Medicare Advantage Plans

Frequently Asked Questions (FAQ): Prior Authorization Request

Q. Who should request a prior authorization?

A. Providers are responsible for submitting the prior authorization request. For covered services that require authorization, the request must be submitted prior to rendering the services.

Q. What if I do not have a prior authorization and perform the service?

A. An authorization should be obtained prior to performing the service to avoid an administrative claim denial. Retro authorization requests will not be accepted; please refer to the Prior Authorization payment policy:

Massachusetts
- Payment Policies

Rhode Island
- Payment Policies

Q. What do I do if the prior authorization is expiring?

A. If the services need to continue, providers are responsible for requesting a new authorization at least 14 days before the current approved authorization expires.

Q. Where do I find the prior authorization forms?

A. To access prior authorization forms, click the appropriate link below:

Massachusetts
- Prior authorization forms
- Medicare Advantage Provider Manual Section 17: Forms

Rhode Island
- Prior authorization forms
- Medicare Advantage Provider Manual Section 17: Forms

Q. Who do I call with questions regarding covered services and prior authorization?

A. If a requested service or item is not listed, please contact our Provider Services team at 866-420-9332 for clarification.

Q. What number should I fax the prior authorization forms to?

A.
- The Inpatient/Observation Admission prior authorization forms must be faxed to 855- 811-3467.
- All other prior authorization forms must be faxed to 855-341-0720.

Q. When will I receive the decision for the prior authorization request submitted?

A.
- Prior authorization decisions will be made no later than fourteen (14) calendar days after CCA receives the request, or within seventy-two (72) hours for expedited requests.
- The decisions are faxed directly to the provider's fax number on file.

Q. When should I request an authorization to be expedited?

A. A member, or any physician, may request that CCA expedite an organization determination (prior authorization request) when the member or his or her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

Q. How do I check on the status of a prior authorization request?

A.
- CCA Provider Portal – Log in or register to access the provider portal and view the status of authorizations associated with your practice.
- Please contact our Provider Services team at 866-420-9332.

Q. What should I do if I do not receive a decision within the timeframe?

A. If you did not receive a decision within the allowed timeframe, please contact our Provider Services team for assistance at 866-420-9332.

Q. Is there a prior authorizations payment policy?

A. Yes. To access the Prior Authorization Payment Policy, please click on the appropriate link below:

Massachusetts
- Payment Policies

Rhode Island
- Payment Policies

Q. Where do I find the prior authorization requirements?

A. Please refer to Section 4 – Prior Authorization Requirements in the Provider Manual.

Massachusetts
- Medicare Advantage Provider Manual

Rhode Island
- Medicare Advantage Provider Manual

Q. Who can I contact if I have questions about the prior authorization?

A. If you have questions about an approved authorization (number of units, procedure code, etc.), please contact our Provider Services team for assistance at 866-420-9332.

Q. How often should I verify member eligibility?

A. Providers are required to confirm member eligibility on a regular basis and prior to rendering services. All prior authorizations are contingent upon member eligibility. Eligibility may be confirmed by:

- Logging in to the CCA Provider Portal
- Logging in to QicLink Benefits Exchange
- Using the NEHEN Provider Portal
- CCA Provider Services at 866-420-9332

Q. Where can I find the Medical Necessity Guidelines?

A. To access the CCA Medical Necessity Guidelines, please click on the appropriate link below:

Massachusetts
- Medical Necessity Guidelines

Rhode Island
- Medical Necessity Guidelines

Q. Why am I receiving a form labeled Referral in addition to the authorization?

A. You may receive a referral for the following reasons:

- To provide demographic information
- To conduct an evaluation to fulfill the service being requested

Q. How do I obtain access to CCA's QICLink Benefits Exchange Claim Portal?

A. CCA offers a secure web portal where providers can view their claim status and validate member eligibility. Information on obtaining access can be found in Section 6 – Claims and Billing Procedures of the Medicare Advantage Provider Manual.

Massachusetts
- Medicare Advantage Provider Manual

Rhode Island
- Medicare Advantage Provider Manual

Q. What should I do if I receive a denial for a claim where prior authorization approval was obtained?

A. If a provider disagrees with a decision of denial or reimbursement of a claim, the provider can file an appeal for reconsideration. For additional information on appeals, please refer to Section 6 – Claims and Billing Procedures of the Medicare Advantage Provider Manual.

Massachusetts
- Medicare Advantage Provider Manual

Rhode Island
- Medicare Advantage Provider Manual

Q. Who should I call if I have questions about claims?

A. For billing, claim status, questions, or inquiries, please contact our Claims department directly at 800-306-0732.