PROVIDER REIMBURSEMENT GUIDANCE			
Clinical Trials			
Original Date Approved	Effective Date Senior Care Options/One Care	Effective Date Medicare Advantage*	Revision Date
05/10/2022	08/01/2022	08/01/2022	

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ Medicare Preferred – (PPO) MA*
☒ Medicare Value - (PPO) MA*
☒ Medicare Preferred – (PPO) RI*
☒ Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance® (CCA) reimburses/covers routine costs for services rendered during qualified clinical trials for cancer and other life-threatening conditions, in accordance with state and federal mandates for coverage.

To meet state and federal mandates for coverage, CCA also covers routine costs for in-network services rendered during qualified clinical trials.

AUTHORIZATION REQUIREMENTS:

Applicable CCA referral, notification and authorization policies and procedures apply, and all inpatient admissions require inpatient notification prior to services being rendered. The admitting physician or facility should submit an inpatient notification at the time of admission. For more information on prior authorizations, please refer to the Prior Authorization Requirements in the plan specific Provider Manual.

REIMBURSEMENT GUIDELINES:

Services and succeeding payments are in alignment with the member's Summary of Benefits. Member eligibility and benefit specifics should be verified prior to initiating services. Additionally, providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered.

Further, CCA will cover routine patient costs when medically necessary and consistent with the member’s benefit if the member was not participating in a clinical trial.

BILLING and CODING GUIDELINES:

Unless otherwise stated, CCA follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with their applicable financial provider agreements and applicable fee schedules.

The following table contains modifiers which are item/service specific and constitute medically necessary routine patient care or treatment of complications arising from a member’s participation in a qualified clinical trial:

BILLING and CODING GUIDELINES (cont.):

Modifier Code	Description
Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study
Q0	Investigational clinical service provided in a clinical research study that is in an approved clinical research study

RELATED SERVICE POLICIES:

N/A

AUDIT and DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies, procedures, and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

- CCA Website
- CMS Website
- CMS NCD 310.1
- Medicare Clinical Trial Policies

POLICY TIMELINE DETAILS:

1. Effective 08/01/2022