

SECTION 11 BILLING AND CLAIMS

11-1 Program Specific Guidelines

Commonwealth Care Alliance pays clean claims submitted within specified contractual timeframes for covered services provided to eligible members. In most cases, Commonwealth Care Alliance pays clean claims within 30 days of receipt. Filing limits are strictly adhered to. Filing limits are specified in your contract.

Commonwealth Care Alliance accepts 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.

Commonwealth Care Alliance accepts the following standard claims forms:

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

****Please note**** If the standard claims forms (mentioned above) are not used, Commonwealth Care Alliance has created an invoice that we will accept instead. The invoice can be sent to you electronically.

Providers shall not seek or accept payment from a Commonwealth Care Alliance Senior Care Options member for any covered service. Providers must accept Commonwealth Care Alliance payment as payment-in-full as detailed in our provider Agreement (contract). Certain providers are responsible for obtaining prior authorization from the primary care team before providing services. Please consult your contract to see whether prior authorization is required.

11-2 Electronic Claims Submission

Submitting claims electronically (referred to as electronic data interchange or EDI), usually results in fewer errors, lower costs, and increased efficiency for businesses on both ends of the transaction. *EDI is our preferred process for submitting claims.* Commonwealth Care Alliance offers three options of submitting EDI claims to our provider network:

Option One

Clearinghouse Submitters: Standard 837 file submission through a clearinghouse where Commonwealth Care Alliance would supply you with our specific payor identification number (PIN). This PIN is the identifier at the clearinghouse to route claims files directly to the Claim Operations Department.

Option Two

Direct Submitter: This option is for those entities that choose to create their own 837 file and submit that file directly to the Commonwealth Care Alliance Web Portal. The secure portal will provide two layers of initial screening of all input claims data (File Structure Validation and Claim Data Validation) to improve the quality of submitted claims.

Option Three

Single Claims Submitters: This option is for those vendors that do not have the technical capabilities of creating an 837 file for batch submissions. Providers are given the opportunity to enter single claims directly into Commonwealth Care Alliance secure web portal and are provided a detailed training via WebEx with technical support provided to assist in the transmissions.

****Please note**** Options 2 & 3 allow vendors to use our automated secure web portal interface to transmit HIPAA compliant

claims for processing and the ability to view member, provider data, and submitted claim processing status data (as permitted by their level of authorization).

Claims sent via EDI must comply with HIPAA transaction requirements. EDI claims are sent via modem or via a clearinghouse. The claim transaction is automatically uploaded into the claims processing system. Commonwealth Care Alliance will supply a Companion Guide and Training Manual upon request.

11-3 How to Apply for Electronic Data Interchange

To submit claims electronically to Commonwealth Care Alliance an [EDI questionnaire](#) must be completed.

For additional information regarding EDI with Commonwealth Care Alliance, please call 1-800-306-0732.

11-4 Paper Claims Submission

Paper claims must have all required elements completed in the appropriate area to be considered a “clean claim”. The receipt date is the day that Commonwealth Care Alliance receives the claim. Claim turnaround timelines are based on the claim receipt date.

[Click here](#) to download the list of required elements for paper claims.

Please mail paper claims to:

Commonwealth Care Alliance
ATTN: Claims Department
148 State Street, 10th Floor
Boston, MA 02109

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
- Submit all claims in a 9”x12” or larger envelope

If Commonwealth Care Alliance returns a paper claim due to missing or incomplete information, please resubmit a clean paper claim no later than 30 days from Commonwealth Care Alliance’s request to the following address:

Commonwealth Care Alliance
ATTN: Claims Department
148 State Street, 10th Floor
Boston, MA 02109

11-5 How to Check Claims Status

Providers utilizing Option 2 or 3 of the EDI process as explained above may check claims status, member eligibility, and provider status on their secure website. All other providers requesting information on the status of a claim, including clarification of any explanation of payment code, must call 1-800-306-0732.

11-6 Electronic Funds Transfer

Commonwealth Care Alliance also offers electronic claims payment and HIPAA compliant 835 electronic remittance advices. These mechanisms provide significant improvements to the efficiency and accuracy of your claims posting operations by eliminating paper processing and the physical handling of checks. These services are provided through JPMorgan Chase’s Healthcare Link.

Advantages of the Healthcare Link

- Automates electronic and paper payments to reduce costs and errors
- Helps providers transition from paper to electronic methods of payment and explanation of benefits (EOB) in an efficient and secure manner
- Allows providers to manage the receipt of payments and EOBs more efficiently
- Provides a secure web site for providers to obtain copies of EOBs and to update payment instructions

If you are interested in electronic funds transfer, please call 1-800-306-0732.

11-7 Claims Appeal

If a provider disagrees with Commonwealth Care Alliance's decision of denial or reimbursement of a claim, the provider can file an appeal for reconsideration by following the procedure below:

1. The provider claim appeal must be made in writing within 30 calendar days of receiving the claim denial, and must be accompanied by documentation supporting the provider's position on the issue(s) in question. Appeal request should be sent to:

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

2. 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 the appeal is pending.
3. Commonwealth Care Alliance reviews all appeals within 60 days. Commonwealth Care Alliance is not responsible for a decision if the appeal request does not contain all supporting documentation. The original denial will remain in effect.

11-8 Coordination of Benefits/Third Party Liability

Members are never required to pay for authorized covered services. In the event that a member suffers an injury covered by Workers Compensation, the Workers Compensation insurer would be the primary payer. If a balance remains, providers should submit the initial claim with the explanation of payment (EOP) from the primary insurer to Commonwealth Care Alliance within 90 days of 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 Commonwealth Care Alliance within 90 days of the date the motor vehicle insurer issued the EOP.

If the member has other primary coverage, the claim must be submitted to the primary carrier first. Once payment and/or denial have been made, the claim can be submitted to Commonwealth Care Alliance. Please note that a secondary claim form should be submitted along with a copy of the primary carrier's explanation of benefits (EOB) in order to be considered.

11-9 Serious Reportable Events

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

Commonwealth Care Alliance will require all participating providers to report SREs by populating present on admission (POA) indicators on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims, where applicable. Otherwise, Commonwealth Care Alliance will follow CMS guidelines for the billing of "never events". In the instance that the "never event" has not been reported,

Commonwealth Care Alliance will use any means available to determine if any charges filed with Commonwealth Care Alliance meet the criteria, as outlined by the NQF and adopted by CMS, as a Serious Reportable Adverse Event.

In the circumstance that a payment has been made for a SRE, Commonwealth Care Alliance reserves the right to re-coup the reimbursement as necessary.

Commonwealth Care Alliance will require all participating acute care hospitals to hold members harmless for any services related to never events in any clinical setting.

11-10 Hospital Acquired Conditions

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

Commonwealth Care Alliance will require all participating providers to report present on admission information for both primary and secondary diagnoses when submitting claims for discharge. Hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present.

Commonwealth Care Alliance will require all participating acute care hospitals to hold members harmless for any services related to HACs in any clinical setting.