Extended Care Facilities

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

Prior Authorization

Prior authorization is required and shall be granted from Commonwealth Care Alliance's designated care team authorizing the Extended Care Facility to render specified covered services to a Commonwealth Care Alliance member. Payment to a facility for covered services requires prior authorization. For more information, please see Section 8 of this manual.

Covered Services include:

• Sub-acute level of care—short term, goal oriented treatment plan requiring nursing care or rehabilitation at a high intensity level; lower intensity than acute care
• Skilled nursing level of care—short term, goal oriented treatment plan whereas the member cannot be treated in a community-based setting; lower intensity than sub-acute
• Custodial level of care—absent of a defined treatment goal, yet the member’s functional or cognitive status requires the support of a facility setting
• Medical leave of absence (MLOA) days and non-medical leave of absence (NMLOA) days—a bed is guaranteed for the member if he or she returns to the facility during the 1st day through the 10th day after transfer out of the facility. If the member returns after this period, his/her admission shall be accommodated upon the availability of a bed, unless otherwise arranged

Level of Care Determinations

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

Rehabilitative Services in a Skilled Nursing Facility

Rehabilitation services provided intermittently while at the custodial level of care. Intermittent therapy cannot exceed four calendar days per week as approved by CCA staff. Prior authorizations are required for all evaluations and treatment.

Status Change Form (SC-1) For SCO Members

In the instance when a SCO member is admitted to an extended care facility, the facility must submit a Status Change Form (SC-1) to Commonwealth Care Alliance and the appropriate member enrollment center with “Commonwealth Care Alliance SCO Member” clearly indicated on the form. Please see the chart below for additional requirements:
Commonwealth Care Alliance provides benefit coverage to its members at extended care facilities or nursing facilities. The protocols for benefit coverage take into account covered services, exclusions, clinical conditions and criteria, authorizations and operational expectations.

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<thead>
<tr>
<th>EVENT TRIGGERS</th>
<th>APPROVALS AND/OR FORMS</th>
<th>WHERE TO SEND INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short Term Stays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 2 months</td>
<td>Nursing facility calls Commonwealth Care Alliance’s Provider Services to request authorization for SNF stay; Provider Services forwards call to appropriate Clinical Coordinator</td>
<td>(866) 420-9332</td>
</tr>
<tr>
<td>Greater than 2 full months but less than 6 months</td>
<td><strong>a) Status Change Form (SC-1)</strong> indicating member is short term with “SCO Member” clearly written on form. Appropriate boxes on form should be checked and physician’s signature is required.</td>
<td>a) MassHealth Enrollment Center, 45–47 Spruce Street Chelsea, MA 02150, fax (617) 889-3285 and fax a copy to Commonwealth Care Alliance (617) 830-0534</td>
</tr>
<tr>
<td></td>
<td><strong>b) “MMQ</strong></td>
<td>b) Electronic submission of MMQ through MassHealth system and fax a copy to Commonwealth Care Alliance (617) 830-0534</td>
</tr>
<tr>
<td></td>
<td><strong>c) MDS 3.0</strong></td>
<td>c) Submit MDS 3.0 to SCO Clinical Coordinator via fax to Commonwealth Care Alliance (617) 507-0416</td>
</tr>
<tr>
<td><strong>Short Term Discharges</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upon discharge of short term Stay greater than 2 months but less than 6 months</td>
<td><strong>Status Change Form (SC-1)</strong> indicating member is short term with “SCO Member” clearly written on form. Appropriate boxes on form should be checked and physician’s signature is required.</td>
<td>MassHealth Enrollment Center, 45–47 Spruce Street Chelsea, MA 02150, fax (617) 889-3285 and fax a copy to Commonwealth Care Alliance (617) 830-0534</td>
</tr>
<tr>
<td><strong>Long Term Stays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the admission is long term (more than 6 months)</td>
<td><strong>a) Status Change Form (SC-1)</strong> indicating long term status with “SCO Member” clearly written on form. Appropriate boxes on form should be checked. <strong>Note</strong>: When the SCO member is admitted for a long term stay in a nursing facility, eligibility for MassHealth is redetermined and Patient Paid Amount is calculated upon completion of additional MassHealth forms as LTC Supplement.</td>
<td>a) Submit to MassHealth Enrollment Center where the nursing facility is located and fax a copy to Commonwealth Care Alliance (617) 830-0534</td>
</tr>
</tbody>
</table>
### EVENT TRIGGERS

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td></td>
</tr>
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### Short Term Stays

- **Less than 2 months**
  - Nursing facility calls Commonwealth Care Alliance's Provider Services to request authorization for SNF stay; Provider Services forwards call to appropriate Clinical Coordinator.
  - **Status Change Form (SC-1)** indicating member is short term with “SCO Member” clearly written on form. Appropriate boxes on form should be checked and physician’s signature is required.

  **a)** MassHealth Enrollment Center, 45–47 Spruce Street Chelsea, MA 02150, fax (617) 889-3285 and fax a copy to Commonwealth Care Alliance (617) 830-0534.
  
  **b)** Electronic submission of MMQ through MassHealth system and fax a copy to Commonwealth Care Alliance (617) 830-0534.
  
  **c)** Submit MDS 3.0 to SCO Clinical Coordinator via fax to Commonwealth Care Alliance (617) 507-0416.

### Short Term Discharges

Upon discharge of short term stay greater than 2 months but less than 6 months:

- **Status Change Form (SC-1)** indicating member is short term with “SCO Member” clearly written on form. Appropriate boxes on form should be checked and physician’s signature is required.

  **a)** MassHealth Enrollment Center, 45–47 Spruce Street Chelsea, MA 02150, fax (617) 889-3285 and fax a copy to Commonwealth Care Alliance (617) 830-0534.
  
  **b)** Electronic submission of MMQ through MassHealth system and fax a copy to Commonwealth Care Alliance (617) 830-0534.
  
  **c)** Submit MDS 3.0 to SCO Clinical Coordinator via fax to Commonwealth Care Alliance (617) 507-0416.

### Long Term Stays

If the admission is long term (more than 6 months):

- **Status Change Form (SC-1)** indicating long term status with “SCO Member” clearly written on form. Appropriate boxes on form should be checked.

  **a)** Submit to MassHealth Enrollment Center where the nursing facility is located and fax a copy to Commonwealth Care Alliance (617) 830-0534.
  
  **b)** Submit MDS 3.0 to SCO Clinical Coordinator via fax to Commonwealth Care Alliance (617) 507-0416.

### If a short term stay becomes a long term stay after 3 months

- **Status Change Form (SC-1)** indicating the member will be long term, with “SCO Member” clearly written on form. Appropriate boxes on form should be checked. **Note**, when the SCO member is admitted for a long term stay in a nursing facility, eligibility for MassHealth is redetermined and Patient Paid Amount is calculated upon completion of additional MassHealth forms as LTC Supplement.

  **Submit to MassHealth Enrollment Center where the nursing facility is located and fax a copy to Commonwealth Care Alliance (617) 830-0534.**

### At the end of the 3rd month

- **MMQ**—needs to be posted at the end of the 3rd calendar month. **Electronic submission of MMQ through MassHealth system and fax a copy to Commonwealth Care Alliance (617) 830-0534.**

### Status Changes

(e.g. when a member meets the MMQ significant change criteria or member is changing from short term to long term status)

- **a)** MMQ
  
  **Submit to MassHealth Enrollment Center where the nursing facility is located and fax a copy to Commonwealth Care Alliance (617) 830-0534.**

- **b)** MDS 3.0
  
  **Submit MDS 3.0 to SCO Clinical Coordinator via fax to Commonwealth Care Alliance (617) 830-0534.**

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*MMQs are also required on scheduled assigned by MassHealth

**Long Term Care Screening form is not required to be completed for SCO Members*
- Extended Care Facilities, Durable Medical Equipment & Vision

Member Enrollment Centers (MEC)

45-47 Spruce Street
Chelsea, MA 02150
Toll-free 800-322-1448 or (888) 665-9993
Fax 617-887-8777

Please note: When submitting or inquiring about a long term care applicant residing in a nursing facility serviced by the Chelsea MEC, use this new fax number 617-889-3285.

333 Bridge Street
Springfield, MA 01103
Toll free 800-332-5545

21 Spring Street, Suite 4
Taunton, MA 02780
Toll-free 800-242-1340

367 East Street
Tewksbury, MA 01876
Toll-free 800-408-1253
Durable Medical Equipment

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

Durable Medical Equipment

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

Medical / Surgical Supplies

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

Prior Authorization

All services provided must be approved by the member’s PCP and/or care team. Certain equipment and supplies may require prior authorization. Payment to providers for those covered services requiring prior authorization is contingent upon the provider receiving prior authorization before services are rendered.

Eligibility

All providers are required to confirm eligibility on a regular basis, even if the prior authorization covers a long period. Eligibility may be confirmed by contacting Commonwealth Care Alliance’s Provider Services or by utilizing the current MassHealth Provider Online Service Center.

Service Specifications for Durable Medical Equipment

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

Accessibility

- Maintain 24 hours a day, 7 days a week availability to provide services, and be accessible by telephone directly by on call coverage at all times
- Provide all emergently needed supplies, services, or equipment within 2 hours of receiving the request. Emergently needed services or equipment shall include that which malfunction or absence presents an immediate life-threatening situation to the member, including, but are not limited to, oxygen, and respiratory services and equipment
- Provide all other needed supplies, services or equipment including wheelchairs and wheelchair repairs within 24 hours of receiving request and notify the PCP or primary care site (PCS) at the time of request, of any anticipated delay or back order in the provision of supplies, services, and/or equipment
- Make every effort to fill a same day order if requested
• Provide the closest available substitute wheelchair on loan, free of charge, for the duration of any wheelchair repair service
• Designate a liaison to accept requests and coordinate supplies, services, and equipment for Commonwealth Care Alliance members

Capped Rentals

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

Repairs

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

Equipment Delivery and Removal

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

Note: Emergently needed supplies are defined as services or equipment including that which malfunctions or absence presents an immediate life-threatening situation.
Dental

Commonwealth Care Alliance has contracted with Scion Dental, a dental benefits administrator specializing in private-label, customized Medicaid dental program management, to administer all Commonwealth Care Alliance member dental benefits. On Commonwealth Care Alliance’s behalf, Scion manages all related dental operations, including utilization review, claims processing; and provider relations, contracting, and credentialing.

All dental providers are required to be a contracted Commonwealth Care Alliance provider, in order to render services to Commonwealth Care Alliance members. Scion Dental administers Commonwealth Care Alliance’s relationship with its contracted dental providers.

Scion Contact Information

Provider Services:
855-434-9243 (general line)
providerservices@sciondental.com

Scion Provider Portal
www.ScionDental.com, Click on “Dentist” to log in with unique ID and password

Covered Services

Covered Services are dental services to which a member is entitled in accordance with Commonwealth Care Alliance’s benefit plan which are consistent with provider training, licensure and the specific scope and conditions. Commonwealth Care Alliance offers a robust dental plan which includes, but is not limited to, diagnostic and routine preventative care, emergency care visits; extractions; restorative services including root canals, crowns and bridges, prosthetics such as partials and dentures; and oral surgery.

Prior Authorization

Certain services may require prior authorization before performing the service. Payment to providers for those covered services requiring prior authorization is contingent upon the provider receiving Prior Authorization from Scion before services are rendered.

All Commonwealth Care Alliance contracted providers should refer to the Commonwealth Care Alliance Office Scion Dental Provider Manual, available on the provider page at http://www.commonwealthcarealliance.org/providers/provider-manual or on the Scion Provider Portal at www.sciondental.com, for service specifications and covered services.
Vision
The plan covers professional care of the eyes for the purpose of preventing, diagnosing, and treating all pathological conditions. Additional services include, but are not limited to, services related to the care and maintenance of glasses and contact lenses.

SCO:
The plan pays for eyewear less than or equal to a combined total of $200, no authorization required. The plan covers up to $200 of routine vision hardware including upgrades. When the $200 Medicare Mandatory Supplemental benefit is exhausted, the Medicaid benefit can be used by the SCO member with prior authorization.

One Care:
• Frames: Limited to one set up to $125 per calendar year without prior authorization. Authorization required for any amount over $125.

Please see below chart for delineation between SCO and OneCare routine vision services, and coverage by Medicare or Medicaid.

<table>
<thead>
<tr>
<th>Routine Vision Benefit</th>
<th>SCO</th>
<th>OneCare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Mandatory</td>
<td>Yes</td>
<td>None</td>
</tr>
<tr>
<td>Supplemental Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>No</td>
<td>Does not apply. No Medicare benefit.</td>
</tr>
<tr>
<td>Frames and lenses</td>
<td>The plan pays up to $200 per calendar year for prescription eyewear purchased separately or together without prior authorization, including: • Contact lenses • Eyeglasses, including frames and lenses purchased separately or together For one or more frames that exceed the combined total of $200, authorization is required.</td>
<td>Does not apply. No Medicare benefit.</td>
</tr>
<tr>
<td>Member reimbursements</td>
<td>Yes, up to the $200 per calendar year limit</td>
<td>Does not apply. No Medicare benefit.</td>
</tr>
<tr>
<td>Medicaid Benefit</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Yes</td>
<td>Comprehensive eye exam covered. No PA required.</td>
</tr>
<tr>
<td>Frames</td>
<td>For one or more frames that exceed the $200 Medicare Mandatory Supplemental benefit above, a prior authorization is required.</td>
<td>Limited to one set up to $125 per calendar year.</td>
</tr>
</tbody>
</table>
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**SCO:**
- The plan pays for eyewear less than or equal to a combined total of $200, no authorization required. The plan covers up to $200 of routine vision hardware including upgrades. When the $200 Medicare Mandatory Supplemental benefit is exhausted, the Medicaid benefit can be used by the SCO member with prior authorization.

**OneCare:**
- Frames: Limited to one set up to $125 per calendar year without prior authorization. Authorization required for any amount over $125.

Please see below chart for delineation between SCO and OneCare routine vision services, and coverage by Medicare or Medicaid.

<table>
<thead>
<tr>
<th>Service</th>
<th>SCO</th>
<th>OneCare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare Mandatory Supplement Benefit</strong></td>
<td>Yes</td>
<td>None</td>
</tr>
<tr>
<td><strong>Eye Exam</strong></td>
<td>No</td>
<td>Does not apply. No Medicare benefit.</td>
</tr>
<tr>
<td><strong>Frames and Lenses</strong></td>
<td>The plan pays up to $200 per calendar year for prescription eyewear purchased separately or together without prior authorization, including:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Contact lenses</td>
<td>1. Contact lenses used for cosmetic purposes (colored lenses)</td>
</tr>
<tr>
<td></td>
<td>• Eyeglasses, including frames and lenses purchased separately or</td>
<td>2. Designer frames</td>
</tr>
<tr>
<td></td>
<td>together</td>
<td>3. Prescription sunglasses (only in a rare circumstance would these be covered)</td>
</tr>
<tr>
<td></td>
<td>For one or more frames that exceed the combined total of $200,</td>
<td>4. Progressive Lenses</td>
</tr>
<tr>
<td></td>
<td>authorization is required.</td>
<td></td>
</tr>
<tr>
<td><strong>Member reimbursements</strong></td>
<td>Yes, up to the $200 per calendar year limit</td>
<td>Does not apply. No Medicare benefit.</td>
</tr>
<tr>
<td><strong>Medicaid Benefit</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Eye Exam</strong></td>
<td>Yes</td>
<td>Comprehensive eye exam covered. No PA required.</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>For one or more frames that exceed the Medicare Mandatory</td>
<td>Limited to one set up to $125 per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Supplemental benefit above, a prior authorization is required.</td>
<td></td>
</tr>
<tr>
<td><strong>Single Vision Lenses (Plastic or Glass)</strong></td>
<td>Covered with a written and dated prescription based on an eye exam by the prescriber.</td>
<td>Cover only with a written and dated prescription based on an eye exam by the prescriber.</td>
</tr>
<tr>
<td><strong>Bifocal Lenses (Plastic or Glass)</strong></td>
<td>Covered with a written and dated prescription based on an eye exam by the prescriber.</td>
<td>Covered with a written and dated prescription based on an eye exam by the prescriber.</td>
</tr>
<tr>
<td><strong>Lenses (high-index and polycarbonate)</strong></td>
<td>Covered with a written and dated prescription based on an eye exam by the prescriber.</td>
<td>Covered with a written and dated prescription based on an eye exam by the prescriber.</td>
</tr>
<tr>
<td><strong>Low-vision aids (i.e. hand held magnifying glasses)</strong></td>
<td>Prior Authorization required.</td>
<td>Prior Authorization required.</td>
</tr>
</tbody>
</table>

**Vision Care Services:**

After the SCO ($200) and One Care ($125.00) benefit is met CCA vision plan follows the Medicaid Benefit 130 CMR 402.

**Service Specifications for Vision**

Commonwealth Care Alliance vision providers are responsible for meeting specified standards for accessibility, repairs, and eyewear care. The standards are listed below:

**Accessibility**

- Provide all needed vision supplies, services, and lenses/frames within one week of receiving request and notify the care team at the time of request of any anticipated delay or back order in the provision of supplies, services, and/or lenses/frames
- Make every effort to fill a same day order if requested
- Designate a liaison to accept requests and coordinate supplies, services and lenses/frames for Commonwealth Care Alliance members

**Repairs**

- Make every effort to complete repair with one service call. Provider shall contact the primary care provider and/or care team if a repair requires more than one service call
- Notify care team in writing if rebuilt parts are used in a repair
- As requested, make available to primary care provider and/or care team with expected life of consumables, and provide warranties, serial or model numbers for materials, etc.
Eyewear Care

- Contact Commonwealth Care Alliance member to make arrangements for delivery of lenses/frames
- Fit all glasses properly to the member’s specifications at the time of delivery
- Instruct member or caretaker in the safe and proper use of glasses/lenses and related vision supplies