



# **Commonwealth Care Alliance**

## **Provider Manual**

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## Section 1: INTRODUCTION

### What Is Commonwealth Care Alliance?

Commonwealth Care Alliance, Inc. (CCA) is a not-for-profit care delivery system committed to the provision of integrated health care and related social support services. Created in 2003, CCA is a “consumer–governed” organization offering a full spectrum of medical and social services for people with complex needs covered under Medicaid and for those “dually eligible” covered by both Medicaid and Medicare, including:

- ▶ older adults (65+)
- ▶ individuals with serious physical, cognitive, or chronic mental illness
- ▶ children with special needs

CCA contracts with a select group of primary care physicians whose commitment to their patients, as well as communities that they serve, is beyond comparison.

Commonwealth Care Alliance believes it is important to recognize the value of community caregivers and to respect the relationship forged in trust between members and their caregivers.

### Our Mission

CCA’s mission is to provide the best possible care, tailored individually to the needs of all elders as well as to people across the age spectrum with special health care needs throughout the state of Massachusetts, by bringing to scale proven clinical strategies that improve care and manage costs, within a team-based, consumer-directed, prepaid, care delivery program.

### Our Vision

It is CCA’s vision to bring people with complex medical and behavioral health needs, high-quality and personalized care resulting in improved health and better self-management of chronic illness, thereby reducing hospitalizations and institutionalizations.

### Our Approach

CCA makes use of these proven methods:

- ▶ team-based care
- ▶ specialized primary care networks
- ▶ flexible benefit designs
- ▶ coordination of care
- ▶ full integration of behavioral health and long-term care support services
- ▶ 24/7 availability
- ▶ resource allocation to enhance primary care and care coordination
- ▶ assurance that members have a meaningful voice in the delivery of their care, and that they receive the care they need when they need it

## **What Is The Senior Care Options Program?**

The Senior Care Options (SCO) program is a comprehensive health plan that covers all the services reimbursable under Medicare and Medicaid (MassHealth), and potentially additional benefits, through a senior care organization and its preferred network of providers. SCOs were created through a partnership between the Centers for Medicare and Medicaid Services (CMS) and the Massachusetts Office of Medicaid. This governmental partnership resulted in a first-in-the-nation Memorandum of Understanding to provide for joint collaboration of the two public payor sources, to deliver and coordinate all components of Medicare and Medicaid health care benefits. This allows the Senior Care Options program to offer a comprehensive array of health care and social services.

The key objectives of the SCO program are to:

- ▶ improve the quality and coordination of care provided to seniors
- ▶ expand member access to covered services
- ▶ maximize member satisfaction with services provided
- ▶ increase the cost effectiveness of care
- ▶ reduce the likelihood that hospitalizations or nursing home placements will be required
- ▶ provide services across a wide range of health care status
- ▶ provide alternatives to traditional health care services

## **Why Would An Elder Be Interested In Enrolling In SCO?**

The purpose of the SCO program is to help elders remain as independent as possible by improving the ability to access the most appropriate and necessary services required according to an individual's need. The SCO program allows for a primary care physician (PCP) and/or primary care team (PCT) to coordinate a comprehensive range of health and health-related services that best suits a person's health care needs. SCO PCPs are dedicated to providing a personalized approach to health care so that members, their families, and CCA's network of providers are able to work together efficiently and effectively.

CCA contracts with community-based health centers and physician practices that have demonstrated experience with, and a particular commitment to, the populations CCA serves.

## **What Are Some Unique Features Of CCA's SCO Program?**

The SCO program offers important and exciting benefits, including:

- ▶ an Individualized Plan of Care (IPC) to address a member's specific care needs;
- ▶ the ability to receive health care and support services in one's community;
- ▶ comprehensive health care services, including pharmacy, in-home services and long term care supports when the PCP/PCT determines they are needed;
- ▶ flexibility to remain at home with needed care and supports rather than be admitted (unnecessarily) to a hospital or nursing home;
- ▶ caring professionals to help ensure that all those involved in providing care are working together as a team to maintain a member's health;
- ▶ 24-hours/7-days per week access to a clinician with knowledge about a member's care; and,
- ▶ active involvement in care decisions by members and their families.

Members have the convenience of a single point of contact for any health related problems or questions as well as access to care 24 hours a day, seven days a week, 365 days a year.

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## Section 2: SERVICE AREA

CCA current service area includes the following cities and towns:

Agawam	Malden
Arlington	Marshfield
Avon	Medford
Belmont	Milton
Boston, including:	Nahant
Allston	Needham
Brighton	Newton
Charlestown	North Quincy
Dorchester	Norwell
East Boston	Norwood
Hyde Park	Quincy
Jamaica Plain	Randolph
Mattapan	Revere
Roslindale	Saugus
Roxbury	Scituate
South Boston	Sharon
West Roxbury	Somerville
Braintree	Southwick
Brockton	Springfield
Brookline	Stoughton
Cambridge	Swampscott
Canton	Waltham
Chelsea	Watertown
Chestnut Hill	West Springfield
Chicopee	Westfield
Dedham	Weymouth
East Longmeadow	Winthrop
Everett	Wollaston
Feeding Hills	
Hingham	
Hull	
Lexington	
Ludlow	
Lynn	
Lynnfield	

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## Section 3: MEMBERS

### SCO Eligibility Requirements

Potential members must be:

- ▶ at least 65 years old; and,
- ▶ a Massachusetts resident living in CCA's service area; and,
- ▶ enrolled in MassHealth Standard or be dually eligible for Medicare and MassHealth (Medicaid).

### Who Is Not Eligible For SCO Enrollment?

- ▶ End Stage Renal Disease (ESRD) diagnosis, prior to becoming a CCA member
- ▶ elders in the community with a six-month deductible (spend down) unless, they are nursing home certifiable
- ▶ resident of an Intermediate Care Facility (ICF) for the Mentally Retarded
- ▶ inpatient in a chronic disease or rehabilitation hospital

## CCA Member Responsibilities and Rights

### CCA Member Responsibilities

Members are informed of their responsibilities when they join CCA. Member responsibilities include, but are not limited to, the following:

- ▶ to select a PCP from our list of contracted primary care physicians
- ▶ to receive services within our contracted network of providers (except in the case of emergency services)
- ▶ to coordinate and work with their PCP before receiving services (except for emergency care)
- ▶ to provide their PCP/PCT accurate and complete information including their current health and past medical history
- ▶ to participate in and follow the plan of care developed in collaboration with the PCP/PCT
- ▶ to inform their provider(s) when they do not understand any instructions or anything else about their health care

### CCA Member Rights Statement

CCA is committed to providing easily accessible, high quality services to our members. This objective is best met by establishing a mutually respectful relationship that promotes privacy, effective treatment and member satisfaction.

The following page is CCA's Member Rights Statement.

**AS A MEMBER IN THE COMMONWEALTH CARE ALLIANCE  
YOU HAVE THE FOLLOWING RIGHTS:**

1. To have the *Member Handbook* fully discussed and explained to you in a clear and understandable manner.
2. To be fully informed, in writing, before enrollment, upon enrollment, during participation and when there is a change in services, of the services available from CCA, including all services delivered through contracted specialists and facilities.
3. To be fully informed, in writing, of your rights and responsibilities and all rules and regulations governing your participation in CCA, as evidenced by your written acknowledgement.
4. To receive comprehensive health care in a safe and clean environment and in an accessible manner.
5. To be treated with dignity and respect, to receive humane care and to be afforded privacy and confidentiality in all aspects of your care.
6. Not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation or source of payment.
7. To be encouraged and assisted to exercise your rights as a participant, including the Medicare and Medicaid appeals processes as well as civil and other legal rights.
8. To have the Complaint and Appeals Process explained to you before enrollment, at the time of enrollment, and during participation, in a clear and understandable manner.
9. To voice complaints to the CCA staff and outside representatives of your choice, free of any restraints, interference, coercion, discrimination or reprisal by CCA staff.
10. To appeal any treatment decision of your PCP/PCT or CCA specialists through the Appeals Process.
11. To be encouraged and assisted to recommend changes in policies and services to you by your PCP and his or her staff as well as to the CCA staff.
12. To examine, or upon reasonable request, to be assisted to examine the results of the most recent review of CCA conducted by the Centers for Medicare and Medicaid Services or the Division of Medical Assistance and any program of correction in effect.
13. To be free from harm, including physical or mental abuse, neglect, corporal punishment, involuntary seclusion, excessive medication and any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat your medical symptoms.
14. To access emergency health care services when and where the need arises, without prior authorization by your PCP/PCT and /or the CCA staff.
15. To receive accurate, easily understood information about your health and functional status and to have all treatment options explained to you in a clear and understandable manner, including your right to refuse treatment and to be informed of the consequences of such refusal.
16. To participate in the development and implementation of your individualized program of care, including the treatment objectives and the frequency of services, as agreed to by your PCP/PCT.
17. To request a reassessment by your PCP/PCT.
18. To choose your primary care physician and specialists within the CCA network, including your choice of a woman's health specialist for routine or preventative women's health services.
19. To participate fully in all decisions related to your treatment or to designate a representative to do so and to receive assistance in making informed health care decisions.
20. To have your PCP/PCT explain advance directives and to establish them, if you so desire.
21. To end your participation in CCA at any time.

## CCA Membership Verification Process

CCA strongly advises its contracted providers to verify CCA membership whenever services are delivered. Mechanisms to verify eligibility include:

1. CCA Member Service Department – providers can call Member Services to verify eligibility at 1-866-610-2273 from 8:30 AM. to 5:00 PM, Monday through Friday. Please have the member's ID number available at the time of call.
2. MassHealth Recipient Verification System (REVS) – can be accessed by:
  - ✓ automated voice response (AVR), 1-800-554-0042
  - ✓ WebREVS, <https://www.massrevs.eds.com>
  - ✓ point-of-service (POS) device

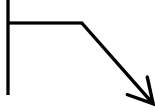
All access methods require providers to have a user ID and password. To obtain a user ID and password, each provider must sign a MassHealth Trading Partner Agreement. To download an agreement go to: <http://www.state.ma.us/dma/hipaa>. For more information about any of these access methods call the MassHealth REVS Help Desk at 1-800-462-7738.

### Identification Card

Each member receives a CCA identification card. The card identifies which CCA program the member is in, the member's name, DOB and identification number and the member's PCP information. An example of the card is on the next page.

Sample Card Front:

MassHealth and  
CCA Member ID#



	<b>Senior Care Options</b>
<b>Sample E. Test</b> <b>DOB: 00/00/1900</b> <b>ID: 1234567890</b> PCP: Real Good Doctor, MD	 CMS – H2225 001
RxBIN 003858    RxPCN A4    RxGrp CW2A    Issuer 80840	



CCA Pharmacy  
Information

Sample Card Back:

<b>Notice to Members:</b> <ul style="list-style-type: none"><li>In an emergency go to the nearest medical facility or call 911 or the local emergency telephone number. It is advised that you have someone notify your PCP or care manager as soon as possible.</li></ul>	
<b>Notice to Providers:</b> <ul style="list-style-type: none"><li>Please call 1-800-311-9529 for 24 hour/7day access to information in the member's medical record.</li></ul>	
<b>Submit claims to:</b> CCA Claims 148 State Street Boston, MA 02109 1-800-306-0732	<b>Important Numbers:</b> Member Services: 1-800-311-2273 TTY: 1-866-322-7357 Pharmacy Calls: 1-800-235-435

## **Primary Care Site (PCS) Member Activities**

The primary care sites play a key role in CCA member outreach, enrollment and orientation activities. CCA provides oversight, training, and tracking of these activities and works in a collaborative manner with its primary care sites. All outreach and marketing materials are produced by CCA and approved by CMS and MassHealth.

CCA and PCS must accept members in the order in which they apply, (as long as eligibility requirements are met), in accordance with Federal/State requirements

### **Outreach**

PCS engage in outreach efforts to enroll potential members into CCA's SCO program. Outreach efforts include, but are not limited to:

- ▶ "inreach" of eligible patient population
- ▶ targeting community agencies involved in elder care with CCA approved material
- ▶ holding meetings at PCS to educate potential elder population
- ▶ family members and/or caregivers

### **Enrollment**

The PCS shall identify staff to help potential members with the enrollment process (e.g. outreach worker, geriatric RN or RNP, social workers, etc.). These staff members will assist potential members with the enrollment process in the most convenient and appropriate setting for the potential member, such as at home visits, open meetings, and scheduled PCP visits.

The enrollment process includes the following steps/items:

- ▶ confirm eligibility (see Appendix for enrollment/disenrollment forms)
- ▶ ensure member understanding and involve family caregiver participation as needed
- ▶ provide choices of PCPs and ensure that PCP selection occurs
- ▶ provide access to required materials, including but not limited to:
  - provider directories
  - benefit summaries
- ▶ complete enrollment forms and submit the forms to CCA
- ▶ performs an initial clinical assessment, which includes:
  - clinical/functional status
  - mental health/substance abuse
  - LTC/informal support availability
- ▶ completes an MDS-HC form, as required, (see Appendix) and submits it to CCA

CCA shall review all enrollment and assessment forms prior to submission to MassHealth and is ultimately responsible to ensure the potential member is SCO eligible.

## **Orientation**

New members must receive a member orientation within 30 days of enrollment. CCA works collaboratively with the PCS to identify the structure of the orientation that will most benefit the member and their family or caregiver. All new members and/or their family member/caregiver receive a Welcome Call from the CCA Member Service staff. Other orientations options include:

- ▶ home visits
- ▶ group orientations
- ▶ mailings
- ▶ email correspondence
- ▶ use of video technology

All orientation materials are developed by CCA with input from the PCS to address community needs.

CCA and PCS specific information included in the orientation:

- ▶ Benefit Summary
- ▶ PCP Directory
- ▶ Specialty Directory
- ▶ how to access services
- ▶ how to change PCPs
- ▶ Member's Rights Statement
- ▶ explanation of Centralized Enrollee Record (CER)
- ▶ complaint and appeals information
- ▶ disenrollment information including, voluntary disenrollment and criteria for involuntary disenrollment

All orientation materials are reviewed and approved by CMS and MassHealth.

## **Complaints and Appeals**

CCA members have the right to file complaints or appeals. A complaint is a member's informal expression of dissatisfaction with any aspect of his or her care. An appeal is defined as a member's formal request for review of a decision to deny, terminate, suspend or reduce services.

The following page is CCA's procedure for member's to file a complaint or appeal.

For a quick reference guide to member complaint and appeal requests see the Appendix.

**Commonwealth Care Alliance's (CCA)**  
**Procedure for a Member's Complaint or Appeal**

Commonwealth Care Alliance shares the responsibility for assuring that members are satisfied with the care they receive. CCA is committed to addressing any dissatisfaction that is experienced. CCA encourages members to let us know as soon as they can about their dissatisfaction.

**Complaint:**

A Complaint is a Member's informal expression of dissatisfaction with any aspect of his or her care.

**How to file a complaint with CCA:**

The member, family or caregiver is encouraged to make a complaint with the CCA Member Service Department if they are dissatisfied with the delivery of services or the quality of care that is provided to them. The complaint may be made verbally or in writing\* to CCA. If they prefer, they can inform the Primary Care Physician or a member of the Primary Care Team of their complaint and they, in turn, will inform CCA of the nature of the complaint. All complaints are treated in a confidential manner.

**CCA's Actions and Complaint Timeline:**

- CCA will acknowledge the complaint and will respond orally or in writing within a reasonable time, but no later than 30 days from when the complaint was received.
- Care will continue to be provided throughout the complaint process.
- All efforts will be made by CCA to pursue a satisfactory resolution so that problems do not go unresolved.
- When CCA communicates a response to the Member's complaint, CCA will also provide the Member with information about how to file an appeal if it is appropriate. CCA Member Service will provide assistance to members in completing any required forms or other procedural steps for filing an appeal should the Member choose to do so.

**Member Appeals:**

An appeal is a Member's formal request for review of a decision to deny, terminate, suspend or reduce services.

### **Member Rights During the Appeal Process include:**

- The right to submit written materials in support of the member's appeal
- The right to be helped or represented by another person of the member's choice
- The right to ask questions of Commonwealth Care Alliance
- The right to access the medical record information Commonwealth Care Alliance uses to review the appeal.

### **Member Responsibility during the Appeal Process include:**

- Completing, signing and returning a request for release of any additional medical records needed to resolve the appeal.

### **How to File an Internal Member Appeal:**

The member, family or caregiver may file an appeal verbally or in writing\* with the CCA Member Service Department. If the member prefers, they can register the appeal with their Primary Care Physician or with a member of their Primary Care Team. It will be their responsibility to ensure that CCA receives the appeal at the time it is registered. Members may also file an internal appeal through the Social Security Administration<sup>1</sup>. Such appeals will be forwarded to CCA. **Any request for appeal needs to be received within 60 calendar days of a written decision from CCA informing the member of a reduction, termination, denial or suspension of services.** All appeals are kept confidential and only those involved with a need to know will be informed of the appeal.

### **CCA's Actions and its Appeal Timeline:**

- CCA will send written acknowledgement of receipt of the member's appeal request within 5 business days to the member, family or caregiver.
- CCA must resolve the appeal within 30 days from the date the appeal is filed.
- If the member, family or caregiver feels that the member's life, health or ability to regain maximum function is seriously impaired without the services in question being provided, they may request an Expedited Appeal.
- Expedited Appeals must be resolved by CCA within 72 hours of receipt of the appeal.
- A written response to the appeal decision will be given to the member, family or caregiver describing the resolution to the problem. The letter will contain the basis for the resolution and the process available should the member, family or caregiver be dissatisfied with the resolution.

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<sup>1</sup> *Or the Railroad Retirement Board if such benefits are received by the member*

**How to File an Appeal or Make a Complaint.**

**Commonwealth Care Alliance's Member Service Department**

**30 Winter Street, 11<sup>th</sup> Floor**

**Boston, MA 02108**

**Phone: 1-866-610-2273**

**TTY: 1-800-322-7357**

**Fax: 1-617-426-1311**

**Hours of Operation: Monday through Friday 8:30 AM – 5:00 PM**

**How to file an External Member Appeal:**

If the internal appeal decided by CCA does not satisfy the member's concern, the member, family or caregiver may request an external review by DMA's Board of Hearing. They must submit a request to MassHealth's Board of Hearing in writing no later than 30 calendar days from the date of the mailing of CCA's Internal Appeal decision. If they request an external appeal within 10 calendar days from the date of the mailing of CCA's internal appeal decision, then CCA is responsible for continued authorization and /or provision of any ongoing service that is being appealed.

If the member has Medicare, CCA will automatically file for review with the Centers for Medicare and Medicaid Services (CMS) any internal appeal decision that does not decide fully in favor of the member.

CCA Member Service Staff are able to assist members with contacting MassHealth and CMS should they decide to file an external appeal.

**Processing an External Appeal:**

- **MassHealth:** if MassHealth's Board of Hearing decides in the member's favor, CCA must authorize or provide the service in dispute within 72 hours of notification of the decision. MassHealth notifies the Member and CCA in writing of the Board of Hearing's decision.
- **CMS:** the CMS Independent Review Entity will send in writing to the member and to CCA their decision within 30 calendar days upon receipt of receiving the case. If the CMS Independent Review Entity decides in the Member's favor, CCA must

authorize or provide the service in dispute within 72 hours of notification of the decision.

**Further Levels of Appeal:**

If CCA or the Member disagrees with either the decision by the CMS Independent Review Entity and/or by DMA's Board of Hearing, additional levels of Appeal are available. CCA is required to cooperate with any request for information or participation from such further Appeal.

**\*If the member submits the complaint or appeal in writing, the explanation should include:**

- Member name and address
- CCA Member ID number
- A detailed description of the concern (including Provider names and important dates)
- Supporting documentation

## **How to Access CCA Member Service Department**

Members, potential members and/or providers can reach a CCA Member Representative toll-free at:

**1-866-610-2273**

**1-866-322-7357 TTY**

Our Member Representatives speak English and Spanish and are available Monday through Friday from 8:30 AM - 5:00 PM. To meet additional member language needs, CCA utilizes the AT&T language line, and to meet members' needs 24 hours a day, 7 days a week, CCA provides before and after hours coverage for the toll-free line.

As HIPAA guidelines require CCA to verify a provider's identity prior to the release of any member information, CCA asks that providers have their CCA provider ID number or tax ID number available each time they contact CCA.

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## Section 4: COVERED SERVICES

CCA's SCO program covers the following services for its members.

### Outpatient Health Services

- ✓ adult day health care
- ✓ general medical and specialist care, including consultation, routine care, preventive health care and physical examinations
- ✓ social services
- ✓ physical, occupational and speech therapies
- ✓ nutrition counseling and education
- ✓ laboratory tests, X-rays and other diagnostic procedures
- ✓ prescription drugs
- ✓ prostheses and durable medical equipment
- ✓ podiatry
- ✓ vision care, including examinations, treatment and corrective devices
- ✓ dental care
- ✓ audiology evaluation, hearing aids, repairs and maintenance

### Inpatient Hospital Services

### Skilled Nursing Facility Care

### Home Health Care

- ✓ skilled nursing services
- ✓ physician visits
- ✓ physical, speech and occupational therapies
- ✓ social services

### Health-Related Services

- ✓ homemaker/chore services
- ✓ personal care attendant (PCA) services
- ✓ transportation
- ✓ dementia and social day care
- ✓ environmental accessibility adaptations
- ✓ personal emergency response systems
- ✓ companion services

End of life Support, provided at home, in a hospital or on an outpatient basis

### Behavioral Health Services

- ✓ inpatient services for mental health or substance abuse diagnoses
- ✓ community support services
- ✓ crisis stabilization
- ✓ partial hospitalization
- ✓ observation
- ✓ psychiatric day treatment
- ✓ residential substance abuse treatment
- ✓ outpatient mental health and substance abuse services

For more details regarding covered services please see the *Covered Services and Prior Authorization Requirements* chart in the Appendix.

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## Section 5: PROVIDERS

### Provider Definitions

CCA providers are part of a unique care delivery system that utilizes primary care teams (PCT), an electronic centralized enrollee record (CER), and a flexible benefit package to ensure that members receive the care they need when and where they need it. Primary care physicians and primary care sites play a key coordination and clinical partnership role in CCA's care delivery system.

### Primary Care Site (PCS)

A PCS, in most cases a community-based medical care or physician practice, is an organized medical group that has demonstrated experience with and a particular commitment to the populations CCA serves. The PCP and members of the primary care team (PCT) are based at the PCS. The PCS is an essential element to the CCA care delivery system.

### Primary Care Physician (PCP)

PCPs are key to members' well-being and satisfaction, as well as to the success of the primary care team (PCT) and CCA.

PCPs are:

- ▶ board-certified or board-eligible in Family Practice or Internal Medicine and may be further certified in Gerontology or Geriatric Medicine with annual continuing medical education units in geriatric practice; and,
- ▶ have at least two years' experience in the care of persons over the age of 65.

### Primary Care Team (PCT)

The PCT is charged with effectively coordinating and delivering a member's care. Team members are experienced in geriatric care; the PCT consists of a:

- ▶ PCP
- ▶ Geriatric Support Services Coordinator (GSSC)
- ▶ nurse practitioner, registered nurse or physician's assistant
- ▶ other professional and support disciplines as the PCP deems necessary, for example, a behavioral health clinician, social worker, etc.

### Aging Services Access Point (ASAP)

ASAPs are entities established under state law that contract with the Commonwealth's Executive Office of Elder Affairs to manage the Home Care Program as well as other elder service programs in Massachusetts.

### Geriatric Support Services Coordinator (GSSC)

GSSCs are Licensed Social Workers who are employees of ASAPs and have expertise in geriatric practice.

## Provider Responsibilities

Provider responsibilities are detailed in the following pages according to provider type.

### Overall, CCA contracted providers must:

- ▶ coordinate care, clinical referrals, and prior authorizations with the member's PCP/PCT
- ▶ transfer indicated information to the Primary Care Site and/or CER in a timely fashion
- ▶ provide care in a manner consistent with recognized standards of health care
- ▶ provide care in a culturally and linguistically appropriate manner
- ▶ follow CCA clinical guidelines and standards of care
- ▶ adhere to CCA Member Rights Statement
- ▶ abide by prompt access to care standards (see chart below)
- ▶ complete and submit a *Provider Change Form* (see Appendix) to inform CCA of relevant changes (i.e., name, address, TIN, panel status, e.g.)
- ▶ comply with CCA administrative policies and procedures and contractual agreements
- ▶ confirm member's eligibility on each date of service
- ▶ cooperate with CCA's Quality Management Program
- ▶ participate in CCA provider surveys/trainings
- ▶ report to CCA category I & II incidents, which include the following:
  - any death required to be reported to the medical examiner or in which the medical examiner takes jurisdiction (M.G.L. c38 section 3)
  - a serious injury while in a health care facility that results in hospitalization
  - sexual assault or alleged sexual assault to or by a member while at health care facility
  - physical assault or alleged physical assault to or by a member while at a health care facility

To report Category I & II incidents call CCA Quality & Clinical Management Department and use the *Incident Report Form* in the Appendix.

<b>Prompt Access to Care Standards</b>	
<b>Visit/Care Type</b>	<b>Standard</b>
PCP Consultation Availability	24-Hours/7 Days A Week  At a minimum by a toll free telephone call that includes access to a licensed, skilled health care professional engaged in CCA's specialized care delivery system who has access to the CER and with the capability to clinically manage the episodic illness, complaints, emergency room evaluation and hospital admission.
Urgent and Symptomatic Care	48 Hours
Non-Symptomatic Care	30 Calendar Days
Emergency Services	Immediately

### **Primary Care Site (PCS)**

The PCS provides, arranges for and coordinates the provision of covered services to members, including the services of the PCP. Its responsibilities cover program administration, membership activities, and care delivery and care coordination. For a comprehensive, detailed list of responsibilities see *Primary Care Program Specifications - Senior Care Options (SCO) Program*, in the Appendix. What follows are responsibilities that are somewhat unique to CCA and the SCO program.

### **Individualized Plan of Care (IPC)**

The IPC is a detailed written description, housed in the CER, of the scope, frequency and duration of all clinical and service needs to be provided on behalf of a member. The PCS is responsible for ensuring the IPC is current and updated as often as deemed appropriate by the PCP/PCT and in accordance with the required SCO reassessment schedule as well as upon any change in a member's healthcare status.

### **Service Plan**

The Service Plan is a standardized template provided by CCA, and housed in the CER, for the recording of all services authorized on behalf of a member by the PCP/PCT in accordance with the IPC. A copy of the Service Plan is in the Appendix.

## **Centralized Enrollee Record (CER)**

The CER is a comprehensive electronic record of all care received by a member, as well as the holder of the IPC, service plan, assessments, progress notes and contacts. The PCS is responsible for maintaining the CER and for ensuring that the PCP/PCT, as well as any other providers make timely and appropriate entries. Additionally, the PCS is responsible to ensure that the CER is:

- ▶ utilized 24-hours/7-days per week either in its entirety or in a current summary of key clinical information to triage and acute care providers for emergency conditions and urgent care
- ▶ available and accessible to specialty, long term care and behavioral health providers through the sites PCT staff or 24/7 on-call coverage system
- ▶ maintained in a confidential manner

## **Advance Directives**

An Advance Directive is a written statement that helps guide a physician in providing the care that a patient would have wanted if he/she were able to participate in their own treatment plan. An Advance Directive may identify someone to serve as a member's representative to manage care or make treatment decisions when the member is incapacitated and unable to do so.

The PCS must initiate asking a member if they have an Advance Directive and note in the member's CER whether they have or want one. It is also expected that the PCS will assist a member in creating an Advance Directive if requested.

In Massachusetts, only one type of Advance Directive is legal and it is called a Health Care Proxy. See the Appendix for a sample *Massachusetts Health Care Proxy*.

## **Notice of Discharge and Medicare Appeal Rates (NODMAR)**

The NODMAR is a written notice that informs members that their covered inpatient hospital care is ending. NODMAR forms are issued only when a member disagrees with or expresses dissatisfaction with his or her impending discharge or non-coverage decision. A NODMAR must be delivered when:

- ▶ a member expresses dissatisfaction with his or her impending discharge; or
- ▶ the PCP/CCA is not discharging the individual, but no longer intends to continue coverage of the inpatient stay

CCA in conjunction with the PCS will be responsible for issuing and delivering the NODMAR to the member or the member's representatives. The NODMAR must be issued according to the following guidelines:

- ▶ the notice must be delivered to the member as soon as possible after learning of the member's dissatisfaction, but no later than 6:00 p.m. of the day before discharge
- ▶ if the member is incompetent or otherwise incapable of receiving the notice, the notice must be delivered to the member's authorized representative

See the Appendix for a sample NODMAR.

## **Encounter Information**

The PCS is responsible to submit to CCA encounter information for all members within 30 days of each encounter. This data is necessary to assess member utilization patterns and costs in a timely manner and allows CCA to provide current reports to the PCS. Pharmacy, laboratory, and behavioral health services information should be included if applicable.

## **Member Related Activities**

For detailed information regarding member related responsibilities see Section 3: Members Section in this manual. The PCS member activity responsibilities include, but are not limited to:

- ▶ enrollment and disenrollment applications;
- ▶ member orientation;
- ▶ health assessment;
- ▶ PCP assignment; and,
- ▶ assistance with the complaints and appeals process.

## Primary Care Physician (PCP)

CCA requires that a PCP:

- ▶ provide 24-hours/7-days a week, including holidays, ambulatory care, consultation, and emergency triage
- ▶ provide ambulatory care and care coordination as medically appropriate in such places and times as are practicable and necessary, including the member's home
- ▶ coordinates care, clinical referrals, and prior authorizations
- ▶ functions as the attending physician of record for hospital admissions, including extended care, rehabilitation and skilled nursing facility admissions for medical admissions
- ▶ communicates with specialty providers regarding any examination or treatment provided by a specialist
- ▶ communicates clinical information to the PCT and ensures the CER is appropriately updated

## Primary Care Team (PCT)

The PCT is responsible for making clinical decisions on behalf of CCA and in conjunction with the member or member's representative. Responsibilities include, but are not limited to:

- ▶ perform initial and ongoing member health and functional status assessments
  - initial assessment must be completed prior to enrollment
  - see Appendix for *Initial Assessment Tool*
- ▶ perform ongoing member health and functional status reassessments
  - every 6 months for members without complex care needs
  - every 3 months for members with complex care needs
- ▶ develop and revise, as appropriate, the IPC and service plan which identifies and addresses the member's status, and needs for medical, behavioral health, social and long term care supports
- ▶ coordinate care, clinical referrals, and prior authorizations
- ▶ promote health, prevention wellness informational activities relevant to the specific health status needs and high-risk behaviors for members
- ▶ record, collect, and maintain current and updated clinical and demographic information on each member in the CER
- ▶ attend PCT meetings to ensure effective communication

## **Geriatric Support Services Coordinator (GSSC)**

The GSSC, as a member of the PCT, is responsible for the following:

- ▶ participate in initial and ongoing member health and functional status assessments
- ▶ arrange and coordinate the provision of appropriate community long term care and social support services, such as assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
- ▶ monitor the appropriate provision and functional outcomes of community long term care services
- ▶ track member transfers from one setting to another, for example, hospital to home or nursing home to adult day health, and adjust the IPC and service plan in conjunction with the PCT
- ▶ assist the PCT in promoting independent functioning of the member and provide services in the most appropriate, least restrictive setting
- ▶ determine, in collaboration with the PCP/PCT, appropriate discharge plans after admissions to an institution in collaboration with the member, the member's designated representative and providers of home and community based services

## **Facilities**

Facilities must notify the member's PCP/PCT within 24 hours of any emergency services it renders.

## **Hospital**

Hospitals are responsible to notify the member's PCP/PCT when a member requires emergent or urgent inpatient admission from any other setting including transfers between hospitals and/or within hospitals. Hospitals must make take all reasonable steps to make the notification within 1 hour of the member's stabilization.

## **Nursing Facility**

When a SCO member is admitted to or discharged from a nursing facility, the facility must submit a Status Change-1 (SC-1) form to a MassHealth Member Enrollment Center. CCA requires that a copy of the form is submitted to CCA.

**\*\*\*\*\*It is required that “SCO Member” is stamped on all SC-1 forms\*\*\*\*\***

### **Admissions: Status Change-1 Forms**

Short term admissions, less than six months, the SC-1 must be submitted to:

Revere Member Enrollment Center  
300 Ocean Ave., Suite 4000  
Revere, MA 02151

The facility must submit a copy of the SC-1 to CCA.

Long term admissions, more than six months, the SC-1 must be submitted to the local Member Enrollment Center where the nursing facility is located, with a copy submitted to CCA.

If a short term admission becomes a long-term stay, another SC-1 must be submitted to the local Member Enrollment Center where the nursing facility is located and a copy submitted to CCA.

### **Discharges: Status Change-1 Forms**

When a SCO member is discharged from the nursing facility, the SC-1 needs to be sent to the local Member Enrollment Center where the nursing facility is located.

## **Durable Medical Equipment (DME)**

CCA DME providers are responsible for meeting specified standards for hours of service and accessibility, repairs, and equipment. The standards are listed below:

### **Hours of Service and Accessibility**

- ▶ maintain 24-hours/7-days a week telephone accessibility and provide services 24-hours/7-days a week
- ▶ within 2 hours of emergently needed request, provide needed supplies, services or equipment
- ▶ within 24 hours of request, provide all other needed supplies, services or equipment, including wheelchairs and wheelchair repairs
- ▶ make every effort to fill a same day order if requested
- ▶ within 48 hours of notification, remove all rental items

Emergently needed supplies, services or equipment includes that which malfunctions or absence presents an immediate life-threatening situation.

For example, oxygen and respiratory services and equipment are emergently needed supplies.

### **Repairs**

- ▶ make every effort to complete a repair with one service call
- ▶ notify PCS and/or CCA in writing, if rebuilt parts are used in a repair
- ▶ provide the closest available substitute wheelchair on loan, free of charge, for the duration of any wheelchair repair service

### **Equipment**

- ▶ provide PCS with expected life of consumables such as batteries
- ▶ provide warranties, serial or model numbers for equipment such as wheelchairs, beds, lifts, batteries, etc. to PCS
- ▶ contact CCA member to make wheelchair delivery arrangements
- ▶ fit all equipment properly to the member's specifications and needs at the time of delivery
- ▶ instruct member and/or caretaker in the safe and proper use of equipment

## **Home Health Agency**

Home Health Agencies are required to:

- ▶ maintain 24-hours/7-days a week telephone availability and provide services 24-hours/7-days a week
- ▶ within 24 hours of request, provide home health care
- ▶ within 1 hour of request, confirm availability of services
- ▶ agree to meet with PCS staff as needed

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## **Section 6: CENTRALIZED ENROLLEE RECORD (CER)**

Key to the CCA care delivery system is the Centralized Enrollee Record (CER). The CER is a comprehensive record of all care received by a member, including, the Individualized Plan of Care (IPC), assessments, encounter and collateral contacts. It is an electronic record available 24 hours a day, seven days a week to the primary care team (PCT).

The CER is the repository for all pertinent information regarding the member's health, functional and social status. All actions taken with or on behalf of the member are to be documented in the CER. It is a provider-driven, secure (HIPAA compliant), web-based application that is accessible from any computer with access to the Internet to authorized users.

All services must be recorded in the CER. The service entries must describe care provided, diagnoses determined, and medication prescribed.

**Behavioral Health Providers: Psychotherapeutic session notes are NOT be recorded in the CER.**

### **Maintenance of the CER**

CCA's SCO primary care sites (PCS) are required to maintain the CER for every member assigned to the PCS. CCA, in collaboration with the PCS, has systems to ensure that the CER is:

- ▶ updated in a timely manner by each provider of care;
- ▶ available and accessible 24 hours a day, seven days a week either in its entirety or in a current summary of key clinical information to the Primary Care Team and acute care providers in order to provide appropriate clinical triage of emergency conditions and urgent care;
- ▶ available and accessible to specialty, long term care and behavioral health and substance abuse providers;
- ▶ confidential and that those who have access to it are bound by and compliant with HIPAA and CCA's written CER confidentiality policies.

## **How to Access the CER**

### **Primary Care Sites**

Once a SCO member is enrolled in the program, demographic data will be loaded into the CER by CCA through an interface with CCA's member database. In addition, certain pre-enrollment documents such as the Initial Assessment Form and the DMA Enrollment Form will be scanned into the record. For each member enrolled, the Primary Care Physician and/or Team will be responsible to enter directly into the "Consult" module the following:

- Problem List
- Allergies and Sensitivities
- Vital Signs
- Immunizations
- Medication Orders

This information is to be kept completely current with on-line capability provided for immediate modification to facilitate this outcome.

The Primary Care Site will also be responsible to ensure that the CER is kept current through the use of the "Clinical Events Chart Detail" component of the record. The CER will house a variety of documents including ongoing assessments, Individualized Plans of Care (IPC), Service Plans, progress notes, administrative forms, etc. Primary Care Sites are trained in the specific procedures to be used for entering and maintaining this information.

### **All Other Providers**

The Primary Care Sites each have a twenty four (24) hour, seven (7) day a week on-call coverage system for CCA's SCO members. Any other providers involved in providing care to a Primary Care Site's CCA SCO member may contact the Primary Care Site to obtain information necessary to inform the provision of care that has been authorized by the PCP/PCT. In certain situations including emergency or urgent circumstances, the PCP/PCT may forward a servicing provider with a summary of the CCA SCO member's demographic and clinical profile to inform the provision of care.

Any provider involved in providing care to a CCA SCO member is also required to contribute to the CER in accordance with contractual obligations and practices agreed to with the Primary Care Site by forwarding documentation to the Primary Care Site for submission. All documentation must be clearly marked with:

- ▶ CCA SCO member's Name
- ▶ CCA SCO member's Identification Number
- ▶ CCA SCO member's PCP name
- ▶ Name of Provider/Organizational Entity
- ▶ Date of Documentation Completed

## Timeframes for Updating Records

Type of Service	Timeframe Standard of When CER Must be Updated
Emergency conditions and urgent care	No more than 18 hours after the PCP or PCT is notified, and a full report of the services entered within 2 business days
Medication Orders	When prescribed by a member of the PCT, within the calendar day. If prescribed by others, PCS must record within 2 business days of information receipt.
All other Non-Primary Care Services	In accordance with contractual obligations and/or standards of practice in place with the Primary Care Sites
Primary Care Team Services	All encounter information including 24/7 after hour coverage documentation is expected to be kept current (within the calendar day) in the CER.

## Troubleshooting

CCA provides each primary care site with a CER dedicated lap top and other required hardware and software to utilize and maintain the requirements of the CER. Updated daily, both tools are utilized by the on-call clinician and available to other clinicians as necessary.

In certain situations including emergency or urgent circumstances, the PCP/PCT may forward a servicing provider with a summary of the CCA SCO member's demographic and clinical profile to inform the provision of care.

The CER Emergency Plan will inform primary care site clinicians sharing on-call coverage responsibilities, information about the member's current health status and the individual circumstances and appropriate interventions to be addressed at the time of an emergency. In addition to pertinent member demographic and designated caregiver information, Emergency Plans include, at a minimum:

- ▶ medical/behavioral problems
- ▶ treatment plans
- ▶ medications
- ▶ known allergies
- ▶ functional status
- ▶ impairments
- ▶ advance directives
- ▶ formal service support information

## Technical Assistance

For technical assistance call, 1-617-621-9775, x330

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## **Section 7: CLINICAL REFERRALS & PRIOR AUTHORIZATIONS**

In this unique care system, CCA's contracted PCP/PCT's are responsible for making all clinical referrals and for approving prior authorizations. CCA maintains oversight of the process and with its primary care sites and PCPs, has collaboratively developed clinical guidelines and policies and procedures that are used throughout the network. Through its quality management program, CCA will continuously monitor utilization and outcomes data and provide timely reporting to the PCS/PCP/PCT. This will allow CCA and the PCS to facilitate appropriate resource allocation to enhance primary care and care coordination and share best practices across the network.

PCP/PCTs are fully responsible for authorizing, denying, reducing, modifying, and terminating covered services.

### **Clinical Referrals**

CCA defines clinical referrals as a communication from a CCA primary care site (PCS) to a provider to furnish covered services for certain outpatient services rendered to CCA members. PCPs are responsible for determining the need for clinical referrals, based on their assessment of the member, for services of specialty providers. If a member is referred to a specialist and the specialist believes the member requires additional services other than those for which they were referred, the specialist must communicate with the PCP/PCT.

The PCS/PCT is responsible for the site's clinical referral process. Generally, the process will follow the steps listed below:

1. PCS/PCT communicates with specialist and an appointment is made for the member.
2. PCS/PCT records the referral need in the CER
3. Specialist's office checks member eligibility
4. Specialist evaluates/treats member as requested by the PCP/PCT and provides prompt feedback to the PCP/PCT including written documentation to be recorded in the CER
5. Specialist's office submits claim to CCA

## Member Self-Referrals

Members may self-refer for certain services, including:

- ▶ emergency services (medical and behavioral health)
- ▶ women's health specialty services for certain women's routine and preventive health care services (must be within the CCA contracted network)
- ▶ urgent care sought out of area
- ▶ out of area renal dialysis services

**Members are always advised and encouraged to consult with their PCP/PCT.**

## Prior Authorizations

CCA defines a prior authorization as a verbal or written communication from the contracted PCP/PCT to another provider approving the need for service prior to the provision and billing of any covered services requiring prior authorization.

The PCP/PCT responsible for CCA SCO member's primary care is responsible for issuing prior authorizations on behalf of the member. Generally, the process will follow the steps listed below:

1. PCP/PCT assesses the need for a service and determines the frequency and scope of service required. (In some circumstances, a provider may request a prior authorization from the PCP/PCT)
2. PCP/PCT records the prior authorization in the CER on the IPC and Service Plan documents.
3. Servicing provider checks the CCA SCO member's eligibility
4. Servicing provider delivers the service and communicates outcomes to the PCP/PCT including written documentation for entry in the CER
5. Servicing provider submits claim to CCA

## Prior Authorization Specifications

The following pages outline prior authorization guidelines for:

- ▶ Dental services
- ▶ DME
- ▶ Hearing aid services
- ▶ Vision services

**For details regarding services other than those listed in this section, please see the *Covered Services and Prior Authorization Requirements* chart in the Appendix.**

**Dental Services:** CCA covers an initial exam after member has been enrolled for a three (3) month period; other restrictions may apply. CCA covers up to \$200.00 per member enrollment month toward the cost for Dental care services up to a maximum of \$1600.00 for the first year of enrollment.

### **Durable Medical Equipment (DME)**

Although DME requires prior authorization, there are some items that **do not** require prior authorization. The following applies:

- ▶ disposables under \$200 per line item total; and,
- ▶ items identified in the chart below.

### **The following Durable Medical Equipment Items Do Not Require Prior Authorization**

#### **CANES**

- E0100 Cane, includes canes of all materials, adjustable or fixed, with tip
- E0105 Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tip

#### **CRUTCHES**

- A4635 Underarm pad, crutch, replacement, each
- A4636 Replacement, handgrip, cane, crutch, or walker, each
- A4637 Replacement, tip, cane, crutch, walker each
- E0110 Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips
- E0111 Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip
- E0112 Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips
- E0113 Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip
- E0114 Crutch, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips
- E0116 Crutch, underarm, other than wood, adjustable or fixed, each, with pad, tip and handgrip

#### **WALKERS**

- B0130 Walker, rigid (pickup), adjustable or fixed height
- E0135 Walker, folding (pickup), adjustable or fixed height
- E0141 Rigid, walker, wheeled, without seat
- E0142 Rigid walker, wheeled, with seat
- E0143 Folding walker, wheeled, without seat
- E0144 Enclosed framed folding walker, wheeled with posterior seat
- E0145 Walker, wheeled, with seat and crutch attachments
- E0146 Folding walker, wheeled, with seat
- E0147 Heavy duty, multiple breaking system, variable wheel resistance walker Supplies associated with walker
- E0148 Walker, heavy duty, without wheels, rigid or folding any type, each
- E0149 Walker, heavy duty, wheeled, rigid or folding, any type, each

#### **NEBULIZERS**

- A7010 Corrugated tubing, disposal, prefilled, used with large volume nebulizer, 100 feet
- A7011 Corrugated tubing, non-disposable, used with large volume nebulizer 10 feet
- A7012 Water collection device, used with large volume nebulizer
- A7013 Filter, disposable, used with aerosol compressor
- A7014 Filter, non-disposable, used with aerosol compressor or ultrasonic generator
- A7015 Aerosol mask, used with DME nebulizer
- A7016 Dome and mouthpiece, used with small volume ultrasonic nebulizer
- A7017 Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen
- A7018 Water, distilled, used with large volume nebulizer, 1000 ml

A7019	Saline solution per 10 ml, metered dose dispenser, for use with inhalation drugs
A7020	Sterile water or sterile saline, 1000 ml, used with large volume nebulizer
E0570	Nebulizer, with compressor
E0571	Aerosol compressor, battery powered, for use with small volume nebulizer
E0572	Aerosol compressor, adjustable pressure, light duty for intermittent use
E0574	Ultrasonic generator with small volume ultrasonic nebulizer
E0575	Nebulizer, ultrasonic, large volume
E0585	Nebulizer, with compressor and heater
A7003	Administration set, with small volume nonfiltered pneumatic nebulizer, disposable
A7004	Small volume nonfiltered pneumatic nebulizer, disposal
A7005	Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable
A7006	Administration set, with small volume filtered pneumatic nebulizer
A7007	Large volume nebulizer, disposable, unfilled, used with aerosol compressor
A7008	Large volume nebulizer, disposable, prefilled, used with aerosol compressor
A7009	Reservoir bottle, non-disposable, used with large volume nebulizer, 100 feet
A7010	Corrugated tubing, disposable, used with large volume nebulizer, 100 feet
<b>MISCELLANEOUS</b>	
L0120	Cervical collar, flexible foam, non-adjustable
A4570	Splint, cock-up splint with stay
A4500	Surgical stockings (TED Stockings)
X5050	Peak flow meter

**Hearing Aid Services:** CCA does not cover more than one hearing aid per ear per member in a 60-month period without authorization in accordance with 130 CMR 426.408. One hearing aid per ear consists of either one binaural hearing-aid fitting, or two monaural hearing aids dispensed more than six months apart, with one dispensed for the left ear and the other dispensed for the right ear.

**Vision Services:** \$125.00 basic coverage for eyeglass frames per member enrollment year

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## **Section 8: CLINICAL & QUALITY MANAGEMENT**

Commonwealth Care Alliance (CCA) is committed to providing the highest quality, most effective health care and related long term support services to SCO members. In pursuance of this, CCA's framework for Quality Management is designed to integrate quality assessment and performance improvement activities throughout all levels of its care delivery system. As a "consumer governed" organization, CCA's Quality Management Program is structured to ensure that the consumer's perspective is built in to all elements of its quality assurance activities; an underlying tenet of the CCA program is that a true partnership between those receiving care and those providing and managing care can promote autonomy, independence and better health outcomes.

The QM program is designed to:

- ▶ Establish clinical and administrative criteria from which to prospectively, concurrently and/or retrospectively identify potential areas for targeted improvement activities and initiate actions focused upon improving performance in a manner that is both measurable and effective.
- ▶ Understand the needs, expectations, and satisfaction of members and their caregivers and implement improvements to better 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 input from across the network.

### **Quality Program Objectives**

1. To assure the effective, timely and safe delivery of care and care coordination to members at the optimal level of quality
2. To assess and evaluate the quality and appropriateness of care across the provider network
3. To design effective mechanisms for problem identification, assessment and resolution at the individual, practice site and system-wide levels
4. To assess, evaluate and monitor key areas of clinical care and care coordination and identify opportunities for improvement when indicated
5. To promote mechanisms for the integration of risk management, utilization review and other activities in a comprehensive quality management program
6. To identify deviations from standards and address such deviations in a manner that optimizes health outcomes
7. To ensure that professional competency and practices are routinely and reliably monitored and evaluated
8. To ensure compliance with state, federal, contractual and other regulatory requirements

## **Quality Program Components**

CCA's Quality Management Program activities are based upon a collaborative and organization-wide approach to problem solving. The program encompasses the entire care delivery network and includes the following components:

### **Annual Quality Improvement Goal**

Two annual quality improvement goals are to be selected, and at a minimum, inclusive of the following elements, and are to be the focus of network-wide improvement activities for a designated 12 month period:

- ▶ the objective;
- ▶ the expected outcomes;
- ▶ a brief justification with background on each objective;
- ▶ how each quality goal will be measured;
- ▶ the target population;
- ▶ the method of evaluating change in the quality goals;
- ▶ communication processes; and
- ▶ documentation requirements.

### **Selected Program Initiatives**

Selected program initiatives are inclusive, as appropriate, of elements such as written protocols; the development and acceptance of written practice guidelines; reporting mechanisms; educational processes for members, caregivers and providers; and monitoring, feedback and evaluation mechanisms, for at least the following program areas:

- ▶ Reduction of Preventable Hospital Admissions
- ▶ Discharge Planning
- ▶ Early Screening for Cancer
- ▶ Disease Management
- ▶ Preventive Immunizations
- ▶ Dementia Management
- ▶ Appropriate Nursing Facility Utilization
- ▶ Alcohol Abuse Prevention and Treatment
- ▶ Appropriate Identification and Treatment of Abuse and Neglect
- ▶ Health And Wellness Activity Promotion

## **Continuous Quality Improvement (CQI) Activities**

CCA's Continuous Quality Improvement (CQI) Activities, the ongoing collection, regular review and analysis of: administrative data and clinical/member information associated with the tracking of certain clinical indicators; cost and utilization information; and monitoring of programmatic improvement activities, inclusive of the administration of and review and follow up on Annual Enrollee Survey and Focus Group Activity. CCA's CQI Activities may include review of the following program areas:

- ▶ Adequacy and accessibility of clinical care and long term support services offered through CCA's primary care network sites
- ▶ Effectiveness of utilization management, coordination of services, care continuity and interdisciplinary care team function across the continuum of care
- ▶ Appropriateness of service delivery and care provision
- ▶ Assessment of patient and caregiver satisfaction and effectiveness of consumer involvement
- ▶ Education and training of provider staff and of caregiver support networks
- ▶ Review of grievances and appeals
- ▶ Credentialing activities
- ▶ Effectiveness of GSSC/PCP/PCT functioning
- ▶ Contractual compliance

## **Quality Program Structure**

### **Board of Directors**

The Board of Directors (BOD) is comprised of up to 15 members appointed by CCA's Corporate members, the two consumer advocacy groups Health Care for All (HCFA) and Boston Center for Independent Living (BCIL), and assumes final authority and responsibility for quality of care and professional practices. The BOD delegates responsibility for the development and oversight of CCA's SCO Quality Management Program to the President/Chief Executive Officer/Chief Medical Officer who delegates responsibility for components of the program to CCA management and clinical staff.

### **Patient Care Advisory Committee**

The PCAC is a committee of the Board whose membership is inclusive of Board representatives, consumer representatives and multi-disciplinary clinical representation drawn from the CCA provider network. Among the responsibilities of the PCAC is the development, approval and monitoring of the organization's Annual Quality Assurance Program.

### **Credentialing Committee**

The Credentialing Committee is a subcommittee of the PCAC and is comprised of clinical professionals both internal and external to the CCA organization. Among

the responsibilities of the Credentialing Committee is the oversight of all delegated and non-delegated provider credentialing activities.

### **Ethics Committee**

The Ethics Committee is a subcommittee of the PCAC and is comprised of clinical professionals both internal and external to the CCA organization, with a particular focus on those bringing an expertise in the area of medical ethics. Among the responsibilities of the Ethics Committee is the provision of input into decision-making with regard to end-of-life issues and advance directives.

### **Quality Management Committee (QMC)**

The Quality Management Committee is an internal CCA committee comprised of staff, consumer and multi-disciplinary clinical representation from the CCA SCO network. QMC responsibilities 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 Management Program for recommendation to the PCAC for review and approval.

### **Utilization Management Committee (UMC)**

The Utilization Management Committee is an internal CCA committee comprised of staff and multi-disciplinary clinical representation from the CCA SCO network. UMC responsibilities include the regular review, monitoring and analysis of utilization and cost information associated with the delivery of care and services to SCO enrollees across the network, development and dissemination of clinical protocols and evidence based practice guidelines, identification and dissemination of best practice policies and procedures, assurance of standardized implementation of policies across the network, etc.

### **Quality Management Program**

The Quality Management Program encompasses the following areas of Clinical Care and Service Delivery:

1. Determination of the extent to which CCA's administrative and clinical practice policies promote appropriate, efficient and effective patient care.
2. Member and caregiver satisfaction and involvement (surveys, focus groups, unsolicited letters and other activities to be defined)
3. Member complaints and appeals
4. Unusual occurrence reports
5. Patient Outcome data
6. Effectiveness of utilization management, coordination of services, care continuity and interdisciplinary care team function across the care continuum
7. Service utilization and costs, inclusive of primary and specialty care, inpatient admissions, LOS, ER utilization, DME utilization, home health, pharmacy, BH, long term supports, etc.

8. Review of enrollment and disenrollment processes and reasons for disenrollment
9. Review of appropriateness of nursing home utilization
10. Review of consistency of policy and procedure application across the CCA SCO network
11. Review of appropriateness of and adherence to clinical protocols

## **Annual Quality Program Evaluation**

The Board of Directors, PCAC and the QMC review the Annual Quality Program and assess the results of the plan on an annual basis. This evaluation guides next steps and the development of a quality improvement program for the coming year.

## **Confidentiality**

All persons participating in quality improvement activities adhere to Commonwealth Care Alliance's 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/federal law and regulation.

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## **Section 9: PHARMACY**

CCA has contracted with Express Scripts, Inc. (ESI), a national Pharmacy Benefits Management (PBM) company to administer the pharmacy benefit on CCA's behalf. CCA has worked with its primary care partners to identify those retail pharmacies in the neighborhoods of the primary care sites with whom CCA's primary care providers have established relationships and members can access easily. CCA has ensured that each of these pharmacies is a part of the ESI network of retail pharmacies. In addition to many smaller independent pharmacies, CCA's pharmacy network through ESI will also include CVS and Walgreen's.

CCA has established a formulary with the expert assistance of the PBM that aims to provide prescribing providers with both a broad range of options for treatment within a geriatric population while promoting the most cost-effective drug choices.

In addition to accessing medications from local retail pharmacies in the network, members and providers will also have the ability to utilize ESI's mail order program for maintenance medications. It is anticipated that this will assist elders and their caregivers with receiving medication refills and greater quantity supply for those medications used on a prolonged basis.

CCA will provide its primary care providers with feedback in the form of profiling data on prescribing patterns. CCA, with support of ESI staff, will provide contracted primary care providers with information to inform their prescribing behavior both clinically and economically.

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## Section 10: BEHAVIORAL HEALTH

### Behavioral Health Provider

CCA requires that a behavioral health provider:

- ▶ provides 24-hours/7-days a week, coverage, as well as back-up/on-call coverage, after-hours and during short-term and long-term leaves of absence
- ▶ communicates clinical information to the PCT and ensures the CER is appropriately updated, including, but not limited to, the behavioral health sections of the IPC
  - Note: Psychotherapeutic session notes must NOT be recorded in the CER.
- ▶ agrees to meet with PCP clinical staff as needed
- ▶ provides the member's PCP with clinical updates appropriate to the member's status in a mutually agreed upon format and frequency
- ▶ involves the member and/or her representative in all treatment planning and recovery
- ▶ accepts for admission all members in need of inpatient admissions who are referred by Emergency Service Providers (ESPs)
- ▶ reports category I and II incidents to CCA within the established timeframes (see Category I & II Incidents section below)
- ▶ complies with state and federal regulations regarding restraints and seclusion
- ▶ obtains the necessary consent to release substance abuse information, as indicted by federal law, to facilitate communication with the member's PCP and to further integrate behavioral and medical care, as well as improving care coordination (see Substance Abuse Consent to Release Information section below for additional information)
- ▶ abides by the Department of Mental Health's consent and human rights policies

## **Behavioral Health Covered Services**

### **Behavioral Health Inpatient Services**

Twenty-four hour services that provide medical intervention for mental health or substance abuse diagnoses, or both, including:

#### ***Inpatient Mental Health Services***

Hospital services to stabilize an acute psychiatric condition that: 1. has a relatively sudden onset; 2. has a short, serve course; 3. poses a significant danger to self or other; or 4. has resulted in marked psycho-social dysfunction or grave mental disability.

#### ***Detoxification***

Inpatient substance-abuse services that provide short-term medical treatment for substance-abuse withdrawal, individual medical assessment, evaluation, intervention, substance-abuse counseling, and post-detoxification referrals. These services may be provided in licensed freestanding or hospital-based programs.

### **Behavioral Health Diversionary Services**

Services that are provided as alternatives to inpatient services, including:

#### ***Community Support***

Services provided in a community setting, which are used to prevent hospitalization, and designed to respond to the needs of Members whose pattern of utilization of services or clinical profile indicates high risk of readmission into 24-hour treatment settings.

#### ***Crisis Stabilization***

Services provided as an alternative to hospitalization which provides short-term psychiatric treatment in structured, community based therapeutic environments. Crisis stabilization provides continuous 24-hour observation and supervision for individuals who do not require the intensive medical treatment of hospital level of care.

#### ***Observation/Holding Beds***

Services to provide hospital level care for up to 24 hours to provide time for assessment, stabilization, and identification of appropriate resources for individuals.

#### ***Partial Hospitalization***

An alternative to inpatient mental health services which offers short-term day mental health programming available seven days per week consisting of therapeutically intensive acute treatment within a stable therapeutic milieu and including daily psychiatric management.

### ***Psychiatric Day Treatment***

Services that constitute a program of a planned combination of diagnostic, treatment, and rehabilitative services provided to mentally or emotionally disturbed persons who need more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual provider's office, or hospital outpatient department, but who do not need full-time hospitalization or institutionalization.

### ***Residential Substance Abuse Treatment***

Short-term 24-hour therapeutically planned treatment and learning situation that provides continuity of care after detoxification for individuals engaging in recovery.

### ***Structured Outpatient Addiction Programs***

Short-term clinically intensive structured day or evening substance-abuse services. Such a program can serve as a step-down service in the continuum of care for individuals being discharged from detoxification or can be utilized by individuals whose symptoms indicate a need for structured outpatient treatment beyond the standard outpatient benefit.

### ***Behavioral Health Emergency Services***

Medically necessary services that are available seven days per week, 24 hours per day to provide treatment of any Member who is experiencing a mental health or substance abuse problem, or both, including:

#### ***Emergency Screening Services***

A face-to-face assessment, conducted by appropriate clinical personnel, of an individual presenting with an emergency in a home, residential program, clinic, hospital emergency room, police station, and other settings.

#### ***Medication Management Services***

An assessment for and prescribing of medication by qualified personnel as a component of emergency services.

#### ***Short Term Crisis Counseling***

The provision of individual therapy as a component of emergency services.

#### ***Short-Term Crisis Stabilization Services***

Short-term crisis stabilization services includes any or all of the following: 1. Crisis Stabilization; 2. Observation/Holding Beds; 3. Specializing Services; 4. Medication Management Services; and 5. Short-Term Crisis Counseling.

#### ***Specializing Services***

Therapeutic services provided to an individual, in a variety of settings, on a one-to-one basis to maintain the individual's safety as a component of Emergency Services.

## **Behavioral Health Outpatient Services**

Services provided in an ambulatory care setting, such as a mental health or substance abuse clinic, hospital outpatient department, community health center, or Provider's office, including:

### ***Mental Health Services***

Mental health services include evaluation, treatment, medication and consultation.

### ***Substance Abuse Services***

Substance abuse services include counseling, diagnostic evaluations, and medication visits.

## **Behavioral Special Procedures**

### ***Electro-Convulsive Therapy (ECT)***

A service that initiates seizure activity with an electric impulse while the member is under anesthesia. It is administered in a hospital facility that is licensed to provide this service by the Department of Mental Health.

### ***Psychological Neuropsychological Testing***

Is the use of standardized test instruments when indicated for behavioral or physical health reasons to evaluate aspects of a Member's functioning, including but not limited to cognitive processes, emotional conflicts, and type and degree of psychopathology.

## **Category I & II Incident Reports**

In accordance with MassHealth regulations, providers shall report category I & II incidents to CCA. The chart below defines category I and II incidents, gives examples of the incidents, and provides the timeframe for when the incidents must be reported to CCA.

### **Category I & II Incidents**

<b>Incident Type</b>	<b>Incident Definition</b>	<b>Incident Examples</b>	<b>Timeframe to Report the Incident to CCA</b>
Category I	A situation that occurs within or on the grounds of a facility that immediately jeopardize the safety of a member receiving services	<ul style="list-style-type: none"><li>• medicolegal deaths pursuant to M.G.L. c.38 s. 3</li><li>• absent without authorization (AWA) from a facility involving a member admitted or committed and who is at high risk of harm to self or others</li><li>• a serious injury, while at a facility, resulting in a medical hospitalization</li><li>• sexual assault or alleged sexual assault</li><li>• an event which results in DMH, DPH,</li></ul>	same day the incident occurs

		and/or a police report	
Category II	An incident that occurs within or on the grounds of a provider site, at any level of care, which does not immediately place a member at risk, but does warrant concern.	<ul style="list-style-type: none"> <li>• non-medicolegal deaths</li> <li>• AWA from a facility involving a member who does not meet the criteria described in category I incidents but does warrant concern</li> <li>• physical assault or alleged physical assault to or by a member, while at a facility</li> <li>• a serious injury that requires the member, while at a facility, to be transported to an acute hospital for medical treatment</li> <li>• an unscheduled event that results in the temporary evacuation of a behavioral health program or facility</li> </ul>	next business day

**The steps to report an incident are as follows:**

1. provider calls CCA Quality & Clinical Management Department to report the incident
  - if the provider is unsure whether or not an event is reportable they should call CCA to review the incident
2. CCA supplies the provider with a CCA Incident Report Form (see Appendix) to complete
3. provider completes the CCA Incident Report Form
  - providers should be prepared to present all relevant information related to the incident including the contact information of all involved parties and the member's current condition
4. the completed form is faxed to CCA with a copy sent to the members PCP

**The procedures CCA employs to resolve an incident include, but are not limited to:**

- ▶ Gathers all necessary data from the reporting provider.
- ▶ Conducts a safety and risk assessment to ensure that the member is not a immediate risk of harming themselves or others. If the member is at immediate risk CCA and the PCS/PCT initiate an emergency response plan.
- ▶ Informs MassHealth of the incident.
- ▶ If indicated, CCA will conduct additional investigative work including interviewing other providers and the member.
- ▶ The incident is reviewed with CCA's Chief Medical Officer and/or a designee from the Quality Management Committee.
- ▶ If indicated, CCA shall request that the provider submit a corrective action plan/follow-up plan.

## **Restraints and Seclusion**

Contracted behavioral health providers shall comply with federal and state regulations governing the restraint and seclusion of members. The state regulations can be found at 104 CMR 27.12 and 104 CMR 28.05.

Providers, as applicable, may be requested to submit a copy of the restraint and seclusion policy to CCA.

CCA supports the Massachusetts Coalition for the Prevention of Medical Errors guiding principles on the use of restraints and seclusion:

“the adoption of an approach that minimizes the use of restraints and seclusion; supports the use of restraints and seclusion only in emergency situations and after less restrictive interventions have been determined to be ineffective; ensures patient/resident staff safety; and promotes an approach that values risk assessment, early intervention, and education.”

## **Substance Abuse Consent To Release Information**

At intake and/or admission to substance abuse treatment, the provider shall explain the importance and benefits of communication with his or her PCP and that federally-legislated requirements, 42 CFR section 2.22, require the provider to obtain the member’s consent to share substance abuse information with his or her PCP. The provider shall obtain the member’s signature on an appropriate consent to release information form.

All CCA members have the option of signing the consent to release information form, limiting the scope of information communicated, or refusing to release any information. For members who refuse to release information, providers should clearly document, with minimally required documentation, in the CER the member’s refusal.

## **DMH Human Rights Statement**

In addition to CCA’s member right statement, providers shall comply with the Massachusetts Department of Mental Health’s (DMH) policies regarding informed consent and human rights. Inpatient providers must have a copy of DMH’s statement of human rights posted in a noticeable place.

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## Section 11: CONFIDENTIALITY

State and federal laws require CCA to protect member and provider confidential information. CCA contracted providers are expected to treat and store member information in a confidential manner as outlined in their CCA contract and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards and other applicable state and federal regulations.

### **Health Insurance Portability and Accountability Act Privacy Standards**

All providers are required to comply with the Standards for Protected Health Information (45 CFR Parts 160 and 164), HIPAA Privacy Rule, and are responsible for obtaining any member consents or releases that are necessary beyond those that CCA has already required through the enrollment process. CCA's *Senior Care Options Program Member Handbook* contains our member privacy notice. It outlines disclosure of their information that is necessary for the provision and administration of services, such as:

- ▶ treatment;
- ▶ payment; and,
- ▶ health care operations, including disease management programs, utilization review and quality assurance.

In accordance with CCA's provider contracts, providers are expected to disclose requested member information for the activities listed above. CCA may also request additional information in the following areas, which include but is not limited to:

- ▶ quality assurance activities
- ▶ payment audits
- ▶ HEDIS measurements
- ▶ utilization management
- ▶ state and federal regulatory compliance

### **Medical Records**

To meet CCA confidentiality requirements providers must:

- ▶ maintain medical records in an area that is protected against loss, destruction, tampering and unauthorized access or use
- ▶ maintain billing information in a secure location in locked files
- ▶ adhere to the confidential requirements of CER documentation

Additional CCA requirements for medical records are:

- ▶ inactive records will be stored in a secure location to prevent unauthorized access; however, records must be stored in such a manner as to provided for prompt retrieval of member information as needed;
- ▶ to retain records for 6 years from the date of the last entry in the record; or for medical records of disenrolled members, six years after the date of disenrollment.

### **CCA Internal Confidentiality Policy**

CCA requires a signed statement attesting to adherence to its corporate confidentiality policy from employees, subcontractors, consultants, students, interns and temporary staff. The purpose of the policy is to maintain the confidentiality of member and provider information.

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## Section 12: CREDENTIALING

### Provider Credentialing

All providers who contract with CCA undergo initial credentialing evaluation and must be approved by CCA's Patient Care Assessment Committee's (PCAC) Credentialing Committee prior to furnishing services to CCA members as a contracted provider. CCA completes the required process of data collection and credential verification in accordance with the standards promulgated by the National Committee for Quality Assurance (NCQA), and as required by state and federal regulations including standards of participation in the Medicare Plus Choice Program. Every three years, a similar re-credentialing process is completed for providers who wish to continue to care for CCA members.

### Credentialing and Re-Credentialing Application

CCA utilizes the Massachusetts Integrated Application for Initial Credentialing/Appointment and the Massachusetts Integrated Application for Re-Credentialing forms. Sample credentialing applications are in the Appendix.

For an application to be considered complete, a provider must submit to CCA the following:

- ✓ a completed signed application form
- ✓ copies of:
  - state medical license
  - most recent application for state licensure
  - malpractice insurance policy "face sheet" indicating professional liability coverage with a minimum level of \$1,000,000 per occurrence/\$3,000,000 aggregate
  - federal DEA certificate
  - Massachusetts Controlled Drug Certificate
  - ECFMG Certificate, if applicable
- ✓ most recent 10-year work history (curriculum vitae)

CCA may require a site visit to be performed at the offices of primary care providers, or other high-volume providers. The site visits are conducted during regular business hours and CCA will provide reasonable notice of the planned visit.

## **Credential Verification**

The following information is verified with those primary sources acceptable to NCQA by its standards:

- ▶ professional licensure
- ▶ highest level of education, training, and/or board certification
- ▶ clinical privileges at the primary admitting facility
- ▶ malpractice claims history
- ▶ DEA certification
- ▶ ECFMG certification, if applicable

Queries are sent to the following data banks:

- ▶ National Practitioner Data Bank
- ▶ State Licensing Boards
- ▶ Office of the Inspector General

## **Delegated Credentialing**

CCA may delegate the credentialing and re-credentialing process to another entity. In these cases, the entity's process is in accordance with standards promulgated by the National Committee for Quality Assurance (NCQA), other accrediting agencies, and as required by state and federal law including standards of participation in the Medicare Plus Choice Program. CCA is obligated to maintain oversight of the process and retains the right to require a provider to undergo CCA's own credentialing and re-credentialing process to gain or maintain status as a CCA contracted provider.

## **Credentialing Process**

Once the completed application and required accompanying documentation is received, primary credentialing verification occurs. If CCA determines that an application is incomplete or there are discrepancies between the verification and the application, the provider will be contacted and requested to submit the required documentation. After verification, CCA's Credentialing Committee reviews each provider's credentials and determines if the provider will be accepted or retained in the CCA network. The entire process, starting from when a completed application and accompanying documentation is received by CCA, and ending with the Credentialing Committee's decision will occur within ninety days or less. The provider is notified in writing of CCA's Credentialing Committee's decision.

## **Provider Termination, Suspension, or Denial**

Providers are responsible to immediately notify CCA, in writing, in the event that any individual rendering services to CCA members:

- ▶ is censured or reprimanded by any health care facility (and such discipline is reportable to the regulatory body responsible for licensure); and/or,
- ▶ has his/her privileges at any health care facility suspended, revoked, restricted made probationary, or otherwise diminished in any way, including resignations; and/or,
- ▶ has his/her license, certification, or Medicare or Medicaid participation limited, suspended or revoked.

In any of these cases, CCA will objectively assess the situation and determine if the provider's status or contract should be suspended, denied or terminated. When a decision has been made, written notification will be sent by certified or registered mail.

## **Facility Credentialing**

Facilities that enter into a contractual agreement with CCA to provide services to members are credentialed. CCA completes a standardized process of data collection and evaluation in accordance with the standards promulgated by the National Committee for Quality Assurance (NCQA), and as required by state and federal regulations. Every three years, a similar re-credentialing process is completed for facilities that wish to continue to care for CCA members.

Contracted facilities must be eligible for payment under Medicare.

## **Credentialing and Recredentialing Application**

The facility submits, at a minimum, to CCA evidence of the following:

- ▶ licensure by the Massachusetts Department of Public Health
- ▶ Medicare and Medicaid certification
- ▶ Joint Commission of the Accreditation of Healthcare Organizations (JCAHO) accreditation or other applicable accreditation documentation

Additional information may be gathered, such as member complaints about a facility and incident report data as well as from external sources such as DPH, EOEA, etc.

Facilities accredited by a recognized, industry standard, accrediting agency will generally not be required to receive a site visit by CCA. However, CCA reserves the right to perform a site visit during regular business hours with prior reasonable notice.

Non-accredited facilities are required to submit additional information including their most recent CMS site visit report and quality management documentation.

### **Credentialing Process**

Once the necessary documentation is received and a site visit is conducted, if applicable, CCA's Credentialing Committee will review the facility's credentials and determine if the facility will be accepted or retained in the CCA network. The entire process, starting from when all required documentation is received by CCA, and ending with the Credentialing Committee's decision, will occur within ninety days or less. The facility will be notified in writing of CCA's Credentialing Committee's decision: approval, time-limited approval, approval with follow-up or denial.

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## Section 13: CLAIMS

CCA pays clean claims submitted within specified contractual timeframes for covered services for eligible members. In most cases, CCA will pay clean claims within forty-five (45) days of receipt. CCA will accept both electronic and paper claims with accepted standard diagnosis and procedure codes that comply with the Health Information Portability and Accountability Act (HIPAA) Transaction Code Set Standards.

CCA accepts the following standard claims forms:

- ▶ CMS 1500
- ▶ CMS 1450 (UB-92)
- ▶ Form 9 (DME)
- ▶ ADA

Copies of claims forms and instructions on how to complete the forms are included in the Appendix.

CCA members **should** never be billed for SCO covered services. Providers shall not seek or accept payment from any CCA member for any SCO covered service and accept CCA's payment as payment in full.

## Unique Payment System

Unlike traditional claims system, CCA's payment system has the unique ability to forward questionable claims for review to the member's PCP/PCT. An example of a questionable claim may be one that required prior authorization for a certain specified covered service. If the prior authorization does not appear in the CER when required and a claim is received for the service, the claim will then be sent to the PCP to verify its validity prior to being denied. This system affords for a more timely and accurate payment as it reduces the need for claim resubmissions and supports CCA's approach to care coordination with its primary care network.

## Prompt Payment Process

CCA's prompt payment process is outlined below:

- ▶ Within 60 calendar days of rendering covered services, provider submits claim to CCA.
- ▶ Within 45 calendar days of receipt of a clean claim for covered services CCA will:
  - make payment; or,
  - provide written notification for reason(s) for nonpayment.
- ▶ Within 10 calendar days of receipt of a non-clean claim for covered services, CCA will provide written notification of additional information or documentation necessary to process the claim for reimbursement.
  - The additional information or documentation must be submitted in its entirety within 10 calendar days of CCA's request or CCA shall not be obligated to make payment.
- ▶ Any claim submitted more than 90 calendar days after the date of covered service will be denied, unless the claim was returned to the provider for more information, and consequently resubmitted to CCA.
- ▶ When a third-party insurer is involved, such as a motor vehicle accident, the claim must be submitted to CCA within 30 days of receiving the other carrier's Explanation of Payment (EOP).
- ▶ If a claim is denied, the member will receive notification on CMS-1003, Notice of Denial of Payment form.

In accordance with Medicare+ Choice regulations, CCA is obligated to pay 90% of clean claims within 90 days of receipt. CCA's policy is more stringent than the regulation; CCA commits to paying clean claims within 45 days of receipt.

## **Clean Claims**

A clean claim is defined as one that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payment.

The following information is required for a clean claim to be accepted for processing:

- ▶ full member name and date of birth
- ▶ CCA member identification number
- ▶ complete service level information
  - date of service
  - place of service
  - industry standard diagnosis codes
  - industry standard procedure codes (e.g., CPT, ICD-9 CM)
  - charge information and units, if applicable
- ▶ provider's name, address, and CCA provider identification number, (TIN #)
- ▶ all mandatory fields must be complete and accurate, as required by Medicare guidelines.

## **Non-Clean Claims**

Non-clean claims are defined as those claims that require CCA to investigate, develop or acquire additional information from the provider or external source.

Non-clean claims include, but are not limited to claims that:

- ▶ have missing or incorrect required data; and,
- ▶ may be subject to medical review and complete medical evidence is not submitted by the provider.

## **Subrogation**

In some cases, CCA has the right to recover the value of services to members for which a third party is responsible. Subrogation is a liability recovery activity in which medical costs that are the result of actions or omissions of a third party are recovered from the third party and/or the third party's insurer. CCA is required to perform subrogation recovery activities, and as a result, a provider may receive correspondence related to duplicate claim payments.

## **Coordination of Benefits (COB)**

Members are never required to pay for covered services rendered. Providers should submit the initial claim with the explanation of payment (EOP) from the primary insurer to CCA within 90 days from the EOP date. Claims submitted without an EOP will be denied.

In the event of a motor vehicle accident, the motor vehicle insurer is the primary payer for the full \$8,000 Person 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 CCA within 90 days from the date the motor vehicle insurer issued the EOP.

## **Electronic Claims Submission**

Filing electronic claims usually results in fewer errors, costs less and is more efficient for businesses on both ends of the transactions. Electronic claims may be submitted directly to CCA through a preferred e-channel or indirectly through an intermediary.

Claims sent via EDI must comply with HIPAA transaction requirements. EDI claims can be sent via modem or via clearinghouses. The claim transaction will be automatically uploaded into the claims processing system.

## **How To Apply For Electronic Data Interchange (EDI)**

To submit claims electronically to CCA an EDI Authorization Form must be completed. Complete the form (see Appendix) and send it to:

Commonwealth Care Alliance  
148 State Street  
Boston, MA 02109  
ATTN: Claims Department

For additional information regarding electronic data interchange with CCA, call: 1-800-306-0732.

## **Paper Claims Submission**

The paper claim receipt date is the date the claim is received by CCA.

Please mail paper claims to:

Commonwealth Care Alliance  
148 State Street  
Boston, MA 02109  
ATTN: Claims Department

An imaging process is used for claims retrieval. To assist with accurate and timely claims imaging, please:

- ✓ type all fields completely and accurately;
- ✓ use black or blue ink only; and,
- ✓ submit all claims in a 9"x12" or larger envelope.

If a paper claim is returned by CCA due to missing or incomplete information, resubmit a clean paper claim no later than 45 days from CCA's request to:

Commonwealth Care Alliance  
148 State Street  
Boston, MA 02109  
Attention: Claims Resubmission

## **How To Check Claims Status**

Providers requesting information on the status of a claim, including clarification of any explanation of payment code, should call 1-800-306-0732.

## Claims Appeals

If a provider disagrees with CCA's decision of denial or reimbursement of a claim, the provider has the option to file an appeal for reconsideration by following the procedure below:

1. The provider claim appeal must be made in writing and accompanied with documentation supporting the provider's position on the issue(s) in question.
2. The appeal request must be made within 30 calendar days of receiving the claim(s) status from CCA of a claim denial or reimbursement status.
3. When substantial new information is provided, the Claims Appeal area will review the request for appeal and notify the provider in writing of its decision or provide notice to the provider that his/her appeal is pending.
4. The appeal review will be completed within 60 days except in circumstances where CCA cannot obtain relevant information or a response in a timely manner.

Refer to the Section 3: Members, in this manual for  
Member Complaints and Appeals.

## Audit and Reconciliation of Fee for Service Claim Payments

CCA may conduct audits of claims payments for covered services. The purpose of the audits is to identify overpayments and underpayments of claims for covered services. In the event that CCA conducts such an audit, the results will be available to identified provider(s). Provider(s) shall reimburse CCA for any overpayments and CCA will reimburse provider(s) for any underpayment of covered services.