

PROVIDER TRANSITION INFORMATION



Table of Contents

Section Title

Slide Number

CCA and CareSource

3

Meet CareSource

4

New Information for Current CCA
Providers

8

New Provider Portal

13

Prior Authorization Submission

25

Claim Submission

39

Key CCA Contacts and Updates

50

CCA + CareSource

- Last year CareSource®, an Ohio-based nonprofit managed care health plan, finalized the acquisition of Commonwealth Care Alliance® (CCA) with the intent to ensure that residents of Massachusetts with complex health needs maintain access to high-quality health care services.
- The affiliation between CareSource and CCA leverages **combined resources** and **expertise** to address the critical needs of members and the broader community. By integrating CareSource's expertise with CCA's specialized programs, members will benefit from **enhanced care coordination**, access to **innovative health solutions**, and a **more robust support network** that prioritizes their unique needs.
- Effective June 28, 2026, CCA Senior Care Options and CCA One Care plans will be operationally supported by CareSource.



MEET CARESOURCE®



About CareSource®

MISSION DRIVEN

CareSource is a nonprofit, nationally recognized managed care organization with more than 35 years of Medicaid managed care experience and over 2.3 million enrollees. Since its founding in 1989, CareSource administers one of the largest Medicaid managed care plans in the U.S., offering Medicaid, Health Insurance Marketplace (Qualified Health Plans) and Medicare products. As a mission-driven organization, CareSource is committed to enrollee-centric care and transforming health care with innovative programs that address social drivers of health, health-related social needs and access to care.

HEALTH CARE WITH HEART

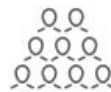
As a national leader in managed care, CareSource firmly believes the future of health care will be shaped by those who innovate and drive value for consumers and the states they serve.

Operations Performance

Key Performance Indicator (KPI)	Claims First Pass Accuracy	Financial Accuracy	Claim Average Days to Pay	Prompt Pay Timeliness	Encounters Submitted in 14 Days	Encounter Completeness and Accuracy
Current Rate	99%	99.96%	10 Days	> 100%	> 99.9%	> 99.9%



4-STAR
CMS Medicare Rating



More than **7,000**
employees in **46 states**



\$39 million invested in
nonprofits and communities through
the CareSource Foundation



Corporate Headquarters:
Dayton, Ohio



Locations:
Arkansas, Florida, Georgia,
Indiana, Massachusetts,
Michigan, Mississippi,
Nevada, Ohio and
Wisconsin



Year Established:
1989



A Partnership with Heart

At CareSource and CCA, we recognize a true partnership can only exist when we listen to and understand your needs. We are dedicated to partnering with you to improve member outcomes and make it easier for you to care for our members.

“The CareSource and Commonwealth Care Alliance partnership ensures residents of Massachusetts with complex health needs continue to have access to high-quality health care.”

Erhardt Preitauer, President and CEO of CareSource



What's Not Changing?

Not everything is new. Some things will remain **exactly the same**.

- Our commitment to our provider partners
- Your Commonwealth Care Alliance® Senior Care Options (HMO D-SNP) and One Care (HMO D-SNP) contract
- Our plans: CCA OneCare and CCA Senior Care Options and associated member benefits
- The CCA Uncommon Care® Model
- Care Management services for all members
- Access to instED mobile acute care services
- Provider Services and Provider Relations — no change to how you reach us
- Provider annual training requirements
- Pharmacy Benefit Manager (PBM) CVS Caremark®
- CCA Senior Care Options and CCA One Care formularies
- Durable Medical Equipment (DME) platform: Tomorrow Health
- Benefit administrators for transportation, routine vision, dental and hearing



NEW INFORMATION FOR CURRENT CCA PROVIDERS



Terminology Update | HMO D-SNP



Provider materials

- Over the past year, we have used the term “FIDE-SNP” to describe the CCA OneCare and CCA Senior Care Options plans.
- These dual-eligible special needs plans are also known as HMO D-SNP plans.
- “FIDE-SNP” and “HMO D-SNP” are synonymous industry terms.
- You may see both terms used in provider materials over the next few months.

Member materials

- Since January 1, 2026, member materials have included the HMO D-SNP plan-type only.
- There will be no changes to plan names or types.



Navigating the CCA Provider Website



commonwealth
care alliance

Massachusetts

English

Home

Contact Us

Home > For Providers

Welcome CCA providers

We're committed to supporting our providers, so that together we deliver the highest-quality, individualized care to your patients. Thank you for the opportunity to partner with you.

Provider Manual

Forms and Referrals

Provider News

Provider Portal

Transition Information →

Home > For Providers > Transition Information

Transition Information

This page contains important information you need to know for CCA Senior Care Options (HMO D-SNP) and CCA One Care (HMO D-SNP) business starting June 26, 2026.

What You Need to Know First

Provider Transition Communications

Transition Orientation

New & Improved Provider Portal – Education & Resources

Important Reminders

Visit the [Transition Information webpage](#) on the CCA Website



Provider Data Management

Practitioners, provider groups and facilities are responsible for notifying CCA of any changes to provider enrollment information.

- All requests must be sent to the Provider Data Management (PDM) department by email at PNMDepartment@CommonwealthCare.org 45 days prior to the change or update.
- Detailed information on changes (e.g., adding and terminating providers, adding and terminating a practice or facility, adding or terminating National Provider Identifiers (NPIs), changes to demographic information and panel status and the appropriate forms needed are located in Section 15 of the Provider Manual).

Please refer to CCA's *Provider Enrollment and Credentialing* (Section 15 of the Provider Manual) for more detail

Electronic Visit Verification (EVV)



CMS requires EVV for Personal Care and Home Health services per the 21st Century Cures Act. Accurate data entry is critical to avoid claim denials. CCA is dedicated to helping providers navigate this process successfully.

To Ensure Compliant Claims:

- Enter correct procedure codes, units, and date of service into the aggregator
- Claim data must match what is reflected in the aggregator
- Verify correct Provider and Member Medicaid IDs in the aggregator
- Confirm the correct payer is listed for the member in the aggregator
- Ensure EVV visit records match submitted claim data

Claims that do not match risk denial.



NEW PROVIDER PORTAL

Provider Portal | Value

SAVE TIME AND MONEY

The Provider Portal is a robust, encrypted and secure online tool available to all providers who serve our members. With our secure online Provider Portal, you can:

Check member eligibility and benefit limits	Submit claims and verify claim status
Submit prior authorization requests	View and update care management and service plans
Check prior authorization status	Verify/update coordination of benefits
View member gap-in-care alerts	And much more!

Review the content on the **Transition Information** web page under **New & Improved Provider Portal - Education and Resources**.

Access the Provider Portal 24 hours a day, seven days a week at ProviderPortal.CareSource.com/GL/User/Login.aspx/.

Provider Portal | Registration

1. Visit ProviderPortal.CareSource.com/GL/User/Login.aspx/ and click the **Sign-up** link on the page.
2. Complete the **Create Account/Sign Up** table and click **Register/Sign Up**.
 - Enter the email address you want to associate with your account. You will use this email to log into the portal.
 - Create a **Password** with a minimum of 12 characters.
 - Contain one lowercase and one capital letter
 - One number, one special character (!, @, \$ or %) not part of your username (email).
 - Enter **First** and **Last Name**.
 - You will receive an email with a verification code.
3. Enter the verification code you receive per your selected Multi-Factor Authentication method.
4. To associate your account with a **Billing ID**, select the **Provider Type, Practitioner's First Name, Practitioner's Last Name, Tax ID, CareSource Provider Number and ZIP Code** to link a provider to your account and then click Next. Required fields are marked with a red asterisk.

The image displays three overlapping screenshots of the CareSource Provider Portal. The top screenshot shows the 'Log in' page with a 'Sign up' button and links for 'Forgot password?', 'Portal Registration Instructions', and 'Check Enrollment Status'. The middle screenshot shows the 'Create Account' form with fields for 'Email *', 'Password *', 'First name *', and 'Last name *', a 'Register' button, and a 'Back to sign in' link. The bottom screenshot shows a confirmation message: 'Verification email sent' with a green checkmark icon, followed by 'To finish signing in, check your email.' and a 'Back to sign in' link. The CareSource logo is visible on all three screens.

Provider Portal | MFA Setup





Set up multifactor authentication

Your company requires multifactor authentication to add an additional layer of security when signing in to your account



Okta Verify
Use a push notification sent to the mobile app.
[Setup](#)



Google Authenticator
Enter single-use code from the mobile app.
[Setup](#)



SMS Authentication
Enter a single-use code sent to your mobile phone.
[Setup](#)



Email Authentication
Enter a verification code sent to your email.
[Setup](#)

1







Verify with Email Authentication

Send a verification code to l...6@

[Send me the code](#)

2







Verify with Email Authentication

A verification code was sent to l...6@gmail.com. Check your email and enter the code below.

Verification code

☐ Do not challenge me on this device for the

[Registration Instructions](#)

4







Verify with Email Authentication

A verification code was sent to l...6@gmail.com. Check your email and enter the code below.

Verification code

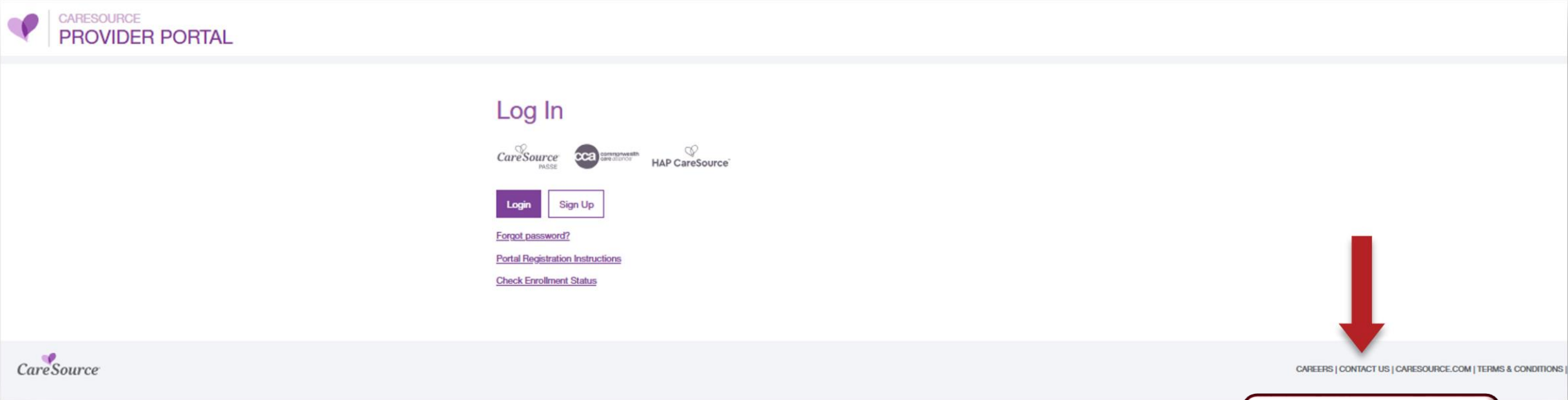
☐ Do not challenge me on this device for the

[Back to sign in](#)

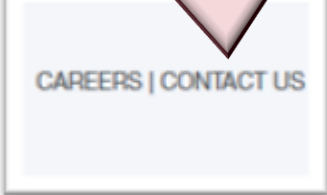
4

For additional details, refer to the Provider Portal Registration Guide found by clicking the **Registration Instructions** link

Provider Portal | Contact Us!



Click Contact Us



Provider Portal | Home Page



Switch state-specific portal



PROVIDER PORTAL

 / [Claims](#) / [Claim Information and Attachments](#)

MEMBER SEARCH

+

CLAIMS

-

Online Claim Submission

Claim Information and Attachments

External Review Request

Rejected Claims

Real Time Claims

Payment History

Recovery Request

Disputes

Pharmacy Appeals

Post Service Appeals

MEMBER REPORTS

+

USERS

+

Claim Information and Attachments

Please select one of the following search methods and enter the requested information to check the status of any claim you have submitted in the last 36 months. We update our claim status daily.

Claim submissions are reviewed within prompt pay guidelines. Please allow 30 days for processing.

You can also upload attachments for denied claims while you are viewing a specific claim or upload attachments proactively for a claim in the **Claim Summary** section after locating a member record.

Claim Information and Attachments

Recent Claims

Claim Search

Active Credit Balance

Payment Plan/Settlement Request

Recent Claims

Claims displayed below for the last 30 days from the date of service. Use the filter option to review additional claims.

 Claims submitted in the past:

30

60

90

120

Denied - Documentation Required

Denied - Other

Pending Recovery

Paid

Review the claim and attach appropriate documentation for claim review. Use the filter option to review additional claims.

CareSource ID

Search

Reset

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18

Provider Portal | Eligibility Status



Verify that members are eligible for care on the date of service prior to rendering services.

MEMBER SEARCH

Member Eligibility

Coordination of Benefits

Community Transition Program

Member File Upload

CLAIMS

MEMBER REPORTS

HEALTH HOMES/COMMUNITY MH

USERS

PROVIDERS

ASSESSMENTS

PROGRESS NOTES

CONTENT

ADMINISTRATION

Member Eligibility

[Edit](#)

Health care providers should always verify member eligibility before rendering services.

It is important to verify that CareSource members are eligible for care on the date of service.

Uploading Consent Forms

If you need to upload a member's consent form for abortion, hysterectomy, or sterilization, please follow the steps below.

Corrected claim forms are not necessary when submitting documentation on the PMS.

[How to Upload Consent Form](#)

NOTE: If you are submitting documentation for a claim and do not indicate the specific claim number for which the documentation applies, the documentation **will apply only to claims received after the receipt date of the consent form**. For example, a consent form uploaded on 1/6/2020 will systematically apply to claims received after 1/6/2020.

To upload a consent form applicable to a **previously submitted claim**, you must enter the corresponding claim number when submitting the attachment to ensure systematic alignment.

Dental and vision history displays services performed within the last 24 months. We update our information nightly.

Note: For the [Multiple Members](#) search, Member Numbers should be separated by commas. For example: 0000000000, 1111111111, 2222222222

CareSource Id	Medicaid Id	Member Info	Case Number	Multiple CareSource Ids	Multiple Medicaid Ids
CareSource ID					
Date of Service	11/10/2023				

Search



Provider Portal | Member Eligibility Verification



Providers are required to confirm member eligibility on a regular basis prior to rendering services, even if prior authorization is on-going.

Of the methods below, the New Provider Portal is the only **NEW** option.

Member Eligibility Verification Resources
New Provider Portal
Availity Essentials Provider Portal*
To register, click on "Get Started" in the upper right corner and follow the instructions
MassHealth Provider Online Service Center
MMIS/Eligibility Verification System (EVS)
NEHEN Provider Portal*
CCA Provider Services at 1-866-420-9332
8 a.m. to 5 p.m., Eastern Time (ET), Monday – Wednesday and Fri; Thursday 8:30 a.m. to 5 p.m., Eastern Time (ET)
<i>*Supports Real Time Eligibility and Benefits Inquiry and response using X12 270/271 transactions.</i>

Provider Portal | Membership List

PROVIDER PORTAL

Member Reports / Provider Membership List

MEMBER SEARCH +

CLAIMS +

MEMBER REPORTS -

Provider Membership List

Clinical Practice Registry

USERS +

PROVIDERS +

ASSESSMENTS +

Provider Membership List

Providers: Default Provider - 999999999999

Filter By Redetermination Date: [Date Picker] - [Date Picker]

Export Options: [Entire Group's Member List as CSV](#)

Alert Legend

- New Assessment
- New Care Treatment Plan
- Updated Care Treatment Plan

Alerts	Details	First Name	Last Name	CareSource Id	Medicaid Id	Gender	Birth Date	Effective Date	Redetermination Date	Lang Type	Member Phone	Prog
												West
												West

To locate member information

1. Select **Provider Membership List** from the menu.
2. Choose the provider's name associated with the member.
 - Note that providers not associated with a group will only see their name.

Provider Portal | Clinical Practice Registry (CPR)



Switch state-specific portal

 PROVIDER PORTAL

[Home](#) / [Member Reports](#) / [Clinical Practice Registry](#)

Clinical Practice Registry

[Learn More.](#)

Sometimes the words "Assignment" and "Attribution" are used interchangeably.

Assignment – The process used to delegate a primary care provider (PCP) to a member, making the provider available and able to administer care but does not guarantee the member will receive care from that provider.

Attribution – The process used to associate a member to the physician via selection, through geographical assignment of a provider. **Attribution drives assignment.**

Attribution Types:

Attributed as PCP via Claims – Indicates the member is attributed to a provider based on claims data.

Attributed as PCP via Self-Selection – Indicates the member has selected a provider as their primary care provider.

Assigned as PCP – Indicates the member is attributed to their geographical location.

Select State

All
Georgia
Indiana

Select Plans

All
Workplace
Medicaid

Select Measures

All
Adult Access
Asthma Control
Blood Pressure

Select Criteria

All
Red
Yellow

Select Patient Status

All
Established
New

Select Enrollment Status

All
Continuous
Recent

Select Attribution Type

All
Assigned as PCP
Attributed as PCP via Claims

Page 1 of 10

Records: 41/105

Attribution Type	Member Name	Member ID	DOB	Sex	State	Plan	LDB	Adult Access	Asthma Control	Blood Pressure	Breast Cancer	Cervical Cancer	Colorectal Cancer	Cholesterol	Diabetes	Eye Exam	A1C	Flu Shots	DK	Lead	# of Visits	DOB	Next Due
Assignment	JOHN, JAMES	123456789	1/1/1950	M	GA	Medicaid	Y	Red															
Claims	JANE, JANE	987654321	2/1/1960	F	GA	Medicaid	N	Green			1/1/2025		6/1/2024	1/1/2024		7/1/2024	6/1/2024	1/1/2024					
Assignment	JOHN, JAMES	123456789	1/1/1950	M	GA	Medicaid	Y	Red															

Green

 Service was rendered

Yellow

 Service needed

Red

 Service past due

Grey

 Not applicable

View the [CPR flier](#) on our [Provider Transition Information](#) page.

Provider Portal | Training Resources

The **New** Provider Portal is a robust, secure and encrypted online tool available for all providers who serve our members.

- Available Documents
 - Provider Portal Solutions
 - Clinical Practice Registry Flier
 - Provider Portal User Guide
 - Provider Portal Quick Start Guide
 - Provider Portal Registration Guide
- Available Training Videos
 - Portal Overview
 - Provider Portal: Service Plan Reviews Prior Authorizations
 - Provider Portal: Managing User Access
 - Provider Education Series: Provider Portal Service Plan Review

Visit the Transition Information page at CCA's website to access these resources.

The screenshot shows the CCA website's 'Transition Information' page. The header includes the CCA logo, location (Massachusetts), language (English), and navigation links (Home, Contact Us, Menu). The main heading is 'Transition Information', followed by a subheading: 'This page contains important information you need to know for CCA Senior Care Options (HMO D-SNP) and CCA One Care (HMO D-SNP) business starting June 26, 2026.' Below this is a list of resources, each with a red plus icon to its right. The resource 'New & Improved Provider Portal - Education & Resources' is highlighted with a red rectangular box. Other resources include 'What You Need to Know First', 'Provider Transition Communications', 'Transition Orientation', and 'Important Reminders'. The footer contains the CCA logo, social media icons (Facebook, Twitter, LinkedIn, YouTube, Instagram), and a copyright notice: '©2026 Commonwealth Care Alliance® Confidential and Proprietary'.

Provider Portal | Training



 PROVIDER PORTAL

 / Users / Provider Training

MEMBER SEARCH +

CLAIMS +

MEMBER REPORTS +

HEALTH HOMES/COMMUNITY MH +

USERS -

Link Account

Manage Users

Update My Account

Impersonate User

Provider Training ←

Edit

Provider Portal Resource Library

CareSource wants you to have the tools you need to manage your CareSource members in an efficient and timesaving manner. The Provider Portal makes it easy for you

Access the links below to learn about resources on the portal, how to use them and which ones will work best for your practice!

If you are having trouble viewing the training materials and are using Chrome, please try to use Firefox or Internet Explorer.

- **Recorded Trainings**
- 2026 CCA Medicaid Deeming Training
- 2026 CCA Senior Care Options and CCA One Care Benefits Overview
- **Reference Documents**
- 2026 CCA Medicaid Deeming FAQ for Providers
- 2026 CCA Senior Care Options and CCA One Care Benefits FAQ for Providers

PRIOR AUTHORIZATION SUBMISSION

Prior Authorization | 2026 Plan Operational Changes

For 2026, CMS reduced the timeframes for decisioning standard prior authorization requests.

- **Standard Requests are now decisioned within seven calendar days**
 - Previously decisioned within 14 calendar days
 - Rationale: Faster response improves care coordination
- **Expedited Requests (no change)**
 - Decision within 72 hours
 - For cases where delay may cause serious harm

Submit Prior Authorizations via:

- **New Provider Portal** ProviderPortal.CareSource.com/GL/User/Login.aspx/ - **preferred method**
- Select Providers > Prior Authorizations and Notifications

Alternative Methods via:

- Phone: 1-866-420-9332
- Fax: 1-855-341-0720

Please refer to CCA's *Prior Authorization Requirements* (Section 4 of the Provider Manual) for more detail.

Prior Authorization | Submission Requirements



All retrospective authorization requests must be submitted within 30 calendar days of the date of service or date of discharge or as specified in a provider contract. The only exception is a Coordination of Benefits (COB) denial. In this case we allow 90 days from the other insurance notification. Providers must submit rationale for retrospective authorizations.

Remember to include:

- Member name and CCA ID number
- Provider name and NPI
- Anticipated date(s) of service
- Diagnosis code and narrative
- Procedure, treatment or service(s) requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider if applicable
- Clinical information to support the medical necessity of a service
- Inpatient services need to include whether the service is elective, urgent or emergency, admitting diagnosis, symptoms & plan of treatment

Prior Authorization | Procedure Code Lookup Tool



Utilize the **Procedure Code Lookup Tool** to verify prior authorization requirements before entering your request for an outpatient or inpatient procedure.

1. Visit ProcedureLookUp.CareSource.com.
2. Select service type
3. Select plan
4. Enter date of service
5. Enter procedure code

The Procedure Lookup Tool will identify requests that need to be submitted to **TurningPoint**, our Third-Party Administrator (TPA) for Cardiac & Musculoskeletal procedures. It will also identify the codes that need to be submitted to our other UM TPA partners. See slide #39.

If you have any additional questions or would like additional training on Prior Authorization Submission, email CiteAutoAssistance@CareSource.com

CareSource Procedure Code Lookup

Is this for an inpatient or outpatient service? * **Outpatient** OR **Inpatient**

Inpatient services are medical care that requires a patient to stay in a healthcare facility for a period, usually a few days.

Line of Business

Line of Business *

Select LOB

Service Date *

MM/DD/YYYY

Today

Enter or select the date the service was provided.

Procedure Code(s) *

Enter one or more codes, separated by commas

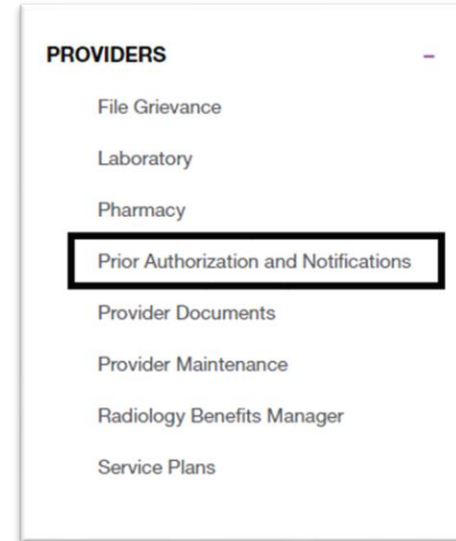
Enter one or more CPT/HCPCS codes, separated by commas (e.g., 99213,99214).

Search

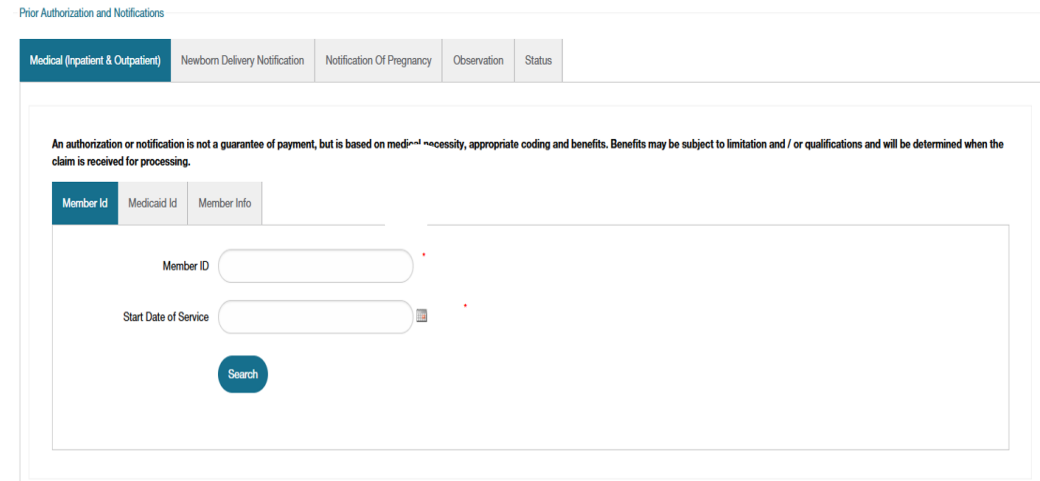
DISCLAIMER CareSource does not represent or warrant, whether expressed or implied, including but not limited to the availability of services. CareSource is not a guarantor of payment for services. Approval or payment of services can be determined by visit variances, provider contracts, provider types, correct coding and billing practices. For specific details, please see the [Authorization](#) page on the CareSource website.

Prior Authorization | Submission via the Provider Portal

Select **Providers** > **Prior Authorization and Notifications** from the left-hand navigation menu.



Enter the member's CCA ID and Start Date of Service in the fields provided. Click **Search**. Confirm eligibility and click **Verified**.

A screenshot of the "Prior Authorization and Notifications" form. At the top, there is a header "Prior Authorization and Notifications". Below the header, there is a row of tabs: "Medical (Inpatient & Outpatient)", "Newborn Delivery Notification", "Notification Of Pregnancy", "Observation", and "Status". The "Medical (Inpatient & Outpatient)" tab is selected. Below the tabs, there is a text box containing the following text: "An authorization or notification is not a guarantee of payment, but is based on medical necessity, appropriate coding and benefits. Benefits may be subject to limitation and / or qualifications and will be determined when the claim is received for processing." Below the text box, there is a row of tabs: "Member ID", "Medicaid ID", and "Member Info". The "Member ID" tab is selected. Below the tabs, there are two input fields: "Member ID" and "Start Date of Service". The "Member ID" field has a red asterisk next to it. The "Start Date of Service" field has a calendar icon next to it. Below the input fields, there is a blue "Search" button.

Prior Authorization | Select the Care Setting



Select the Care Setting and enter the authorization details based on the type of request.

Authorization Request

Select Care Setting

☒ Inpatient
☐ Outpatient

Inpatient Emergency Start Dates of Service cannot be in the future.

Select Type of Prior Authorization Request

--Select One--

- Select One--
- Detox
- Hospice
- Institute Of Mental Disease
- Long Term Acute Care
- Medical Elective
- Psychiatric
- Rehabilitation
- Skilled Nursing Facility

Authorization Request

Select Care Setting

☐ Inpatient
☒ Outpatient

Select Category

--Select Category--

- Select Category--
- Behavioral Health
- DME
- Genetic Testing
- Home Health Care
- Hospice
- Outpatient Services
- Pain Management Services
- Physician Administered Pharmacy Codes
- Surgery Or Procedures

Prior Authorization | Complete the Required Fields



Requesting/Ordering Provider Information

Search:

Provider Name

* Required

Facility Information

☐ Same As Requesting/Ordering

Search:

Provider Name

* Required

Dates of Service

An authorization or notification is not a guarantee of payment, but is based on medical necessity, appropriate coding and benefits. Benefits may be subject to limitation and / or qualifications and will be determined when the claim is received for processing.

Start Date:

2/28/2022

?

Treatment Type

Treatment Type:

--Choose One--

* Required

Diagnosis Codes

Code Type:

ICD10 Diagnosis Codes

Search By:

Code

* Required

Procedure Codes

Code Type:

All Procedure Codes

Search By:

Code

For clarification regarding unit definitions for your specific prior authorization type, please refer to the medical policy.

Primary	Code	Description	Requested Units	Modifiers	Action
☒	23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))		22 23 24	Delete

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31

Prior Authorization | Add the Guideline

If unable to answer review questions at time of entry, or appropriate guideline not listed, click **Document Clinical** and **add** for No Guideline Applies.

Guideline Title	Product	Code	Action
Migraine Headache, Surgical Treatment	AC	A-0578	add
Septoplasty	AC	A-0182	add
No Guideline Applies			add

Enter comment in field, click **Save**.

No Guideline Applies

Please provide patient's clinical information...

1000 characters left for notes.

✓ Save

✕ Cancel

Proceed with attaching supporting documentation.

When Clinical Review Questions are Not Required



Click **Attach File**.

The screenshot shows a section titled "Attachments" with a blue "Attach File" button in the top right corner. At the bottom right of the section are two buttons: a yellow "Submit Request" button with a checkmark icon and a white "Cancel Request" button with an 'X' icon.

Click **Choose File** to locate document. Click **Upload** to attach to case and close.



The "Upload Attachment" dialog box contains a "File Name" section with a "Choose File" button, the text "No file chosen", and an "Upload" button. Below this is a "File Description" text input field. A "Close" button is located in the bottom right corner.

File Name will show. Repeat process to add additional files. Click **Submit Request** to process.

The screenshot shows the "Attachments" section with a table of uploaded files. The table has four columns: File Name, File Name, Date/Time, and Actions. The first row contains "TEST DOCUMENT FOR TRAINING.docx", "TEST DOCUMENT FOR TRAINING.docx", "4/11/2022 3:06 PM", and "Open Remove". At the bottom right are three buttons: a yellow "Submit Request" button with a checkmark icon, a white "Cancel Request" button with an 'X' icon, and a white "Back" button with a left arrow icon.

Prior Authorization | Results Screen

Prior Authorization request has been successfully submitted. If clinical information to support this request has not been submitted, please send (via e-mail, fax or telephone) clinical review to the Medical Management Department within one business day.

Your reference ID for this submission request is: [REDACTED]

An authorization or notification is not a guarantee of payment, but is based on medical necessity, appropriate coding and benefits. Benefits may be subject to limitation and / or qualifications and will be determined when the claim is received for processing.

To submit another prior authorization request please return to the top of the page and enter the member's CareSource ID, Medicaid ID or Member info.

Member Info

Member ID: [REDACTED]
Member Name: [REDACTED]
Member DOB: [REDACTED]

Reference #: [REDACTED]

Reference #: [REDACTED]
Description: Outpatient Elective
Place Of Service: 22 On Campus-Outpatient Hospital
Submitting Provider: Default Provider
Requesting/Ordering Provider: [REDACTED]
Servicing/Rendering Provider: [REDACTED]
Facility:

Member Information

Member Name: [REDACTED]
CareSource Id: [REDACTED]
Birth Date: [REDACTED]
Gender: Female

Service Event

Diagnosis Code: J34.2 Deviated nasal septum
Procedure: 30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

Line #1

Requested Received Date:	4/11/2022 9:00:00 AM	Requested Units:	2
Start Date of Service:	4/28/2022	Authorized Units:	0
End Date of Service:	7/28/2022	Status:	Pending

Results will display with Case Reference number and status.

Prior Authorization | Checking Status

Select **Prior Authorization and Notifications**.

Click **Status** tab, then select the **Authorization Number**. Click **Search**.

Case will display at bottom of screen.

Click **View Details | Update** to review case information.

You may also search Prior Authorization status by facility.

1. Under the **Status** tab select **Facility**.
2. Use the drop-down menu to **Select the Facility**.
3. Choose your **Start** and **End Dates**, and all prior authorizations that are associated with the facility during the given date range will populate.

The screenshot shows the 'Prior Authorization and Notifications' interface. At the top, there are four tabs: 'Medical (Inpatient & Outpatient)', 'Newborn Delivery Notification', 'Observation', and 'Status'. The 'Status' tab is selected. Below the tabs, there are two sub-tabs: 'Member Id', 'Medicaid Id', 'Member Info', 'Authorization Number', and 'Facility'. The 'Authorization Number' sub-tab is selected. Below the sub-tabs, there is a search form with a label 'Authorization Number:' and a text input field. A red arrow points from the 'Status' tab to the 'Authorization Number' sub-tab, and another red arrow points from the 'Authorization Number' sub-tab to the search input field. Below the search form, there is a 'Search' button. A red arrow points from the 'Search' button to the search results table. The search results table has columns: 'Details', 'Authorization Number', 'Member ID', 'Description', 'Service Start Date', and 'Status'. The first row of the table shows 'View Details | Update | Letters' in the 'Details' column, a blurred 'Authorization Number', a blurred 'Member ID', 'Inpatient Elective' in the 'Description' column, '1/31/2022' in the 'Service Start Date' column, and 'Fully Approved' in the 'Status' column. A red arrow points from the 'View Details | Update | Letters' link to the 'View Details' link. Below the table, there is a 'Page(s): 1' label and a 'Record(s):1' label. A red arrow points from the 'View Details' link to the 'Page(s): 1' label.

Prior Authorization | Request for Change or Update

Select **Prior Authorization and Notifications**.

Click **Status** tab, then select the **Authorization Number**. Click **Search**.

Case will display at bottom of screen.

Click **View Details | Update**.

Access is restricted to those authorizations affiliated with each Tax ID number.

Prior Authorization and Notifications

Medical (Inpatient & Outpatient) Newborn Delivery Notification Observation **Status**

Member Id Medicaid Id Member Info **Authorization Number** Facility

Authorization Number:

Search

Page(s): 1					Record(s):1	
Details		Authorization Number	Member ID	Description	Service Start Date	Status
View Details	Update	Letters		Inpatient Elective	1/31/2022	Fully Approved
Page(s): 1					Record(s):1	

Prior Authorization | Change Details



Change Details

Select Change Request type: --Choose One--

- Choose One--
- Attach Additional Clinical
- Continued Stay Review Request
- Discharge Details
- Start Date of Service Change
- Other

Change Details

Select Change Request type: --Choose One--

- Choose One--
- Attach Additional Clinical Request For Change

- Use drop-down to select **Change Details**.
- Complete changes and required fields. Click drop-down to select type of attachment.
- Choose **File** and locate electronic saved copy (no limit on number of attachments).
- Click **Submit**. The request will be sent to UM to review case and complete process.

Change requests for approved authorizations are accepted when the service intent is the same/similar and does not require a new medical necessity review.

Note that if the case status is Denied or Voided, you will be unable to update the case.

You must submit a new case.

Prior Authorizations | Cardiac & Musculoskeletal Surgery

CCA utilizes **TurningPoint** to implement cardiac and musculoskeletal surgical procedures.

TurningPoint Authorization	Turnaround Times	Required Information
Phone: 1-304-603-4673 1-855-578-7350 Fax Intake Form: 1-304-553-7061 1-844-472-0481 TurningPoint Portal	• Standard non-urgent = seven calendar days • Expedited Requests = 72 hours • Retrospective requests = 30 calendar days from the date on which the vendor received the authorization request	• Provider information • Facility information • Anticipated surgery date • Health plan information • Member demographics • Requested procedures/diagnosis • Clinical Information
Turning Point Customer Service Phone: 1-866-422-0800 Email: ProviderSupport@tpshealth.com		

See [CCA and TurningPoint announcement](#) for additional information.

Please contact CCA directly for appeals and claims

CLAIM SUBMISSION

Claims | Billing Overview

CCA accepts electronic (EDI), provider portal and paper claim submissions.

- Electronic billing is preferred. Use Payer ID **A2793**.
- Mail paper claims to: Commonwealth Care Alliance
P.O. Box 1127
Dayton, OH 45401-1127
- Contracted providers must file claims no later than 90 days from date of service unless the filing limit is otherwise stipulated in their contract.

Provider shall not seek or accept payment from a CCA member for any covered service if the member is wholly enrolled and eligible for both Medicare and MassHealth.

Please refer to *CCA's Claims and Billing Procedures* (Section 7 of the [Provider Manual](#)) for detail.



Claims | Submissions

ELECTRONIC CLAIM SUBMISSIONS

- It is encouraged to use electronic claim submission as the primary submission method.

Portal Submission

- Providers can submit claims through our **NEW** secure, online Provider Portal at [CCA Provider Homepage | Commonwealth Care Alliance MA > Provider Portal](#). Here, providers can submit claims along with any documentation, track payments and more.

CLEARINGHOUSES

- For electronic data interchange (EDI) transactions, CareSource accepts electronic claims through our clearinghouse, Availity. Providers can also use their existing clearinghouse if they are configured to accept the CCA Payer ID (A2793). Providers can find a list of EDI vendors online at: [availity.com/ediclearinghouse](https://www.availity.com/ediclearinghouse).

Claims | Electronic Funds Transfer



ELECTRONIC FUNDS TRANSFER (EFT)

ECHO Health offers three payment options:

1. Electronic fund transfer (EFT) – preferred
2. [Default] Virtual Card Payment (QuicRemit) – Standard bank and card issuer fees apply*
3. Paper Checks

It is encouraged to use electronic claim submission as the primary submission method. We partner with ECHO Health for electronic funds transfer (EFT). You must enroll with ECHO Health to participate. Find the enrollment form for ECHO Health online at: enrollments.echohealthinc.com/. For questions, call ECHO Support at: 1-888-485-6233.

*Payment processing fees are what you pay your bank and credit card processor for use of a payment terminal to process payments via credit card.

Visit our Transition Information webpage at CommonwealthCareAlliance.org/ma/providers/ for additional information about getting paid electronically and enrolling in EFT.

[Enroll](#) to complete your enrollment online. ECHO Health will work directly with you to complete your enrollment in EFT.

Providers who elect to receive EFT payment can also choose to receive an EDI 835 (Electronic Remittance Advice) through a designated clearinghouse. Providers can download the PDF version of the Explanation of Provider Payment (EPP) from the [Provider Portal](#).

**Notice: Email notifications are not sent when a deposit/payment is made.
Deposits/payments are made twice weekly.**

EPP | ECHO

1. Click the **Search Type** drop-down list and choose appropriate search criteria.
 - The below search options may provide the best results:
 - **ECHO Draft Number**: this is the payment check number on the Remittance tab on the claim.
 - **Provider ID**: the provider's tax ID number.
 - **Claim Number**: CareSource's claim number.
2. Input the appropriate information in the **Search Criteria** field.
3. Click **Search**.
4. Locate the appropriate payment.
5. Click **EPP**.

Advanced Search

Search Type 1 Claim Number **Search Criteria** 2 2525405TLL00 3 **SEARCH**

Please enter your search criteria

Produced

Filtered Search:

Claim Number	Insured	Patient	Certificate No	Group ID	Provider Name	Payee Name	Amt Paid	Check No	ECHO Draft	EOB Prepared	EOB	EOD	EPP	Draft	OD	835	Payment Details
2525405TLL00	Hobson, Teresa	Hobson, Teresa	11261856600	MS-CSMS	EyeMed	EyeMed (Routine Vision)	\$103.34	25263B10005060870ECPT0	1209489598				5 EPP	Draft	OD	835	Details

Payment Details

ECHO Draft #	Type	Payment Date	Payee	Address	Status	Status Date	Remarks	Activity By	Draft
1209489598	ACH/EFT Notification Date: 09/23/2025	09/22/2025	EyeMed (Routine Vision)	PO Box 74008410 Chicago IL 60674	Clear	09/23/2025			Draft

Rows per page: 100

« First « Prev 1 Next » Last »

Claims | Transition Impact



Transition Impacts

- EPP format
- Accessing EOPs/835/EPP
- Portal Submission Options
- Recovery Letter format
- Claims/Payment Policy Updates
- Application of CMS Claim Standards
 - FQHC Standardization
 - Therapy limits
 - Adult Daycare
 - And others... *be sure to follow CMS submission guidelines to ensure no interruption in claim processing*
- Mailing Addresses *(in some cases)*

Not Impacted

- Deeming
- Benefits
- Opt-Out/Medicaid Run Out
- Payor ID
- Wholesale Policy
- Accessing Payment Policies Online

Find more Claims Transition Information training at
commonwealthcarealliance.org/ma/providers/transition-information/

Claims | Appeals and Disputes



ALL CLAIMS APPEALS MUST BE:

- Submitted within 60 calendar days from the date of the claim denial unless it is a COB denial. COB denials must be submitted 60 days from the date of the COB denial (the retro-authorization policy must still be followed). The appeals process is applicable to non-contracted providers. Non-contracted providers must include a signed Waiver of Liability form holding the member harmless regardless of the outcome of the Appeal.

- Submitted via one of these methods

Provider Portal

Mail: Commonwealth Care Alliance

P.O. Box 1947

Dayton, OH 45401-1947

Fax: 857-453-4517

CLAIM DISPUTES

CCA also offers a claim payment dispute process. Additional information pertaining to claim appeals and claim payment disputes can be found in the [Provider Manual](#).

****Note: An appeal or dispute is not a retro-authorization request.****

- The Provider Portal is the most efficient method of submission to ensure timely receipt and resolution of the appeal.
- As a CCA provider, you may submit a dispute or appeal for a member.
- Providers must obtain a member's written consent to appeal an Adverse Benefit Determination on their behalf.
- We may contact you to obtain documentation when a member has filed a request for one of these reviews. CCA does not retaliate or discriminate against any member or provider for utilizing the grievance and appeals process.
- For additional information, contact Provider Services at 1-866-420-9332.

Claims | Payment Disputes

Contracted Providers may file a payment dispute for CCA's reconsideration if they disagree with CCA's decision of denial or reimbursement of a claim.

- Disputes must be submitted via fax, portal or mail. Disputes should be sent to:
 - Mail:
Commonwealth Care Alliance
Attn: Appeals Department
P.O. Box 1947
Dayton, OH 45401-1947

Fax: 1-937-531-2398
 - Payment dispute requests will be considered when received within 90 days from the original payment or denial date, as indicated on the EPP, with supporting documentation and the *Request for Claim Review* form.

Contracted providers may file a dispute for CCA's reconsideration if they believe CCA is paying an amount different than contractually agreed upon.

- Please direct correspondence to CCACContracting@commonwealthcare.org.

For additional questions on provider Payment Disputes or Appeals, please contact CCA Provider Services at 1-866-420-9332 from 8 a.m. to 5 p.m. ET Monday, Tuesday, Wednesday, and Friday, and from 8:30 a.m. to 5 p.m. ET Thursday.

Please refer to *CCA's Claims and Billing Procedures* (Section 7 of the [Provider Manual](#)) for detail.

Claims | Corrected Claims

- To modify a paid, denied, or rejected claim, providers must submit a corrected claim electronically or on paper.
 - If the correction requires additional information such as an invoice or prescription, the corrected claim can be submitted on paper or in the **new Provider Portal**.
- Corrected claims submissions should include:
 - Original claim number
 - Any necessary modifications from the original claim
 - CMS-1500/HCFA-1500 or UB-04 paper claim with the corrections
 - Any required supporting documentation
- Mailing address for corrected and rejected paper claims: Commonwealth Care Alliance
P.O. Box 1127
Dayton, OH 45401-1127

Please refer to *CCA's Claims and Billing Procedures* (Section 7 of the [Provider Manual](#)) for more detail.



Claims | Contact & Billing Support

Provider Claims, Billing Support, and EDI Support

CCA Provider Services at 1-866-420-9332

Weekdays, excluding Thursday, 8 a.m. to 5 p.m., ET and Thursdays, 8:30 a.m. to 5 p.m., ET

EDI Support by Availity Client Services at 1-800-282-4548

8 a.m. to 8 p.m., Monday to Friday

Availity Essentials Provider Portal

To register, click on "Get Started" in the upper right corner and follow the instructions

Please refer to CCA's *Claims and Billing Procedures* (Section 7 of the [Provider Manual](#)) for detail.

Claims | Key Reminders



Additional items to remember as of July 1, 2026

Member IDs

Current CCA members will not receive new cards in 2026. Members will have either a 10- or 11-digit ID number, there is no significant difference to the digit count; other than the date they became a CCA member.

Opt Out Medicaid Run Out

Term ended December 31, 2025, run out continues based on timely filing rules.

Deeming

All deeming related processes will remain the same. Eligibility sweeps will be in effect to look for retro-eligibility.

Payment Policies

Payment policies may be changing. All updated policies are located at the [CCA website> For Providers> Policies and Guidelines](#).

CMS Standards

In enforcing CMS claim rules adjustments may be required to ensure accurate and clean claim submission.

Payments outside of claims will be addressed directly with providers.

KEY CCA CONTACTS AND UPDATES



Key CCA Contacts

Member Services: 1-866-610-2273 (TTY 711) MemberServices@CommonwealthCare.org

- April 1 to Sept 30: Monday-Friday 8 a.m. to 8 p.m., ET; 8 a.m. to 6 p.m., Saturday and Sunday
- Interpretation services are available

Provider Services: 1-866-420-9332 ProviderServices@CommonwealthCare.org

- Monday, Tuesday, Wednesday, and Friday 8 a.m. to 5 p.m., ET and Thursday 8:30 a.m. to 5 p.m., ET)
- Providers can call with inquiries about covered services, authorization status, service denials, claims, and benefits
- For clinical concerns or to contact the care partner team, select option

Provider Relations: ProviderRelations@CommonwealthCare.org

- Email us with questions and inquiries
- Send us an email to be added to the Provider News

Contracting: CCAContracting@CommonwealthCare.org

- Providers can email with inquiries and questions related to their contract

Provider Training

CCA provides several trainings to our contracted providers to support quality of care, safety and compliance.

CCA's required and recommended trainings can be found on our website in the *For Providers > Training and Programs* and *Language Services Cultural Support Resources for Providers* sections.

Trainings that require completion include:

- Fraud, Waste, and Abuse
- Compliance
- Cultural Competency
- CCA Senior Care Options and CCA One Care Model Of Care
- CCA One Care Specific Training for Providers Serving on Interdisciplinary Care Teams

[Home](#) > [For Providers](#) > [Training and Programs](#)

Training and programs for CCA providers

Commonwealth Care Alliance (CCA) offers training and programs to help providers learn more about drug management, reporting compliance concerns, and more.



CCA One Care Training for Providers

As a network provider for CCA One Care, you and your staff are required to complete a healthcare training series that is designed to help you better meet the needs of future enrollees.

[Learn More →](#)

Senior Care Options (SCO) Model of Care Training

The Centers for Medicare & Medicaid Services (CMS) requires all providers to complete an annual Commonwealth Care Alliance (CCA) Senior Care Options Model of Care (MOC) training if you are either contracted to see CCA SCO members or an out-of-network licensed independent practitioner (LIP) who routinely treats and/or provides services to CCA SCO members. The intent of the CMS requirement is to ensure providers and SCO plans can seamlessly coordinate the care for this population with complex needs.

[Learn More →](#)



Compliance and Fraud, Waste, and Abuse Program

The CCA Compliance and Fraud, Waste, and Abuse Program acts as a resource of compliance policies and procedures for CCA-contracted providers and members.

[Learn More →](#)

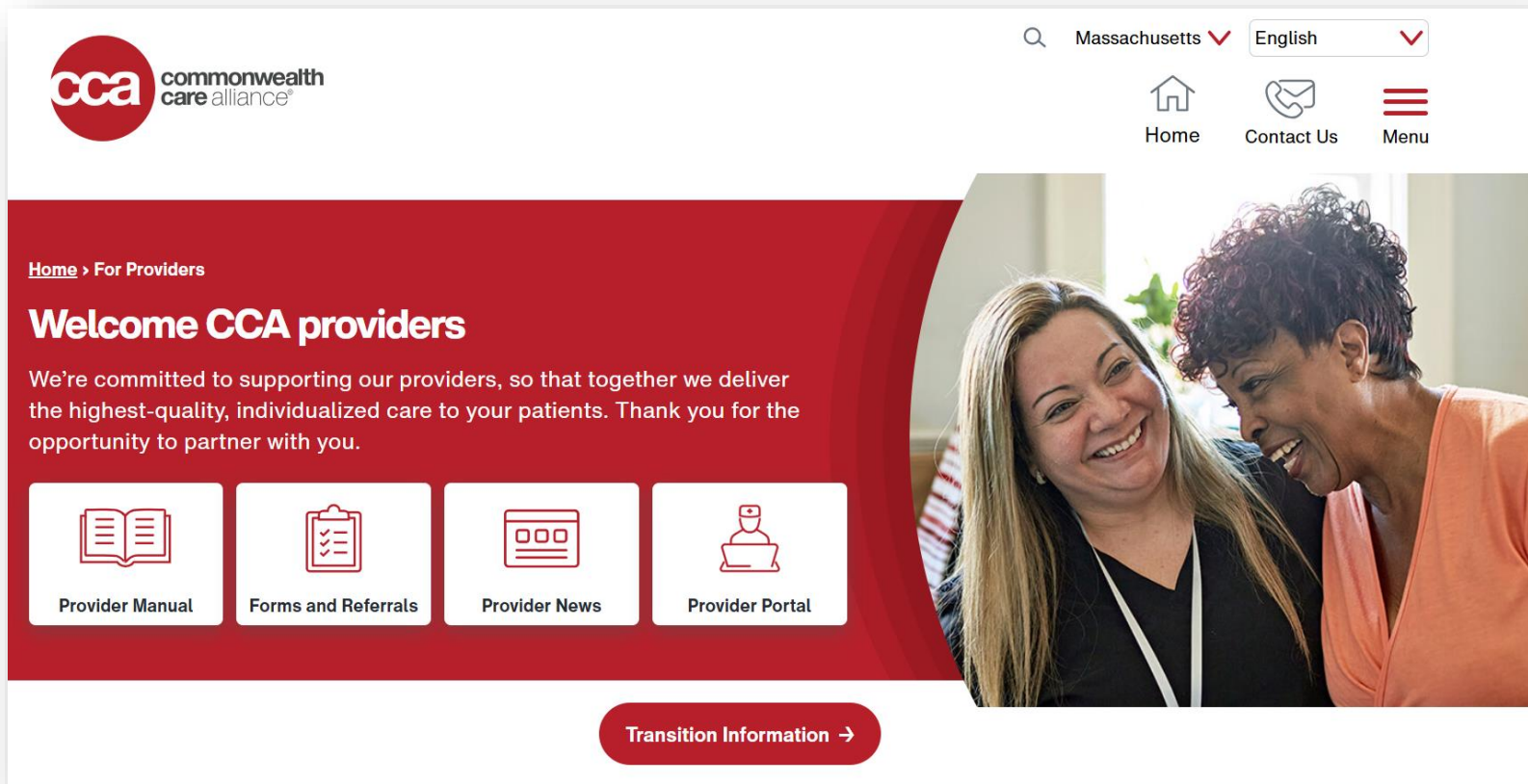


Please refer to *CCA's Provider Training Requirements* (section 18 of the [Provider Manual link](#)) for more detail.

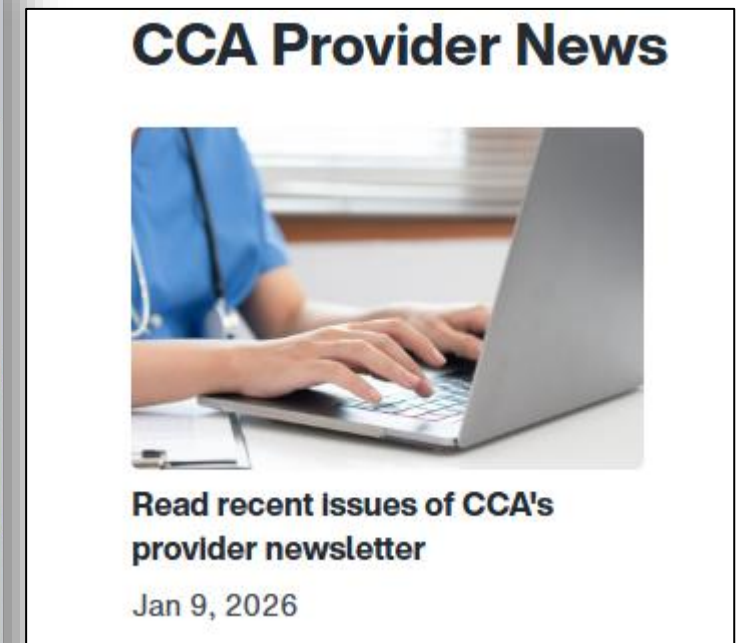
Provider News and Updates

CCA communicates with providers through *Provider News* and *Provider Updates* to highlight the unique role our organization, network team and providers play in delivering quality care. We also use these tools to communicate about key policy changes, program updates, operational guidance and time-sensitive announcements that may require action.

View current and archived news and sign up for email distribution preferences at the [CCA Provider Homepage](#).



The screenshot shows the CCA Provider Homepage. At the top left is the CCA logo (commonwealth care alliance). To the right are dropdown menus for 'Massachusetts' and 'English'. Below these are icons for 'Home', 'Contact Us', and 'Menu'. The main content area has a red header with the text 'Home > For Providers' and 'Welcome CCA providers'. Below this is a paragraph: 'We're committed to supporting our providers, so that together we deliver the highest-quality, individualized care to your patients. Thank you for the opportunity to partner with you.' There are four icons in a row: 'Provider Manual' (book icon), 'Forms and Referrals' (clipboard icon), 'Provider News' (document icon), and 'Provider Portal' (person at a desk icon). At the bottom right is a red button labeled 'Transition Information →'. A large photo of two smiling women is on the right side of the page.



The newsletter cover features the title 'CCA Provider News' at the top. Below it is a photo of a person's hands typing on a laptop. The text on the cover reads: 'Read recent issues of CCA's provider newsletter' and 'Jan 9, 2026'.

Thank you!

