

## SECTION 9 CLINICAL MANAGEMENT

This section outlines how Commonwealth Care Alliance manages the clinical component of care. Included in this section is information regarding clinical referrals, prior authorizations, service decisions/organization determinations, Medicare Notification of Discharge, and complaints and appeals.

### 9-1 Clinical Referrals and Prior Authorizations

In Commonwealth Care Alliance's unique system of care, contracted primary care physicians (PCP)/primary care teams (PCT) are responsible for making all clinical referrals and for approving prior authorizations. Commonwealth Care Alliance maintains oversight of the process, and, with its primary care sites (PCS) and PCPs, has collaboratively developed clinical guidelines, policies and procedures that are used throughout the network. Through its utilization and quality management programs, Commonwealth Care Alliance continuously monitors utilization and outcome data and provides timely reporting to the PCS, PCP, and PCT.

#### Clinical Referrals

Commonwealth Care Alliance defines clinical referrals as a communication from a Commonwealth Care Alliance primary care provider to a clinical provider to furnish covered services for certain outpatient services rendered to Commonwealth Care Alliance members. PCPs are responsible for determining the need for clinical referrals, based on the 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 the member was referred, the specialist must communicate with the PCP/PCT.

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

1. PCT communicates with specialist and an appointment is made for the member
2. Specialist's office checks member eligibility
3. Specialist evaluates/treats member as requested by the PCP/PCT and provides prompt feedback to the PCP/PCT including written documentation to be entered in the centralized enrollee record (CER)
4. Specialist's office submits claim to Commonwealth Care Alliance

#### Prior Authorizations

Commonwealth Care Alliance 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 difference between a clinical referral and a prior authorization is that a prior authorization must be entered into the authorization module of the Commonwealth Care Alliance CER and a clinical referral does not necessitate authorization for purposes of payment. Although many durable medical equipment items require prior authorization, low cost items (under \$250) do not require prior authorization.

### 9-2 Service Authorization Module

The Commonwealth Care Alliance CER contains an authorization module to record services that require prior authorization prior to rendering a service and to allow claims payment.

To view the services that require prior authorization, [click here](#) to download the Prior Authorization grid.

Service authorizations are done by the PCP/PCT in accordance with the identified needs of the member.

### 9-3 Self-Referrals

There are a few services that members may get on their own, without a referral or prior authorization from the PCP. Members may “self-refer” for the following services:

- Any medical service for an emergency condition
- Emergency behavioral health care
- Urgent care sought out of the service area
- Urgent care under unusual circumstances provided in the service area
- Direct access to women’s services (must stay within Commonwealth Care Alliance’s preferred network)
- Out-of-area renal dialysis services
- Lab and x-ray services (must stay within Commonwealth Care Alliance’s preferred network)
- Radiation therapy services (must stay within Commonwealth Care Alliance’s preferred network)
- Clinical trials — original Medicare covers routine cost of qualifying clinical trials
- Influenza vaccine, pneumococcal vaccines and hepatitis B vaccines (must stay within Commonwealth Care Alliance’s preferred network)
- Mammograms

### 9-4 Service Decisions and Organization Determinations

Commonwealth Care Alliance and its PCTs make organization determinations/service decisions in a fair and consistent manner after evaluating relevant clinical information, including a member’s individual health care needs and the covered benefits available under the program.

An *adverse decision* is a determination to deny, suspend, reduce or terminate coverage for a particular benefit or service.

An *organization determination/service decision letter* is a written notification sent to a member to state that coverage has been denied. Types of service decision letters include the Notice of Denial of Medical Coverage, the Important Message from Medicare, the Notice of Medicare Non-Coverage, and the Notice of Denial of Payment.

### 9-5 Commonwealth Care Alliance Responsibilities

Commonwealth Care Alliance issues a *written communication* called an organization determination/service decision letter to the member that reflects the PCT’s recommendation and the reason for the service decision as the basis for Commonwealth Care Alliance’s actions. As part of this same communication, Commonwealth Care Alliance notifies the member of their right to appeal the decision. For denial of payment, the provider receives a copy of the denial of payment letter along with the denied claim.

Commonwealth Care Alliance tracks all adverse organization determination/service decisions in the Commonwealth Care Alliance *Service Decision Log*. If an appeal is initiated on the basis of an adverse decision, the process is tracked in the Commonwealth Care Alliance Appeal Database.

Commonwealth Care Alliance performs *training* for PCPs and the other members of the PCT about the Commonwealth Care Alliance organization determination/service decision policy and procedure process.

### 9-6 Primary Care Team Responsibilities for the Senior Care Options Program

A PCP/PCT authorizing a service requiring prior authorization is responsible for:

- Entering information on the member’s individualized plan of care (IPC) and service plan. The IPC is signed by the

member. The information required on the service plan contains:

- Problem
  - Service begin date
  - Authorized by
  - Specific service and the frequency and/or units
  - Service provider/contact phone number
  - Service end date
- Updating and modifying the CER authorization module whenever there is an additional service authorized
  - PCTs are required to provide Commonwealth Care Alliance with a clinical recommendation of the need to deny, reduce, suspend or terminate any service request. Teams make a decision regarding a member's request for a service within 14 days of the request for service. [Click here](#) to download Clinical Recommendation form
  - If the PCP/PCT decides to terminate, suspend or reduce a previously authorized service, the PCP is required to notify Commonwealth Care Alliance in writing of its recommendation, utilizing the Clinical Recommendation Form, and Commonwealth Care Alliance will issue a written notification to the member 10 days in advance of the effective date of its action. The written notice states the reasons for the decision and informs the member of their right to request an expedited or a standard appeal. If 10 days is not reasonable because of the nature of the service or circumstances of the member, the PCP/PCT will call the member to alert the member of the decision and Commonwealth Care Alliance will follow up in writing.
  - Detailed documentation in the CER of the member's medical, functional and/or psychosocial status is required to support decisions made related to services
  - Denial of Payment — If Commonwealth Care Alliance receives a claim for a

service that is not authorized by the PCT, a communication is sent to the PCT to determine payment or denial of the claim. If payment is approved, the PCT is responsible to enter the authorization for the service in the CER. If payment is denied, Commonwealth Care Alliance sends a Denial of Payment letter to the member and the provider.

### 9-7 Medicare Notifications

The PCT follows the member in any setting across the continuum of care. When a member is receiving care at a hospital, skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) the PCT works collaboratively with facility or agency staff to identify when it is appropriate to discharge the member from this setting.

Members are informed in writing, using Medicare documents, when discharge is planned (services are discontinued) or skilled services are reduced in SNFs, HHAs, CORFs, and when inpatient services at an acute hospital are terminated.

Commonwealth Care Alliance's contracted providers (hospitals, SNFs, HHAs, and CORFs) are responsible for collaborating with the PCT to determine the plan to discharge the member or to reduce or terminate skilled services. Commonwealth Care Alliance members must be informed in writing when discharge from these settings is planned or reductions in skilled services are to take place.

When a discharge or reduction in skilled services from a SNF, HHA, or CORF is planned, the discharging facility or agency provides the member with the Notice of Medicare Non-Coverage. The Notice of Medicare Non-Coverage, a Medicare standard form, is delivered to the member at least 48 hours in advance of discharge or reduction and contains the member's appeal rights. [Click here](#) to view the Notice of Medicare Non-Coverage.

While a member is an inpatient of an acute care hospital, hospital staff informs the member of discharge by delivering an Important Message from Medicare. Hospitals must issue the Important Message from Medicare within two calendar days of hospital admission. The Important Message contains the process for members to appeal the intent to discharge. Provider hospitals must follow Medicare regulations when delivering the Important Message and other information associated with discharges from the hospital. [Click here](#) to view the Important Message from Medicare.

### 9-8 Complaints

A complaint is a member's informal oral or written expression of dissatisfaction with any aspect of his or her care. A member/caregiver may file a complaint at any time with the Commonwealth Care Alliance Member Services staff, either verbally or in writing.

#### Commonwealth Care Alliance Responsibilities

- Commonwealth Care Alliance submits a monthly report to the SCO Operations at MassHealth of all its complaints for the previous month regardless of disposition or resolution
- Commonwealth Care Alliance performs training for members of the PCT about the Commonwealth Care Alliance complaint and appeals policy and procedure process

#### Provider Responsibilities

- Facilitate the receipt of member complaints and appeals via phone, writing, or in person

### 9-9 Appeals

An appeal is defined as a member's request for a formal reconsideration of a decision to deny, terminate, suspend, or reduce services. An appeal also applies to a member's request for a formal reconsideration of Commonwealth Care

Alliance's decision not to provide payment for services received by the member.

There are two types of appeal, Standard and Expedited:

- *Standard (30 days)* — if the member wants to appeal a denial by Commonwealth Care Alliance, the member must inform Commonwealth Care Alliance Member Services staff in writing within 60 calendar days from the date the member received the written Notice of Denial. Commonwealth Care Alliance Member Services staff will help members file an appeal
- *Expedited (72 hour review)* — if the member believes his/her life, health, or ability to regain maximum function would be seriously jeopardized if the disputed service were not provided, the member may request an expedited appeal. The member can file an expedited appeal in writing to the Commonwealth Care Alliance Member Services staff.

#### Commonwealth Care Alliance Responsibilities

- Member Services staff will record the appeal in the Commonwealth Care Alliance appeal tracking database. Commonwealth Care Alliance Member Services staff will notify the designated manager responsible for appeals. The PCT is notified of the member's appeal
- A member of the Commonwealth Care Alliance clinical leadership who was not involved in the original decision will complete an impartial reconsideration
- Commonwealth Care Alliance will resolve the appeal as expeditiously as the member's health condition requires, and will notify the member, in writing, of the decision no later than 30 calendar days from receipt of the appeal
- In the case of an expedited appeal, Commonwealth Care Alliance will make a decision on the member's appeal as expeditiously as the member's health

requires, but no later than 72 hours after receiving the request for an appeal. (Commonwealth Care Alliance may extend this time frame up to 14 days if the member requests the extension or if Commonwealth Care Alliance justifies to MassHealth the need for additional information and how the extension will benefit the member)

- If Commonwealth Care Alliance decides fully in the member's favor on either a standard or expedited appeal for a request for a service, Commonwealth Care Alliance must arrange for the member to get the service as quickly as the member's health condition requires
- If Commonwealth Care Alliance decides fully in the member's favor on a request for payment, Commonwealth Care Alliance must make the requested payment
- If Commonwealth Care Alliance does not decide in the member's favor on a standard or expedited appeal, either in whole or in part, on a request for payment or for services, the member has the right to pursue additional appeal rights
- If the Commonwealth Care Alliance reconsideration is wholly or partially adverse to the member, at the time the decision is made, Commonwealth Care Alliance will notify the member and the [Center for Health Dispute Resolution](#) (CHDR), the CMS independent review entity.

### **Appeals Process**

The member or the member's provider may file an Internal Appeal within 60 days of receipt of a written Notice of Denial. Internal appeals may be filed by writing, faxing or calling Commonwealth Care Alliance at:

Commonwealth Care Alliance  
ATTN: Appeals  
30 Winter Street, Boston, MA 02108  
Phone: (866) 610- 2273  
Fax: (617) 426-1311