliance practices and general risk adjustment guidelines described above should be adhered to in documenting and coding the findings of an annual comprehensive assessment visit.

Collaboration with Contracted Providers

Commonwealth Care Alliance requires providers to monitor the quality, access, and cost effectiveness of their services and identify and address opportunities for improvement on an ongoing basis. Providers may be required to submit clinical data to Commonwealth Care Alliance, if requested.

SECTION 8: Coordination of Benefits and Third-Party Liability

SECTION 8: Coordination of Benefits and Third-Party Liability

Coordination of benefits (COB) applies to members who are covered by more than one insurance policy and serves to determine which insurance is primarily responsible for payment to ensure claims are paid correctly. COB is administered by Commonwealth Care Alliance based on the member's benefit plan and applicable law.

Third-party liability (TPL) occurs when members are injured as a result of an accident when another party may be liable for the payment of the member's medical claims. The most common types of TPL cases are motor vehicle accidents, workers' compensation injuries, work-related or involve occupational injuries, and slip -and- fall injuries.

In some circumstances, as provided under the member's benefits and applicable state and federal law, Commonwealth Care Alliance has the right to recover from third parties.

Member Covered by Employer-Sponsored Health Insurance Plan

Commonwealth Care Alliance is the secondary payer of coverage. Commonwealth Care Alliance payment would include any remaining balance of medical claims such as deductibles and co-insurance amounts (up to the Commonwealth Care Alliance contractual amount). When a claim has been paid by a member's primary insurance carrier, providers should submit the Explanation of Benefits (EOB) indicating payment amounts and any outstanding balance. The EOB must be submitted to Commonwealth Care Alliance within 60 days from the primary insurance payment date. Claims submitted without an EOB will be denied.

Member Involved in a Motor Vehicle Accident

In the event of a motor vehicle accident, the motor vehicle insurer is the primary payer for the full \$8,000 personal injury protection (PIP) coverage. Once the provider has received a PIP exhaustion letter, if further payment is requested, the provider should submit a bill and copy of the PIP letter to Commonwealth Care Alliance within 60 days from the date the motor vehicle insurer issued the EOB form.

Occupational Injuries

In instances where a member suffers a work-related accident, the workers' compensation insurer is primary, and Commonwealth Care Alliance is the secondary payer of coverage. Commonwealth Care Alliance will not make payment on claims until the TPL case has reached settlement. For all claims relating to a workers' compensation case, the provider should submit the claim and include additional information, when possible, such as date of injury, name of the workers' compensation insurance carrier, and claim number.

In instances of a COB or TPL claim, a secondary claim form should be submitted along with other related documentation to the address below:

Commonwealth Care Alliance
Attn: TPL/Subrogation Department
30 Winter Street, 11th Floor
Boston, MA 02108

For questions regarding medical liens, payments, third-party liability, or coordination of benefits, please contact the Commonwealth Care Alliance Third-Party Claims Investigation Analyst at tplcoordinator@commonwealthcare.org or call 617--426--0600 (ext. 5-1221).

Note: Commonwealth Care Alliance remains the primary payer in all cases for the provision of services not related to the TPL or COB issue.

SECTION 9: Pharmacy Program

This section outlines the Commonwealth Care Alliance pharmacy program, including details on our formulary and utilization management programs. Also included is a description of the Commonwealth Care Alliance Step Therapy, Medication Therapy Management (MTM), and Mail Order Programs.

Commonwealth Care Alliance has contracted with Navitus Health Solutions, a national pharmacy benefit management company, to administer the pharmacy benefit on behalf of Commonwealth Care Alliance. Commonwealth Care Alliance has worked with its primary care partners to identify those community pharmacies in the neighborhoods of the primary care sites with whom the Commonwealth Care Alliance primary care providers have established relationships and members can access easily. In addition to many smaller independent pharmacies, the Commonwealth Care Alliance pharmacy network includes CVS, Stop and Shop, Walgreens, and many others.

For a complete and up-to-date listing of contracted providers and pharmacies, use the links below.

[CCA Pharmacy Directory](#)

Formulary

Commonwealth Care Alliance has established a formulary that aims to provide prescribing clinicians with a broad range of options for treatment while promoting the most cost-effective drug choices. Commonwealth Care Alliance will cover the drugs listed in the formulary as long as they are medically necessary. Use the links below to access the formulary list on our website:

- Massachusetts – [Drug Formulary](#)
- Rhode Island – [Drug Formulary](#)

Please be advised of monthly formulary changes and our preferred arrangement with Abbott Freestyle and LifeScan OneTouch for glucometer and test strips, which can be obtained through the Commonwealth Care Alliance pharmacy network. Prior authorization is required for non-preferred diabetic testing supplies.

Prior Authorization

Certain medications require prior authorization (prior approval) before a pharmacy can fill the prescription. Clinicians may request prior authorization by calling 866-270-3877. Clinicians may also complete and mail or fax the Coverage Determination Request form and a doctor's supporting statement to 855-668-8552.

Click below to access the list of medications that require prior authorization. Information regarding pharmacy-related grievances, appeals, and exceptions may be found here as well.

- Massachusetts – [Prior Authorization Criteria](#)
- Rhode Island – [Prior Authorization Criteria](#)

Part B vs. D Coverage Determination

Some medications require specific information to help ensure appropriate payment under Medicare "Part B versus Part D" per the Centers for Medicare & Medicaid Services (CMS).

Part D Medications

Medications covered under the pharmacy benefit can be oral, injectable, infusible, or topical medications such as creams and lotions. Prescription drugs under the pharmacy benefit are subject to formulary tiers and may require authorization.

SECTION 9: Pharmacy Program

- Massachusetts – [View the list of drugs and prior authorization requirements by plan.](#)
- Rhode Island – [View the list of drugs and prior authorization requirements by plan.](#)

Part B Medications

Outpatient (part B) medications are covered when Medicare coverage criteria are met. Outpatient (part B) medications, in accordance with Medicare coverage criteria, are covered when furnished “incident” to a physician service for drugs that are “not usually self-administered by the patient.”

- Massachusetts
 - View the list of [office - administered part B medications that do not require authorization.](#)
- Rhode Island
 - View the list of [office - administered part B medications that do not require authorization.](#)

Please note: Requests for outpatient part B medical pharmacy drugs (J-Codes) are reviewed by the Utilization Management department.

For medications not addressed in this document, refer to the Medicare Coverage Database to search for applicable coverage policies (national coverage determinations, local coverage determinations, and local coverage articles).

SECTION 9: Pharmacy Program

Part B versus D

Medicare medical insurance or part B also covers other selected medications. Some of these medications include:

- Oral anti-emetics if used within 48 hours after chemotherapy administration.
- Immunosuppressants for members who received a Medicare-covered transplant.
- Immune globulins for members with primary immune deficiency when provided in the home.
- Infusion/injectable drugs that require a pump for infusion.
- Nebulized drugs for members in the home that require administration via DME.

View the list and billing determination forms for [part B vs D drugs](#).

Where to Submit a Prior Authorization

1. Medications that are processed under the pharmacy benefit and filled at retail pharmacies, as well as self-administered specialty medications should be submitted to Navitus:

Phone [866-270-3877](tel:866-270-3877)
Fax 855-668-8552
Mail Navitus Health Solutions
PO Box 1039
Appleton, WI 54912-1039

For your convenience, the standard prior authorization request form used for submitting requests for medications to be obtained by the member using their pharmacy benefit can be found [here](#).

2. Medications that are processed under the medical benefit and administered by healthcare professionals in the physician office setting should be faxed to the Utilization department at 855-341-0720. For your convenience, the standard prior authorization request form used for submitting requests for outpatient part B medical pharmacy drugs (J Codes) can be found [here](#).

Where to Submit an Appeal

1. Appeals for medications that are processed under the pharmacy benefit and filled at retail pharmacies, as well as self-administered specialty medications should be submitted to CCA using the [Request for Redetermination of Medicare Prescription Drug Denial form](#).

Phone 866-610-2273 (MA) 833-346-9222 (RI)
Fax 857-453-4517
Mail Commonwealth Care Alliance
Appeals and Grievances Department
30 Winter Street
Boston, MA 02108

SECTION 9: Pharmacy Program

2. Appeals for medications that are processed under the medical benefit and administered by healthcare professionals in the physician office setting, can be submitted to CCA.

Phone 866-610-2273 (MA) or 833-346-9222 (RI)

Fax 857-453-4517

Mail Commonwealth Care Alliance
Appeals and Grievances Department
30 Winter Street
Boston, MA 02108

Avoid Delays

Completing and submitting the correct PA form will ensure there is sufficient information for processing your request. This will prevent delays and unnecessary denials.

Please be sure to include:

- Prescriber name,
- Office phone number,
- Member name,
- Member ID,
- Requested medication/JCode,
- Anticipated treatment start date,
- Dosing information and frequency,
- Diagnosis,
- Past therapeutic failures or contraindications,
- Any pertinent clinical notes,
- Pathology reports,
- Lab test results.

The timeframe for processing coverage determination requests is 24 hours for expedited requests and 72 hours for standard requests. To ensure efficient review of prior authorization requests, please submit complete requests.

Step Therapy Program

In support of efforts to provide members with the best medical care at a reasonable cost, Commonwealth Care Alliance has worked closely with healthcare professionals to develop step therapy programs. These programs initiate drug therapy for a medical condition with the most cost-effective and safest drug and “step up” through a sequence of alternative drug therapies as a preceding treatment option fails.

Step therapy applies coverage rules at the pharmacy point of service (e.g., a first-line drug must be tried before a second-line drug can be used). If a prescription is written for a second-line drug and the step therapy rule is not met, the claim is rejected. A message is transmitted to the pharmacy indicating that the patient should be treated with the first-line drug before coverage of the second-line drug can be authorized. If a new member has been stabilized on a second-line drug prior to enrolling with Commonwealth Care Alliance, the new member is allowed to remain on the second-line drug, per the Commonwealth Care Alliance transition policy—a 30-day medication supply within a 90-day period. During the transition period, the prescriber will need to submit a prior authorization with clinical documentation stating why the member has tried and failed or is unable to take the first-line drug

SECTION 9: Pharmacy Program

Click below to review the Commonwealth Care Alliance transition policy.

- Massachusetts – [Transition Policy](#)
- Rhode Island – [Transition Policy](#)

Click below to access step therapy program information on our website.

- Massachusetts – [Step Therapy Program](#)
- Rhode Island – [Step Therapy Program](#)

Extended Day Supply

Commonwealth Care Alliance members can get an extended day supply (up to 100 days) for most drugs at contracted community pharmacies for medications that are used for the treatment or management of chronic conditions. This is in addition to members being able to receive extended day supply through mail order.

Medication Therapy Management Program

Commonwealth Care Alliance offers medication therapy management (MTM) programs to members who take a number of different drugs, have chronic diseases (such as asthma, diabetes, or COPD), and have high annual drug costs. If members meet these three qualifications, they may be eligible for extra help in taking their medications. This program improves patients' knowledge of their medications by offering members a one-on-one consultation with a clinical pharmacist. This includes prescription, non-prescription, and over-the-counter medications along with herbals or other supplements.

The MTM program helps to identify and to address medication related problems or concerns that the patient may be experiencing and empowers patients to self-manage their medications and their health conditions.

For more information, please click below.

- Massachusetts – [Pharmacy Information and Programs](#)
- Rhode Island – [Pharmacy Information and Programs](#)

SECTION 10: Information for Ancillary Providers—Extended Care Facilities, Durable Medical Equipment & Vision

Extended Care Facilities

Commonwealth Care Alliance provides benefit coverage to its members at extended care facilities or nursing facilities. The protocols for benefit coverage take into account covered services, exclusions, clinical conditions and criteria, authorizations, and operational expectations.

Prior Authorization

Prior authorization is required and shall be granted from Commonwealth Care Alliance's designated care team authorizing the extended care facility to render specified covered services to a Commonwealth Care Alliance member. Payment to a facility for covered services requires prior authorization. For more information, please see Section 4 of this manual.

Covered Services Include

- Sub-acute level of care: Short-term, goal-oriented treatment plan requiring nursing care or rehabilitation at a high intensity level; lower intensity than acute care. Sub-acute/skilled days shall be limited to 100 days per benefit period.
- Skilled nursing level of care: Short-term, goal-oriented treatment plan when the member cannot be treated in a community-based setting; lower intensity than sub-acute. Sub-acute/skilled days shall be limited to 100 days per benefit period.
- Inpatient rehabilitation: Intensive rehabilitation program for members. Members who are admitted must be able to tolerate an intensive level of rehabilitation services and benefit from a team approach.
- Long-term acute care facility services: Treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures.

Level-of-Care Determinations

All level-of-care determinations prior to, and during a member's admission to an extended care facility are made at the discretion of Commonwealth Care Alliance clinical staff or those designated and authorized by Commonwealth Care Alliance to direct member care.

Conditions and criteria for **Skilled Nursing Facility (SNF) Services Under Medicare Part A** are determined in the Medical Necessity Guidelines found here: <https://www.commonwealthcarealliance.org/ma/providers/medical-policies/medical-necessity-guidelines/>.

Conditions and criteria for **Determination and Documentation of Medical Necessity in an Inpatient Rehabilitation Facility** are determined in the Medical Necessity Guidelines found here: <https://www.commonwealthcarealliance.org/ma/providers/medical-policies/medical-necessity-guidelines/>.

Conditions and criteria for **Long-Term Acute Care Hospital (LTACH)** are determined by InterQual guidelines.

SECTION 10: Information for Ancillary Providers—Extended Care Facilities, Durable Medical Equipment & Vision

Notice of Medicare Non-Coverage (NOMNC)

The extended care facility shall deliver the Notice of Medicare Non-Coverage (NOMNC) on behalf of CCA no later than 2 days before a member's covered services end in accordance with Medicare requirements. The extended care facility shall provide CCA with a copy of the notice within the same timeframe as the member for monitoring and documentation purposes.

Service Specification of Extended Care Facilities

1. Maintain 24 hours a day, 7 days a week availability to provide extended care facility services in accordance with state and federal regulations, and be accessible by phone, directly, at all times.
2. Upon request, provide admission for extended care facility services within 24 hours of the request subject to bed availability and with the prior authorization of CCA nursing staff and/or those designated and authorized by CCA to direct patient care.
3. Maintain and respect the rights of members at all times.
4. Inform CCA nursing staff and/or those designated and authorized by CCA to direct patient care as to the availability of beds upon their request.
5. Ensure that personnel providing services under this agreement meet current applicable federal, state, and local licensing standards for the provision of healthcare services, and are fully state credentialed healthcare providers, as described in Section 13, Provider Credentialing. The extended care facility services agree to notify CCA of changes in provider(s) status that would disqualify provider(s) from meeting above standards.
6. Before or during admission, a full written transfer summary with appropriate physician's orders signed by the PCP will be provided to the facility by the member's PCP or designee.
7. Provide extended care facility services to enrollees in conformance and full cooperation with the treatment plan developed by the PCP or provider care team (PCT). Facility agrees to allow the member's PCP or designee to continue as the member's physician of record.
8. Contact the PCP/PCT immediately upon notice of significant changes and/or relevant findings in regard to the status of the enrollee.
9. Agree to meet with PCT clinical staff as needed.
10. A. **Skilled Nursing Facility.** Conform to CCA protocols for timely updates and submissions of clinical updates, and Medications List forms upon CCA request; provide the PCT and/or CCA with timely clinical updates appropriate to the member's status in a mutually agreed upon format and frequency. Additionally, the quarterly submission of facility care plans is required to be sent to the Transitions of Care Department via fax to 855-811-3467.

B. **Rehabilitation Facility.** Provide CCA with timely clinical updates appropriate to the member's status in a mutually agreed upon format and frequency.

C. **Long Term Acute Care Facility Services.** Provide CCA with timely updates of Medications List forms upon CCA request; provide the PCT and/or CCA with timely clinical updates appropriate to the member's status in a mutually agreed upon format and frequency.
11. For long term care members, providers are encouraged to download members CCA's quarterly care plans from CCA's provider portal.

SECTION 10: Information for Ancillary Providers—Extended Care Facilities, Durable Medical Equipment & Vision

Member Enrollment Centers (MEC)	
Massachusetts – Member Enrollment Centers (MEC)	Rhode Island – Member Enrollment Centers (MEC)
<p>Chelsea 80 Everett Avenue Chelsea, MA 02170 Toll-free: 800-841-2900 Fax: 617-887-8777</p> <p>When submitting or inquiring about a long-term care applicant residing in a nursing facility serviced by the Chelsea MEC, please use this fax number: 617-889-3285.</p>	<p>Providence 1 Reservoir Avenue Providence, RI 02907</p> <p>1-855-MY-RIDHS (1-855-697-4347)</p>
<p>Springfield 88 Industry Avenue, Suite D Springfield, MA 01104-3259</p> <p>Toll-free: 800-841-2900</p>	<p>Pawtucket 249 Roosevelt Avenue Pawtucket, RI 02860</p> <p>1-855-MY-RIDHS (1-855-697-4347)</p>
<p>Taunton 21 Spring Street, Suite 4 Taunton, MA 02780</p> <p>Toll-free: 800-841-2900</p>	<p>Woonsocket 219 Pond Street Woonsocket, RI 02895</p> <p>1-855-MY-RIDHS (1-855-697-4347)</p>
<p>Tewksbury 367 East Street Tewksbury, MA 01876</p> <p>Toll-free: 888-665-9993 or 800-841-2900</p>	<p>Warwick 195 Buttonwoods Avenue Warwick, RI 02886</p> <p>1-855-MY-RIDHS (1-855-697-4347)</p>
	<p>South County Regional Family Center 4808 Tower Hill Road, Suite G1 Wakefield, RI 02879</p> <p>1-855-MY-RIDHS (1-855-697-4347)</p>
	<p>Newport Regional Family Center 31 John Clarke Road Middletown, RI 02842</p> <p>1-855-MY-RIDHS (1-855-697-4347)</p>

SECTION 10: Information for Ancillary Providers—Extended Care Facilities, Durable Medical Equipment & Vision

Durable Medical Equipment

Commonwealth Care Alliance contracts with local, statewide, and national vendors to provide durable medical equipment (DME) and medical/surgical supplies for its members.

DME are products that are (a) fabricated primarily and customarily to fulfill a medical purpose; (b) generally, not useful in the absence of illness or injury; (c) able to withstand repeated use over an extended period of time; and (d) appropriate for home use. DME services include, but are not limited to, the purchase of medical equipment, replacement parts, and repairs for such items such as canes, crutches, wheelchairs (manual, motorized, custom fitted, and rentals), walkers, commodes, special beds, monitoring equipment, and orthotic and prosthetic devices. Coverage includes related supplies, repair, and replacement of the equipment.

Medical/Surgical Supplies

Medical and surgical supplies are products that are (a) fabricated primarily and customarily to fulfill a medical or surgical purpose; (b) used in the treatment of a specific medical condition; and (c) non-reusable and disposable. This includes, but is not limited to, items such as urinary catheters, wound dressings, and glucose monitor supplies.

Prior Authorization

All services provided must be deemed appropriate by the member’s physician, nurse practitioner, physician’s assistant, clinical nurse specialist, and/or care team. Certain equipment and supplies may require prior authorization. Payment to providers for those covered services requiring prior authorization is contingent upon the provider receiving prior authorization before services are rendered.

Eligibility

All providers are required to confirm eligibility on a regular basis, even if the prior authorization covers a long period.

Eligibility may be confirmed by:	
For Dates of Service: Through March 31, 2023	For Dates of Service: April 1, 2023 – Onward
Logging in to the CCA Provider Portal	Use the Availity Essentials Provider Portal *
	Logging in to the CCA Provider Portal
Using the NEHEN Provider Portal *	Using the NEHEN Provider Portal *
Contacting CCA Provider Services at 866-420-9332	Contacting CCA Provider Services at 866-420-9332

*Supports batch Eligibility transactions

Service Specifications for Durable Medical Equipment

Commonwealth Care Alliance DME providers are responsible for meeting specified standards for accessibility, repairs, and equipment delivery and removal. The standards are listed below.

Accessibility

- Maintain 24 hours a day, 7 days a week availability to provide services, and be accessible by telephone directly by on-call coverage at all times

SECTION 10: Information for Ancillary Providers—Extended Care Facilities, Durable Medical Equipment & Vision

- Provide all emergently needed supplies, services, or equipment within 2 hours of receiving the request. Emergently needed services or equipment shall include that for which malfunctions or absence presents an immediate life-threatening situation to the member, including, but not limited to, oxygen and respiratory services and equipment
- Provide all other needed supplies, services, or equipment, including wheelchairs and wheelchair repairs, within 24 hours of receiving request, and notify the PCP or primary care site (PCS), at the time of request, of any anticipated delay or back order in the provision of supplies, services, and/or equipment
- Make every effort to fill a same-day order if requested
- Provide the closest available substitute wheelchair on loan, free of charge, for the duration of any wheelchair repair service
- Designate a liaison to accept requests and coordinate supplies, services, and equipment for Commonwealth Care Alliance members

Capped Rentals

- Payments for this category are made on a monthly rental basis not to exceed a continuous 13-month period. For the first three rental months, the monthly rental fee schedule is limited to 10% of the average allowed purchase price. For each of the remaining months, the monthly rental is limited to 7.5% of the average allowed purchase price. This means that months 1–3 are paid at the fee schedule allowed rental rate, and months 4–13 are paid at 75% of the fee schedule allowed rate. At the end of the capped rental period (after 13 paid rental months), the title of ownership for capped rental devices transfers from the provider to the patient
- Reimbursement claims for capped rental items must be submitted with the appropriate modifier. Claims submitted without the appropriate modifier will be denied. When billing a capped rental item, please include the modifier “RR” as primary modifier. The “KH” modifier shall only be used for the first month of billing, the “KI” modifier shall only be used for the second and third months of billing, and the “KJ” modifier shall then be used for the remainder of the capped rental period (months 4–13)
- Payment for routinely purchased equipment category is made in a lump sum and the total payment may not exceed the actual charge or the fee for a purchase. New equipment should be billed with modifier “NU” and used equipment with modifier “UE”

Repairs

- Make every effort to complete repair with one service call. Provider shall contact the PCP and/or care team prior to subsequent visits if a repair requires more than one service call
- Notify PCP and/or care team in writing if rebuilt parts are used in a repair
- As requested, make available to PCP and/or care team the expected life of consumables such as batteries, and provide warranties and serial or model numbers for equipment such as wheelchairs, batteries, beds, lifts, etc.

Equipment Delivery and Removal

- Contact Commonwealth Care Alliance member to make arrangements for delivery of equipment
- Fit all equipment properly to the member’s specifications at the time of delivery
- Instruct member or caretaker in the safe and proper use of equipment (lifts, walkers, oxygen concentrators, etc.)
- Remove any rental items within 48 hours of notification

Note: Emergently needed services or equipment shall include that for which malfunctions or absence presents an immediate life-threatening situation to the member, including, but not limited to, oxygen and respiratory services and equipment.

Prescriptions

In accordance with CMS requirements, Commonwealth Care Alliance requires a prescription for all DME and medical supply orders. Prescriptions become an important source of supporting documentation if a provider is asked to submit records for a claims audit or other necessary reviews. Examples of when a prescription is required include, but are not limited to, disposable items, purchases, rentals, order changes, replacement items, or if the supplying provider changes.

SECTION 10: Information for Ancillary Providers—Extended Care Facilities, Durable Medical Equipment & Vision

Proof of Delivery

In accordance with CMS requirements, providers are expected to ensure proof of delivery protocols are met and that documentation is available if requested by Commonwealth Care Alliance. The proof of delivery documentation verifies that the member received the item(s) and includes, but is not limited to, the member's name, description of item(s), quantity, and date delivered.



SECTION 10: Information for Ancillary Providers—Extended Care Facilities, Durable Medical Equipment & Vision

Dental

Commonwealth Care Alliance (CCA) uses Skygen for preventive and comprehensive dental services. Skygen's provider line is 855-434-9243. Medical dental services, such as emergency care, should be billed through CCA's medical claims. Please refer to the [Key Contact information section](#) for claims information.

Skygen Portal: pwp.sciondental.com

Skygen:

Electronic submission payer ID "SCION"

Paper claim via current ADA Dental Claim form, sent via postal mail:

CCA Claims

PO Box 508

Milwaukee WI 53201

Vision

CCA uses VSP for routine eye care and eyewear. VSP's provider line is 800-615-1883. Medical vision services, such as emergency care, should be billed through CCA's medical claims. Please refer to the [Key Contact information section](#) for claims information.

Vision Service Plan Portal: eyefinity.com

In-network providers

Vision Service Plan

Attention: Claim Services

PO Box 495907

Cincinnati, OH 45249-5907

Out-of-network providers

Vision Service Plan

Attention: Claim Services

PO Box 595918

Cincinnati, OH 45249-5918

Hearing

CCA uses NationsHearing for routine hearing services, including hearing exams and hearing aids. NationsHearing's provider line is 800-921-4559. Medical hearing services, such as emergency care, should be billed through CCA's medical claims. Please refer to the [Key Contact information section](#) for claims information.

NationsHearing Provider Portal: providers.nationshearing.com

NationsHearing claims address:

NationsBenefits

Attn: Claims

1801 NW 66th Avenue, Suite 100

Plantation, FL 33313

SECTION 11: Behavioral Health Services Providers

Commonwealth Care Alliance’s person-centered approach is an integral part of who we are as a leading healthcare organization. Our behavioral health services are designed to ensure broad access to behavioral healthcare as well as appropriate utilization of behavioral health and substance use disorder treatment resources. This coordination assures the promotion of the delivery of services in a quality-oriented, timely, clinically appropriate, and cost-effective manner for members.

The CCA behavioral health (BH) Utilization Management staff base their utilization-related decisions on the clinical needs of members, the benefit plan, well-established clinical decision-making support tools, the appropriateness of care, Medicare National Coverage Guidelines, healthcare objectives, scientifically based clinical criteria and treatment guidelines in the context of provider and/or member-supplied clinical information, and other relevant information. For requests for behavioral health services that require authorization, CCA will approve the request or issue a notice of denial if the request does not meet medical necessity guidelines.

Behavioral Health Clinical Provider Engagement Department (BH PE):

BH PE is responsible for building collaborative relationships with providers and driving provider performance through the use of data and education. The team utilizes data to help support community relations with providers as well as support clinical improvement in the care delivered to CCA members. Provider Engagement works to educate providers about the CCA mission and vision and the value that each provider is delivering to CCA members, including a focus on creating linkages between all behavioral health and substance use levels of care, from psychiatric inpatient to community-based services, for improved transitions of care. Provider Engagement analyzes network utilization and shares provider performance with our network. By highlighting key areas of focus, including monitoring and interpreting utilization data, we are better able to support understanding of meaningful utilization patterns and strategic analysis of clinical issues using member specific data to inform larger system trends. In response to provider data and performance, Provider Engagement supports provider activities consistent with provider and CCA priorities, including but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®) metrics, discharge planning, readmissions, and community tenure.

Provider Concerns

CCA encourages its network providers to relay any concerns they have regarding any aspect of care for CCA members. This includes, but is not limited to, quality of care, administrative operations, and access to care. These concerns should be reported to CCA Provider Services at 866-420-9332.

Health Record Maintenance

Providers must meet all requirements related to maintenance of health records, including documentation of the following in the member’s health record: acknowledgment of member rights, consent to treatment, releases of information, and demographic information; clinical (medical and behavioral health) history; comprehensive clinical biopsychosocial/behavioral health assessments; individualized treatment plans; progress notes; safety plans (if applicable), recovery plans (if applicable), relapse prevention plans (if applicable), and discharge plans and/or transition of care plans for all services provided, documentation of contact with the member, their family, guardians, or significant others; and documentation of treatment outcomes. Health records are made available to CCA when requested. Health records should conform to CCA documentation standards, to the standards of the community, and to all applicable laws and regulations including, but not limited to, state licensing, Centers for Medicare & Medicaid Services (CMS), and/or national certification board standards. Providers should be aware that CCA can request to review records (onsite or remotely) at any time, with the expectation of the review being able to be conducted within 48 hours of this request. For detailed information on Behavioral Health documentation requirements, please click the link below.

- Massachusetts – [Behavioral Health Documentation Requirements](#)
- Rhode Island – [Behavioral Health Documentation Requirements](#)

SECTION 11: Behavioral Health Services Providers

Levels of Care

Behavioral Health Services That Require Authorization or Notification of Admission							
Type of Service	Level of Care	Forms/ Resources	PA or Notification for Admission	Notification Process	PA and/or Medical Necessity Review Process	Continued Authorization Process	Determination Turnaround Time
Inpatient Services	Level 4 Medical Detox		PA not required for admission Admitting facility required to notify CCA BH UM within 48 hours of admission at 866-420-9332 (MA) or 833-346-9222 (RI)	Admitting facility required to notify CCA BH UM within 48 hours of admission at 866-420-9332 (MA) or 833-346-9222 (RI)	No authorization required. Medical necessity determination is made by the provider	No continued authorization required. Medical necessity determination is made by the provider	Not applicable
Inpatient Services	Psychiatric Inpatient Level of Care		<u>Emergency admissions:</u> PA not required; CCA BH UM at 866-420-9332 (MA) or 833-346-9222 (RI) before bed placement.	<u>Emergency admissions:</u> PA not required; CCA BH UM at 866-420-9332 (MA) or 833-346-9222 (RI) before bed placement	<u>Emergency admissions:</u> See notification process	Admitting facility calls CCA BH UM on the last covered day. Continued stay review process is conducted by phone and medical necessity is determined for continued authorization	<u>Within 72 hours</u>
Inpatient Services	Observation Beds/Holding Beds (OBS)		No PA required. Notification is required within 24 hours	See process for medical	No authorization or medical necessity review process required	No continued authorization required	Not applicable
Diversionsary Services	Acute Treatment Service (ATS): ASAM Level 3.7 (including Enhanced ATS/E-ATS)		PA not required for admission Admitting facility required to notify CCA BH UM within 48 hours of admission at 866-420-9332 (MA) or 833-346-9222 (RI)	Admitting facility required to notify CCA BH UM within 48 hours of admission at 866-420-9332 (MA) or 833-346-9222 (RI)	No authorization required. Medical necessity determination is made by the provider	No continued authorization required. Medical necessity determination is made by the provider	Not applicable
Diversionsary Services	Clinical Stabilization Services (CSS): ASAM Level 3.5		PA not required for admission. Admitting facility required to notify CCA BH UM within 48 hours of admission at 866-420-9332 (MA) or 833-346-9222 (RI)	Admitting facility required to notify CCA BH UM within 48 hours of admission at 866-420-9332 (MA) or 833-346-9222 (RI)	No authorization required. Medical necessity determination is made by the provider	No continued authorization required. Medical necessity determination is made by the provider	Not applicable
Behavioral Health Special Procedures	rTMS Services	PA Form – RTMS	Prior authorization is required	Provider faxes form to 855-341-0720	BH UM will review request for medical necessity	Same as prior authorization process	Within 14 calendar days

SECTION 11: Behavioral Health Services Providers

Behavioral Health Services That Require Authorization or Notification of Admission

Type of Service	Level of Care	Forms/ Resources	PA or Notification for Admission	Notification Process	PA and/or Medical Necessity Review Process	Continued Authorization Process	Determination Turnaround Time
Behavioral Health Special Procedures	Esketamine for Treatment-Resistant Depression	Standardized Prior Authorization Days	Prior authorization is required	Provider faxes form to 855-341-0720	BH UM will review request for medical necessity	Same as prior authorization process	Within 14 calendar days
Behavioral Health Special Procedures	Vagus Nerve Stimulation (VNS) for Treatment-Resistant Depression	Standardized Prior Authorization Days	Prior authorization is required	Provider faxes form to 855-341-0720	BH UM will review request for medical necessity	Same as prior authorization process	Within 14 calendar days

SECTION 11: Behavioral Health Services Providers

Behavioral Health Services That Do Not Require Prior Authorization or Notification of Admission

Diversionary Services:

- Partial Hospitalization and Day Treatment (PHP)
- Intensive Outpatient Programs (IOP)
- Community Behavioral Health Centers (CBHC) *MA Only

Behavioral Health Emergency Service:

- Adult Mobile Crisis Intervention for—Risk management/safety planning (AMCI) *MA Only
- Medication Management crisis
- Diagnostic evaluation
- Emergency Department visit

Outpatient Services:

- Behavioral Health Outpatient Treatment
- Diagnostic evaluation
- Urgent Outpatient: (UOS)
- Electroconvulsive Therapy (ECT)
- Neuropsychological/Psychological Testing
- Case Consultation
- Consultations in the ED
- Medication management
- Opioid Treatment Programs (OTP)

SECTION 11: Behavioral Health Services Providers

Behavioral Health Inpatient Services

Level 4 Medical Detox: Provide a planned substance use disorder treatment program offering 24-hour, medically managed evaluation and treatment for individuals who are experiencing severe withdrawal symptoms and/or acute biomedical complications as a result of a substance use disorder. Level 4 services are rendered in a hospital that can provide life support in addition to 24-hour physician and nursing care. Daily individual physician contact is a required component of this level of care. A multi-disciplinary staff of clinicians trained in the treatment of addictions and mental health conditions, as well as overall management of medical care, are involved in the member's treatment. The program staff facilitates the integrated treatment of co-existing biomedical and behavioral health conditions.

Psychiatric Inpatient Level of Care (IPLOC): Represents the most intensive level of psychiatric care, which is delivered in a general hospital with a psychiatric unit licensed by the Department of Mental Health (DMH), or a private psychiatric hospital licensed by the DMH. Multi-disciplinary assessments and multimodal interventions are provided in a 24-hour, locked, secure and protected, medically staffed, and psychiatrically supervised treatment environment. 24-hour skilled nursing care, daily medical care, and a structured treatment milieu are required. The goal of acute inpatient care is to stabilize members who display acute psychiatric conditions associated with either a relatively sudden onset and a short, severe course, or a marked exacerbation of symptoms associated with a more persistent, recurring disorder. Typically, the member poses a significant danger to self or others, and/or displays severe psychosocial dysfunction. Inpatient mental health providers comply with the following **No Reject Policy:** The provider accepts for admission all individuals in need of inpatient mental health services who are referred by an emergency department, regardless of the availability of capacity or clinical presentation. Providers are expected to collaborate and communicate with the CCA BH UM team within 48 hours of admission and discharge from a substance use disorder facility.

Observation/Holding Beds (OBS/HB): Provide up to 24 hours of care in a locked, secure, and protected, medically staffed, psychiatrically supervised treatment environment that includes 24-hour skilled nursing care and an onsite or on-call physician. The goal of this level of care is prompt evaluation and/or stabilization of members who display acute psychiatric conditions associated with either a relatively sudden onset and a short, severe course, or a marked exacerbation of symptoms associated with a more persistent, recurring disorder. A comprehensive assessment is conducted upon admission, and a treatment plan is developed. The treatment plan emphasizes crisis intervention services necessary to stabilize and restore the member to a level of functioning that does not require hospitalization. This service is not appropriate for members who, by history or initial clinical presentation, are likely to require services in an acute care setting exceeding 24 hours. The duration of services at this level of care may not exceed 24 hours. Admissions to observation/holding beds occur 24 hours per day, 7 days per week, 365 days a year and are on a voluntary basis only. Members on an involuntary status who require observation will be authorized for a one-day inpatient admission.

Community Behavioral Health Centers (Applicable for MA Medicare Advantage members only)

Community Behavioral Health Centers (CBHC): Comprehensive community behavioral health providers that offer substance use disorder and mental health services, care coordination, peer supports, and screening and coordination with primary care. A CBHC provider (the provider) is required to provide behavioral health urgent care services, including access to same-day or next-day services, and expanded hours with evening and weekend services. Providers contracted for this service are expected to comply with all requirements of these service-specific performance specifications. CBHCs must provide Adult Community-Based Mobile Crisis Intervention (AMCI), services, also known as Emergency Services Program (ESP) services for adult members, and Mobile Crisis Intervention (MCI) services. AMCI is co-located at the CBHC site. A CBHC shall be a legal entity with the capacity to contract and meet all provider enrollment qualifications. Multiple providers may partner to form a CBHC, or the CBHC may subcontract to other providers for the delivery of required services. However, the CBHC as the primary entity shall be solely accountable for ensuring all adult and AMCI services are delivered in compliance with these specifications and all other applicable laws, regulations, and standards. The CBHC must be a licensed Massachusetts Department of Public Health (DPH) clinic with a mental health service designation, or a DPH-licensed hospital satellite that provides outpatient mental health and substance use disorder services and be a Medicare-participating provider. The CBHC must either (1) be licensed by the DPH Bureau of Substance Addiction Services (BSAS) or (2) have a substance use disorder service designation on their DPH clinic license and a BSAS Certificate of Approval or be a DPH-licensed hospital that provides substance use disorder services. The CBHC must have

SECTION 11: Behavioral Health Services Providers

a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver and the appropriate state and federal controlled substance registrations. For reimbursement, please see the CCA payment policies.
<https://www.commonwealthcarealliance.org/ma/providers/medical-policies/cca-payment-policies/>

Behavioral Health Diversionary Covered Services

Treatment services for mental health and substance use include services that are provided as clinically appropriate alternatives to behavioral health inpatient services, or to support a member returning to the community after an inpatient admission.

Diversionary services are more clinically intensive than typical weekly outpatient care but less intensive than inpatient treatment. Diversionary services are provided in facility and community settings, and range in intensity from 24-hour acute treatment to 6 or fewer hours per week. CCA providers of BH diversionary services are expected to collaborate with CCA's BH UM, giving notice within 48 hours of admission, so that the CCA care team can coordinate follow-up after discharge for aftercare.

Acute Treatment Services (ATS) ASAM Level 3.7: Consists of 24/7 medically monitored addiction treatment services that provide evaluation, counseling, education, and withdrawal management, in a nonhospital setting. Medical withdrawal services are delivered by nursing and counseling staff under the supervision of a licensed physician. Services include: bio-psychosocial evaluation, individual and group counseling; psycho-educational groups, and discharge planning. Acute Treatment Services are provided to members experiencing, or at significant risk of developing, an uncomplicated, acute withdrawal syndrome as a result of an alcohol and/or other substance use disorder. Members receiving ATS do not require the medical and clinical intensity of a hospital-based, medically managed detoxification service, nor can they be effectively treated in a less intensive outpatient level of care.

Providers of this level of care are expected to communicate with CCA's BH UM team within 48 hours of admission and discharge from an ATS.

Enhanced Acute Treatment Services for Individuals with Co-occurring Mental Health and Substance Use (E-ATS) ASAM Level 3.7: E-ATS services are for individuals with co-occurring mental health and substance use are provided in a licensed, acute care or community-based setting with 24-hour physician and psychiatrist consultation availability, 24-hour nursing care and observation, counseling staff trained in substance use disorders and mental health treatment, and overall monitoring of medical care. Services are provided under a defined set of physician-approved policies, procedures, and clinical protocols. E-ATS programs provide evaluation, counseling, education, and withdrawal management, including the prescription and dosage of medications typically used for the treatment of mental health disorders in a nonhospital setting. Medical withdrawal services are delivered by nursing and counseling staff under the supervision of a licensed physician.

Individuals may be admitted to an E-ATS program directly from the community, a hospital emergency department, or as a transition from inpatient services. Members with co-occurring (substance use and behavioral health) diagnosis receive specialized services within Enhanced Acute Treatment Services. E-ATS also serves pregnant women who require specialized services, including obstetrical care in addition to substance use treatment. These services are provided in licensed freestanding or hospital-based programs.

Clinical Stabilization Services (CSS) ASAM Level 3.5: Consist of 24-hour, clinically managed detoxification services that are provided in a non-medical setting. These services, which usually follow Acute Treatment Services (ATS) for substance use, include supervision, observation, support, intensive education, counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for members beginning to engage in recovery.

CSS provides multi-disciplinary treatment interventions and emphasizes individual, group, family, and other forms of therapy. Linkage to aftercare, relapse prevention services, and peer support and recovery-oriented services, such as Alcoholics Anonymous and Narcotics Anonymous, are integrated into treatment and discharge planning.

SECTION 11: Behavioral Health Services Providers

CSS is intended for members with a primary substance use diagnosis manageable at this level. Members may be admitted to CSS directly from the community, from an emergency department, or as a transition from inpatient services.

Partial Hospitalization and Day Treatment (PHP): PHP is a non-24-hour diversionary treatment program that is hospital based or community based. The program provides diagnostic and clinical treatment services on a level of intensity similar to an inpatient program, but on a less than a 24-hour basis. These services include therapeutic milieu; nursing; psychiatric evaluation; medication management; individual, group, and family therapy; peer support and/or other recovery-oriented services; substance use disorder evaluation and counseling; and behavioral plan development. The environment at this level of treatment is highly structured, and there is a staff-to-member ratio sufficient to ensure necessary therapeutic services, professional monitoring, and risk management. PHP may be appropriate when a member does not require the more restrictive and intensive environment of a 24-hour inpatient setting but does need up to eight hours of clinical services, multiple days per week. PHP is used as a time-limited response to stabilize acute symptoms. As such, it can be used both as a transitional level of care, such as a step-down from inpatient services, as well as a standalone, diversionary level of care to stabilize a member's deteriorating condition, support him/her in remaining in the community, and avert hospitalization. Treatment efforts focus on the member's response during treatment program hours, as well as the continuity and transfer of treatment gains during the member's non-program hours in the home/community.

Intensive Outpatient Programs (IOP): Provides a time-limited, multi-disciplinary, multimodal structured treatment in an outpatient setting. Such programs are less intensive than a partial hospitalization program or psychiatric day treatment but are significantly more intensive than standard outpatient services. This level of care is used to support and treat complex clinical presentations and is differentiated from longer-term, structured day programs intended to achieve or maintain stability for individuals with severe and persistent mental illness. IOPs may be developed to address the unique needs of a special population. Clinical interventions are targeted toward the specific clinical population or presentation and generally include modalities typically delivered in office-based settings, such as individual, couple, and family therapy, group therapies, medication management, and psycho-educational services. Adjunctive therapies such as life planning skills (assistance with vocational, educational, and financial issues) and expressive therapies may be provided but must have a specific function within a given member's treatment plan. As the targeted clinical presentation and the member's functioning improves, treatment intensity and duration are modified. All treatment plans are individualized and focus on acute stabilization and transition to community-based outpatient treatment and supports as needed.

Behavioral Health Emergency Services

Emergency services are available to members in a hospital emergency department and include the following components:

- Emergency department visit
- Diagnostic evaluation
- Medication management
- Risk management/safety planning

SECTION 11: Behavioral Health Services Providers

Behavioral Health Outpatient Services

Outpatient behavioral health (BH) services are provided in an ambulatory care setting, such as an office, clinic environment, a member's home, or other locations appropriate for psychotherapy or counseling. Services consist of time-effective, defined episodes of care that focus on the restoration, enhancement, and/or maintenance of a member's optimal level of functioning, and the alleviation of significant and debilitating symptoms impacting at least one area of the member's life domains (e.g., family, social, occupational). The goals, frequency, intensity, and length of treatment vary according to the needs of the member and the response to treatment. A clear treatment focus, SMART goals, measurable outcomes, and a discharge plan including the identification of realistic discharge criteria are developed as part of the initial assessment and treatment planning process and are evaluated and revised as needed.

Commonwealth Care Alliance is committed to providing convenient access and availability of behavioral health services that support the needs of each member and support each member's care plan. Behavioral health office visits will be made available within the following timeframes to members for the following behavioral health services:

- Non-24-hour diversionary services: Within 2 calendar days of discharge
- Urgent care services access: Within 48 hours
- Other outpatient services: Within 7 calendar days of discharge
- Appointments to review and refill medications: Within 14 calendar days of discharge
- All other behavioral health services: Within 14 calendar days

In addition to our contracted network, CCA behavioral health licensed clinicians are available 24/7 on call to coordinate care and support meeting the BH goals of a CCA member's care plan. CCA encourages all outpatient clinicians to coordinate with the CCA care team, which can be accessed via the CCA Provider Services line.

Telehealth: Telehealth services are available for members with specific geographic, cultural, linguistic, or special needs that cannot be met in their community but can be provided using a combination of interactive video, audio, and externally acquired images through a networking environment between a member and a provider.

Behavioral Health Outpatient Treatment: Outpatient behavioral health should result in positive outcomes within a reasonable time frame for specific disorders, symptoms, and/or problems. The evaluation of goals and treatment should be based on the member's diagnosis, symptoms, and level of functioning. Treatment should be targeted to specific SMART goals that have been mutually negotiated between the provider and the member. Goals of initial and extended outpatient therapy may include crisis resolution, symptom reduction, stabilization, improvement in adaptation, and/or recovery from addiction. Treatment modality, frequency, and length of treatment should be individualized for each member. Most clinical situations can be effectively managed using a short-term and/or intermittent model of treatment with varying modalities and frequency of contact as needed.

Individuals with chronic or recurring behavioral health disorders may require a longer-term approach with intermittent visits over extended periods, or sustained contacts with increased intensity of services around periods of relapse or decompensation, and members must have flexibility in accessing outpatient treatment, including transferring.

Diagnostic Evaluation: Diagnostic evaluation is an assessment of a member's level of functioning, including physical, psychological, social, educational, and environmental strengths and challenges for the purpose of diagnosis and treatment planning.

Family Consultation: A family consultation is a meeting of at least 15 minutes' duration, either in person or by telephone, with family members or others who are significant to the member and clinically relevant to a member's treatment to: identify and plan for additional services; coordinate a treatment plan; review the individual's progress; or revise the treatment plan, as required.

SECTION 11: Behavioral Health Services Providers

Consultations in the ED: A consultation in the ED is an in-person meeting of at least 15 minutes' duration between a psychiatrist and/or an advanced practice registered nurse clinical specialist (APRN) and a member, at the request of the medical unit or attending physician, to assess the member's mental status, provide greater diagnostic clarity, and/or assist the unit medical and nursing staff with a BH or psychopharmacological treatment plan for the member.

Medication Management: Medication management is the level of outpatient treatment where the primary service rendered is by a qualified prescribing provider, either a psychiatrist or an APRN. The prescriber evaluates the member's need for psychotropic medications and provides a prescription and ongoing medical monitoring for efficacy and side effects of medication administration. There is also coordination of care with other mental health, medical, and substance use disorder providers. Medication visits may consist specifically of a psychopharmacological evaluation, prescription, review, and/or monitoring by the prescriber. Visits may also include counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies. Treatment is provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The length of the appointment time varies depending on whether the member is new or already established with the provider.

Behavioral Health Outpatient Services for Substance Use Treatment

Opioid Treatment Program (OTP): OTPs include licensed and accredited opioid agonist treatment programs currently authorized to dispense methadone and buprenorphine using highly structured protocols defined by federal and state law. These programs medically monitor the administration of methadone, buprenorphine, or other U.S. Food and Drug Administration (FDA)-approved medications to treat opioid use disorder (OUD) as a medication-assisted treatment (MAT), as well as for pain management. This service combines medical and pharmacological interventions with counseling, educational, and vocational services and is offered on a short-term (withdrawal management) and long-term (maintenance) basis. An opioid treatment program is provided under a defined set of policies and procedures, including admission, continued stay, and discharge criteria stipulated by state and federal regulations. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts made and documented to involve them.

SECTION 11: Behavioral Health Services Providers

Behavioral Health Special Procedures

Electroconvulsive Therapy (ECT): ECT is a procedure during which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity. The individual receiving ECT is placed under general anesthesia, and muscle relaxants are given to prevent body spasms. ECT electrodes can be placed on both sides of the head (bilateral placement) or on one side of the head (unilateral placement). The number of sessions undertaken during a course of ECT usually ranges from 6 to 12. ECT is most commonly performed at a schedule of three (3) times per week. Maintenance ECT is most commonly administered at intervals of one to three weeks.

The decision to recommend the use of ECT derives from a risk/benefit analysis for the specific individual. This analysis considers the diagnosis of the individual and the severity of the presenting illness, the individual's treatment history, the anticipated speed of action and efficacy of ECT, the medical risks, and anticipated adverse side effects. These factors should be considered against the likely speed of action, efficacy, and medical risks of alternative treatments in making a determination to use ECT.

Neuropsychological/Psychological Testing: Neurological and psychological testing both involve the use of standardized assessment tools to gather information relevant to a member's intellectual and psychological functioning. Psychological assessment (testing) involves the culturally and linguistically competent administration and interpretation of standardized tests to assess a member's psychological or cognitive functioning. Psychological tests are used to assess a member's cognitive, emotional, behavioral, and intrapsychic functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing. They are used to determine differential diagnosis and assess overall cognitive functioning related to a member's mental health or substance use disorder status. The psychologist's aim is to obtain data from standardized, valid, and reliable instruments that:

- Lead to an accurate diagnosis
- Allow for hypothesis to be generated about the member's problems and difficulties in functioning
- Point to effective treatment strategies

Testing includes both standard psychological and neuropsychological assessment procedures.

Neuropsychological assessment (testing) often includes specifically designed tasks used to measure a psychological function known to be linked to a particular brain structure or pathway in an effort to assess cognitive functioning. Neuropsychological tests are a core component of the process of conducting neuropsychological assessment, along with personal, interpersonal, and contextual factors.

The term "psychologist" will refer to both psychologists and neuropsychologists interchangeably.

Psychological assessment (testing) is defined by a referral driven by behavioral health and/or substance use disorder treatment/assessment issues. A medical co-morbidity may exist, but the primary purpose of the assessment is related to behavioral health and/or substance use disorder treatment/assessment.

Referrals may also be driven by specific, medical (non-psychiatric) treatment/assessment issues such as documented neurological injury or other medical/neurological condition (e.g., stroke, traumatic brain injury, multiple sclerosis). A behavioral health and/or substance use disorder co-morbidity may exist, but the primary purpose of the assessment is related to a medical (non-psychiatric) treatment/assessment issue.

SECTION 11: Behavioral Health Services Providers

Repetitive Transcranial Magnetic Stimulation Services (rTMS): rTMS is a noninvasive method of brain stimulation. Magnetic Resonance Imaging (MRI)–strength, pulse, magnetic fields induce an electric current in a localized region of the cerebral cortex, which induces a focal current in the brain and temporary modulation of cerebral cortical function. rTMS does not induce seizures or involve complete sedation with anesthesia, in contrast to ECT. The FDA approval for this treatment modality was sought for members with treatment-resistant depression.

The population for which rTMS efficacy has been shown in the literature consists of those with treatment-resistant depression. Individuals would be considered to have treatment-resistant depression if their current episode of depression was not responsive to two trials of medication in different classes for adequate duration and with treatment adherence. rTMS is usually administered four to six times per week and for six weeks or less. It is typically performed in an outpatient office. The decision to recommend the use of rTMS derives from a risk/benefit analysis for the specific member. This analysis considers the diagnosis of the member and the severity of the presenting illness, the member's treatment history, any potential risks, anticipated adverse side effects, and the expected efficacy. Licensure and credentialing requirements specific to facilities and individual practitioners do apply and are found in Section 13 of this Provider Manual.

Esketamine for Treatment-Resistant Depression: Esketamine treatment has been shown to be an effective intervention for severe depression, with or without anxiety, particularly for individuals who have struggled with standard therapies. Esketamine therapy is an outpatient or inpatient service that focuses on treating individuals living with major depressive disorder (MDD) who are not responding to standard treatments. In addition, those who are experiencing severe symptoms of depression or other mental illness that are threatening their health or safety may be good candidates for esketamine, which can often work more quickly than other treatments. Esketamine is used to help depressed individuals who have not responded to at least two courses of medications most often prescribed for depression or are experiencing acute suicidal thoughts or behaviors and urgently require a fast-acting intervention. The FDA-approved drug esketamine nasal spray allows the drug to be taken more easily in an outpatient treatment setting (under the supervision of a doctor), making it more accessible for patients. The medication administration is completed under the direct observation of a healthcare provider, and patients are required to be monitored by a healthcare provider for at least two hours. Esketamine is only part of the treatment for a person with depression and has only been shown to be effective when taken in combination with an oral antidepressant. For these reasons, esketamine is not considered a first-line treatment option for depression. It's only prescribed for people who have major depressive disorder (MDD) with acute suicidal ideation or behavior and who haven't been helped by at least two other depression medications.

Vagus Nerve Stimulation (VNS) for Treatment-Resistant Depression: VNS technique has been proposed as a treatment for refractory seizures, chronic migraines and cluster headaches, depression, and other disorders. VNS is a pulse generator, similar to a pacemaker, that is surgically implanted under the skin and an electrical lead (wire) is connected from the generator to the left vagus nerve. VNS provides indirect modulation of brain activity through the stimulation of the vagus nerve. Relevant outcomes are symptom management, change in disease status, and functional outcomes. CCA will provide coverage for vagus nerve stimulation for treatment of seizures when it is determined to be medically necessary and when medical criteria and guidelines are met.

SECTION 12: Quality Improvement Program

Commonwealth Care Alliance is committed to providing the highest-quality, most effective healthcare to its members. In pursuance of this, the Commonwealth Care Alliance framework for quality improvement is designed to integrate quality assessment and performance improvement activities throughout all levels of its care delivery system. As an organization governed by consumer experience, the Commonwealth Care Alliance Quality Program is structured to ensure that the members' perspective is built into all elements of its quality improvement activities. An underlying tenet of the program is a true partnership between those receiving care and those providing and managing care can promote autonomy, independence, and better health outcomes.

The Quality Program is designed to:

- Understand the needs, expectations, and experience of members and caregivers and implement improvements to incorporate these perspectives into care delivery and system operations
- Continually improve organizational and clinical processes throughout the delivery system based upon analysis of available data and clinical, administrative, and member and provider input from across the network
- Improve clinical quality by identifying and disseminating best clinical practices throughout the network

Quality Program Objectives

- To ensure the effective, timely, and safe delivery of care and care coordination to members at the optimal level of quality
- To assess and evaluate the quality and appropriateness of care across the provider network
- To design effective mechanisms for problem identification, assessment and resolution at the individual, practice-site, and system-wide levels
- To assess, evaluate, and monitor key areas of clinical care and care coordination and identify opportunities for improvement. This includes incorporating a health equity framework into our quality program and actively working to identify and improve disparities that exist in the healthcare system
- To promote mechanisms for the integration of risk management, utilization review and other activities in a comprehensive Quality Improvement Program
- To identify deviations from standards and address such deviations in a manner that optimizes health outcomes
- To ensure that professional competency and practices are routinely and reliably monitored and evaluated
- To ensure program compliance with state, federal, contractual, and other regulatory requirements

Quality Program Structure

Board of Directors

The board of directors is composed of up to 15 members appointed by Commonwealth Care Alliance's corporate members. The board of directors assumes final authority and responsibility for quality of care and professional practices, including:

- Approval of the Commonwealth Care Alliance annual Quality Program and Quality Work Plan
- Recommendations related to Commonwealth Care Alliance quality assessment and performance improvement activities

The board of directors delegate's responsibility for the development and oversight of the Commonwealth Care Alliance Quality Program to the Chief Executive Officer/Chief Medical Officer, who delegate responsibility for components of the program to Commonwealth Care Alliance Chief Quality Officer, Quality and Clinical staff.

SECTION 12: Quality Improvement Program

Board Quality Committee

The Board of Directors of Commonwealth Care Alliance (CCA) established the Board Quality Committee to assist the board in fulfilling its responsibilities for oversight of the CCA quality program to ensure the quality of CCA's clinical care, patient safety and customer service. The Board Quality Committee operates under a written charter, which is approved by the board of directors. The Board Quality Committee's oversight includes: 1) the CCA's Quality Strategy, 2) the CCA annual Quality Improvement Work Plan, and 3) reviewing progress toward achievement of CCA's quality strategic objectives as measured by key quality indicators. The Board Quality Committee is composed of at least three members (including the chair of the Committee) who are voting members of the board and appointed by the board chair in consultation with the CEO. The Board Chair and the CEO are ex officio members of the Committee and the Chief Quality Officer and Chief Medical Officer are staff liaisons to the Committee.

Management Quality Committee

The Management Quality Committee is an internal Commonwealth Care Alliance committee, with responsibilities that include the development, coordination, and facilitation of all quality-improvement activities throughout the organization, including monitoring and evaluation, and the development of the organization's annual Quality Program Work Plan for recommendation to the Board Quality Committee for review and approval.

The Management Quality Committee assumes responsibility for:

- Designating areas to be monitored and evaluated
- Generating suggestions for quality improvement activities
- Designing mechanisms for problem identification and prioritization, assessment, resolution, and follow-up evaluation
- Selecting criteria for monitoring activities
- Reviewing and analyzing all monitoring activities and assisting in developing focused improvement plans
- Evaluating the annual Quality Program regarding its effectiveness in addressing issues of quality of patient care and professional practice
- Reviewing policies, procedures annually and as needed, related to implementation of quality improvement initiatives

Utilization Management Committee

The Utilization Management Committee, a standing committee of Commonwealth Care Alliance, oversees the development and implementation of an effective utilization management program. The Utilization Management Committee is responsible for monitoring the quality, continuity, and coordination of care, including monitoring for overutilization and underutilization of services. These activities are coordinated closely with the Commonwealth Care Alliance Quality Program.

Utilization Management Committee responsibilities include the regular review, monitoring, and analysis of utilization and cost information associated with the delivery of care and services to members across the network. Members of the Committee include appropriate Commonwealth Care Alliance clinical staff, consultants, and multidisciplinary clinical representation from the provider network, as well as others as appropriate on an ad hoc basis.

SECTION 12: Quality Improvement Program

Scope of the Quality Program

The Quality Improvement Program is designed to:

- Attend to all aspects of quality of care and service, with a particular focus on assessing and improving patient centeredness and empowerment, identifying, and reducing disparities, and addressing unmet social needs
- Understand the needs, expectations, and satisfaction of members and their caregivers and implement improvements to incorporate these perspectives into care delivery and system operations
- Continually improve organizational, operational and clinical processes throughout the enterprise and the network delivery systems based upon analysis of available data and clinical, administrative and member input from across the network
- Improve clinical and service quality by identifying and disseminating best practices

Annual Quality Improvement Plan

Commonwealth Care Alliance chooses activities annually that facilitate the organization's achievement of its quality improvement goals. Activities are tracked in the Commonwealth Care Alliance Annual Quality Improvement Plan.

Several factors are considered when establishing the Quality Improvement Plan. They include but are not limited to:

- Alignment with Commonwealth Care Alliance's mission and strategic goals
- Fit with previous Work Plan projects
- Performance in prior initiatives and quality metrics
- Predicted impact on overall health and well-being of membership
- Predicted impact on member and provider experience
- Scope and urgency

Measurement and evaluation are fully integrated into the Improvement Plan, and progress toward Improvement Plan objectives are tracked and monitored throughout the year.

Program Monitoring and Evaluation

The board of directors, Board Quality Committee, and the Management Quality Committee review the annual Quality Improvement Work Plan and assess the results of the plan annually. This evaluation guides the next steps and development of a Quality Improvement Plan for the coming year.

Collaboration with Contracted Providers in the Creation, Implementation, and Monitoring of the Quality Program Improvement Plan

Commonwealth Care Alliance strongly believes that its provider network has a substantial and fundamental role in determining the success of its annual Improvement Plan. Specifically, collaboration with and cooperation of Commonwealth Care Alliance's contracted providers is critical to Improvement Plan generation, execution, and evaluation. Commonwealth Care Alliance collaborates with contracted providers to identify opportunities for improvement. To this end, CCA has established a Provider Advisory Council, a group of in-network, contracted healthcare providers practicing in primary care and behavioral health to engage with CCA leadership to facilitate the open exchange of ideas and promote collaboration and mutual accountability between CCA and the network.

SECTION 12: Quality Improvement Program

Prioritized Quality Initiatives

Though they change over time, Commonwealth Care Alliance's priority quality initiatives, as outlined in each year's Improvement Plan, typically focus on protocols, processes, and procedures to improve the effectiveness and/or efficiency of care delivery.

In addition to ongoing monitoring and maintenance of Commonwealth Care Alliance compliance with CMS quality-related standards and expectations, priority initiatives include:

- Maximizing the efficiency and efficacy of telehealth care
- Increasing the execution of flu vaccinations
- Cardiovascular disease prevention
- Behavioral health integration
- Preventative health screenings
- Reducing isolation and loneliness
- Social determinants of health
- Life Choices: palliative and end-of-life care
- Diabetes disease management

Compliance with CMS

Commonwealth Care Alliance must comply with CMS quality-related standards and expectations. Requirements for compliance include several ongoing data submissions, including but not limited to:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Health Outcomes Survey (HOS)
- Quality-of-care grievances
- Quality Improvement Program description
- Quality Improvement Program evaluation
- Annual Quality Improvement Work Plan, inclusive of Quality Improvement Program descriptions and Chronic Care Improvement Program (CCIP) descriptions

In addition, Commonwealth Care Alliance is committed to using evidence-based guidelines as a basis for quality measurement and improvement.

Healthcare Effectiveness Data and Information Set Guidelines (HEDIS®)

Commonwealth Care Alliance assesses its performance using several different tools and measurement methodologies, including HEDIS. HEDIS is a standardized set of performance measures widely used by managed care organizations to enable comparisons of performance over time. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, asthma, and diabetes. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA), which defines standards for accreditation of health plans in the U.S. A subset of the HEDIS performance measures is reported to certain bodies on an annual basis according to state requirements.

SECTION 12: Quality Improvement Program

Commonwealth Care Alliance is assessed on eight domains of HEDIS:

- Prevention/screenings
- Respiratory/cardiovascular conditions
- Diabetes/musculoskeletal/behavioral care
- Medication management/care coordination
- Overuse/appropriateness of care
- HOS/CAHPS
- Access and availability

Specifications for HEDIS measurement are updated annually by NCQA.

Performance results, assessed and reported annually, are sourced by administrative claims data as well as medical record reviews. Commonwealth Care Alliance works with each of its providers to ensure uniformity in understanding documentation requirements to support the medical record review component of this annual assessment.

A subset of HEDIS results is used to calculate Commonwealth Care Alliance's Medicare star rating.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

In addition to HEDIS, Commonwealth Care Alliance uses a standardized survey of consumers' experiences to evaluate its performance in areas such as customer service and access to care. The survey used is called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). CAHPS is sponsored, supported, and maintained by the Agency for Healthcare Research and Quality ..

Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS), another standard tool, is employed by Commonwealth Care Alliance to evaluate the healthcare status and health-related quality of life of its members by comparing response data from year one to response data provided by the same set of members in year two.

Data are collected each spring. A subset of HOS results is used to calculate Commonwealth Care Alliance's Medicare star rating.

Quality of Care Concerns

Commonwealth Care Alliance is committed to providing the highest-quality, most effective healthcare to its members. Commonwealth Care Alliance relies heavily on its provider network to identify potential quality of care concerns and to escalate them to the appropriate CCA functional departments according to standard policy.

Confidentiality

All persons participating in quality improvement activities adhere to the Commonwealth Care Alliance confidentiality policy, which is compliant with HIPAA rules and regulations. Results of improvement activities and reports do not contain any identified patient information, and if necessary, are coded or reported in aggregate. All information generated by improvement activities is protected by applicable state and federal laws and regulations.

SECTION 13: Provider Credentialing

The Commonwealth Care Alliance Credentialing Committee oversees the credentialing and re-credentialing process for all provider applicants to the Commonwealth Care Alliance network. The Credentialing Committee approves or denies the provider's participation in our network based upon the review of the application, supporting documents, and results of the credentialing verification process.

In some specific instances, Commonwealth Care Alliance delegates primary source verification to another entity. Notwithstanding delegation, Commonwealth Care Alliance retains the right to approve, suspend, or terminate practitioners from our network. If you have any questions, please contact the Credentialing department at credentialing@commonwealthcare.org.

Credentialing and Re-credentialing Process

Types of Providers Credentialed

Commonwealth Care Alliance credentials providers that are permitted to practice independently under Massachusetts and Rhode Island state law, including but not limited to:

- Acupuncturists
- Audiologists
- Chiropractors
- Hearing instrument specialists
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Mental Health Counselors (LMHC)
- Licensed Independent Clinical Social Workers (LICSW)
- Nurses—nurse practitioners and other advanced practice nurses (ARNP, CNS, CRNP, NP, PNMHCS, RNCS)
- Optometrists
- Oral surgeons
- Physician assistants
- Physicians (MD and DO), including locum tenens physicians
- Podiatrists
- Psychologists (Ed.D., LP, PhD, PsyD)
- Speech, occupational, and physical therapists

SECTION 13: Provider Credentialing

Information Required for Credentialing

Commonwealth Care Alliance requires the following information for credentialing:

Application: A completed, signed, and dated practitioner application form (i.e., HCAS, CAQH) that include [supporting documents](#), work history, education and training, attestation, authorization and release, professional liability insurance information, malpractice history, disciplinary action information, board certification status, primary hospital, and names of all other hospitals where you have privileges.

Work history must be submitted via the application or a CV. As of the date the application is signed, physicians must submit 5 years of history, and all other practitioners 5 years of history. Each entry of work history must be dated with the month and year. Any gap of employment of greater than 6 months must include a written explanation.

For behavioral health providers treating substance use disorders, providers need to report on Continuing Education Units trainings they have participated in on substance use disorder.

Physicians must give written confirmation from their primary hospital stating that they are credentialed or re-credentialed pursuant to Massachusetts and/or Rhode Island state law.

Either Commonwealth Care Alliance or a delegated contracted, NCQA-certified CVO will perform and document primary source verification on certain information that you have provided to us. Examples of this information include verification of full license to practice, DEA certificate, board certification, highest level of education or training, professional liability claims history, work history, Medicare sanctions, and disciplinary action history. Sources of primary source verification include, but are not limited to, the National Practitioner Data Bank, state licensing agencies, malpractice carriers, and the Office of the Inspector General.

Credentialing Quality: Commonwealth Care Alliance assembles internal quality issues related to the practitioner that have been identified and documented through our ongoing quality monitoring process, including adverse events, member grievances, appeals and complaints, and audits of practitioner records.

Your Right to Review and Correct Erroneous Information

You have a right to review information that we have obtained to evaluate your credentialing application, including information from outside sources, except for references, recommendations, or other peer-review protected information.

If the information we receive from outside sources varies substantially from information submitted to us by you, we will notify you in writing of the discrepancy. Our letter to you will include a description of the discrepancy, a request for an explanation and/or correction from you, who you should return the letter to, and the time frame you have, to do so. We will document receipt of your response.

Your Right to Be Informed

You have a right to be informed, upon request, of the status of your application at any time during the credentialing process. If you make an inquiry to the Credentialing department, we will respond to any questions you have, inform you of any outstanding information needed by us prior to a credentialing/re-credentialing determination, and, if none, inform you of the date your application is scheduled to be reviewed for a final credentialing determination.

SECTION 13: Provider Credentialing

Credentialing File Review, Determinations, Notice, and Reporting

After all necessary information has been collected and verified, provider credentialing files are reviewed by the Credentialing Committee to determine if credentialing criteria is met. Based on this review, practitioners may be credentialed, approved with conditions, denied initial credentialing, or terminated from participation in our programs.

Notice to Practitioners

All applicants granted initial credentialing are notified in writing of the approval no later than 45 calendar days from the approval date. Any initial applicant who is denied credentialing, or a participating practitioner whose credentials are approved with conditions or terminated, is notified in writing of the action, and the reasons therefore, within 45 calendar days from the Committee's decision. Practitioners who are re-credentialed in the ordinary course do not receive written notice.

Notice to Members

If a PCP or certain specialists are terminated for any reason, Commonwealth Care Alliance is required to notify members who have been obtaining services from these practitioners that the practitioner is no longer participating with Commonwealth Care Alliance.

Reporting

Commonwealth Care Alliance complies with all regulatory and government reporting requirements. All denials, conditional approvals, or terminations that constitute disciplinary actions under state law and/or adverse professional review actions under federal law will be reported as required. Reports to the Board of Registration in Medicine are required to be made within 30 days of the date of the Credentialing Committee action.

Credentialing/Re-credentialing Criteria

Practitioners are credentialed and re-credentialed based on the following credentialing criteria:

- Contract with Commonwealth Care Alliance: Practitioner must be contracted with Commonwealth Care Alliance
- Completed credentialing application: Practitioner must have submitted an accurate and fully completed credentialing application
- Education and training: Practitioner must have appropriate education and training consistent with his/her profession and specialty, as further described in our Credentialing Policies and Procedures
- License: Practitioner must have an active and valid Massachusetts or Rhode Island license, and additional certifications where required, to practice his/her profession and specialty
- DEA and MCSR/CDS Certification: Practitioner must have DEA or MCSR/CDS certification, as applicable
- Professional liability insurance: Practitioner must maintain professional liability insurance no less than \$1,000,000 per claim/\$3,000,000 annual aggregate, or higher if required by the Commonwealth of Massachusetts or the State of Rhode Island or be covered under the Federal Tort Claims Act (FTCA). (Applicants who meet the professional liability requirements because they are covered under the FTCA and are credentialed by Commonwealth Care Alliance may only deliver services to members who are patients of the entity that is covered by the FTCA.) Dentists must maintain at least \$1,000,000/\$2,000,000, or as specified by the Commonwealth of Massachusetts or State of Rhode Island
- Board certification: In accordance with the Commonwealth Care Alliance Board Certification Policy, physicians, podiatrists, oral surgeons, and nurse practitioners must be:
 - Board certified by a Commonwealth Care Alliance–recognized specialty board; or
 - In the process of achieving initial board certification by a Commonwealth Care Alliance–recognized specialty board and achieve board certification in a time frame relevant to the guidelines established by the applicable specialty board. Waivers will be considered by Commonwealth Care Alliance only when necessary for Commonwealth Care Alliance to maintain adequate member access

SECTION 13: Provider Credentialing

- Hospital privileges: Physicians must have hospital admitting privileges at a hospital contracted with Commonwealth Care Alliance, unless the physician has alternative admitting arrangements as described below. If there are any restrictions on the physician's hospital privileges, the physician must provide a detailed description of the nature and reason for such restrictions, which shall be considered and evaluated by the Credentialing Committee at its discretion
- Alternative admitting arrangements: If you do not have hospital admitting privileges at a hospital contracted by Commonwealth Care Alliance, you must provide an explanation of arrangements you have put in place for members to be admitted to plan contracting hospitals (which can be an arrangement with a contracted physician who does have privileges at the hospital, provided that the covering physician sends confirmation of these arrangements to the Credentialing department)
- If you do not have hospital admitting privileges at any hospital, you must:
 - Provide the names of two Commonwealth Care Alliance–contracted physicians (who are not financially linked to your practice) who can provide reference letters attesting to your clinical competence. (Credentialing department staff will request reference letters from these two physicians at the time of initial credentialing and re-credentialing.) The Credentialing Committee will review these references and at its sole discretion determine whether they are adequate for an exception to be made
 - Provide an explanation of arrangements you have put in place for your members to be admitted to a Commonwealth Care Alliance–contracted hospital (which can be an arrangement with a Commonwealth Care Alliance–contracted covering physician who does have privileges at a Commonwealth Care Alliance–contracted hospital, provided that the covering physician sends confirmation of these arrangements to the Credentialing department)
- Federal/state program exclusions: Practitioner must not be currently excluded, terminated, or suspended from participation in Medicare or any other federal or state healthcare program
- Criminal proceedings: Practitioner must not have been involved in any criminal proceedings that may be grounds for suspension or termination of your license to practice
- Compliance with legal standards: Practitioner must be in compliance with all applicable legal requirements relating to the practice of your profession, including meeting all continuing education requirements
- Quality care and service:
 - Based on all the information collected as part of the credentialing process, practitioner must reasonably be expected to provide quality and cost-effective clinical care and services to plan members
 - Practitioner must not have engaged in behavior which may adversely impact member care or service, including but not limited to behavior which negatively impacts the ability of other participating providers to work cooperatively with you; reflects a lack of good faith and fair dealing in your dealings with Commonwealth Care Alliance, its provider network, or its members; reflects a lack of commitment to managed care principles or a repeated failure to comply with Commonwealth Care Alliance's managed care policies and procedures; indicates a lack of cooperation with the Commonwealth Care Alliance's Quality improvement or Utilization Management Programs; or constitutes unlawful discrimination against a member under any state or federal law or regulation. Provider shall not discriminate by product and shall maintain access and hours equally for all CCA members.
 - Practitioner must not have engaged in any behavior which could harm other healthcare professionals, patients, or Commonwealth Care Alliance employees. Such behaviors include, but are not limited to, acts of violence committed within or outside the practitioner's practice, whether or not directed toward other healthcare professionals, patients, or Commonwealth Care Alliance employees, and must be judged by the Credentialing Committee to create a significant risk to other healthcare professionals, patients, or Commonwealth Care Alliance employees
- Primary care providers (PCPs): In addition to meeting the above criteria, applicants applying for credentials as PCPs must be:

SECTION 13: Provider Credentialing

- A physician or osteopathic physician trained in Family Medicine, Geriatric Medicine, Internal Medicine, General Practice, Adolescent and Family Medicine, Pediatric Medicine or Obstetrical and Gynecological Medicine (for female members only); or a nurse practitioner (NP). For NPs: the NP must submit the name of the participating supervising physician. NPs are required to be trained as an adult nurse practitioner, pediatric nurse practitioner, or family nurse practitioner
 - PCPs (who are physicians or osteopathic physicians) must be board certified in Family Medicine, Internal Medicine, Pediatric Medicine, or Obstetrics & Gynecology or must meet the criteria specified in the Board Certification Policy
 - Exceptions: The Credentialing Committee may authorize a specialist physician to serve as a member's PCP if the member has a life threatening, degenerative, or disabling condition or disease that requires prolonged specialized care (e.g., HIV, end-stage renal disease, or an oncology diagnosis), and the Committee believes it will be in the best interest of the member to make this exception. Specialists acting in the capacity of a PCP must be or must become Commonwealth Care Alliance participating providers and must adhere to all Commonwealth Care Alliance standards applicable to PCPs. Covering practitioners for the specialist-PCP must be credentialed by Commonwealth Care Alliance
- Access and Availability: As part of its credentialing determinations, the Credentialing Committee may consider, at its discretion, Commonwealth Care Alliance network access and availability needs

You are not entitled to be credentialed or re-credentialed on the basis that you are licensed by the state to practice a particular health profession, or that you are certified by any clinical board or have clinical privileges in a Commonwealth Care Alliance–contracted entity. Commonwealth Care Alliance, at its sole discretion, credentials and re-credentials practitioners based on its credentialing criteria set forth in its Credentialing Policies and summarized in this manual. Commonwealth Care Alliance is responsible for all final determinations regarding whether a practitioner is accepted or rejected as a participant in our network. No Commonwealth Care Alliance credentialing or re-credentialing decisions are based on a practitioner's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures in which the practitioner specializes. We may include practitioners in our network who meet certain demographic, specialty, or cultural needs of members.

SECTION 13: Provider Credentialing

Re-credentialing

You will be required to update and re-attest to your information every three years. If a practitioner does not keep his/her information current, or re-attest to information to ensure it is available for re-credentialing, termination may result, in which case the practitioner would need to re-apply to Commonwealth Care Alliance as an initial applicant.

Please note that, unlike initial credentialing, re-credentialing includes an assessment of quality-related information collected by Commonwealth Care Alliance as a result of its ongoing clinical and service quality monitoring process. This information may include, but is not limited to, adverse events, member grievances, appeals and complaints, member satisfaction surveys, utilization management information, and information generated from Commonwealth Care Alliance site reviews or audits of practitioner records.

Ongoing Monitoring and Off-Cycle Credentialing Reviews and Actions

Between re-credentialing cycles, Commonwealth Care Alliance conducts ongoing monitoring of information from external sources, such as sanctions from state licensing boards (e.g., Massachusetts Board of Registration in Medicine or Rhode Island Board of Medical Licensure), Medicare or the Office of Inspector General, and internal sources, such as member grievances and adverse clinical events. This information is routinely included in practitioner file reviews during re-credentialing cycles, but it may also be reviewed by a Medical Director or the Credentialing Committee at any time between re-credentialing cycles. After review, the Committee may take no action, may continue the practitioner's credentials with conditions, may require the practitioner to complete a full off-cycle credentialing application and review, or may terminate the practitioner from Commonwealth Care Alliance programs.

If information is received through the monitoring process that causes the Commonwealth Care Alliance Medical Director or the Chief Medical Officer to believe that a practitioner has placed or is at substantial risk for placing a member in imminent danger and that failure to summarily suspend credentials is contrary to the immediate best interests of member care, he or she may summarily suspend a practitioner's credentials. In such an event, the practitioner is notified in writing immediately, including the reasons for the action and the subsequent procedure to be followed by Commonwealth Care Alliance. Any summary suspension will be reviewed by the full Credentialing Committee at its next regularly scheduled meeting. The Committee may reinstate the practitioner or take any action described in the preceding paragraph.

Under its state contracts, if Commonwealth Care Alliance receives a direct notification from CMS or the MA Health Connector to suspend or terminate a practitioner, Commonwealth Care Alliance is required to suspend or terminate the practitioner from its network. In such a case, Commonwealth Care Alliance will notify the practitioner in writing, with the reasons therefore, no later than three business days from the date Commonwealth Care Alliance receives such notice. There is no right of appeal from a suspension or termination based on a termination directive from CMS or the MA Health Connector.

SECTION 13: Provider Credentialing

Credentialing Appeals Process for Practitioners

Right of Appeal

If the Credentialing Committee denies your initial credentialing application, approves your network participation with conditions, or terminates your network participation, and such action constitutes a “disciplinary action” as defined in the Commonwealth Care Alliance Credentialing Policies, you are entitled to appeal the disciplinary action. A disciplinary action is an adverse action taken by the Commonwealth Care Alliance Credentialing Committee, up to and including termination from Commonwealth Care Alliance, on the basis of a Committee determination that the practitioner does not meet Commonwealth Care Alliance credentialing criteria related to the competence or professional conduct of the practitioner (i.e., quality of care or service). Examples include, but are not limited to, a denial or termination due to the volume or nature of malpractice suits against the practitioner, or the quality or quantity of adverse clinical events generated during a practitioner’s affiliation with Commonwealth Care Alliance.

Practitioners have no right of appeal from an action that is:

- An “adverse administrative action”—an adverse action taken by the Credentialing Committee against a practitioner, up to and including termination from Commonwealth Care Alliance, that is not related to the Committee’s assessment of your competence or professional conduct. Examples include, but are not limited to, a denial or termination due to failure to meet Commonwealth Care Alliance board certification requirements, failure to maintain adequate professional liability coverage, or failure to meet other contractually specified obligations; or
- A Commonwealth Care Alliance termination based on a directive from CMS or the MA Health Connector to terminate or suspend a practitioner who is contracted with the plan for CMS or Commonwealth Care

Notice

If the Credentialing Committee takes a disciplinary action, the practitioner will be notified in writing (by signature-requested delivery) within 30 calendar days following the date of the action. The notice will contain a summary of the reasons for the disciplinary action and a detailed description of the appeal process.

Practitioner Request for Appeal

You may request an appeal in writing by sending a letter to the Commonwealth Care Alliance Credentialing Committee Chairperson postmarked no more than 3 calendar days following your receipt of Commonwealth Care Alliance’s notice of disciplinary action. Commonwealth Care Alliance will not accept provider appeals after the 30-calendar-day period. You have a right to be represented in an appeal by another person of your choice (including an attorney). Your appeal should include any supporting documentation you wish to submit.

When we receive a timely appeal, we will send you an acknowledgement letter. The Credentialing Committee Chairperson will arrange for your case to be sent back to the Credentialing Committee for reconsideration.

If no appeal request is received by the filing deadline, the Credentialing Committee’s action is final.

Credentialing Committee Reconsideration

Upon timely receipt of an appeal request, the Credentialing Committee will review the appeal and reconsider its original decision. Upon reconsideration, if the Committee overturns its original decision, you will be notified in writing. If the Committee upholds its original decision or modifies it such that another type or level of disciplinary action is taken, you will be notified in writing that an appeals panel will be assembled to review the appeal, the date and time of the appeal panel hearing, whether you are invited to attend the hearing, and other administrative details.

Appeals Panel Hearing and Notice

The appeals panel is a medical peer-review committee that is appointed by Commonwealth Care Alliance to hear the appeal.

SECTION 13: Provider Credentialing

The hearing will occur no earlier than 30 calendar days and no later than 90 calendar days following Commonwealth Care Alliance's receipt of your appeal request, unless otherwise determined by the Commonwealth Care Alliance. The hearing shall consist, at a minimum, of the panel's review of the written submissions by Commonwealth Care Alliance and the practitioner, but may, at the sole discretion of Commonwealth Care Alliance, allow for presentation of live testimony by Commonwealth Care Alliance and/or the practitioner. The panel is empowered to uphold, modify, or overturn the Credentialing Committee's decision. The appeals panel's decision is final.

You will be notified of the decision of the appeals panel, and the reasons therefore, no later than 45 calendar days from the date of the hearing.

Re-application Following Denial or Termination

In the event initial credentialing is denied, or if a practitioner is terminated from the network, Commonwealth Care Alliance will not reconsider his/her reapplication for credentialing for 2 years following the effective date of denial or termination, unless the Credentialing Committee, at its sole discretion, deems a shorter period to be appropriate.

Role of the Credentialed Primary Care Provider (PCP)

A PCP is responsible for supervising, coordinating, and providing initial and basic care of members who have selected that provider for general healthcare services. The PCP also initiates referrals for specialty care and assessments needed by a member and maintains overall continuity of a member's care. Examples of specialty care services may include medical, behavioral, and long-term support services. The referral process may include PCPs utilizing the CCA directory of contracted providers wherever possible and a review of the prior authorization requirements, found in Section 4 of this Provider Manual. The PCP provides coverage for members 24 hours a day, 7 days a week. A PCP is a provider selected by the member, or assigned by Commonwealth Care Alliance, to provide and coordinate the member's care.

PCPs are physicians practicing in one of the following specialties: Family Medicine, Internal Medicine, Geriatrics, General Practice, Adolescent and Family Medicine, Pediatric Medicine, and Obstetrics/Gynecology (for female members only). Nurse practitioners (NPs) may also function as PCP, if they are trained in Internal Medicine, Pediatrics, Family Medicine, or Women's Health.

Specialists as Primary Care Provider (PCP): When designated as a PCP, a specialist assumes all administrative and clinical responsibilities of a PCP, including responsibility for making necessary referrals to other specialists and addressing the preventive and routine care needs of the assigned member. A PCP who believes that one of his/her plan members should receive primary care from a specialist should contact our Care Management department.

Role of the Credentialed Specialist

Credentialed specialists are physicians who are board certified in a specific specialty recognized by the American Board of Medical Specialties. In addition to specialty physicians, contracted providers may be credentialed in the disciplines of podiatry, chiropractic, audiology, or other specialties where an accrediting body has established criteria for education and continuing medical education. We must credential all covering providers.

Organizational Providers

We assess the quality of all organizational providers prior to contracting. We will confirm that the provider is in good standing with all state and federal regulatory bodies, has been reviewed and approved by an accrediting body, or if not accredited, we will compare the facility's most recent Department of Public Health survey against Commonwealth Care Alliance standards. We will conduct an onsite assessment if the facility is not accredited and has not had a recent Department of Public Health survey.

We credential the following types of medical/ancillary organizational providers:

- Acute care hospitals
- Addiction disorder facilities

SECTION 13: Provider Credentialing

- Adult day health
- Adult foster care
- Ambulatory surgery centers
- Assisted living facilities
- Certified home health agencies
- Community-based organizations
- Community health centers
- Community mental health centers
- Durable medical equipment suppliers
- Freestanding diagnostic radiology centers
- Freestanding outpatient dialysis centers
- Freestanding laboratories
- Hospices
- Inpatient psychiatric facilities
- Intermediate care facilities for the mentally disabled
- Long-term acute care hospitals (LTACs)
- Long-term service and support providers
- Nursing facilities (NFs)
- Outpatient behavioral health clinics
- Rehabilitation hospitals
- Residential treatment centers for psychiatric and addiction disorders
- Skilled nursing facilities (SNFs)

The initial network application process for organizational providers includes the submission of the following, at a minimum:

- A CCA facility/group application
- State license
- Medicare certification
- Professional liability insurance
- A copy of accreditation status

We may request other documentation, based on provider type. For those facilities not accredited by one of the accreditation agencies listed below or not recently visited by the Department of Public Health, a Commonwealth Care Alliance site visit to that facility is required.

- AAAASF: American Association for the Accreditation of Ambulatory Surgery Facilities
- AAAHC: Accreditation Association for Ambulatory Health Care
- AASM: American Academy of Sleep Medicine

SECTION 13: Provider Credentialing

- ACDD: Accreditation Council for Developmental Disabilities
- ACHC: Accreditation Commission for Health Care
- ACR: American College of Radiology
- CAP: College of American Pathologists
- CARF: Commission on Accreditation of Rehabilitation Facilities
- CCAC: Continuing Care Accreditation Commission
- CHAP: Community Health Accreditation Program
- CLIA Clinical Laboratory Improvement Amendment
- COA: Council on Accreditation
- COLA: Clinical Laboratory Accreditation (a deemed accrediting authority for CLIA)
- DNV: Det Norske Veritas Healthcare, Inc.
- HFAP: Healthcare Facilities Accreditation Program
- HQAA: Healthcare Quality Association Accreditation
- IAC: Intersocial Accreditation Commission
- NCQA: National Committee for Quality Assurance
- TCT: The Compliance Team, Inc., of Exemplary Providers
- TJC: The Joint Commission

Re-credentialing of Organizational Providers

All contracted organizational providers are re-credentialed every three years, or more often, as determined necessary or as requested by the Credentialing Committee.

Quality of Care Issues

Organizational providers may be required to have a site visit in the event a serious quality of care issue has been identified, the provider has been sanctioned, the provider's accreditation has been withdrawn, or a pattern of quality of care problems has been identified by Commonwealth Care Alliance. Organizational providers are required to notify us within 10 business days of any actions by a state agency that might affect their credentialing status with us, including, but not limited to, a change in license status, change in ability to perform specific procedures, or a freeze in admissions, type, or number of patients the provider is allowed to admit.

Credentialing Contact Information

Credentialing Department Commonwealth Care Alliance
2 Avenue de Lafayette, 5th Floor
Boston, MA 02111

credentialing@commonwealthcare.org

SECTION 14: Marketing Guidelines

Providers may market Commonwealth Care Alliance to prospective members; however, they must follow current Medicare and Medicaid Marketing Guidelines.

Provider-Based Activities

To the extent that a provider can assist a member in an objective assessment of his/her needs and potential options to meet those needs, they may do so. Contracted providers may engage in discussions with members should a member seek advice. However, Commonwealth Care Alliance must ensure that contracted providers are aware of their responsibility to remain neutral when assisting with enrollment decisions and do not:

- Offer scope-of-appointment forms
- Accept Medicare enrollment applications
- Make phone calls or direct, urge, or attempt to persuade members to enroll in a specific plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of Commonwealth Care Alliance
- Offer anything of value to induce plan members to select them as their provider
- Offer incentives to persuade members to enroll in a particular plan or organization
- Conduct health screening as a marketing activity
- Accept compensation directly or indirectly from the plan for enrollment activities
- Distribute materials/applications in an exam room

Contracted providers may:

- Provide the names of plans/Part D Sponsors with which they contract and/or participate
- Provide information and assistance in applying for the low-income subsidy (LIS)
- Make available or distribute plan marketing materials and enrollment forms in common areas
- Conduct sales activities, including sales presentations, the distribution of marketing materials, and the distribution of and collection of enrollment forms in common areas of a healthcare setting (not in restricted areas).
- Refer their patients to other sources of information, such as State Health Insurance Assistance Programs (SHIPS) Commonwealth Care Alliance marketing representatives, their State Medicaid Office, local Social Security Office, the CMS website www.medicare.gov, or 1-800-MEDICARE
- Share information with patients from the CMS website, including the Medicare and You Handbook or Medicare Options Compare (from www.medicare.gov), or other documents that were written by or previously approved by CMS

SECTION 14: Marketing Guidelines

Provider Affiliation Information

Plans/Part D sponsors may allow contracted providers to announce new or continuing affiliations.

Continuing affiliation announcements may be made through direct mail, email, phone, or advertisement.

The announcement must clearly state that the provider may also contract with other plans/Part D sponsors. A provider affiliation announcement may not contain marketing information, as defined in CMS at 42 CFR 422.2260

New provider affiliation announcements may be made once within the first 30 days of a new contract agreement. In the announcement, plans/Part D sponsors may allow contracted providers to name only one plan/Part D sponsor. This may be done through direct mail, by email, or by telephone.

Neither the plan/Part D sponsor nor the contracted provider is required to notify beneficiaries that the provider may contract with other plans/Part D sponsors in new affiliation announcements. Any affiliation communication materials that describe plans in any way, (e.g., benefits, formularies), must be approved by Medicaid and CMS. Commonwealth Care Alliance is responsible to work with the contracted provider to ensure approval is granted from both Medicaid and CMS.

For more details, please see the current [Medicare Advantage Communication Requirements at 42 CFR 422.2260](#) and the Medicare Communications [Marketing Guidelines](#), updated 3/16/2022. Marketing guidelines are updated typically once per year.

SECTION 15: Compliance and Fraud, Waste and Abuse Pprograms

The Commonwealth Care Alliance Compliance Program

Commonwealth Care Alliance, Inc. (CCA), is committed to conducting its business operations in compliance with ethical standards, internal policies and procedures, contractual obligations, and all applicable federal and state statutes, regulations, and rules, including but not limited to those pertaining to the Centers for Medicare & Medicaid Services (CMS) Part C and D programs. This Compliance Program applies to all CCA lines of business. CCA's compliance commitment includes its internal business operations, as well as its oversight and monitoring responsibilities related to its first-tier, downstream and related entities (FDR).

CCA has formalized its compliance activities through a comprehensive Compliance Program. The Compliance Program incorporates the fundamental elements of an effective compliance program identified by CFR 422.503(b) (4) (vi) and CFR 423.504(b) (4) (vi) and the Office of Inspector General (OIG) Federal Sentencing Guidelines.

The CCA Compliance Program contains the following core elements, including measures to prevent, detect, and correct Fraud, Waste, and Abuse (FWA):

- Code of Conduct and written policies and procedures
- Compliance Officer, Compliance Committee, and appropriate oversight
- Compliance training and education program
- Effective lines of communication and reporting
- Well-publicized disciplinary standards and enforcement
- Effective system for routine monitoring, auditing, and identification of compliance risks
- Procedures for prompt response to compliance issues and remediation
- First-tier, downstream, and related entity compliance oversight

The CCA Compliance Program is developed to:

- Promote compliance with all applicable federal and state laws and contractual obligations
- Prevent, detect, investigate, mitigate, and appropriately report suspected incidents of program non-compliance
- Prevent, detect, investigate, mitigate, and appropriately report suspected incidents of fraud, waste, and abuse
- Promote and enforce the CCA Code of Conduct

SECTION 15: Compliance and Fraud, Waste and Abuse Programs

The Commonwealth Care Alliance Fraud, Waste and Abuse Program

CCA is committed to preventing, identifying, investigating, correcting, and appropriately reporting suspected cases of fraud, waste, and abuse. CCA looks to its providers to assist in this effort.

The mission of the CCA FWA Program is to assist in protecting the integrity of CCA, federal, and state programs by working to prevent, identify, investigate, correct, and report suspected incidents of fraud, waste, and abuse. This FWA Program is an integral part of the CCA Compliance Program. CCA must work collaboratively to combat fraud, waste, and abuse.

Regulations

In accordance with 42 C.F.R. §§ 422.504(i)(4)(v), all business conducted by CCA, and its contracted entities must be in compliance with applicable federal and state requirements, laws and regulations; applicable local laws and ordinances; and the ethical standards/practices of the industry.

General Compliance and Fraud, Waste and Abuse Training

All providers contracted with CCA are required to complete General Compliance and FWA training on an annual basis. If a provider is enrolled in the Medicare Part A or B program, these training and education requirements are determined to have been satisfied. The Centers for Medicare & Medicaid Services (CMS) has developed a training program Medicare Parts C and D General Compliance Training and a Medicare Parts C and D Fraud Waste and Abuse Training. There is a certificate of completion at the end of the training and we encourage all providers and their employees to retain a copy of the certificate in their records. CCA reserves the right to request verification and/or conduct audits of our providers to verify adherence to this training requirement. Definitions of fraud, waste, and abuse:

- **Fraud** is defined as knowingly, intentionally, and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any money or property owned by or under the custody or control of any healthcare benefit program. Examples of fraud include but are not limited to: a provider billing for services or supplies that were not provided; or a member knowingly sharing their CCA ID card with a non-member of CCA in order to obtain services.
- **Waste** is defined as the overutilization of services, or other practices that directly or indirectly result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources. Examples of waste include but are not limited to: a mail-order pharmacy sending medications to members without first confirming the member still needs them; or a physician ordering excessive diagnostic tests.
- **Abuse** involves payment for items or services when there is no legal entitlement to that payment even when the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Examples of abuse include, but are not limited to, a medical professional providing treatment to a patient that is inconsistent with the diagnosis; or misusing codes and modifiers on a claim such as upcoding or unbundling codes.

SECTION 15: Compliance and Fraud, Waste and Abuse Programs

Investigative Process

The CCA FWA Program, in conducting fraud, waste and abuse investigations, may:

- Interview providers, members, or other witnesses.
- Visit a provider's facility to collect records and/or inspect the equipment and premises.
- Request records via mail, fax, or verbal request.
- Inspect business records, payroll, inventory, or other items.

Providers are required to cooperate with CCA Health audits or investigations, consistent with your CCA Health contract provisions, CCA Health policy and applicable laws. The lookback period related to FWA recoveries shall supersede any audit period or lookback period stipulated in any CCA Health contract provisions. Failure to cooperate in FWA Program audits or investigations may result in claim payments being denied or recovered by CCA Health.

If an investigation finds there is evidence of fraud, waste, or abuse, CCA Health may recover identified overpayments, place the provider on a corrective action plan, bar the provider from billing certain codes, require pre-payment review of claims or submission of records, and if necessary, suspend or terminate the provider's participation. If a credible allegation of fraud is uncovered, CCA Health may suspend payment to the provider in accordance with state and federal requirements and applicable law. In the event that FWA overpayments are identified by or reported to the FWA Program, they will be recovered in a manner that complies with CCA's Encounter reporting and will be reported to state and federal agencies accordingly. As required by law, CCA Health makes referrals as appropriate to the National Benefit Integrity (NBI) MEDIC, state Medicaid agencies, and/or law enforcement agencies.

The CCA FWA Program as well as specific policies and procedures are designed to prevent, detect, investigate, mitigate, and appropriately report suspected cases of fraud, waste, and/or abuse. CCA is subject to several laws and regulations pertaining to FWA, including, but not limited to, the federal Anti-Kickback Statute, the federal False Claims Act, and applicable state False Claims Acts, and federal and state whistleblower protections.

The [Anti-Kickback Statute](#) prohibits the exchange, or offer to exchange, anything of value in an effort to induce (or reward) the referral of federal healthcare program business. It is an intent-based statute requiring that the party "knowingly and willingly" engaged in the prohibited conduct.

[The Federal False Claims Act](#) imposes civil liability on any person who knowingly submits or causes the submission of a false or fraudulent claim to the federal government. A whistleblower is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organization that is either private or public. Whistleblower protections protect reporters against retaliation and grant federal and state protection. Learn more at https://www.whistleblowers.gov/know_your_rights.

Access Compliance and FWA resources information on the CCA website.

- Massachusetts – [CCA Compliance and FWA resources](#)
- Rhode Island – [CCA Compliance and FWA resources](#)

How to Report any Suspected Compliance Concerns:

If you suspect any compliance concern, including suspected incidents of FWA related to CCA member or program, please report it in one of the following methods:

- Fill out a [Compliance Incident Report](#)
- [Report](#) to the CCA Compliance Hotline at 866-457-4953 (may be reported anonymously)

SECTION 15: Compliance and Fraud, Waste and Abuse Programs

- Email cca_compliance@commonwealthcare.org
- Mail directly to:

Commonwealth Care Alliance
Attn: Fraud, Waste, and Abuse Department
30 Winter Street, 11th Floor
Boston, MA 02108

Policies and Procedures:

CCA maintains compliance and FWA policies, including the following relevant topics:

- Compliance Training and Education
- Fraud Waste and Abuse
- Reporting, Investigating, and Externally Reporting a Compliance Concern
- Compliance Monitoring
- Compliance Auditing
- Whistleblower Protections, False Claims Act, and Deficit Reduction Act
- Anti-Kickback Statute and Stark Law

SECTION 16: Provider Training

Training and shared learning among our contracted providers is a key element of our strategy for communicating best practices and assuring the quality and integration of services delivered to Commonwealth Care Alliance members.

Provider Training Requirements – Fraud, Waste, and Abuse

All contracted providers, and their downstream and related entities, must comply with federal and state requirements for fraud, waste, and abuse training and annual compliance training of all employees. Instructions for performing these trainings and Commonwealth Care Alliance oversight can be found on our website.

- Massachusetts – [CCA Compliance and FWA resources](#)
- Rhode Island – [CCA Compliance and FWA resources](#)

Primary Care Providers

In addition to the training above, Commonwealth Care Alliance providers contracted as primary care providers, and their downstream and related entities, must comply with state requirements for training, including trainings for compliance, cultural competency, and DNSP model of care.

Commonwealth Care Alliance reserves the right to request verification that all primary care site providers and their downstream and related entities have completed required trainings. Failure to demonstrate compliance with training requirements may result in Commonwealth Care Alliance terminating its contract with the primary care site.

Behavioral Health Facility Human Rights

All contracted behavioral health facilities that offer inpatient care are required to have human rights protocols in place. These protocols must be consistent with state Department of Mental Health protocols and periodically reviewed. The protocols include, but are not limited to, staff training and education. In addition to training, the facility should also have, or designate a human rights officer and a human rights oversight committee and be able to provide written documentation to members regarding these rights.

All licensed clinicians must obtain Continuing Education Units or Continuing Medical Education Credits to maintain their license; this content may include topics of current concern as determined by the state's public health department. It is the provider's responsibility to ensure that staff have valid licensure and documented on an annual basis. CCA has the right to request documentation to audit the validity of all licenses to ensure they are current and valid and may verify elements related to an applicants' legal authority to practice, relevant training, experience, and competency, where applicable, during the credentialing process.

SECTION 17: Forms

Massachusetts Forms: All forms below may be accessed utilizing this link: [Download the forms.](#)

Administrative Forms

Appointment of Representative (Form CMS-1696) *

Notice of Privacy Practices

The Patient Health Questionnaire 2 Overview (PHQ-2)

The Patient Health Questionnaire (PHQ-9)

Mental Status Exam

CAGE Questionnaire

Prior Authorization Forms

Esketamine Prior Authorization Request Form

Prior Authorization Standardized Request Form

Prior Authorization Form – Massachusetts Medication Requests

Prior Authorization Form – Repetitive Transcranial Magnetic Stimulation Request

Out of Network Prior Authorization Form – Psychological and Neuropsychological Assessment

Out of Network ECT Authorization Request

Rhode Island Forms: All forms below may be accessed utilizing this link: [Download the forms.](#)

Administrative Forms

Appointment of Representative (Form CMS-1696)*

Notice of Privacy Practices

The Patient Health Questionnaire 2 Overview (PHQ-2)

The Patient Health Questionnaire (PHQ-9)

Mental Status Exam

CAGE Questionnaire

Prior Authorization Forms

Esketamine Prior Authorization Request Form

Prior Authorization Standardized Request Form

Prior Authorization Form – Rhode Island Medication Requests

Prior Authorization Form – Repetitive Transcranial Magnetic Stimulation Request

Out of Network Prior Authorization Form - Psychological & Neuropsychological Assessment (RI)

Out of Network ECT Authorization Request