| PROVIDER REIMBURSEMENT GUIDANCE | | | |
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| Out of Network Provider | | | |
| Original Date Approved | Effective Date Senior Care Options/One Care | Effective Date Medicare Advantage* | Revision Date |
| 12/04/2020 | 04/23/2022 | 04/23/2022 | 07/29/2022 |

**Scope:** Commonwealth Care Alliance (CCA) Product Lines

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

## Payment Policy Summary

CCA members are expected to receive services from in-network providers. In certain circumstances, CCA will cover Out-of-Network providers using the reimbursement methodology described within this policy.

## Authorization Requirements

As indicated in the CCA One Care Member Handbook or Senior Care Options Evidence of Coverage, Commonwealth Care Alliance (CCA) requires prior authorization (PA) for all Out of Network (OON) services except for emergency care, urgent care when not available in network, out of service area renal dialysis services, Family Planning services for One Care Members, and services rendered under the Continuity of Care Period.

OON Providers should refer to the CCA Out of Network Medical Necessity Guideline found on the CCA Medical Policy website for standards by which CCA reviews prior authorization requests for out of network exceptions.

CCA reserves the right to limit services and remit or recoup payment post-service if these requirements have not been met. Prior authorization will be considered on a case-by-case basis.

For more information on prior authorizations, please refer to the Prior Authorization Requirements in the plan specific Provider Manual.

### Medicare Advantage Plans

**CCA Medicare Preferred, and Medicare Advantage Plans (MA and RI):** Prior authorization is not required for out of network services. Services will be subject to all applicable copayments, coinsurance and deductibles as allowed under the member's Maximum Out of Pocket (MOOP) limitations.

**Medicare Maximum (RI):** members must use network providers to receive medical care and services. Exceptions are limited to emergencies, urgently needed services when the network is not available (i.e.: When members are out of the area), out-of-area dialysis services, and cases in which CCA Medicare Maximum authorizes use of out-of-network providers.

## Billing & Coding Guidelines

Claims should be submitted following Medicare/Medicaid industry standards. CCA will not reimburse a provider who is not eligible to participate in Medicare and/or Medicaid. Providers are required to abide by all federal and state laws and regulations. Providers should reference procedure codes from the current CPT, HCPCS (Healthcare Common Procedure Coding System) Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA (Health Insurance Portability and Accountability) medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

**Continuity of Care Coverage:** During the Continuity of Care period, newly enrolled CCA members may continue receiving services from Out-of-Network providers with whom they have a pre-existing relationship. The Continuity of Care period is valid until the member has completed an Individualized Care Plan, or until the plan-specific Continuity of Care period expires, usually within the first 90 days of becoming a member. CCA reserves the right to deny services and/or remit or recoup payment for services rendered during this period if the provider cannot demonstrate a pre-existing relationship.

## Reimbursement Guidelines

CCA will not impose a deductible for covered services provided by an Out-of-Network provider. CCA will pay the appropriate Original Medicare payment amount under the terms of their three-way contract, as well as any Medicaid-covered cost-sharing under the terms of the Medicaid State Plan. Payments made to Out-of-Network providers constitute payment in full. Providers may not bill CCA members for the difference between the actual billed charges and the allowed amount paid by CCA. Providers shall not seek or accept payment, in any amount(s) or form, from CCA members for any Covered Service rendered, nor shall Providers maintain any action at law or in equity against CCA members to collect any sums Provider claims may be owed for services rendered.

If a provider disagrees with CCA's decision of denial or reimbursement of a claim, the provider can file an appeal for reconsideration. All provider appeals must be received in writing. All Out-Of-Network providers must submit a Waiver of Liability form with each appeal. For more information, please reference the Provider Manual.

In summary, CCA will pay qualifying Out-of-Network providers using the following methodology:

- For services/products payable under Original Medicare, CCA shall pay 100% of the Medicare rate, plus Merit-based Incentive Payment System (MIPS) incentive/penalty and less sequestration, and Medicare's cost-share shall be compared to the State Medicaid payable amount. No more than 100% plus MIPS incentive and less sequestration will be paid.
- For services/products never payable under Original Medicare, but payable by Medicaid, 100% of the State Medicaid payable amount shall be paid.
- For services/products designated within a valid and existing LOA, reimbursement will be provided at the agreed upon rate.

A member may utilize an Out-of-Network pharmacy if necessary but is limited to a 30-day supply of medication. The pharmacy will be reimbursed at the same rate as in-network providers.

## Definitions

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| Out-of-Network Provider | Providers that do not have a valid contract or Letter of Agreement (LOA) with CCA for both the service rendered and the member's CCA plan, prior to the date that service was rendered. Services provided beyond the scope of an in-network provider's contract will be considered Out-of-Network and are subject to this policy. |
| Letter of Agreement | An agreement between a non-contracted provider and CCA for payment for specified services rendered to a specific member or members for a specific timeframe. All services rendered by noncontracted providers outside of the scope the LOA are considered Out-of-Network services and are subject to this payment policy. |
| Continuity of Care Period | The period during which newly enrolled members may continue to receive services from an Out-of-Network provider with whom they have an active care plan and/or prior authorization. This designated period for new enrollees protects enrollees' provider relationships, services, and prior authorizations during their assessment and care planning processes. Coverage for services is typically provided for up to a maximum of 90 calendar days after enrollment and coverage is often modified with a completed assessment. |

## Audit and Disclaimer Information:

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. Please refer to CPT/HCPCS for complete and updated list of codes. 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
- CCA Medical Necessity Guideline #106: Out of Network Coverage
- Medicare Advantage Out-of-Network Payments
- Payment Policies: Massachusetts / Rhode Island
- Provider Manuals: Massachusetts / Rhode Island
- Prior Authorization Forms: Massachusetts / Rhode Island

## Policy Timeline Details

1. Effective 1/1/2018
2. Annual Review Revised Format, December 2019
3. Revised Format, November 2021
4. Revised Format, March 2022
5. Revision: June 2022, updated formatting
6. Revision: July 2022, updated Authorization Guidelines removal of Prior Authorization