CarePartners of Connecticut

2020

CarePartners of Connecticut

Provider Manual

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INTRODUCTION

Purpose of Manual

This manual provides CarePartners of Connecticut providers and their office staff with details on the structure, products, policies and procedures of CarePartners of Connecticut. Providers and their office staff are required to read, abide by and reference this manual as necessary.

Overview of CarePartners of Connecticut

CarePartners of Connecticut, Inc. (CarePartners of Connecticut or CPCT) is a Medicare Advantage Organization (MAO) that has entered into a Medicare risk contract with the Centers for Medicare and Medicaid Services (CMS). CarePartners of Connecticut's products are known as CareAdvantage Preferred, CareAdvantage Prime and CareAdvantage Premier.

CMS pays CarePartners of Connecticut a "per member per month" (PMPM) amount to cover the cost of approved services.

CMS issues regulations to implement the various statutes on which the Medicare Advantage Program is based. CMS also publishes various manuals, memoranda and statements necessary to administer the programs. Each MAO with a Medicare Advantage contract with CMS must comply with these requirements. CMS conducts routine regulatory audits to review the MAO's procedures and to ensure compliance by the MAO as well as providers under contract to the MAO with federal requirements.

CarePartners of Connecticut members are Medicare beneficiaries and effectively assign their Medicare benefits to CarePartners of Connecticut upon enrollment. CarePartners of Connecticut arranges coverage for covered health care needs of its members. In addition to services covered by Medicare, CarePartners of Connecticut also provides other specific benefits.

Primary Care Physicians

CarePartners of Connecticut members are required to choose a primary care physician (PCP) within the CarePartners of Connecticut network. Appropriately authorized, medically necessary services are paid based on the terms in the applicable provider contract.

Inpatient notification is required for all inpatient admissions but is not required for ambulatory surgical day care or observation services.

Department Directory

When contacting CarePartners of Connecticut, use the department directory below to identify the most appropriate department, phone and fax contact numbers, and individual role responsibilities. The Provider Services and Provider Information departments manage CarePartners of Connecticut provider information.

DEPARTMENT	CONTACT	RESPONSIBILITY
Care Management		
Care Management	Care Management List	• Concurrently reviews members hospitalized at an in-plan facility • Coordinates discharge planning, including rehabilitation, SNF, or chronic hospital placement, home health care, home therapies, and DME • Coordinates care for high-risk members in the community
Network Management and Contracting		

DEPARTMENT	CONTACT	RESPONSIBILITY
Allied Health Contracting	617.972.9411	• Negotiates and administers contracts for all ancillary services, included but not limited to skilled nursing facilities (SNFs), inpatient rehabilitation facilities, and home care services • Evaluates prospective ancillary providers and assesses need for additions and changes to the contracting provider network • Monitors contract compliance and performs utilization review of contracts
Network Contracting and Performance Management (NCPM)	888.880.8699, ext. 52169	• Negotiates and executes contracts for medical groups, providers and hospitals • Processes operational changes • Fosters and maintains medical group relationships • Ensures contracts are implemented in the appropriate CarePartners of Connecticut systems
Provider Credentialing	617.972.9495	Maintains practitioner credentialing/recredentialing process
Provider Information	888.306.6307	Facilitates change of provider information, practice or payment information
Pharmacy Utilization Management		
Pharmacy Utilization Management	617.673.0956 (fax)	Reviews and processes the initial pharmacy prior authorization request for coverage determinations and exceptions (CDE)
Precertification Operations		
Precertification Operations - Inpatient	857.304.6410 (fax)	Processes inpatient admission notifications
Precertification Operations - Outpatient	857.304.6463 (fax)	Reviews preservice organization determination requests for medical services requiring prior authorization **Note:** Pharmacy requests should be directed to the Pharmacy Utilization Management (UM) Department
Provider Education		
Provider Education	Provider_Training@carepartnersct.com 888.306.6307, option 7	Offers the following educational programs that are designed to help providers learn about products, policies and procedures and online self-service tools: • Training videos • Webinars • In-person and live-streamed presentations • Customized on-site meetings
Provider Services		
Provider Specialist	888.341.1508	• Addresses inquiries regarding covered benefits, claims and explanations of payment • Confirms member eligibility • Answers general and specific provider questions

MEMBERS

CarePartners of Connecticut members receive an identification card as well as benefit materials that contain information on plan benefits, cost-sharing amounts, exclusions, and plan policies and procedures, including the evidence of coverage (EOC), which is made available to the member upon enrollment and annually thereafter.

CarePartners of Connecticut members are required to choose a primary care provider (PCP) and are encouraged to transfer their medical records to the PCP. If the member does not choose a PCP upon enrollment, CarePartners of Connecticut will assign a PCP to the member. If new members are receiving ongoing medical care, they are advised to contact their new PCP as soon as their membership becomes effective with CarePartners of Connecticut.

Any new members who are not receiving ongoing care are advised to call their PCP to schedule a routine physical examination. New members are encouraged to receive an initial health assessment within 90 days of the effective date of enrollment. CarePartners of Connecticut provides each medical group with a monthly eligibility listing report that identifies both new and existing members who have a provider within the group designated as their PCP. The PCP may elect to contact new members who appear on the eligibility listing report.

Coverage Options

CarePartners of Connecticut offers various medical and prescription drug coverage options for its members. All plans cover all Medicare benefits as well as Part D prescription drug coverage. Refer to the Our Plans section of the CarePartners of Connecticut website for more information.

Eligibility

Individuals joining CarePartners of Connecticut must meet specific requirements, as outlined in 42 CFR 422.50 and outlined in Chapter 2 of the Medicare Managed Care Manual, Chapter 2 – Medicare Advantage Enrollment and Disenrollment.

End-Stage Renal Disease (ESRD)

An individual who elects a Medicare Advantage Plan and who is medically determined to first have ESRD after the date on which the enrollment form is signed (or receipt date stamp if no date is on the form), or the election is made by alternate means provided by CMS, but before the effective date of coverage under the plan, is still eligible to elect CarePartners of Connecticut.

An individual who develops ESRD while enrolled in a Medicare Advantage Plan may continue to be enrolled in the Medicare Advantage plan. Once enrolled in a Medicare Advantage Plan, an individual who has ESRD may elect other Medicare Advantage Plans in the same Medicare Advantage Organization (MAO) and during allowable election periods. However, the member would not be eligible to elect a Medicare Advantage Plan in a different MAO, or a plan in the same MAO in a different state (with exceptions).

An individual with ESRD whose enrollment in a Medicare Advantage Plan was terminated on or after December 31, 1998 (as a result of a contract termination, nonrenewal, or service area reduction) can make one election into a new Medicare Advantage Plan. An individual must meet all other Medicare Advantage eligibility requirements and must enroll during a Medicare Advantage election period. An individual who has exhausted their one election will not be permitted to join another Medicare Advantage Plan unless the new plan is terminated.

An individual who develops ESRD while a member of a health plan offered by a Medicare Advantage Plan in the same organization as their plan (within the same state, with exceptions) during the initial coverage election period is eligible to elect the plan. An individual must meet all other Medicare Advantage Plan eligibility requirements and must fill out an election form to complete an alternate enrollment election to join the Medicare Advantage Plan.

Enrollment

Members enrolling in CarePartners of Connecticut may use one of the following methods:

- Online enrollment tool
- Mail a completed enrollment form to CarePartners of Connecticut
- Call CarePartners of Connecticut at 844.267.1361 (TTY 711)
- Attend a local meeting with a licensed Medicare Agent
- Enroll through Medicare by calling 1.800.MEDICARE (1.800.633.4227) (TTY 1.877.486.2048) 24 hours a day, 7 days a week; or online via the CMS Medicare Online Enrollment Center

Completed election forms received by CarePartners of Connecticut on or before the last day of the month will generally be effective the first day of the next calendar month.

Enrollment Rules

CarePartners of Connecticut includes limits on when and how often individuals may change the way they obtain Medicare for the HMO plan, in accordance with CMS' Medicare Managed Care Manual, Chapter 2 – Medicare Advantage Enrollment and Disenrollment. Switching from one CarePartners of Connecticut plan to another, or to a plan offered by another MAO, is considered a change.

Enrollment Periods and Effective Dates

Initial Coverage Election Period (ICEP): The time during which an individual who is newly eligible for Medicare Advantage can make an initial election to enroll in a Medicare Advantage Plan. This period begins 3 months before the individual's first entitlement to both Medicare Part A and Part B, and ends on the last day of the month preceding entitlement to both Part A and Part B, or the last day of the individual's Part B enrollment period (whichever date is later).

The initial enrollment period for Part B is the 7-month period that begins 3 months before the month that an individual meets the eligibility requirements for Part B and ends 3 months after the month of eligibility.

Initial Enrollment Period for Part D (IEP for Part D): The time during which an individual is first eligible to enroll in a Part D plan. Generally an individual is eligible to enroll in a Part D plan when the individual is entitled to Part A or the individual is enrolled in Part B and permanently resides in the service area of a Part D plan.

Annual Election Period (AEP): The time from October 15 through December 7 each year when individuals enrolled in Medicare may change the way they participate in Medicare and to add or drop Medicare prescription drug coverage, effective January 1st of the following year.

Medicare Advantage Open Enrollment Period (MA OEP): From January 1 through March 31 each year, anyone enrolled in a Medicare Advantage Plan (except a Medicare Savings Account (MSA) or other Medicare health plan type) has an opportunity to enroll in another MA plan or disenroll from their current plan and return to Original Medicare. A MA OEP also applies to new Medicare beneficiaries who are enrolled in a MA plan during their ICEP; this MA OEP occurs during the month of entitlement to Part A and Part B to the last day of the 3rd month of entitlement. Individuals may make only one election during the MA OEP. Individuals may add or drop Part D coverage during the MA OEP. Individuals enrolled in either MA-PD or MA-only plans can switch to: MA-PD, MA-only or Original Medicare (with or without stand-alone Part D plan). The effective date for an MA OEP election is the first of the month following receipt of the enrollment request. The MA OEP does not provide an opportunity for an individual enrolled in Original Medicare to join a MA plan, nor does it allow for Part D changes for individuals enrolled in Original Medicare, including those enrolled in stand-alone Part D plans. If individuals join a Medicare Prescription Drug Plan, they will be automatically disenrolled from the CarePartners of Connecticut plan and returned to Original Medicare.

Note: Generally, individuals cannot make any other changes during the year unless they meet special exceptions (e.g., if an individual moves out of the plan's service area or has both Medicare and Medicaid coverage). If an individual has both Medicare and Medicaid coverage, they may change to another plan at any time. If a member lives in a long-term care facility (such as a nursing home) they may also change to another plan at any time. Individuals joining another Medicare plan, including a Medicare Prescription Drug Plan, will be disenrolled from CarePartners of Connecticut when enrollment in the new plan begins.

If an individual leaves their current plan and does not join a plan that offers Medicare Prescription Drug Coverage or a Medicare Prescription Drug Plan, and they do not have prescription drug coverage that offers the same or better benefits as the basic Medicare Prescription Drug Coverage, the individual may have to pay a Medicare Part D late enrollment penalty (LEP) if they decide to join later, resulting in a higher monthly premium.

Disenrollment

CarePartners of Connecticut may not, either orally or in writing or by any action or inaction, request or encourage any member to disenroll. While a MAO may contact members to determine the reason for disenrollment, the MAO may not discourage members from disenrolling after they indicate their desire to do so. The MAO must apply disenrollment policies in a consistent manner for similar members in similar circumstances.

Voluntary Disenrollment by Member

CarePartners of Connecticut members may voluntarily disenroll in accordance with the approved election periods noted in the enrollment rules. To disenroll from a plan, members must do one of the following:

- Hand-deliver, mail or fax a signed written notice to CarePartners of Connecticut
- Call 1.800.MEDICARE for disenrollment from CarePartners of Connecticut
- Join another Medicare Advantage Prescription Drug Plan or Prescription Drug Plan during a valid enrollment period to be automatically disenrolled from CarePartners of Connecticut coverage

Note: If a member verbally requests to disenroll, CarePartners of Connecticut must instruct the member to make the request through one of the methods described above.

Required Involuntary Disenrollment

CarePartners of Connecticut must disenroll a member in the following situations:

- The member has a change in residence (including incarceration) that makes them ineligible to be a member of CarePartners of Connecticut. An HMO member disenrolled under this provision has a special election period to elect a different Medicare Advantage Plan or to return to Original Medicare. A member who fails to make an election will be deemed to have elected Original Medicare.
- The member loses entitlement to either Medicare Part A or Part B
- The member dies
- The CarePartners of Connecticut contract is terminated, or if the member resides in an area where the plan is no longer offered. A CarePartners of Connecticut member disenrolled under this provision has a special election period to elect a different Medicare Advantage Plan or to return to Original Medicare. A member who fails to make an election is deemed to have elected Original Medicare
- The member fails to pay his or her Part D-IRMAA to the government and CMS notifies the plan to effectuate the disenrollment
- The member is not lawfully present in the United States

Optional Involuntary Disenrollment

CarePartners of Connecticut may disenroll a member from a Medicare Advantage Plan in the following situations:

- Premiums are not paid on a timely basis
- The member engages in disruptive behavior
- The member provides fraudulent information on an election form, permits abuse of a CarePartners of Connecticut enrollment card, or the member engages in other fraudulent conduct with respect to the program.

Member Education

CarePartners of Connecticut's member education outreach includes literature that helps certain prospective and active members understand how to utilize their plan benefits. All members have access to the EOC and summary of benefits. These documents provide important information about CarePartners of Connecticut plan benefits, policies and procedures.

Member Identification Cards

Members are encouraged to carry their CarePartners of Connecticut ID card and Medicare card with them at all times. If a member has enrolled but has not received their ID card, the pink copy of the Individual Enrollment

form may be used as temporary identification.

The CarePartners of Connecticut ID card includes the following information:

Front of Card	
PCP	Primary care provider name
RxBIN RxPCN RxGRP	Prescription drug references
Plan	CarePartners of Connecticut identification number
ID	Member's identification number
Name	Member's name
PCP OV Spec OV ER	Office visit (OV) and emergency room (ER) cost-sharing amount information
Issued	Date ID card was generated
CMS-H5273-xxx	CMS tracking number based on member's selected coverage (CarePartners of Connecticut, Inc)
Back of Card	
Claim submission address and contact information Contact phone numbers and website	

Health Risk Appraisal

As part of the Health Risk Appraisal program, newly enrolled members are provided a Health Needs Questionnaire within the first two weeks of their effective date. Completing the questionnaire is voluntary. The purpose of the program is to profile members' health risk status at enrollment and provide information regarding member risk to the PCP. CarePartners of Connecticut ultimately expects the sharing of information to lead to better management of care, which will result in improved health outcomes.

A Health Needs Summary Report is sent to the member's PCP based on specific member responses. If requested, a copy is sent to a central group contact. Members are also screened for eligibility for additional care management services.

Advance Directives

The federal Patient Self-Determination Act requires certain facilities, including MAOs, to document whether or not a member has executed an advance directive. An advance directive is a written instruction relating to the provision of health care when the member is unable to communicate their wishes regarding medical treatment. This document is sometimes called a living will, healthcare proxy, or durable power of attorney for healthcare.

CarePartners of Connecticut maintains written policies and procedures that provide for community education regarding advance directives. CarePartners of Connecticut members receive educational materials upon enrollment that define advance directives, emphasizing that advance directives are designed to enhance an incapacitated individual's control over medical treatment decisions. Applicable state laws concerning advance directives are also included in the materials.

To ensure compliance with the provisions of the federal Patient Self-Determination Act, CarePartners of Connecticut requires documentation as to whether or not a member has executed an advance directive, and that the advance directive is located in a prominent part of the member's medical record.

Member Rights and Responsibilities

CarePartners of Connecticut makes available to its members the Member Rights and Responsibilities Statement. This document explains the member's responsibility in adhering to CarePartners of Connecticut policies, and informs members that they have certain rights with regard to their care, such as their access to care and sharing in decisions about their care. Members may refer to their EOCs or contact CarePartners of Connecticut Provider Services at 888.341.1508 for additional information on this statement.

Member Appeals and Grievances

Members have the right to file a complaint if they have concerns or problems related to their coverage or care. Appeals and grievances are two different types of member complaints. CMS defines appeals and grievances in the Parts C & D Enrollee Grievances, Organization/Determinations, and Appeals Guidance.

CarePartners of Connecticut and its contracting providers must not treat members unfairly or discriminate against them because they initiate a complaint. Refer to the Member Appeals and Grievances chapter of this manual for more information on member appeals.

PROVIDERS

General Responsibilities

CarePartners of Connecticut providers agree to comply with all state and federal laws and regulations including, but not limited to, CMS regulatory requirements applicable to CarePartners of Connecticut in providing or arranging for services to any member.

Providers must also comply with CarePartners of Connecticut's contractual obligations, such as requests for information necessitated by government contracting requirements.

Provider Update

Provider Update is CarePartners of Connecticut's quarterly newsletter for providers, hospital administrators and ancillary providers in the CarePartners of Connecticut network. *Provider Update* is CarePartners of Connecticut's primary vehicle for providing 60-day notifications and other critical business-related information to providers.

CarePartners of Connecticut distributes its *Provider Update* newsletter by email. To receive *Provider Update* by email, providers must register by completing the online registration form, available in the News section of the CarePartners of Connecticut public Provider website. Providers who routinely visit the public Provider website for updates and who prefer not to receive *Provider Update* by email will have the opportunity to indicate that preference on the online registration form.

This requirement applies to all contracting providers, including but not limited to, providers who are currently registered users of the secure Provider website as well as those who have previously submitted an email address to CarePartners of Connecticut for any reason. Office staff and provider organization and hospital leadership can also register to receive *Provider Update* by email.

Office staff may also register a provider on his or her behalf by using the provider's name, email address and NPI.

Individuals who register to receive *Provider Update* by email are responsible for keeping their email addresses and contact information updated. To update information that was previously submitted through the online registration form, providers should resubmit the form with updated information.

Note: Providers who register to receive *Provider Update* by email but are still not receiving it must check their spam folder or check with their organization's system administrator to ensure the organization's firewall is adjusted to allow for receipt (sender: *providerupdate@email-carepartnersct.com*).

Current and recent past issues, as well as the articles featured in *Provider Update*, will be available in the News section of the CarePartners of Connecticut Provider website.

Confidentiality of Member Medical Records

CarePartners of Connecticut requires that providers comply with all applicable state and federal laws relating to the confidentiality of member medical records, including but not limited to the privacy regulations of Health Insurance Portability and Accountability Act (HIPAA).

To meet CarePartners of Connecticut confidentiality requirements, providers must do the following:

- Maintain medical records in a space staffed by office personnel
- Maintain medical records in a locked office when staff is not present
- Prohibit unauthorized review and/or removal of medical records
- Maintain and adhere to policies and procedures regarding patient confidentiality

CarePartners of Connecticut also requires that providers, upon request, provide member medical information and medical records for the following purposes:

- Administering its health benefit plans, such as claims payment, coordination of benefits, subrogation, enrollment eligibility verification, reinsurance, and audit activities
- Managing care, including but not limited to utilization management (UM) and quality improvement activities

- Carrying out member satisfaction procedures described in member benefit booklets
- Participating in bona fide medical research and in reporting on quality and utilization indicators, such as Healthcare Effectiveness Data and Information Set (HEDIS®)
- Complying with all applicable federal and state laws

Providers are responsible for obtaining any member consents or releases that are necessary beyond those that CarePartners of Connecticut has already acquired through the enrollment process or the member benefit booklets. CarePartners of Connecticut maintains and uses member medical information in accordance with CarePartners of Connecticut's confidentiality policies and procedures.

Primary Care Providers (PCPs)

PCPs are responsible for monitoring the care of their CarePartners of Connecticut members to provide quality and cost-efficient medical management.

The PCP must be able to provide integrated, accessible health care services and be accountable for addressing a large majority of personal health needs, developing a sustained partnership with members, and practicing in the context of the family and community.

The following list encompasses a common set of proficiencies for all PCPs:

- Training in a primary care discipline, or significant additional training in primary care subsequent to training in a non-primary care discipline
- Periodic assessment of the asymptomatic patient
- Screening for early disease detection
- Evaluation and management of acute illness
- Ongoing management of members with established chronic diseases
- Coordination of care among specialists, including acute hospital care and long-term care
- Assessment and either management or care coordination of members with more complex problems requiring the diagnostic and therapeutic tools of a specialist or other health care professional.

Note: The PCP must be either an MD, DO, NP or PA who is appropriately trained and provides integrated, accessible, preventive health care services and health care services for members. The PCP must be accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of the family and the community.

Responsibilities

PCPs are responsible for providing or arranging the total care of their CarePartners of Connecticut members. This includes providing high-quality, cost-efficient medical care and/or management. The PCP's role in successfully recognizing and addressing the member's needs is key to the success and satisfaction of the member, the medical group and CarePartners of Connecticut.

PCP responsibilities include the following:

- Providing care in a manner consistent with recognized standards of health care and in a culturally-competent manner to all CarePartners of Connecticut members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds and/or physical or mental disabilities. Successful medical service management and coordination ensures continuity of care and eliminates test and procedure duplication.
- Being accessible to members 24 hours a day, 7 days a week via direct contact or through PCP-arranged provider alternative, another CarePartners of Connecticut participating provider.
- Coordinating services that allow for continuity of care and integration of services, including:
  - Continuous patient care and quality review
  - An initial assessment of the member's health care needs within 90 days of the member's initial enrollment
  - Systems to address barriers to the member's compliance with the practitioner's prescribed treatments or regimens
  - Procedures to ensure that members are informed by providers of specific health care needs that require follow-up care and receive care/treatment as appropriate
  - Training in self-care and other measures members should take to promote their health.

- Arranging for the continuation of benefits in the event of plan contract termination, non-renewal, or insolvency through the end of the period for which the CarePartners of Connecticut member's premium is paid or hospital discharge date by the following:
  - Honoring all open authorizations for care
  - Placing outbound calls to affected CarePartners of Connecticut members who are scheduled for services and undergoing treatment plans to coordinate continuation of care
  - Providing an opportunity for members undergoing a treatment plan to continue to see providers who are no longer in the network due to the group insolvency
  - Providing standard and expedited organization determinations in accordance with the requirements described in the Referrals, Authorizations and Notifications chapter.

Specialty Care Referrals

Referrals for specialty services are not required for CarePartners of Connecticut members unless the specialist is outside the CarePartners of Connecticut network. If the member sees an out-of-network specialist without a referral, the member is liable for these services.

If a member believes that CarePartners of Connecticut should pay for a service that is considered noncovered, that constitutes an organization determination according to the Medicare Managed Care Manual, Chapter 4, section 160 ("Beneficiary Protections Related to Plan-Directed Care").

Refer to the Referrals, Authorizations and Notifications chapter of this provider manual for more information on organization determinations.

Closing and Opening a Panel

PCPs may close their practices to new members for reasons such as maternity leave, a research leave, or for capacity reasons. However, the PCP cannot close a panel for selected plans; closing a panel pertains to all CarePartners of Connecticut members.

PCPs must submit written notification to their CarePartners of Connecticut Associate Contract Specialist at least 90 days prior to closing their panels, or as otherwise specified in their contract with CarePartners of Connecticut. During the 90-day transition period, members will still be allowed to select the provider as their PCP. After the 90-day period, neither CarePartners of Connecticut enrollment representative nor the sales representative will direct any prospective members to select this PCP.

To reopen the panel, the provider must notify the CarePartners of Connecticut Associate Contract Specialist in writing and must include the date the panel will reopen.

Temporary Transfer of Responsibility

Provider agreements obligate CarePartners of Connecticut PCPs to establish and maintain coverage 24 hours a day, 7 days a week. However, personal illness, sabbatical or maternity leave are examples of situations in which briefly withdrawing from your practice and temporary transfer of this responsibility may be necessary.

If the intended interruption will exceed 60 calendar days, CarePartners of Connecticut requires the PCP to provide written notice to CarePartners of Connecticut. At a minimum, this notification must include the dates and general reasons for the temporary transfer of responsibility. CarePartners of Connecticut can then close the panel, since absence beyond two months does not allow for direct patient management.

Leave of Absence

CarePartners of Connecticut requires prior notification from providers if they are going on a leave of absence (LOA) for longer than 60 calendar days. At a minimum, this notification must include the dates and the general reason for the LOA (sabbatical, medical reason, etc.). CarePartners of Connecticut must be notified of a pending LOA as soon as possible.

Providers taking a leave of absence must arrange for coverage by another participating practitioner in the CarePartners of Connecticut network. All covering arrangements must be acceptable to CarePartners of

Connecticut.

Arrangements for coverage by a nonparticipating practitioner (i.e., locum tenens) may be considered. These arrangements must have CarePartners of Connecticut prior approval and must be consistent with established policies and procedures.

If the LOA is scheduled for **six months or less**, CarePartners of Connecticut will confirm the conclusion of the LOA. If the LOA is concluded within six months, the provider's LOA status will be removed and will reflect his or her prior status.

If the LOA is scheduled for **longer than six months**, CarePartners of Connecticut reserves the right to terminate the provider from the network based upon continuity of care issues. In addition, if a provider's recredentialing is due during the LOA and the practitioner does not complete recredentialing materials, the provider may be terminated from the network based on contractual noncompliance.

Covering Practitioner

All CarePartners of Connecticut providers have contractually agreed to be accessible to CarePartners of Connecticut members 24 hours a day, seven days a week, either directly or through a covering practitioner. Providers who are unavailable are responsible for maintaining appropriate coverage that is acceptable to CarePartners of Connecticut. Covering providers must be credentialed by Tufts Health Plan on behalf of CarePartners of Connecticut.

Information regarding on-call activities must be relayed by the covering practitioner or the PCP to the Utilization Management (UM) Committee, for logging and tracking purposes and for continuity of care. This information includes:

- All admissions
- Member's name, date of birth and ID number
- Instructions to members regarding follow-up care
- Instructions given or authorized services

Locum Tenens Policy

If coverage will be rendered by a *locum tenens* provider, the provider must be credentialed by Tufts Health Plan on behalf of CarePartners of Connecticut.

When notice is given by an independent practice association (IPA) or practice office that a practitioner will be joining under a *locum tenens* status, the *locum tenens* provider(s) must submit the appropriate documents to the Tufts Health Plan Credentialing Department. If a practitioner does not have a primary hospital affiliation, they must submit the name of the practitioner who will be admitting on their behalf.

Tufts Health Plan's credentialing staff, on behalf of CarePartners of Connecticut, will:

- Obtain primary verification of hospital privileges and confirmation that the hospital has credentialed the practitioner pursuant to 243 CMR 3.05 or other regulation, as applicable
- Collect information from the National Practitioner Databank.

Changing PCPs

CarePartners of Connecticut members or their authorized representatives may request to change their selected PCP to a PCP within the CarePartners of Connecticut service area. CarePartners of Connecticut must receive the member's request either by phone or in writing by 4 p.m. of the last business day of the month for the transfer to be effective the first day of the following month. Transfers are normally effective on the first day of the following month. CarePartners of Connecticut providers should make efforts to ensure that the member's records are transferred to the new PCP in a timely manner to ensure continuity of care.

Each CarePartners of Connecticut member selects a PCP and at times during this practitioner/patient relationship situations may arise where the PCP and member do not agree. These disagreements can usually be discussed to develop an action plan agreed upon by both parties. For instance, members may disagree with the PCP suggested treatments or may opt for no treatment for some medical issues. These issues usually do not cause alarm or grave concern for the member's health.

In some cases members select PCPs but choose not to participate in annual visits. This is the member's choice and cannot be a reason to discharge a member from a PCP panel. Providers may request the member's care manager reach out to the member to determine if there are barriers that may be preventing the member from visiting the PCP's office. If so, transportation services, nurse practitioner home visits, or other benefits that address the member's barriers should be considered.

In rare circumstances, a member's behavior may interfere with the member's treatment plan initiated by the PCP. The PCP must discuss their concerns with the member and document the discussion in the member's medical record. If the member's behavior continues to interfere with the treatment plan, the PCP may issue a notice to the member documenting their discussion and actions agreed upon. This notice is titled Noncompliance of Practitioner Treatment Plan. This notice describes the situations in which the member's behavior has impaired the physician's ability to furnish services and for which the PCP has given the member opportunity to explain his or her behavior. After the notice has been issued, this notice may be issued a second time if the member has not taken action to correct the noncompliance issue. If the noncompliance of treatment persists despite discussions with the member and sending two written notices, both parties may come to an agreement that the member would best be served by arranging to change their PCP. If the member has not taken action to change their behavior and does not want to change their PCP, the PCP should contact Provider Services for assistance with ongoing management of the member's care. The PCP may not discharge a CarePartners of Connecticut member; however, the member may voluntarily make a PCP change.

In extremely rare circumstances, inappropriate disruptive behavior on the part of the member may exist, impairing the ability of the provider to furnish quality medical services. A PCP is expected to contact CarePartners of Connecticut if they feel a member has displayed true disruptive behavior. This disruptive behavior is behavior that will substantially impair the PCP's ability to arrange for or provide services to either that particular member or other CarePartners of Connecticut members. In these cases of behavioral concern, the PCP must discuss the case with CarePartners of Connecticut who will investigate the case details and determine if further actions, up to and including requesting disenrollment, will be initiated.

In the event a provider believes they have a disruptive member, the provider should contact Provider Services and notify the member's care manager.

Notes

CarePartners of Connecticut requires the following:

- Documentation that the provider has discussed with the member (or authorized representative) the issues that are affecting the member's medical treatment
- The PCP must send the Noncompliance of Practitioner Treatment Plan letter(s) to the member, with copies to CarePartners of Connecticut for the member's file
- The letter must provide specific description of the concern with specific practitioner orders, dates of noncompliance and provider recommendations
- The notice should include how the member may comply with the treatment plan and should be sent to the member on two separate occasions, allowing a reasonable time for the member to demonstrate compliance with the treatment plan.

Examples of when PCPs may use this letter include situations such as when the member's treatment plan involves appointments with the PCP every other week to evaluate a wound status and wound care regimen, but the member has failed to keep the last two appointments although the PCP's office staff has called in advance to remind the member of each appointment.

Provider Terminations and Network Changes

A provider must provide CarePartners of Connecticut with at least 180 calendar days' written notice when a PCP or specialist is terminating, subject to any notice requirements and deadlines as may be found in the provider's contract.

CarePartners of Connecticut will make a good-faith effort to provide written notice of the termination of a contracted provider at least 30 calendar days prior to the termination effective date to all members who are seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a PCP, all of that PCP's members must be notified by the Plan.

Specialists

Specialists within the CarePartners of Connecticut network are expected to provide quality, cost-efficient health care to CarePartners of Connecticut members. Contracted providers must provide care in a culturally competent manner to all CarePartners of Connecticut members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and/or physical or mental disabilities.

The specialist's primary responsibility is to provide authorized medical treatment to CarePartners of Connecticut members. Services rendered without authorization (when applicable) are only covered if the member received prior notice that such services will be covered. Such prior notice of coverage is the issuance of an organization determination. Refer to the Referrals, Authorizations and Notifications chapter for more information on Organization Determinations.

Specialists are also responsible for submitting a summary report to the member's PCP following the member's appointment, prior to requesting additional services.

Contracting specialists are required to provide 90 days prior notice of termination of their participation with CarePartners of Connecticut to members who have been/are under their ongoing care.

Nurse Practitioners and Physician Assistants

Nurse practitioners (NPs) and physician assistants (PAs) may elect to bill under their supervising or collaborating physician. NPs and PAs who are working under the auspices of a licensed practitioner, as permitted by state law, and for whom the provider and/or facility (e.g., hospital) have met all applicable requirements, may bill for those covered services under the supervising provider's identification number.

A Provider Organization may, in its discretion, include NPs and PAs in their contracts through the signature pages attached to the contract to provide or arrange for Health Services pursuant to the Agreement. NPs and PAs, once contracted through a CarePartners of Connecticut contract and credentialed by Tufts Health Plan on behalf of CarePartners of Connecticut, may be listed in directories and may hold a panel as a PCP, or serve as a specialist and are subject to the terms as set forth in the relevant Health Services Agreement's financial exhibit(s).

Use of Nurse Triage Service

If a practitioner uses a nurse triage service for telephone screening after hours, the practitioner must instruct the nursing staff to identify themselves as nurses covering for a practitioner. This service also includes the following:

- Communication to members that if they are in an emergency situation, they should hang up and call 911 or go to the nearest emergency department.
- At the completion of the call, verification that the member is comfortable with the advice that they received, and inform the members of their right to speak to the covering provider.

Note: All practitioners used for covering purposes must be licensed as required by law.

Summary of Credentialing Process

Tufts Health Plan on behalf of CarePartners of Connecticut, credentials affiliated providers when they join the plan, and again at least every three years in accordance with state and federal regulatory and accrediting agency requirements. All contracting providers must be eligible for and accepting payment under Medicare.

The credentialing process involves collecting documents from providers and direct verification through various outside agencies, all in accordance with the standards of Centers for Medicare and Medicaid Services (CMS) and as required by state and federal laws.

Provider Requirements

For initial credentialing and recredentialing, each provider is required to comply with Tufts Health Plan's Credentialing Program, on behalf of CarePartners of Connecticut, and to submit the following information for review:

- Signed and completed credentialing/recredentialing application through CAQH ProView™
- Current malpractice insurance information
- Signed health services agreement (initial credentialing only) and appropriate contract documents
- Signed W-9 form (initial credentialing only)

Primary Hospital Requirements

Each practitioner must indicate their primary admitting hospital in the application. Tufts Health Plan on behalf of CarePartners of Connecticut sends a request to the primary hospital confirming that it has assessed the practitioner's performance, as mandated by the Joint Commission or other accrediting agency acceptable to CMS and Tufts Health Plan. The hospital is queried again during recredentialing. Appointment verification is then sent by the primary admitting hospital for each practitioner. The practitioner must notify CarePartners of Connecticut, through written communication to Tufts Health Plan, of changes in primary hospital affiliation.

Credentialing Requirements

In addition to verification of certain credentialing elements, Tufts Health Plan on behalf of CarePartners of Connecticut must obtain and review the following information prior to the final assessment of each provider:

- Board certification status
- Information obtained from the National Practitioner Data Bank (NPDB)
- Medicare/Medicaid sanctions
- System award management sanctions
- State disciplinary actions

The Quality of Care Committee (QOCC), chaired by a Tufts Health Plan medical director, meets monthly to review and discuss providers who are being credentialed or recredentialed. No provider will be authorized to provide services to members unless the following criteria are met:

- Review of all data requirements from the provider
- Approval by a designated medical director or by the QOCC

If the contract provides for credentialing activities by a first-tier or downstream entity, the first-tier or downstream entity must meet all applicable Tufts Health Plan credentialing requirements, including Tufts Health Plan either reviewing the credentials of medical professionals or reviewing, preapproving and auditing the credentialing process.

Provider Contracting Requirements

Health care providers and plans must abide by specific contracting requirements, including, but not limited to the following:

Privacy, Confidentiality and Accuracy

Providers and subcontractors must:

- Safeguard member privacy and confidentiality
- Assure the accuracy of member health records
- Comply with all federal and state laws regarding the privacy, security and disclosure of member information (including HIPAA), as amended

Availability of Health Services

Practitioners must provide access to health services 24 hours a day, 7 days a week, or arrange for coverage that is reasonably acceptable to CarePartners of Connecticut.

Cultural Competency

Providers must offer covered benefits in a culturally competent manner consistent with professionally recognized standards of health care and in a culturally competent manner, and, if possible, provide interpreters/translator

services for those who are deaf or hearing-impaired.

Providers must provide health services in a way that is responsive to the linguistic, cultural, ethnic, or other unique needs of members of minority groups, homeless individuals, disabled individuals and other special populations served under this program.

Urgently Needed Care

CarePartners of Connecticut must pay for, and providers may not bill or require members to receive prior authorization for, emergency and urgently need care. This information is outlined in the Referrals, Authorizations and Notifications chapter.

Data Submission

Providers must submit to CarePartners of Connecticut all data (including medical records) that are necessary to characterize the content/purpose of each visit with a member. Providers must also certify that any data resulting from a visit or any other information submitted to CarePartners of Connecticut will be complete, accurate and truthful.

Data must be in a format that is compatible with CarePartners of Connecticut systems and should include the management, clinical data, utilization and cost data needed to administer the product.

Fraud, Waste and Abuse

Providers must comply with federal and state laws and regulations designed to prevent, identify and correct fraud, waste and abuse (FWA). If a practitioner becomes aware of a questionable practice by a CarePartners of Connecticut provider or member that may indicate possible health care fraud, CarePartners of Connecticut has a Hotline for reporting concerns. The Hotline was established to help CarePartners of Connecticut's members, providers and vendors who have questions, concerns and/or complaints related to possible wasteful, fraudulent or abusive activity.

Providers can call the CarePartners of Connecticut Compliance and Fraud Hotline to report concerns 24 hours a day, 7 days a week at 877.824.7123. Callers may self-identify or choose to remain anonymous.

Providers who care for CarePartners of Connecticut members are required to comply with CMS certification requirements. For additional educational materials about FWA, including web-based training, refer to CMS.

Disclosure of Relevant Information

Providers must disclose to CarePartners of Connecticut and CMS all information necessary to establish and facilitate a process for current and prospective enrollees to exercise choice in obtaining Medicare and Medicaid covered services.

Inspections and Audits

First tier and downstream entities must:

- Comply with Medicare laws, regulations and CMS instructions (422.504(i)(4)(v))
- Agree to audits and inspection by CMS and/or its designees and to cooperate, assist, provide information as requested, and maintain records for a minimum of ten years
- comply with all state and federal confidentiality requirements, including those established by CarePartners of Connecticut.
- Comply with all federal and state laws and regulations concerning the privacy and confidentiality of member information, including HIPAA.

Responsibilities of Administrative Services Providers

The contract must clearly state the responsibilities of the administrative services provider and its reporting arrangements.

Advance Directives

If a member has a signed advance directive, providers must document this information in a noticeable place in

the member's medical record.

Outreach

CarePartners of Connecticut will not contact a prospective member without a direct request from that individual or that individual's representative or as permitted, under applicable CMS requirements. If an individual is interested in learning about a CarePartners of Connecticut plan, they can call Customer Service at 888.341.1507 (TTY: 711).

Additional outreach methods include the following:

- A provider can request assistance from CarePartners of Connecticut to mail a CMS-approved letter to current patients.
- Additionally, a representative is available to conduct informational sessions at provider practice locations. For additional information, contact the Sales department at 833.270.2728.

In addition, if CarePartners of Connecticut decides not to include individuals or groups of providers in its provider network, the affected providers will be given written notice of the reason for this decision.

Treatment Plan

Providers must:

- Educate members regarding their unique heath care needs
- Inform members of follow-up care or provide training in self-care as necessary
- Share the findings of medical history and physical examinations
- Discuss potential treatment options, including alternative medications, side effect of treatment and management of symptoms
- Recognize that the member generally has the right to choose the final course of action among clinically acceptable choices regardless of any coverage limitations or exclusions
- PCPs must make best efforts to conduct or arrange an initial health needs assessment of each member in his or her panel within 90 days of the member's date of enrollment

Communication of Clinical Information

Appropriate and confidential exchange of information among providers should occur such that:

- The provider coordinating the member's care transmits necessary information to the provider supplying the specialty service
- The provider supplying the referral service reports appropriate information to the referring provider
- Providers request information from treating providers as needed to furnish care

Discrimination Prohibited

CarePartners of Connecticut may not limit, deny, or condition the coverage of benefits to individuals eligible to enroll in a Medicare Advantage Plan on the basis of any factor that is related to health status, including but not limited to:

- Medical condition
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence and disability

Exceptions include an individual who:

- Has been medically determined to have ESRD
- Lives inpatient in a chronic or rehabilitation hospital
- Resides in an intermediate care facility for the intellectually disabled

Provider Compliance

CarePartners of Connecticut participating providers agree to comply with all applicable state and federal laws

and regulations. Providers must cooperate in a timely manner with plan policies and procedures and its activities to comply with these laws and regulations, and with plan contractual obligations, such as requests for information necessitated by CMS contracting requirements, as applicable.

Provider Rights

Federal regulations require CarePartners of Connecticut to maintain procedures relating to the rights of participating providers.

Contracting Rights

All participating providers must be furnished with plan participation rules and notice of material changes in participation rules.

If Tufts Health Plan decides not to include individuals or groups of providers in its provider network after an application has been submitted, the affected providers will be given written notice of the reason for this decision.

In some cases, providers may appeal adverse participation decisions. In the case of termination or suspension of a provider contract by CarePartners of Connecticut, the provider must be given written notice of the reasons for such action and notification of appeal rights, if applicable, including the process and timing for a hearing request, as required by law.

Providers who have not been notified of the suspension or termination of an existing contract with CarePartners of Connecticut may be allowed to appeal adverse participation decisions.

Credentialing Rights

Participating providers may appeal adverse credentialing decisions. In the case of termination or suspension of a provider for quality reasons by Tufts Health Plan on behalf of CarePartners of Connecticut, the provider must be given written notice of the reasons for such action and be informed of their right to appeal the action, including the process and timing for a hearing request, as required by law. There is no right of appeal on initial application decision.

Providers have the right to review information submitted to Tufts Health Plan for purposes of credentialing or recredentialing the provider on behalf of CarePartners of Connecticut, including information obtained by Tufts Health Plan from any outside primary source, (e.g., malpractice carrier, state license board or the NPDB). Tufts Health Plan shall notify the provider of the right to review such information.

Notwithstanding the foregoing, Tufts Health Plan on behalf of CarePartners of Connecticut is not required to reveal the source of information if the information was not obtained for the purpose of meeting Tufts Health Plan credentialing requirements.

- Providers are not entitled to review references, recommendations or information that is peer-review privileged or information, which by law Tufts Health Plan on behalf of CarePartners of Connecticut is prohibited from disclosing.
- Tufts Health Plan, on behalf of CarePartners of Connecticut, shall notify providers in the event that credentialing information, which is obtained from sources other than the provider, varies substantially from credentialing information provided to Tufts Health Plan by the provider.

Providers have the right to correct erroneous information submitted by another party and Tufts Health Plan shall notify providers of their right to correct erroneous information.

If the QOCC votes to take disciplinary action, the provider is entitled to a notice consisting of a written statement of the reasons for the action and, if applicable, has the right to appeal such action by filing a written appeal within 30 days of receipt of the statement of reasons.

Providers have the right, upon request, to be informed of the status of their credentialing or recredentialing application.

Provider Marketing Activities

CarePartners of Connecticut requires that any provider contracted with CarePartners of Connecticut (and its subcontractors) or agent (or its subcontractors) performing functions on behalf of CarePartners of Connecticut related to the administration of the benefit, including all activities related to assisting in enrollment and education, agrees to the same restrictions and conditions that apply to CarePartners of Connecticut through its contract(s) with CMS, and prohibits providers from steering, or attempting to steer, an undecided potential enrollee toward a plan, or limited number of plans, offered either by CarePartners of Connecticut or another plan sponsor, based on the financial interest of the provider or agent (or their subcontractors). Providers that have entered into co-branding relationships with CarePartners of Connecticut must also follow this guidance.

Guidelines associated with provider marketing activities and additional information can be found in CMS' Medicare Communications and Marketing Guidelines.

REFERRALS, AUTHORIZATIONS AND NOTIFICATIONS

Referrals

A referral verifies that the member's PCP has approved the member's request to receive services from a specialist provider outside the CarePartners of Connecticut network. It is the responsibility of the PCP to ensure that the member is directed to the appropriate specialist. Referrals should be coordinated prior to services being rendered.

To ensure that appropriate specialty care is provided, the PCP initiates and coordinates the referral management process for CarePartners of Connecticut members according to the following list:

- The PCP may approve a referral to a specialist outside the CarePartners of Connecticut network, indicating the specific services and number of visits to be provided to the member, when:
  - The PCP decides that such a referral is medically necessary
  - The services cannot be obtained from an in-network provider
  - The specialist agrees to a treatment plan and provides the PCP with all necessary clinical and administrative information on a regular basis
  - The health care services to be provided are consistent with the terms of the member's plan benefits
- Specialists must submit a summary report on a timely basis to the medical group following the member's appointment.
- Any questions or problems regarding referrals should be directed to CarePartners of Connecticut Provider Services at 888.341.1508.

Refer to the Referral, Authorization and Notification Policy for additional information.

Completing the Paper Referral Form

The paper referral form requires information about the PCP, the member, and the consulting provider. To order paper referral forms, providers may fill out the W.B. Mason Provider Forms Requisition and fax it to W.B. Mason at 800.773.4488 or email it to carepartnersct@wbmason.com.

The PCP must complete the referral form. If any required fields are left blank, the referral form will be returned to the PCP requesting additional information. Upon receipt, the Claims Department enters the referral in the system.

Claim reviewers verify the date range on the referral matches the date of service on the claim. If no matching referral is found, the claim will pend for *AUREQ* (authorization/referral expired).

Member name, ID number, and date of birth are required for claim adjudication. Member information may be obtained from the following sources:

- Member ID card
- Individual Election Form
- Monthly eligibility listing report
- Eligibility inquiry on the CarePartners of Connecticut secure Provider website
- Change Healthcare™

Electronic Referral Exclusions

CarePartners of Connecticut referral policies apply to electronic referrals. However, certain services and/or coverage for certain specialties do not require referrals or may have alternative prior authorization or inpatient notification requirements, as applicable. Refer to the CarePartners of Connecticut Prior Authorization and Inpatient Notification List for a list of specific procedures, items, and/or services that fall under these requirements.

Out-of-Area Services

CarePartners of Connecticut may provide coverage outside the CarePartners of Connecticut service area to members in certain circumstances, including but not limited to the following:

- Urgent/emergency care (including emergency ambulance transportation to the nearest appropriate facility)
- Post-stabilization services provided after an emergency to either maintain the stabilized condition, or under certain circumstances, to improve or resolve the member's condition
- Kidney dialysis services provided by a Medicare-certified dialysis facility

Providers may contact CarePartners of Connecticut Provider Services at 888.341.1508 to verify benefit coverage when the member is outside the service area.

Referral Inquiry

Providers may check the status of an existing referral by using the **Referral Status Inquiry** on the CarePartners of Connecticut secure Provider website. The referral status inquiry tool provides the status of any referral submitted to CarePartners of Connecticut, regardless of how the referral was initially submitted.

Referral Adjustments

To request an adjustment to a referral that is already in the CarePartners of Connecticut system, the PCP must contact Provider Services at 888.341.1508 for assistance. CarePartners of Connecticut cannot adjust referrals based on the specialist's request. If the specialist would like to request an adjustment to a referral, the specialist should follow up directly with the member's PCP.

Prior Authorizations

A prior authorization (PA) may be required to determine medical necessity and appropriateness of certain health care services. Services that may require prior authorization include surgical services, durable medical equipment (DME), and/or prescription drugs.

Prior Authorization through the Precertification Operations Department

To obtain authorization for a medical service, device or equipment requiring prior authorization through the Precertification Operations Department, the provider must submit the appropriate clinical documentation for review. As a condition of payment, the **treating** provider is required to submit documentation of medical necessity for services requiring authorization. Documentation must detail:

- The member's diagnosis
- Planned treatment, including medical rationale for the service requested
- All pertinent medical information available for review.

Prior authorization requests should be faxed to the Precertification Operations Department at 857.304.6463. Refer to the CarePartners of Connecticut Prior Authorization and Inpatient Notification List for a complete listing of nonpharmacy services, items and supplies that require PA.

Prescription Drugs Prior Authorization Requests

Certain prescription medications require prior authorization through CarePartners of Connecticut. For requests regarding prescription medications that have coverage limitations, the provider may submit the appropriate supporting clinical documentation on the Coverage Determination and Prior Authorization Request Form: Medicare "Part B versus Part D" Drugs or the Request for Medicare Prescription Drug Coverage Determination forms prior to rendering services.

Requests for coverage determinations and exceptions may be submitted to the Pharmacy Utilization Management Department via the following:

Fax: 617.673.0956
Mail: CarePartners of Connecticut
Attn: Pharmacy Utilization Management Department
705 Mount Auburn Street
Watertown, MA 02472

Note: Providers may also submit electronic prior authorizations (ePA) through their EMR system or through a third party ePA vendor for review by Tufts Health Plan.

Exception Requests

All formulary exception requests require a supporting statement from the prescribing provider. The provider can submit the request using the Request for Medicare Prescription Drug Coverage Determination form. These forms request information regarding diagnoses and what other drugs (if any) have been prescribed for the diagnoses and why they have not worked. The provider may submit either form via the ePA, fax or mail options listed above.

The provider may also provide an oral supporting statement by calling Provider Services at 888.341.1508, Monday through Friday, 8 a.m.–8 p.m.

All **standard** coverage determination and exception requests will be made within **72 hours** after receipt of the request, but can be up to six days if supporting information is needed from the requesting provider.

All **expedited** coverage determination and exception requests will be made within **24 hours** after receipt of the request, but can be up to four days if supporting information is needed from the requesting provider.

Note: Coverage determinations may not exceed 14 calendar days from the date the request is received.

Formulary

A formulary is a list of covered drugs selected for CarePartners of Connecticut in consultation with a team of health care providers. This list represents the prescription therapies believed to be a necessary part of a quality treatment program CarePartners of Connecticut will cover drugs listed in the CarePartners of Connecticut formulary as long as the drug is medically necessary, the prescription is filled at a CarePartners of Connecticut network pharmacy, and all other plan rules are followed. If approved, the member will be covered for the drug. If denied, members and providers may follow the appeal process outlined in the Member Appeals and Grievances chapter of this Provider Manual.

Note: Some Part D drugs obtained at out-of-network pharmacies are covered by CarePartners of Connecticut, as required by CMS and federal regulations (Medicare Prescription Drug Benefit Manual, Chapter 6, Section 10.2: "Covered Part D Drugs," in accordance with 42CFR §423.124).

Note: The CarePartners of Connecticut comprehensive formulary includes the Part D formulary approved by CMS.

Medicare Part D Transition

CarePartners of Connecticut may offer a temporary 30-day supply of prescription drugs that were either not on the previous year's formulary or that may have been restricted in some way. Members may receive this "transition fill" during the first 90 calendar days of new membership or the first 90 calendar days of the calendar year for existing members. If the member receives a transition fill, CarePartners of Connecticut will send a letter to the practitioner and the member detailing the nature of the temporary supply.

Medications Covered by Original Medicare Part B

CarePartners of Connecticut provides coverage for most drugs and biologicals that are covered by Original Medicare Part B.

Note: Medications covered by Original Medicare Part B are not part of the member's Part D prescription drug benefit. Refer to the Medicare Part B vs. Part D Coverage Determination Request Form for more information.

Original Medicare-covered Part B medications include the following:

- Drugs billed by providers and typically provided in an office setting
- Drugs billed by pharmacy suppliers and administered through DME (e.g., respiratory drugs given through a nebulizer)
- Some drugs filled by the pharmacy (e.g., some immunosuppressant drugs depending upon use and some oral chemotherapy drugs)
- Some end-stage renal disease (ESRD) drugs

Vaccines

Some vaccines are covered under the member's medical benefit (Part B) while others are covered under the pharmacy benefit (Part D). When vaccines are covered under Part D, the administration costs will be reimbursed under Medicare Part D. Refer to the Immunization Payment Policy for more information.

Pharmacy Plan Management Programs

Prior Authorization (PA)

The PA process encourages rational prescribing of drug products with significant safety and/or financial concerns. A provider can submit a request for coverage based on a member's medical need for a particular drug.

Quantity Limit (QL)

Because of potential safety and utilization concerns, CarePartners of Connecticut has placed dispensing limitations on certain prescription drugs. Pharmacies may only dispense a certain quantity of these drugs within a given time period. These quantities are based on recognized standards of care, such as FDA recommendations for use. If a member needs a quantity greater than the program limitation, their prescribing provider may submit a formulary exception request for coverage under the medical review process.

Step Therapy Prior Authorization (STPA)

Step therapy is an automated form of PA that uses claims history for approval of a drug at the point of sale. STPA programs help encourage the clinically proven use of first-line therapies and are designed to ensure the utilization of the most therapeutically appropriate and cost-effective agents first, before other treatments may be covered. Members who are currently on drugs that meet the initial STPA criteria will automatically be able to fill their prescriptions for a stepped medication. If the member does not meet the initial STPA criteria, the prescription will deny at the point of sale with a message indicating that PA is required.

Medication Therapy Management (MTM) Program

CarePartners of Connecticut members may be eligible for the Medication Therapy Management (MTM) Program. Eligible members are automatically enrolled in the program and are offered a one-to-one telephone consultation with a clinical pharmacist. Information gathered during this process, along with pharmacy claims and clinical notes from the provider (when made available), are used to develop clinical recommendations where appropriate. Pharmacist recommendations are faxed to the provider for consideration. Members will receive an individualized written summary of the consultation and comprehensive medication review (CMR) by mail. CMRs are offered at least once a year.

In addition, targeted medication reviews (TMRs) are done to assess medication use, monitor unresolved issues, and identify new drug therapy problems. These TMRs are performed on a quarterly basis with any recommendations sent to the provider via fax. Participation in the program is voluntary and a member can disenroll at any time.

For additional information on program eligibility criteria, refer to the MTM Program.

Appeals and Grievances for Pharmacy Benefits

Timelines for appeals and/or grievances for pharmacy benefits may differ from those surrounding preservice coverage determinations (also known as organization determinations). For more information regarding appeals and grievances, refer to the Member Appeals and Grievances chapter.

Organization Determinations

The term "organization determination" is a CMS term used to describe preservice coverage decisions made by CarePartners of Connecticut. CarePartners of Connecticut's processes may include prior authorization requests for services addressed in this chapter and other coverage decisions, such as benefit exhaustions.

Preservice organization determinations may be requested for any Medicare procedure, service, or supply, regardless of whether or not that service requires prior authorization. If the member disagrees with a treatment decision or plan of care, an organization determination may be initiated by the member, the member's authorized representative, or the provider on the member's behalf.

Once an organization determination is requested, CarePartners of Connecticut will:

- Validate that the requestor is approved to make a request
- Determine whether the request is expedited or standard, as defined by CMS
- Collect and review the applicable coverage documents (e.g., Medicare regulations, member evidence of coverage [EOC], or supporting medical necessity documentation)
- Ensure that the member and provider are notified of coverage decisions within the required time frames

Organization Determination Time Frames

Requests may be expedited if either the member or provider believes that waiting for a decision under the standard timeframe could place the member's life, health or ability to regain maximum function in serious jeopardy.

CarePartners of Connecticut follows CMS regulations regarding decision and notification time frames for organization determinations and expects contracting providers to comply with these regulations. Providers may contact Provider Services at 888.341.1508 with additional questions regarding the organization determination process.

CarePartners of Connecticut must notify the member of the determination as expeditiously as the member's condition requires but not later than the expiration of the time frames below:

- For expedited requests, the member must be notified of the decision no later than 72 hours from the time of the request.
- For standard requests, the member must be notified of the decision no later than 14 calendar days from the time of the request.

An extension to the above time frames may be requested under certain limited circumstances, as defined by CMS. Refer to the Utilization Review Determination Time Frames for more information.

Organization Determination Process

In order to process an organization determination, CarePartners of Connecticut must collect and review all necessary supporting documentation to make a decision. Documentation may include, but not be limited to, the member's EOC, Medicare regulations (including LCD/NCDs) and clinical documentation submitted by the provider.

It is expected that all Medicare-certified providers be familiar with the coverage regulations related to the services that they order and/or provide. Providers must participate in discussions with CarePartners of Connecticut medical directors and clinicians as needed to discuss coverage requests. CarePartners of Connecticut providers are expected to submit all organization determination requests with sufficient clinical documentation for CarePartners of Connecticut to make a timely decision.

If a request is received with insufficient clinical information to make a decision, CarePartners of Connecticut will fax a request for more information (RFMI) letter to the provider (or call the provider in expedited cases). The

RFMI letter includes the specific clinical information being requested, submission options, and a due date by which the information must be received by CarePartners of Connecticut in order to process the request within regulatory requirements.

In general, providers are asked to respond to these requests by the end of the next business day. If there is no timely response from the provider to the RFMI request, follow-up outreach calls to the provider office and group medical director or integrated delivery networks leader will be made.

Note: RFMI letters will be directed to the treating provider. These requests will be directed to the centralized contact specified by each medical group for such requests instead of the PCP.

Once all the necessary documentation is on hand, CarePartners of Connecticut will make an organization determination. The member and provider will be notified verbally and in writing of the decision, according to regulations.

In the event of an adverse determination (denial), the decision may be appealed (reconsideration). Medicare does not allow for a peer-to-peer discussion of the decision in lieu of filing an appeal. Refer to the Member Appeals and Grievances chapter for additional information about the appeal process.

Refer to Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for complete information about the organization determination requirements under Medicare.

Member-Initiated Requests for Organization Determinations

If there is a disagreement between the member and provider with a provider's decision to deny a service or course of treatment, in whole or part, the provider must inform the member of the right to contact CarePartners of Connecticut and request an organization determination. The same organization determination timeframe, notice and process requirements are in effect for all member-initiated requests as those described above.

Although it is encouraged, members are not required to discuss their request with their provider before contacting CarePartners of Connecticut. Members who have not discussed the requested coverage with their provider will be educated about the CarePartners of Connecticut plan design and the benefit of discussing treatment options with their PCP who is familiar with their health condition.

Once a member requests an organization determination, the Precertification Operations Department will fax an RFMI letter to the group medical director or IDN leader explaining the member's request, the specific information being requested to complete the review, and the deadline by which the information must be returned to CarePartners of Connecticut, unless sufficient information can be provided directly by the member at the time of the request. Responding by the deadline is expected so CarePartners of Connecticut can make a timely decision in compliance with CMS regulations. Phone calls will also be made in expedited cases.

Benefit Exhaustions

Certain services, such as skilled nursing facility, inpatient rehabilitation and long-term acute care hospital care may have benefit limitations for CarePartners of Connecticut members. Members receiving these services must be notified in writing that their benefit will be exhausted as of a certain date prior to the exhaustion of their benefit.

CarePartners of Connecticut must be notified by the provider in advance of the benefit exhaustion so a letter may be generated and the member may be notified, in accordance with CMS requirements. In order for the member to receive timely notice, the letter will be written by CarePartners of Connecticut and must be delivered to the member in the facility, or to their authorized representative.

The following information should be faxed by a provider treating a member approaching the exhaustion of their benefit to the Precertification Operations Department at 857.304.6463:

- Member name, ID number and date of birth
- Name, phone number and relationship to the member for the member's authorized representative, if applicable
- Name of facility and level of care (SNF, acute rehab, LTAC, etc.)
- Date of last covered day
- Name and phone number for medical group care manager

- Name, phone and fax numbers for the facility care manager who will facilitate delivery of the notice to the member.

Notifications

Inpatient Notification Policy

Inpatient notification is a process that makes CarePartners of Connecticut aware of all inpatient admissions and/or transfers to another facility. Inpatient notification is completed by the facility where the member is scheduled to be admitted or may be completed by the specialist provider.

Inpatient notification is required for the following services:

- Inpatient acute hospital admissions, including acute rehabilitation and long-term acute care
- Inpatient behavioral health and substance use disorder admissions and partial hospitalization services (PHP)
- Skilled nursing facility (SNF) admissions
- Institutional long-term care and other services provided to members while at a custodial level of care

Note: Home health care services require prior notification beyond the initial evaluation. Refer to the Home Health Care Payment Policy for additional information.

Prior Authorizations

Prior authorization may be required for certain items, procedures, and services **in addition to** inpatient notifications. For a complete listing of services requiring prior authorization, refer to the CarePartners of Connecticut Prior Authorization and Inpatient Notification List. Refer to the Prior Authorizations chapter of this manual for more information on obtaining and verifying prior authorizations.

Inpatient Notification Process

Inpatient notification is a notification to CarePartners of Connecticut of utilization of inpatient services. Inpatient notification is required for all elective, urgent, and emergent hospital admissions, as well as acute rehabilitation and skilled nursing facility (SNF) admissions services listed above.

When an admission is reported, the inpatient notification process does the following:

- Confirm that the admission is received by CarePartners of Connecticut
- Verifies member eligibility (subject to retroactive reporting of disenrollment)
- Screens for coverage/benefit exclusions
- Identifies the facility as an in-network CarePartners of Connecticut facility
- Verifies authorization for inpatient services outside of the CarePartners of Connecticut network.
- Identifies the facility as Medicare-approved, for services that must be performed in a Medicare-approved facility. Refer to the Medicare-Approved Facilities List for more information.

CarePartners of Connecticut verifies that covered services are directed by the PCP and/or the care manager. The CarePartners of Connecticut clinical team will also be notified so they can identify and intervene in any potential transition planning and/or discharge needs for the member. When the inpatient notification process is completed, an inpatient notification reference number is assigned and is used as a reference for adjudication of claims associated with that particular hospitalization.

Inpatient Notification Requirements

Notification verifies that covered services are directed by the PCP and have appropriate approvals by the medical group. The care manager is also notified so they can initiate concurrent review using Medicare coverage guidelines and InterQual® criteria and can identify and intervene in any potential discharge needs for the member. InterQual criteria are used for screening purposes only and are not used for medical necessity determinations.

Admitting providers and hospital admitting departments share the responsibility of notifying CarePartners of Connecticut in accordance with the following timelines:

- Elective admissions must be reported no later than **five business days** prior to admission (**Note:** SNF and LTAC admissions are not subject to this time frame)
- Urgent or emergent admissions must be reported by 5 p.m. the **next business day** following admission. This includes admissions that occur after-hours, on weekends, or on holidays.

If a previously submitted inpatient notification of admission is cancelled, the Precertification Operations Department must be notified of that cancellation and the reschedule date, if applicable. If an admission changes from outpatient or emergency to inpatient, the provider must notify the Precertification Operations Department within one business day.

Submission Channels

Registered providers may submit inpatient notification 24 hours a day, 7 days a week using the CarePartners of Connecticut secure Provider website and will receive a notification number upon submission in most cases.

Providers may also fax a completed Inpatient Notification Form to the Precertification Operations Department at 857.304.6410, 24 hours a day, seven days a week. No other forms will be accepted. Incomplete forms will be returned to the submitting provider for completion and resubmission. Processing of the request will be delayed until all required information is submitted.

Confirmation of Inpatient Notification

Notifications submitted via the web will be confirmed on entry. Notifications submitted via fax are confirmed via the web **Provider Inquiry** screen within 24 hours of submission. If a provider wants to obtain an inpatient notification number after submitting a notification request via fax, they can access this information via the Provider Inquiry screen or contact Provider Services at 888.341.1508.

Payment

Inpatient admissions for which an inpatient notification has been submitted according to the foregoing requirements are eligible for claim adjudication by CarePartners of Connecticut, as long as all other requirements have been met.

An inpatient notification number or the report of an admission does not guarantee payment. Denial of payment for late or lack of inpatient notification applies to the hospital claims. CarePartners of Connecticut network providers who are denied payment for late notification or lack of notification may not bill the member. To dispute a denial or request a claim review in writing, refer to instructions outlined in the Provider Payment Dispute Policy.

Medicare-Approved Facility Requirement

Medicare has issued several National Coverage Determinations (NCDs) providing coverage for services and procedures of a complex nature, with the stipulation that the facilities providing these services meet certain criteria. These criteria usually require, in part, that the facilities meet minimum standards to ensure the safety of beneficiaries receiving these services. Certification as a Medicare-approved facility is required for performing the following procedures. For coverage criteria, refer to the Medicare National Coverage Determination Manual (NCD manual):

- Lung volume reduction surgery (LVRS): NCD manual, Section 240.1
- Carotid artery stenting (CAS) : NCD manual, Section 20.7

Note: This requirement does not apply to CAS performed in a Medicare-covered Category B IDE study or postapproval study.

- Ventricular assist device (VAD) destination therapy: NCD manual, Section 20.9
- Certain oncologic positron emission tomography (PET) scans in Medicare-specified studies: NCD Manual, Section 220.6.17

In addition to these procedures, there is also a long-standing requirement that all heart, heart-lung, liver, intestinal/multivisceral, kidney, and pancreas transplants be performed at a Medicare-approved facility. The transplant work-up evaluation must also be performed in a Medicare-approved transplant facility. For more

information regarding transplants, refer to the Transplant Facility Payment Policy.

To determine if a facility is Medicare-approved to perform a particular service, refer to the List of CMS-Approved Organ Transplant Programs available on the Quality, Certification and Oversight Reports (QCOR) website.

Not all in-network providers who perform these services are Medicare-approved. CarePartners of Connecticut will not pay for services rendered at a non-Medicare-approved facility and network providers cannot hold the member liable for these services. Refer to the CarePartners of Connecticut Medicare-Approved Facilities List for a listing of Medicare-approved facilities that are also contracting with CarePartners of Connecticut.

In addition to the Medicare-approved facility requirement, all plan inpatient notification, prior authorization, and in-network and out-of-network plan rules apply. Providers must be sure members are referred only to Medicare-approved facilities for these services. To the extent a medical group/PCP is involved in referring a member to a non-Medicare-approved facility, the provider will be financially liable for the associated costs. Because these services must be provided in a Medicare-approved facility to be covered, the costs of services in a non-Medicare-approved facility cannot be paid using Medicare funds.

CLAIM REQUIREMENTS, COORDINATION OF BENEFITS AND DISPUTE GUIDELINES

General Guidelines

CarePartners of Connecticut processes completed claims that meet the conditions of payment and that are submitted within the time frame identified in the provider's contract with CarePartners of Connecticut. Completed claims are claims submitted in industry-standard electronic format or on industry-standard forms with all fields completed accurately (refer to the Claim Specifications section in this chapter).

Claims must be submitted within the contracted filing deadline according to the date of service, date of discharge, or date of the primary insurance carrier's explanation of benefits (EOB). CarePartners of Connecticut will deny claims submitted after the filing deadline, and the member may not be held responsible for payment. Refer to the Filing Deadline section of this chapter for more information.

Additional guidelines, payment policies, and clinical coverage criteria for specific services are available on the CarePartners of Connecticut public Provider website. To ensure accurate claims processing, CarePartners of Connecticut providers must follow the payment policies on the CarePartners of Connecticut website.

Electronic Data Interchange Claims

CarePartners of Connecticut encourages direct electronic submission to the plan, but also accepts claims submitted via a clearinghouse. To be accepted, claims submitted directly to CarePartners of Connecticut must be in HIPAA-compliant standard 837 format and include all required information. Refer to the 837 Companion Guide for additional information. All methods of electronic data interchange (EDI) claim submission produce claim reports that can be accessed electronically. These reports are used to confirm the receipt of claims, as well as to follow up on rejected claims.

If required information is missing, CarePartners of Connecticut (or the clearinghouse) will reject the claim. If an electronic claim is rejected, a clean electronic claim must be resubmitted no later than 60 days from the date of service.

For more information about submitting electronic transactions, contact CarePartners of Connecticut's EDI Operations Department via email at EDI_CT_Operations@carepartnersct.com or by phone at 888. 631.7002 ext. 52994 for a setup request. Refer to the Electronic Services Guide in the Provider Resource Center to download a set-up form and companion documents for submitting claims electronically directly to CarePartners of Connecticut.

EDI Referrals, Eligibility and Claim Status Inquiry

EDI submission commonly refers to claims, referral and eligibility transactions, but can be applied to other transaction types as well. CarePartners of Connecticut offers options for electronic referrals, online eligibility inquiries and claim status information, as follows:

Referral	• Web-based referral inquiry via the secure Provider website • ANSI 278: Request for review and response for outpatient referrals available through Change Healthcare™
Eligibility	• Web-based eligibility status via the secure Provider website • Change Healthcare™ • Integrated voice response (IVR) at 888.341.1508
Claim status inquiry	• Web-based claims inquiry via the secure Provider website • Change Healthcare™

Multiple Payees

For providers billing through EDI, CarePartners of Connecticut cannot accommodate payment to multiple payees

at multiple payment addresses. Payment will be sent to the address listed as the primary provider's office location in the CarePartners of Connecticut provider database. Any address changes or primary vendor/payee changes should be submitted in writing to the Provider Information Department.

Paper Claims

Some claims cannot be submitted electronically. Claims that must be submitted on industry-standard paper claim forms are:

- Claims requiring additional supporting documentation, such as operative or medical notes
- Claims for provider payment disputes
- Unlisted CPT procedures that require explanations or descriptions

Paper Claim Submission Requirements

All paper CMS-1500 and UB-04 claims must be submitted on standard red claim forms. Black and white versions of these forms, including photocopied versions, faxed versions and resized representations of the form that do not replicate the scale and color of the form required for accurate OCR scanning, will not be accepted and will be returned with a request to submit on the proper claim form.

To avoid a filing deadline denial, rejected paper claims must be received by CarePartners of Connecticut within 60 days from the date of service for professional or outpatient services or within 60 days from the date of discharge.

Submitted paper claim forms should include all mandatory fields, as noted in the Claim Specifications section of this chapter. Paper claim forms deemed incomplete will be rejected and returned to the submitter. The rejected claim will be returned to the submitter along with a letter stating the reason for the rejection, and a new claim with the required information must be resubmitted for processing.

- Industry-standard codes should be submitted on all paper claims.
- Diagnosis codes must be entered in priority order (primary, secondary condition) for proper adjudication. Up to 12 diagnosis codes will be accepted on the CMS-1500 form.
- Paper claims will be rejected and returned to the submitter if required information is missing or invalid. Common omissions and errors include, but are not limited to, the following:
  - Illegible claim forms
  - Member ID number
  - Date of service or admission date
  - Physician's signature (CMS-1500 Box 31)
  - Place of service

Paper claims should be mailed to the following address:

CarePartners of Connecticut
PO Box 9183
Watertown, MA 02741-9183

Claims Payment

Clean Claims

Medicare defines a clean claim as a claim that does not require the Medicare contractor to investigate or develop prior to adjudication. Clean claims must be filed within the filing period. For information about the forms to use for submitting claims, refer to the Claim Specifications section in this chapter.

To qualify for payment, clean claims must also meet the following conditions of payment:

- The billed services must be:
  - Covered in accordance with the applicable benefit document provided to CarePartners of Connecticut members who meet eligibility criteria and who are members on the date of service
  - Furnished by a provider eligible for payment under Medicare

  - Provided or authorized by the member's PCP or the PCP's covering provider in accordance with the applicable benefit document, or as identified elsewhere in the provider's contract with CarePartners of Connecticut (if applicable)
  - Provided in the member's evidence of coverage document
  - Medically necessary as defined in the Medicare coverage guidelines
- CarePartners of Connecticut received the claim within 60 days of the date of service (or date of discharge if the member was inpatient), or date of the primary insurance carrier's EOB.
- The services were preregistered and/or prior authorized in accordance with CarePartners of Connecticut's inpatient notification and inpatient notification procedures as outlined in the Referrals, Authorizations and Notifications chapter.
- Services were billed using appropriate procedure codes
- In the case of professional services billed by the hospital, services were billed electronically according to the HIPAA standard or on CMS-1500 and/or UB-04 forms with a valid CPT code and/or HCPCS code.

All services rendered to CarePartners of Connecticut members must be reported to CarePartners of Connecticut as encounter or claims data. An encounter is a billing form submitted by capitated providers for tracking purposes. Claim forms are submitted by noncapitated providers for both payment and tracking purposes.

Explanation of Payment

The CarePartners of Connecticut explanation of payment (EOP) is a weekly report of all claims that have been paid, pended, or denied to that provider. Your EOP will also include a summary of claims in process. This summary indicates the claims that CarePartners of Connecticut has received, however, may require additional review or information before being finalized in the system. The EOP for capitated providers shows zero dollars paid, and the pay code indicates that services were prepaid under the capitation agreement. The EOP for noncapitated providers indicates the amount paid, denied or pended, with a message code indicating the claim status.

EOPs may be viewed electronically by logging on to the PaySpan Health website and electronic versions of EOPs are available for download and printing through PaySpan Health.

Summary of Claims in Process

CarePartners of Connecticut generates a weekly Summary of Claims in Process report that shows all claims received to date and pending for payment.

Note: The Summary of Claims in Process report is similar to the EOP report, except "Summary of Claims in Process" appears at the top of the barred section, and pay codes display a pending message rather than a payment or denial message.

When adjudicated, all entries on the Summary of Claims in Process report appear on the EOP.

Electronic Remittance Advice

CarePartners of Connecticut offers the 835 Health Care Claim Payment Advice through PaySpan Health. This electronic remittance advice (ERA) includes paid and denied claims submitted either via EDI or on paper forms and uses HIPAA-standard reason codes.

PaySpan Health provides support for this process. All registration and support questions for retrieving an 835 from PaySpan Health and for ongoing support is handled by PaySpan Health Provider Support Team via their website or phone by dialing 877.331.7154, option 1. Provider Support Team specialists are available Monday through Friday from 8 a.m. to 8 p.m., EST.

Claims Reports

CarePartners of Connecticut sends the following reports to medical groups regarding claims for members in their group:

- The biweekly **adjusted claims report** includes claims that CarePartners of Connecticut has retracted and reprocessed. Medical groups can then review claims that have been adjusted for denial or payment.
- Two **paid claims reports** are generated biweekly and show claims processed from the Medical Services Fund and those processed from the Hospital Services Fund. These reports allow the medical group to review claims processed from each service fund. Refer to the Financial Programs chapter for more information.

Corrected Claims and Disputes

CarePartners of Connecticut accepts both electronic and paper corrected claims, in accordance with guidelines of the National Uniform Claim Committee (NUCC), Medicare Managed Care Manual and HIPAA EDI standards for CarePartners of Connecticut claims.

Online Adjustment Requests

Registered providers may submit corrected claims or dispute a claim using the CarePartners of Connecticut secure provider website. Follow the instructions when submitting online claim adjustments. After the provider's transaction has been completed, providers will receive a tracking number as confirmation the adjustment has been received. Refer to the Provider Payment Dispute Policy for more information on corrected claims and disputes.

Provider Services is unable to process claim adjustment requests. Registered providers may submit claim adjustments using the secure provider website. If you are not a registered user of our website, go to the secure Provider website and follow the instructions.

Note: Some claims may not be adjustable online. If a claim cannot be adjusted online, a message will appear indicating the claim is not adjustable. In this instance, claim adjustments may be submitted on paper.

EDI Submissions

To submit a corrected facility or professional claim via EDI:

- Enter the frequency code (third digit of the bill type for institutional claims; separate code for professional claims) in **Loop 2300, CLM05-3** as one of the following:
  - **7** (corrected claim)
  - **5** (late charges)
  - **8** (void or cancel a prior claim)
- Enter the last 8 digits of the original claim number in Loop 2300, REF segment with an F8 qualifier. For example, for claim #000123456789, enter **REF*F8*23456789**.

Note: Provider payment disputes that require additional documentation **must** be submitted on paper.

Paper Submissions

Disputes (not corrected claims) must include a completed Request for Claim Review Form. Both corrected claims and disputes, however, should be mailed to the address on the form.

Facility claims

On the UB-04 form, enter either 7 (corrected claim), 5 (late charges), or 8 (void or cancel a prior claim) as the third digit in Box 4 (Type of Bill), and enter the original claim number in Box 64 (Document Control Number).

Professional claims

In Box 22 on the CMS-1500 form, enter the frequency code 7 under "Code" and the original claim number in the same box under "Original Ref No."

Filing Deadline

Claims for professional or outpatient services must be received by CarePartners of Connecticut within 60 days of the date of service, or within 60 days of the date of hospital discharge for inpatient or institutional services. When a member has multiple insurance plans, the filing deadline for claims submission is 60 days from the date of the primary insurer's EOB.

Filing Deadline Adjustments

To be considered for review, requests for review and adjustment for a claim received over the filing deadline must be submitted within 120 calendar days of the EOP date on which the claim originally denied. Disputes received after 120 calendar days will not be considered.

If the initial claim submission is after the filing deadline and the circumstances for the late submission are beyond the provider's control, the provider may submit a payment dispute for reconsideration by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing deadline and any supporting documentation.

Documented proof of timely submission must be submitted with any request for review and payment of a claim previously denied due to the filing deadline. A completed Request for Claim Review Form must also be sent with the request.

For paper claim submissions, the following are considered acceptable proof of timely submission:

- Copy of patient ledger that shows the date the claim was submitted to CarePartners of Connecticut.
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim.
- Copy of EOB as proof that the member or another carrier had been billed, if the member did not identify him/herself as a CarePartners of Connecticut member at the time of service.

For EDI claim submissions, the following are considered acceptable proof of timely submission:

- For claims submitted though a clearinghouse or MD On-line, a copy of the transmission report and rejection report showing that the claim did not reject at the clearinghouse or at CarePartners of Connecticut (two separate reports).
- For claims submitted directly to CarePartners of Connecticut, the corresponding report showing that the claim did not reject at CarePartners of Connecticut
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim
- Copy of EOB as proof that the member or another carrier had been billed, if the member did not identify him/herself as a CarePartners of Connecticut member at the time of service

The following are not considered to be valid proof of timely submission:

- Copy of original claim form
- Copy of transmission report without matching rejection/error reports (EDI)
- Verbal requests

Requests for filing deadline adjustments for CarePartners of Connecticut claims should be sent to the following address:

CarePartners of Connecticut
Provider Payment Disputes
PO Box 9162
Watertown, MA 02471-9162

Provider Disputes

Providers who disagree with the reimbursement, adjudication or denial of a CarePartners of Connecticut claim may submit a payment dispute to the following address:

CarePartners of Connecticut

PO Box 9162
Watertown, MA 02471-9162

Payment disputes must include a copy of the EOP, appropriate documentation, and a completed Request for Claim Review Form. For more information on the dispute process, see the CarePartners of Connecticut Provider Payment Dispute Policy.

Note: Payment disputes cannot be submitted via EDI; however, corrected claims may be submitted via EDI using the appropriate frequency code.

Coordination of Benefits

Regardless of whether Tufts Health Plan is the primary or secondary insurer, members must follow plan procedures to receive benefits. For additional information, refer to the Coordination of Benefits Policy.

Motor Vehicle Accidents (No-Fault or PIP Coverage)

CarePartners of Connecticut coordinates with auto insurance coverage, including personal injury protection (PIP) and/or Medical Payment (MedPay) on claims for services rendered as a result of a motor vehicle accident (MVA).

The auto insurance coverage is primary for the full PIP coverage and/or any available MedPay coverage until all benefits are exhausted. Providers should bill the motor vehicle insurance carrier directly. Members should not be billed or required to pay up front for services as a result of an MVA, other than applicable cost-sharing amounts.

If further payment is requested after receiving the insurer's statement or check, providers must submit a copy of the auto carrier's documents (i.e., PIP exhaust or benefit denial letter) along with the claim(s) to CarePartners of Connecticut within the 60-calendar day filing deadline date from the date the statement or check was issued.

Note: CarePartners of Connecticut does not accept PIP notification or claim forms from any entities other than the member's motor vehicle insurer and contracting providers of CarePartners of Connecticut.

Under the provider's CarePartners of Connecticut contract, after the member's PIP and MedPay benefits are exhausted, the member cannot be balance-billed or have a lien filed against their third-party settlement or judgment. Do not bill the member or the member's attorney directly even if requested by either of them. If a provider chooses to bill the member or attorney directly, it is done so at the provider's own risk.

The following applies to claims for services rendered as a result of a motor vehicle accident:

- Claims should not be submitted beyond the filing deadline from the date on the auto insurer's notification of benefit payment, denial, or exhaustion
- Claims should be submitted with dated notification from the auto insurer that benefits have been paid, denied or exhausted
- Inpatient notification procedures for any inpatient admissions resulting from an MVA, regardless of whether or not CarePartners of Connecticut is the primary or secondary insurer. Refer to the Referrals, Authorizations and Notifications chapter for additional information.

Note: CarePartners of Connecticut does not routinely compensate conditional bills.

Subrogation

Subrogation is a liability recovery activity in which medical costs that are the result of actions or omissions of a third party are recovered from the third party (and/or their insurer). In some instances, CarePartners of Connecticut has the right to recover the value of services provided to members for which a third party is responsible.

CarePartners of Connecticut has outsourced subrogation recovery services to the Rawlings Company in La Grange, KY, and as a result, providers may receive correspondence from Rawlings related to duplicate claim payments (e.g., CarePartners of Connecticut and a motor vehicle carrier). Inquiries related to such

claims should be directed to the Rawlings Company representative at the number indicated on the correspondence. All other subrogation questions should be directed to CarePartners of Connecticut Provider Services at 888.341.1508.

Claim Specifications

Completing the UB-04 Form

Use the UB-04 form to complete a Medicare claim for institutional services. To complete this form, refer to the instructions in UB-04 Claim Form Specifications in this chapter. Field information is required unless otherwise noted. This form may be prepared according to Medicare guidelines as long as all required fields are completed.

Completing the CMS-1500 Form

Use the CMS-1500 form to submit a Medicare claim for noninstitutional services. All providers should use ICD-CM diagnosis codes and HCPCS/CPT procedure codes. Oral surgeons may use CDT-3 codes, and dentists may use the ADA procedure codes and ADA form. To complete this form, refer to the instructions in CMS-1500 (02/12) Claim Form Specifications section.

Note: Unlisted or miscellaneous codes require notes and/or a description of services rendered to be submitted with the claim. Using unlisted or miscellaneous codes will delay claims adjudication and should be avoided whenever possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may result in a claim denial, and the member may not be held liable for payment.

UB-04 Claim Form Specifications

Box	Field Name	Type	Description
1	Untitled	M	Name and address of the hospital/provider
2	Untitled	M	Address of payee (if different from the address in box 1)
3a–b	Patient control number	O	3a: Patient account number 3b: Medical record number
4	Type of bill	M	3-digit code to indicate the type of bill. Claim will be returned if the type of bill is missing
5	Federal tax number	M	Hospital/provider federal tax ID. Claim will be returned if federal tax ID is not on the claim.
6	Statement covers period	M	Beginning and ending service dates of the period covered by this bill (MMDDYY). These dates are necessary on all claims. For services received on a single day, both the "from" and "through" dates will be the same If the "from" and "through" dates differ, then these services must be itemized by date of service (see Box #45)
7	Untitled	N/A	
8a	Patient ID and name	M	8a: Member ID number 8b: Member's last name, first name and middle initial, if any, as shown on the member's CarePartners of Connecticut member ID card.
9a–e	Patient address	M	Member's mailing address from the patient record
10	Birth date	M	Member's date of birth (MMDDYYYY)
11	Sex	M	Indicate (M)ale or (F)emale
12	Admission date	M	Date of admission/visit
13	Admission hour	M	Time (hour: 00–23) of admission/visit
14	Admission type	M	Code indicating the type of admission/visit
15	Source of admission (SRC)	M	Code indicating the source of admission/visit
16	Discharge hour	M	Time (hour: 00–23) the member was discharged

Box	Field Name	Type	Description
17	STAT (Patient discharge status)	M	Indicates the status of the member as of the through date on bill (interim billing is not allowed and the member's status cannot be 'member')
18-28	Condition codes	O	Code used to identify conditions relating to this bill (can affect payer processing)
29	Accident state	M	Enter the state in which accident occurred
30	Untitled	N/A	
31-34	Occurrence codes and dates	M (if applicable)	Enter the code and associated date defining a significant event relating to this bill that can affect payer processing. **Note:** CarePartners of Connecticut requires all accident-related occurrence codes to be reported.
35-36	Occurrence span code and dates	O	Code and related dates that identify an event that relates to the payment of the claim
37	Untitled	N/A	
38	Untitled	N/A	
39-41	Value codes and amounts	N/A	
42	Revenue code	M	Most current industry standard revenue codes
43	Revenue description	M	Narrative description of services/procedures rendered. Use CPT-4/HCPCS definitions whenever possible
44	HCPCS/rates	M	Use CPT/HCPCS Level II codes for outpatient procedures, services, and supplies Do not use unlisted codes. If an unlisted code is used, supporting documentation must accompany the claim Do not indicate rates
45	Service date	M	Date the indicated service was provided
46	Units of service	M	Units of service rendered per procedure
47	Total charges	M	Enter the charge amount for each reported line item. A negative amount will not be accepted.
48	Noncovered charges	O	Enter any noncovered charges for the primary payer pertaining to the revenue code.
49	Untitled	N/A	
50a-c	Payer	M	All other health insurance carriers on file (attach EOB from other carrier, if applicable)
51	Health plan ID	O	Provider number assigned by health insurance carrier
52	Rel. info (release of information)	N/A	
53	Asg ben (assignment of benefits)	N/A	
54	Prior payments (payer and patient)	M	Report all prior payment for claim (attach EOB from other carrier, if applicable) A negative amount will not be accepted
55	Est. amount due	N/A	
56	NPI	M	Valid NPI number of the servicing provider
57a-c	Other Prv ID (other provider ID)	N/A	
58a-c	Insured's name	M	Name of the individual who is carrying the insurance
59	P. rel (patient's relationship to insured)	M	Code indicating the relationship of the member to the identified insured/subscriber
60 a-c	Insured's unique ID (health insurance claim/identification #)	M	Member's ID number, as shown on the CarePartners of Connecticut ID card
61 a-c	Group name	M	Name of the group or plan through which the insurance is proved to the insured
62 a-c	Insurance group number	M	Identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered

Box	Field Name	Type	Description
63 a-c	Treatment authorization code	O	CarePartners of Connecticut referral/authorization number for outpatient services
64 a-c	Document control number	N/A	
65 a-c	Employer name	M (if applicable)	Name of the employer for the individual identified in box 58
66	DX version qualifier	N/A	
67 a-q	Principal diagnosis code	M	ICD-CM code describing the principal diagnosis chiefly responsible for causing admission/visit. The code must be to the appropriate digit specification, if applicable. If the diagnosis is accident related, then an occurrence code and accident date are required. Present on admission (POA) indicator should be entered as the 8th character
68	Other diagnosis codes	M (if applicable)	ICD-CM codes corresponding to additional conditions that coexist at the time of admission or develop subsequently. The code must be to the appropriate digit specification, if applicable.
69	Admit DX	M	ICD-CM code provided at the time of admission as stated by the provider
70	Patient reason DX	O	
71	PPS code (Prospective Payment System)	O	
72	ECI (external cause of injury code)	M (if applicable)	ICD-CM code for the external cause of an injury, poisoning or adverse effect
73	Untitled	N/A	
74 a–e	Principal procedure code (code and date)	M	Most current ICD-CM code to the appropriate digit specification, if applicable, to describe the principal procedure performed for this service billed. Also, enter the date the procedure was performed. Date must be recorded as month and day (MMDD)
75	Unlisted	N/A	
76	Attending physician	M	Ordering physicians NPI, physician's last name, first name and middle initial
77	Operating physician	M (if applicable)	Name and NPI number of the physician who performed the principal procedure
78–79	Other provider types	O	Optional
80	Remarks	O	Examples: "COB-related" or "billing for denial purposes only"
81a–d	ICC	O	Optional

Figure 2: CMS-1500 Claim Form Specifications

Box	Field Name	Type	Instructions
1	Type of insurance coverage	O	Check the appropriate box to show health insurance coverage applicable to this claim. This field is optional. If the *Other* box is checked, complete Box #9.
1a	Insured's ID number	M	Enter the member's current identification number exactly as it appears on the member's CarePartners of Connecticut ID card, including the alpha prefix and number suffix. Inaccurate or incomplete ID numbers will delay processing the claim and can result in a denial.
2	Patient's name	M	Member's last name, first name and middle initial, if any, as shown on the member's ID card.
3	Patient's birth date and sex	M	Member's date of birth and sex.

Box	Field Name	Type	Instructions
4	Insured's name	M	If the insured and the member are the same person, enter SAME. If the insured and the member are not the same person, enter the name of the insured (last name, first name and middle initial).
5	Patient's address	M	Member's permanent mailing address and telephone number: 2nd line: street address, city and state 3rd line: zip code and telephone number
6	Patient relationship to insured	M	Member's relationship to the insured (i.e., self)
7	Insured's address	M	If the insured's address is the same as member's address, enter SAME. If the insured's address is different than the member's address, enter insured's permanent mailing address (street number and name, city, state, zip code) and telephone number, if available.
8	Reserved for NUCC use	O	
9	Other insured's name	M	If the insured is the same as the person in Box #4, enter SAME. If the insured is not the same as the person in Box #4, enter name of the other insured (last name, first name and middle initial).
9a	Other insured's policy or group number	M	If the other insured is covered under another health benefit plan, enter the other insured's policy or group number.
9b-c	Reserved for NUCC use	O	
9d	Insurance plan name or program name	M	Other insured's insurance plan name or program name and attach the other insurer's EOB to the claim.
10a-c	Is patient's condition related to:	M	For each category (Employment, Auto Accident, Other Accident), check either YES or NO. When applicable, attach an EOB or letter from the auto carrier indicating that personal injury protection (PIP) benefits have been exhausted. State postal code where the auto accident occurred
10d	Claim codes	O	Up to 4 claim condition codes may be entered
11	Insured's policy group or FECA number	M	If the insured has other insurance, indicate the insured's policy or group number.
11a	Insured's date of birth and sex	M	Insured's date of birth and sex if different from the information in Box #3.
11b	Other claim ID	O	Enter 2-character qualifier found in 837 electronic claim to the left of the dotted line. Enter claim number from other insured's plan to the right of the dotted line
11c	Insurance plan name or program name	M	Insurance plan or program name, if applicable (this field is used to determine if supplemental or other insurance is involved)
11d	Is there another health benefit plan?	M	Check YES or NO to indicate if there is another primary health benefit plan. For example, a member may be covered under insurance held by a spouse, parent, or other person

Box	Field Name	Type	Instructions
12	Patient's or authorized person's signature	M	If the signature is not on file, the member or authorized representative must sign and date this box If the signature is on file, enter Signature on File If an authorized representative signs, indicate this person's relationship to the member
13	Insured's or authorized person's signature	M	If the signature is not on file, the insured or authorized representative must sign this block to authorize payment of benefits to the participating practitioner or supplier If the signature is on file, enter Signature on File
14	Date of current illness, injury or pregnancy (LMP)	O	Date of current illness, injury or pregnancy in the designated MMDDYY space Qualifier found in the 837 electronic claim to the right of the QUAL dotted line
15	Other date	O	Qualifier found in the 837 electronic claim between the dotted lines to the right of QUAL Date in the designated MMDDYY space
16	Dates patient unable to work in current occupation	O	Enter dates if the member is unable to work in current occupation. An entry in this box could indicate employment-related insurance coverage
17	Name of referring provider or other source	O	Enter 2-character qualifier found in 837 electronic claim to the left of the dotted line Enter the name of the referring and/or ordering practitioner or other source if the member: Was referred to the performing practitioner for consultation or treatment Was referred to an entity, such as clinical laboratory, for a service Obtained a practitioner's order for an item or service from an entity, such as a DME supplier
17a-b	ID number of referring physician	O	NPI-assigned practitioner ID number of the referring or ordering practitioner Referring practitioner information is required if another practitioner referred the member to the performing practitioner for consultation or treatment Ordering practitioner information is required if a physician ordered the diagnostic services, test or equipment
18	Hospitalization dates related to current services	M	Admission and discharge dates when a medical service was furnished as a result of, or subsequent to, a related hospitalization
19	Additional claim information (designated by NUCC)	O	Additional claim information
20	Outside lab	O	Check YES or NO to indicate if laboratory work was performed outside the practitioner's office
21	Diagnoses	M	Up to 12 ICD-CM 12 codes in priority order (primary, secondary condition) may be entered. Codes are arrayed across the box.
22	Resubmission code	O	Identifies a resubmission code
23	Prior authorization number	O	Inpatient notification or prior authorization number, if applicable

Box	Field Name	Type	Instructions
24a	Date(s) of service	M	Dates for each procedure in MMDDYY format, omitting any punctuation Itemize each date of service. Do not use a date range
24b	Place of service	M	Appropriate place of service code
24c	EMG	N/A	Check this item if the service was rendered in a hospital or emergency room
24d	Procedures, services, or supplies	M	Valid CPT/HCPCS procedure codes and any modifiers
24e	Diagnosis pointer	M	Diagnosis reference letter for up to 4 ICD-CM codes, as shown in box #21, to relate the date of service and the procedures performed to the appropriate diagnosis. Maximum of 4 letters that refer to four diagnosis codes. If multiple services are being performed, enter the diagnosis codes warranting each service.
24f	$ Charges	M	Charges for each listed service
24g	Days or units	M	Days or units of service rendered for the procedures reported in Box 24d
24h	EPSDT family plan	O	Check only if EPSDT or family planning services were used
24i	ID QUAL	O	Check only if the service was rendered in a hospital emergency room Note: If this box is checked, the place of service code in Field #24b should match.
24j	Rendering provider ID #	M	Rendering practitioner's NPI number (if different from billing practitioner)
25	Federal Tax ID number	M	Practitioner/supplier's federal tax ID, employer ID number, or Social Security number
26	Patient's account number	O	Member's account number assigned by the physician's/supplier's accounting system **Note:** This is an optional field to enhance member identification by the practitioner or supplier.
27	Accept assignment?	M	Indicate if the practitioner accepts assignment for the claim (by checking yes, the practitioner agrees to accept the amount paid by Medicare or CHAMPUS as payment in full for the encounter)
28	Total charge	M	Total charges for the services (total of all charges in Box 24f).
29	Amount paid	M	Total amount paid by any other carrier/entity for the submitted charges in Box 28 Attach supporting documentation of any payments (e.g., EOB, EOP or a copy of a cancelled check, if applicable)
30	Reserved for NUCC use	O	
31	Signature of physician or supplier including degrees or credentials	M	If the signature is not on file, have the physician/supplier or authorized representative sign and date this block. If the signature is on file, enter Signature on File.
32, 32a-b	Service facility location information	M	If other than home or office, enter the name and address of the facility where services were rendered to the member, enter NPI number for the facility (or other ID number, if applicable)

Box	Field Name	Type	Instructions
33, 33a	Billing provider info and phone	M	33: Name and payment address of the entity receiving payment (this must match the Tax ID and name on file with the IRS) 33a: NPI number for the entity receiving payment

MEMBER APPEALS AND GRIEVANCES

Members have the right to file a complaint if they have concerns or problems related to their coverage or care. Appeals and grievances are two different types of member complaints, as defined in the Parts C & D Enrollee Grievances, Organization/Determinations, and Appeals Guidance. Appeals are intended to review an adverse organization determination for health care services and/or an adverse coverage determination for drugs that the member feels they are entitled to. Grievances are intended to address concerns or problems members have with their coverage or care.

- Appeals
- Grievances

Quality Improvement Organizations

Quality improvement organizations (QIOs) are groups of health care professionals that monitor the quality of care provided to Medicare members enrolled in Medicare Advantage products with CMS, including CarePartners of Connecticut members. The KEPRO review process is designed to help prevent any improper practices. This process is separate and distinct from the CarePartners of Connecticut grievance process.

KEPRO Beneficiary and Family-Centered Care is the QIO (BFCC-QIO) for Connecticut. CarePartners of Connecticut members concerned about the quality of care received may also file a complaint with KEPRO at 866.815.5440.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended by the Omnibus Budget Reconciliation Act (OBRA) of 1986, CarePartners of Connecticut participates in an external review of its Quality Improvement (QI) program for members enrolled in CarePartners of Connecticut. The responsibilities of each organization that conducts the external review of the CarePartners of Connecticut plan are delineated in CarePartners of Connecticut's agreement with KEPRO.

KEPRO Contact Information

KEPRO
BFCC-QIO Program
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131

Phone: 888.319.8452
TTY: 855.843.4776
Fax: 833.868.4055
KEPRO.com

KEPRO Reviews

KEPRO maintains a review system to ensure that services provided to Medicare beneficiaries enrolled in Medicare health plans are of adequate quality across all settings. This review system addresses the following issues:

- Appropriateness of treatment
- Potential for under-utilization of services
- Accessibility to services
- Potential for premature discharge of patients
- Timeliness of services provided
- Appropriateness of the setting for the provision of services
- Appropriateness of the Medicare health plan's activities to coordinate care (e.g., adequacy of discharge planning and follow-up of abnormal diagnostic studies)

KEPRO will notify CarePartners of Connecticut regarding issues that include results of KEPRO review activities, unless otherwise specified in KEPRO's agreement with CMS. These issues will be identified as Quality of Care concerns or documentation concerns.

CarePartners of Connecticut will be notified when a KEPRO review indicates a quality problem regarding an out-

of-plan emergency or urgently needed care that an out-of-plan hospital, SNF, or other health care facility provided to a member, and the problem is attributable to the institution. However, the quality problem identified with respect to these services will be attributed to the out-of-plan provider/practitioner, rather than to CarePartners of Connecticut.

Appeals

As defined in 42 CFR 422.561 and 423.560, appeals are procedures that deal with the review of adverse initial determinations made by CarePartners of Connecticut regarding health care services or benefits under Part C or D that the member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the member) or on any amounts the member must pay for a service or drug defined in 42 CFR 422.566(b) and 423.566(b). These appeal procedures include the following:

- CarePartners of Connecticut reconsideration or redetermination (also referred to as a level 1 appeal)
- Reconsideration by an independent review entity (IRE)
- Adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator
- Review by the Medicare Appeals Council (Council)
- Judicial review

Under Part C, a reconsideration is the first level in the appeals process, which involves a review of an adverse organization determination by a MA plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS.

Under Part D, a redetermination is the first level in the Part D appeal process in which the plan sponsor reviews an adverse Part D coverage determination, including the findings upon which the decision was based and any other evidence submitted or obtained.

Note: CarePartners of Connecticut and its network providers must not treat members unfairly or discriminate against them because they initiate a complaint.

Fast-Track Appeals

A fast-track appeal is appropriate when the member disagrees with the coverage termination decision from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF), or upon notification of discharge for an inpatient hospital stay.

To initiate a fast-track review, the member must submit a fast-track appeal request within the required time frame to KEPRO. Once an appeal is filed, beneficiaries remain entitled to continuation of coverage for their inpatient hospital stay, SNFs, HHAs, or CORFs until KEPRO renders a decision. KEPRO may be contacted by the member (or member's representative), attorney, or court-appointed guardian. KEPRO is authorized by Medicare to review the services noted above provided to CarePartners of Connecticut members.

The provider must submit a copy of the important message (IM) or Notice of Medicare Noncoverage (NOMNC) and documentation from the medical record supporting the member's discharge from services to KEPRO. Submission of these documents is a condition of payment and failure to submit these upon request may result in a claim denial.

The following documentation supporting the member's discharge from the current level of services is required:

1. Valid IM/NOMNC
2. At a minimum, the medical record must include **all of the following**:
    a. An attending practitioner's (e.g., MD or NP) progress note, written within two calendar days of delivery of IM/NOMNC and including **all of the following**:
        i. A statement that the member's current condition is stable and they are ready for discharge
        ii. A statement that the member no longer requires or will benefit from current level of services
        iii. An outline of the member's discharge plan: where member will be discharged to and what the transition of care plan is
        iv. A statement that addresses any open medical issues and how they will be managed

b. Attending practitioner's order to discharge member from the current level of services, documented in the medical record by the date that the IM/NOMNC is issued.
c. A progress note from each applicable rehabilitation service (physical, occupational, and/or speech therapy) describing the member's current functional level, stability of their medical condition and a description of the discharge plan including any treatments to be carried out after discharge

If KEPRO agrees with the member and overturns the decision to discharge, the member will be reinstated. The process recommences if/when the member is ready to be discharged again.

CarePartners of Connecticut monitors compliance with the time frame associated with KEPRO hospital discharge appeals.

If the member misses the KEPRO deadline (up until noon on the day of discharge), they have the right to call 888.341.1507 to request an expedited CarePartners of Connecticut appeal. CarePartners of Connecticut generally makes a decision within 72 hours. During the fast-track appeals process, the member may not be held financially responsible for coverage of the requested services until an appeal determination has been made by KEPRO.

Standard and Expedited Appeals

A member (or provider acting on the member's behalf) may appeal any adverse organization determinations or coverage determinations they believe they are entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or any amounts the member must pay for.

These appeals can include hospital discharge decisions, as well as SNF/HHA/CORF discharge decisions if the member missed the QIO (KEPRO) deadline.

Standard Member Appeals

In most cases the organization determination and coverage determinations are final unless a member contacts CarePartners of Connecticut within 60 calendar days of receiving the determination (or longer if there is a reason for a good cause extension). If a member requests reconsideration (appeal) of a denial, CarePartners of Connecticut follows the standard member appeals procedure below. The appeal procedure takes place after the adverse organization determination has been issued by CarePartners of Connecticut.

Appeals Procedure for Part C Services

1. The member submits a written request for reconsideration to the Appeals and Grievances Department or a verbal request through CarePartners of Connecticut Customer Service at 888.341.1507. For **preservice requests**, the treating provider may also request an appeal verbally or in writing without being appointed as the member's representative as long as the provider notifies the member the provider is filing the appeal. For **post-service requests**, the provider must be appointed as the member's representative.
    a. The Appeals and Grievances Department receives and reviews the appeal and, if needed, will request additional documentation.
    b. The member can identify an Appointment of Representative (AOR) as an authorized representative to act on their behalf during the appeal process.
    Note: If the member does have an AOR or activated health care proxy, all correspondence regarding the appeal must be sent to the AOR and a copy may be sent to the member.
    c. On a request for a medical item or service, the Appeals and Grievances Department consults with other CarePartners of Connecticut departments, when appropriate, and completes the investigation and notifies the member as expeditiously as the member's health condition requires, not exceeding 30 calendar days (preservice requests) from the date the reconsideration request was received (or no later than upon expiration of a 14 calendar-day extension), regardless of whether or not the organization determination was overturned. If the request is for a Medicare Part B prescription drug, the Appeals and Grievances Department will complete the investigation and notify the member as expeditiously as the member's condition requires, but not exceeding **seven calendar days** (preservice requests) from the date the request was received. The review time frame for Part B drugs requests will not be extended.

Post service requests will be resolved within 60 calendar days from the date the reconsideration request was received. Post service requests for Medicare Part B prescription drugs will be resolved within 14 calendar days. Post service requests for Medicare Part B prescription drugs will be resolved within calendar 14 days.

2. CarePartners of Connecticut can extend a preservice review time frame up to 14 calendar days if the extension is requested by the member, or if CarePartners of Connecticut determines that additional information is necessary and the delay is in the best interest of the member (e.g., for additional diagnostic testing or consultation with medical specialists). Lack of availability of plan provider medical records is not considered an acceptable reason for delay. The review time frame for requests for Medicare Part B prescription drugs will not be extended.
3. If the organization determination was not overturned, the notice informs the member that all relevant information was forwarded to the CMS reconsideration contractor, MAXIMUS Federal Services, Inc.

Appeals Procedure for Part D Services

1. The member sends a written request for reconsideration to the Appeals and Grievances Department or a verbal request through CarePartners of Connecticut Customer Service at 888.341.1507. For preservice requests, the prescribing provider may also request an appeal verbally or in writing without being appointed as the member's representative, as long as the provider notifies the member that they are filing the appeal on the member's behalf.
    a. The Appeals and Grievances Department receives and reviews the appeal and, if needed, requests additional documentation.
    b. The member may identify an AOR to act on their behalf during the appeal process. If the member does have an AOR or activated health care proxy, all correspondence regarding the appeal must be sent to the AOR and a copy may be sent to the member.
    c. The Appeals and Grievances Department consults with other CarePartners of Connecticut departments when appropriate, and completes the investigation as expeditiously as the member's health condition requires, not exceeding seven calendar days from the date the redetermination request was received for pre-service requests. Requests for reimbursement are completed within 14 calendar days from the date the redetermination request was received.
2. CarePartners of Connecticut may not extend the review time frame beyond seven calendar days for Part D appeals or requests for a Medicare Part B prescription drug.
3. If the coverage determination was not overturned, the notice informs the member of the right to submit a reconsideration request to MAXIMUS Federal Services, Inc. Included with the decision notice is a Request for Reconsideration notice for the member to send to the MAXIMUS Federal Services, Inc.

Independent Review Entity (IRE) Review and Additional Appeal Levels

MAXIMUS Federal Services, Inc. is the IRE that reviews the information provided by CarePartners of Connecticut and requests any additional documentation needed from either CarePartners of Connecticut or the member. MAXIMUS Federal Services, Inc. is a separate entity from KEPRO.

MAXIMUS Federal Services, Inc.'s reconsideration determination is final and binding unless a request for a hearing before an ALJ is filed within 60 calendar days of receiving the reconsideration notice.

Any member may request a judicial review (after notifying other parties) of an ALJ decision, if the amount in controversy meets the appropriate threshold (new thresholds are published by CMS every fall) and the Medicare Appeals Council (MAC) has denied the member's request for review.

Any decision by CarePartners of Connecticut, MAXIMUS Federal Services, Inc., the ALJ, or the MAC may be reopened within 12 months (or within four years for good cause). Once a revised determination or decision is issued, any party may file an appeal.

Expedited Appeals

An expedited appeal is a review of a time-sensitive adverse organization determination or coverage determination that a member believes that they are entitled to receive, including:

- Any delay in providing, arranging for, or approving health care services/medications that would adversely affect the health of the member

- Reduction or stoppage of treatment or services that would adversely affect the member's health
  Note: Time-sensitive is defined as a situation in which applying the standard decision time frame could seriously jeopardize a member's life, health, or ability to regain maximum function.

Members, their representatives, or any treating or prescribing physician (regardless of whether the provider is affiliated with CarePartners of Connecticut) can request an expedited appeal. Verbal and written requests for expedited appeals are accepted. If the request meets the necessary time-sensitive criteria, a decision will be made within 72 hours of receipt of the request, unless an extension is needed. Extensions of up to 14 calendar days can be granted if in the best interest of the member.

Note: Extensions are not allowed for expedited Part D appeals or requests for a Medicare Part B prescription drug.

Providers may access appeals information on the CMS website as well as at the following links:

- Medicare Managed Care Appeals and Grievances
- Managed Care Appeals Flow Chart
- Beneficiary Notices Initiative (BNI)
- Advance Notice Form Instructions

Grievances

A grievance is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.

Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Grievance Procedure

Per regulatory guidelines, CarePartners of Connecticut has established a forum for members or authorized representatives to express concerns regarding their experiences with health care providers. The member grievance procedure, allows for the documentation and review of member complaints, as follows:

1. Upon receipt of a verbal or written complaint, the grievance specialist/intake coordinator acknowledges either verbally or in writing that the complaint was received and will be reviewed within 30 calendar days (or within 24 hours if the grievance is expedited). All grievances pertaining to clinical care and/or services issues are reviewed within the Quality Management (QM) Department. All grievances pertaining to provider billing, along with operations and activities of CarePartners of Connecticut are reviewed within the Appeals and Grievances or QM departments. The QM and Appeals and Grievances departments can accept any information or evidence concerning the grievance orally or in writing.
2. In most instances, providers or their office managers (depending on the specific situation) are notified either verbally or in writing about the complaint and asked for input.
3. If the complaint pertains to a quality of care issue (clinical grievance), the QM RN Specialist evaluates the information. The clinical grievance is assigned a severity and preventability rating related to the issue or concern. The provider is notified of the results of the quality review. All grievances and their respective ratings are entered into our secured quality database for tracking and trending purposes. This data becomes part of the provider's credentialing file and is reviewed periodically.

It is the member's responsibility to notify CarePartners of Connecticut of concerns about their health care services. It is the responsibility of all network providers to participate in the grievance review process.

Providers are expected to respond to a request for information within five business days, as it is standard for providers to respond to the plan's request for information in investigating member grievances. This turnaround time is required to ensure that the plan meets its regulatory and accreditation requirements to the member and remains compliant with all state and federal requirements.

FINANCIAL PROGRAMS

Under a Medicare Advantage contract, CarePartners of Connecticut receives revenue from CMS each month. This payment to CarePartners of Connecticut, as a contractor, constitutes federal funds and therefore subjects CarePartners of Connecticut and its participating providers to applicable laws.

Risk Adjustment

The CMS payment amount is based solely upon a risk adjustment methodology used to adjust payments based on the care required to treat a condition. Each year, a member is given a risk score based on their historical diseases and demographic characteristics that impact their costs/payments for that year. Documentation for conditions must be submitted to CMS annually, particularly documentation for chronic conditions. The risk score may also be adjusted from year to year to reflect changes to the risk score model as determined by CMS.

The risk adjustment model is a lagged model, meaning that current year revenue is based on the previous year's risk scores. A Risk Adjustment Department oversees multiple programs aimed at capturing a more accurate depiction of a member's risk score. These include but are not limited to chart reviews, comprehensive health assessments, and prospective assessment forms. Administrative costs incurred and additional revenue realized from these programs are shared with participating groups based on their contract arrangements.

Refer to CMS for more information on risk adjustment arrangements.

Reimbursement

Hospital Service Fund (HSF)

Through a contractual arrangement with CarePartners of Connecticut, an HSF is established for each medical group. Each month, a percentage of the PMPM amount received from CMS is credited to the HSF for a member who has selected or has been assigned to a PCP from that medical group. The HSF is included in a Summary of Fund Services table. This summary is not all-inclusive.

PCP Payments

A specified per member per month (PMPM) payment may be paid to the medical group based on the number of CarePartners of Connecticut members who have selected providers participating through the medical group as their PCPs. The predetermined PMPM amount is paid to the medical group for certain services that the medical group PCPs provide directly to its CarePartners of Connecticut members. This type of payment arrangement, i.e., capitation, is made to the medical group monthly.

Specialists

CarePartners of Connecticut makes payments to specialists and other providers. The amount paid is debited against the medical group's medical services fund. CarePartners of Connecticut administers payment amounts and methodologies, such as fee for service and capitation, according to the specialist's contract. Noncontracting providers are paid according to Medicare regulations.

Out-of-State Services

CarePartners of Connecticut's out-of-state benefit covers urgent and emergent events occurring when a member is out-of-state. CarePartners of Connecticut care management manages out-of-state services for both internally and externally managed groups. When a group or PCP prior authorizes out-of-state care in advance of the service or at time of service, the care is the responsibility of the medical group. For more information, refer to the Referrals, Authorizations and Notifications chapter.

Medical Group Financial Responsibility

Any out-of-area services prospectively authorized by the medical group are the medical group's financial responsibility.

Medicare Advantage regulation requires that Medicare Advantage plans pay for medically necessary dialysis services from any qualified provider chosen by a member when the member is temporarily outside the plan's service area. Furthermore, Medicare Advantage regulation states that Medicare Advantage plans cannot require prior authorization or advance notification for dialysis services as a condition of coverage when a member is temporarily outside the service area.

Because chronic renal dialysis is considered anticipated, regularly scheduled care and the payment of out-of-area routine care for chronic dialysis is the responsibility of the medical group.

Services Received under Contracts

CarePartners of Connecticut is a Medicare Advantage plan, and as such, may not compensate, directly or indirectly, for services furnished to a Medicare enrollee by a provider or other health care practitioner who has filed with the local Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts.

Pharmacy Services

All Medicare beneficiaries are eligible to enroll in the Medicare Part D prescription drug plan. All CarePartners of Connecticut product offerings include pharmacy coverage. Monthly pharmacy premiums vary by plan design.

Stop Loss Reinsurance

The medical group shall have the responsibility to ensure that its internal risk arrangements, subcontracts and stop-loss covered comply with applicable state or federal law or regulations. Such responsibility includes, but it not limited to, the following: If individual medical group physicians and/or groups within medical group are at substantial financial risk as defined in the physician incentive plan regulations found at 42 CFR 417. 479 and as subsequently amended or revised (the "PIP regulations"), to:

- Allocate appropriate stop-loss coverage (or cause such coverage to be allocated) to physician groups downstream and individual medical group physicians within such groups, as well as other medical group physicians CarePartners of Connecticut, Inc), or
- Purchase or cause to be purchased alternate stop-loss coverage to cover physician groups, individual medical group physicians within such groups and other individual medical group physicians downstream to comply with the PIP regulations.

Summary of Fund Services

Hospital Services Fund (including ancillary services)
• Inpatient hospital care, including behavioral health/substance use disorder (BH/SUD) day treatment • Skilled nursing facilities (SNFs) • Hospital-based provider services • Ambulance • In-area emergency department (ED) • Home health care • Ambulatory surgery, including hospital/surgical • Dialysis for end-stage renal disease (ESRD) • Other services including, but not limited to surgical devices, chemotherapy, drugs and radiation therapy
Medical Services Fund (MSF)
• In-area inpatient and outpatient provider services

- Out-of-area provider services if authorized by the group
- Outpatient pathology, radiology and diagnostics, including preventive screening
- Outpatient BH/SUD
- Outpatient speech, physical and occupational therapies
- Durable medical equipment (DME)
- Health education and preventive services.
- Other services including, but not limited to urgent care services, post stabilization care and supplemental benefits.

Settlement of Funds

Medical Services

The MSF is settled according to contract terms to determine the relationship between credits and expenses. The MSF capitation credit, inclusive of any applicable coordination of benefits and subrogation, will be compared to the MSF expenses, inclusive of estimated incurred but not yet reported claims.

If the MSF capitation credit exceeds the MSF expenses, the surplus is paid to the medical group. If the MSF expenses exceed the MSF capitation credit, the medical group will be invoiced for the deficit. Future month's capitation payments to the medical group may be adjusted to balance an actual or projected deficit.

Hospital Services

The HSF is periodically settled according to the contract terms to determine the relationship between credits and expenses. The HSF capitation credit, inclusive of any applicable coordination of benefits and subrogation, will be compared to the HSF expenses, inclusive of the value of the services rendered and estimated incurred but not yet reported claims.

If the HSF capitation credit exceeds the HSF expenses, the surplus is paid to the hospital. If the HSF expenses exceed the HSF capitation credit, the hospital will be invoiced for the deficit. The medical group shares financial risk with the hospital for any deficit or surplus as defined in the group contract. The medical group's share of the hospital surplus or deficit is combined with the settlement of the medical group's MSF.

Pharmacy

Part D requires Medicare Advantage plans to share risk directly with CMS. The medical group is not at risk.

Special Member Status

Hospice Election

Members certified as terminally ill by their PCP or attending provider may elect the hospice benefit. The hospice obtains a copy of the certification and the beneficiary-election document from Medicare directly. The beneficiary election document identifies the effective date and the beneficiary's acknowledgment that certain services are waived, such as the right to therapeutic services in favor of palliative care.

Once a CarePartners of Connecticut member has elected the hospice benefit, CMS pays CarePartners of Connecticut a reduced capitation for each CarePartners of Connecticut member. This reduced capitation is allocated for supplemental benefits (such as routine vision) that CarePartners of Connecticut offers to each member. A copy of the beneficiary election document should be obtained for CarePartners of Connecticut records, if possible.

For further information about hospice election, refer to the Hospice Payment Policy and the Medicare Managed Care Manual, Chapter 2 - Medicare + Choice Enrollment and Disenrollment, Section 20.7, Eligibility and the Hospice Benefit.

Members who have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors (carrier/fiscal intermediary), as if the beneficiary were a fee-for-service beneficiary, until the first day of the month following the month in which hospice was revoked. Therefore,

providers need to bill the carrier/fiscal intermediary, and CarePartners of Connecticut will pay the cost-sharing amount not paid by the carrier/fiscal intermediary.

CarePartners of Connecticut remains responsible for providing its members who have elected hospice with the following benefits:

- All cost-sharing amounts for Medicare-covered services that are not related to the member's hospice status
- Any nonhospice services that are not Medicare-covered, but are supplemental benefits provided under the plan

Hospice Billing Guidelines

Billing guidelines for hospice members is included in the following sections of the Medicare Managed Care Manual:

- Chapter 7: Risk Adjustment
- Chapter 9, Section 20.2: Election, Revocation, and Discharge

Additional Benefits Billing Guidelines

CarePartners of Connecticut covers additional benefits that are not covered by Medicare. These are referred to as supplemental benefits. The provider must bill CarePartners of Connecticut directly for any CarePartners of Connecticut covered services which Medicare does not cover and which are not related to terminal illness. CarePartners of Connecticut will make payment directly to the provider of services.

End-Stage Renal Disease

CarePartners of Connecticut and a capitated medical group receive additional capitation from CMS for reported ESRD members.

The attending provider at the dialysis center completes the ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. The dialysis center sends this form to the Social Security District Office and to the ESRD network.

The medical group must obtain a completed ESRD form from the center providing dialysis treatment and forward a copy to CarePartners of Connecticut. The additional capitation for ESRD is not paid without verification from CMS.

CarePartners of Connecticut must provide coverage to a CarePartners of Connecticut member for renal dialysis services provided by noncontracting providers while the member is temporarily outside the CarePartners of Connecticut's service area. Additional capitation may not be applied to the medical group without appropriate reporting to CarePartners of Connecticut.

Provider Reimbursement

CarePartners of Connecticut will continue to reimburse providers minus the cost-sharing amount for all CarePartners of Connecticut covered services. To obtain payment for the cost-sharing amount and HUSKY Health-covered services, providers must submit the appropriate invoice to HUSKY Health, DMA's claims-processing contractor. The DMA has compiled a manual that details the billing procedures for HUSKY Health providers.

To be eligible for payment from HUSKY Health for services provided to the dual-eligible population, in addition to being a Medicare provider, you must also be a HUSKY Health or Qualified Medicare Beneficiary (QMB)-only provider. To become a HUSKY Health provider, the provider must contact the HUSKY Health Provider Engagement Services at or 800.440.5071.

To apply for QMB-only status, the provider should contact Connecticut's Department of Social Services at 855.626.6632.

When submitting an invoice for reimbursement for HUSKY Health-covered medical and provider services, the provider must attach a copy of their CarePartners of Connecticut explanation of payment (EOP). To receive

training or to set up an individual consultation concerning questions about billing from HUSKY Health services, providers can contact HUSKY Health at 800.440.5071.

MEDICAL MANAGEMENT

Medical Management Program

The goal of the medical management program is to monitor and manage the delivery of health care services to ensure that all services meet Centers for Medicare and Medicaid Services (CMS) coverage criteria. The Care Management team is an integral part of the CarePartners of Connecticut medical management program. Physicians and other providers are responsible for:

- Sharing clinical information (including, but not limited to, discharge summaries, test results and medication records) in a timely manner to facilitate coordination and continuity of care
- Abiding by plan inpatient notification policies providing timely notification of acute inpatient and skilled nursing facility (SNF) admissions
- Collaborating with the CarePartners of Connecticut Care Management team to coordinate and oversee the delivery of each CarePartners of Connecticut member's medical services
- Responding promptly to quality of care concerns raised either concurrently or retrospectively
- Participating fully with the Care Management team to share clinical information concerning members under their care
- The medical management program's scope encompasses all health care delivery activities across the continuum of care, including inpatient admissions to hospitals, acute rehabilitation facilities and SNF, home care services, outpatient care and office visits.

CarePartners of Connecticut Medical Management

For CarePartners of Connecticut, the Care Management team will collaborate with the medical group and their associated health care team, to facilitate the medical management of members assigned to their group. The Care Management team will support each medical group in developing their individual group's medical management program.

Roles and Responsibilities

Health Care Team

The health care team consists of a group of health care professionals including:

- The group's medical director
- Primary care providers (PCPs) and their office staff
- All other providers associated with the medical group, including specialists, preferred SNF and home health care providers
- The CarePartners of Connecticut Care Management team

Care Management

Each of the CarePartners of Connecticut medical groups will have a Care Management team assigned to facilitate medical management activities for their members. The Care Management leadership team will provide oversight of the care management processes and outcomes for all CarePartners of Connecticut members.

The CarePartners of Connecticut Care Management team works with the PCP, attending provider and CarePartners of Connecticut medical director to coordinate and oversee the delivery of a member's medical services, following the Case Management Society of America's Standards of Practice for Case Management.

For more information on how CarePartners of Connecticut works with medical groups, refer to the CarePartners of Connecticut Care Management Resource Guide.

Medical Management Program Activities

The Care Management team works with the medical groups to identify forums to facilitate medical management discussions and case reviews. The Care Management team consults Medicare coverage guidelines as well as the

member's evidence of coverage (EOC) when determining coverage of benefits.

The Care Management team collaborates with the rest of the health care team to ensure the member receives appropriate care and services in a timely, cost-effective manner by conducting concurrent and retrospective review for the following services:

- Acute inpatient hospitalization, utilizing InterQual® criteria
- Acute inpatient rehabilitation
- Extended and skilled nursing services
- Home care services
- Hospice care
- Community-based services

Medical Management Meetings

The Medical Management Forum provides an opportunity for the multi-disciplinary team to perform clinical reviews of individual utilization patterns that may identify opportunities for CM intervention. Committee members may include the medical group's medical director and the associated PCPs, as well as office staff and a member of the Care Management team.

Utilization Review

Federal and state regulatory agencies and accrediting bodies establish regulations and standards that govern utilization management (UM) functions. When utilization review is conducted, the decision time frame and notifications must adhere to the requirements outlined in Utilization Review Determination Time Frames for CarePartners of Connecticut members.

This resource for staff engaged in the UM decision-making process outlines the required time frame for rendering coverage decisions and providing verbal and written notifications to the member and provider. CarePartners of Connecticut Medical Management policies and plan documents assist the care manager, physicians and other providers in planning and managing care with efficiency and high quality standards.

The process for conducting initial utilization review determinations for requests for coverage applies to all individuals performing utilization review for CarePartners of Connecticut. This process will be followed when reviewing prospective, concurrent and retrospective coverage of inpatient and outpatient services. All initial utilization review should be conducted on a case-by-case basis.

Urgent and Emergency Care

Although prior authorization is not required, both inpatient and outpatient urgent or emergency care involves coordination by the Care Management team. Emergencies and urgent care that occur out of the service area should be reported to the Care Management team.

Urgent Care

Urgently needed care is medical attention needed for an unforeseen illness or injury in which the member's health is not in serious danger, but it is not reasonable given the situation for the member to get medical care from his or her PCP or other plan providers. Urgent care services are covered services provided when an enrollee is temporarily absent from the CarePartners of Connecticut service area (or under unusual and extraordinary circumstances, provided when the enrollee is in the service area but the organization's provider network is temporarily unavailable or inaccessible).

CarePartners of Connecticut Coverage Rules

Urgently Needed Care in the Service Area

If the member is in the CarePartners of Connecticut service area and has a sudden illness or injury that is not a medical emergency, the member should call their PCP or listen for instructions if the PCP's office is closed.

There will always be a doctor on call to help.

Hearing or speech-impaired members with TTY/TDD machines may also call the Connecticut Telecommunications Relay Service at 860.243.0351 (TTY/TDD 860.242.4536) for assistance contacting their PCP after hours. CarePartners of Connecticut expects that members get such care from CarePartners of Connecticut providers. In most cases, CarePartners of Connecticut will not pay for urgently needed care that a member receives from an out-of-network provider while the member is in the CarePartners of Connecticut service area.

Urgently Needed Care Outside of the Service Area

Authorization is not required for urgently needed care outside the CarePartners of Connecticut service area. If the member is treated for an urgent care condition while out of the service area, CarePartners of Connecticut prefers that they return to the service area to receive follow-up care through their PCP. However, CarePartners of Connecticut will cover follow-up care provided from out-of-network providers outside the CarePartners of Connecticut service area as long as the care the member is getting still meets the definition of "urgently needed care."

CarePartners of Connecticut cannot restrict access to urgently needed care to a certain place of service (e.g., outpatient clinics). Urgently needed services can be rendered in any Medicare-certified clinical setting (e.g., a provider's office). CarePartners of Connecticut will refer members to their PCPs if they call requesting clinical guidance prior to receiving urgent or nonurgent out of area care.

Urgent care that occurs outside the service area should be reported to the Care Management team who will follow urgent cases that occur outside the service area while the member remains inpatient and when receiving follow-up care services within 14 calendar days of an urgent/emergent episode. Members who call with questions regarding follow-up care more than two weeks after receiving urgent care will be referred back to the PCP.

Emergency Services

Emergency care that occurs outside the CarePartners of Connecticut service area should be reported to the Care Management team, who will follow all emergency cases that occur outside the service area within the first two weeks of the member receiving emergent or urgent out of area care. Members who call with questions regarding follow-up care more than two weeks after receiving emergent or urgent care will be referred back to the PCP.

Poststabilization Care

Poststabilization services are covered services that are related to an emergency medical condition and that are provided after a member is stabilized, and provided either to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member's condition. CarePartners of Connecticut must cover poststabilization care services in accordance with Chapter 4, Section 20.5 of the Medicare Managed Care Manual.

InterQual Criteria

InterQual criteria are applied to all medical and surgical acute inpatient admissions and subsequent inpatient days. The criteria may be applied to assist in determining the most appropriate level of care for CarePartners of Connecticut members.

These criteria are based on the use of the severity of illness and/or the intensity of service being provided. In general, the severity of illness criteria are used for the day of admission and the intensity of service criteria are applied to continued stay days. However, both sets of criteria are flexible and can be used at any point during an acute stay.

InterQual criteria are used to facilitate communication with the provider about a member's health status for the coordination of care. These criteria do not replace Medicare coverage guidelines and are not to be used by the provider when making coverage determinations for a CarePartners of Connecticut member. Medicare coverage guidelines must be used when making coverage determinations, as applicable. InterQual criteria are for screening purposes only and are not used for medical necessity determinations.

Coverage Resources

CarePartners of Connecticut provides coverage for all services and items covered by Original Medicare. When making coverage determinations for services, providers should refer to the applicable CMS coverage guidelines.

There are additional services covered for members that are not covered under traditional Medicare. To determine which services/items are covered as supplemental benefits, providers should also refer to the most current versions of the member's Summary of Benefits and Evidence of Coverage.

Medicare Coverage Guidelines

At a minimum, CarePartners of Connecticut provides coverage for all services and items covered by Medicare.

CarePartners of Connecticut uses Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs) and Medicare interpretive manuals (e.g., the Medicare Benefit Policy Manual) to make coverage determinations for CarePartners of Connecticut members. Users can also search the Medicare Coverage Database for additional information.

CarePartners of Connecticut medical necessity guidelines do not replace Medicare coverage guidelines and are not to be used by providers when making coverage determinations, except for services that are covered by CarePartners of Connecticut as a supplemental benefit.

Local Coverage Determinations (LCDs)

An LCD is a decision issued by a carrier or fiscal intermediary to cover (or not cover) a particular service on an intermediary-wide or carrier-wide basis.

- LCDs cannot restrict or conflict with NCDs or coverage provisions in interpretative manuals
- LCDs are binding on Medicare Advantage Organizations
- LCDs are accessible through the Medicare Coverage Database

Providers must adhere to the LCDs associated with the following contractors that have jurisdiction in Connecticut:

- Durable Medical Equipment (DME MAC): NHIC, DME MAC LCDs
- Part B carrier: National Government Services
- Part A fiscal intermediary: jurisdiction is dictated by which contractor the hospital bills for fee-for-service

National Coverage Determinations (NCDs)

National Coverage Determinations (NCDs) are developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service, procedure or device. NCDs are binding on all Medicare Advantage plans as well as other Medicare contractors (such as carriers and fiscal intermediaries).

NCDs are contained in the Medicare NCD Manual, which is updated via NCD Transmittals. NCDs are also accessible through the Medicare Coverage Database.

Interpretive Manuals

Coverage provisions in interpretive manuals are instructions that are used to further define when and under what circumstances services may be covered (or not covered). Coverage information can be found in the following interpretative manuals available on the CMS website:

- Medicare Benefit Policy Manual
- Medicare Claims Processing Manual
- Medicare Program Integrity Manual
- Medicare Managed Care Manual

Case-by-Case Review

If there is no national policy or the national policy is purposefully vague and the applicable contractor does not

have an LCD, providers or CarePartners of Connecticut staff should review the case on an individual case basis using Medicare's existing national guidance and any other LCDs in Connecticut, if available. If there are no other LCDs in Connecticut, contact the Medical Policy Department, who will contact the applicable contractor for input.

QUALITY ADMINISTRATIVE GUIDELINES

Quality Improvement Program

Tufts Health Plan performs credentialing for the CarePartners of Connecticut provider network. A Corporate Quality Improvement (QI) program addresses the quality of care of all settings in which care is delivered to members. This program has five primary components:

- Ongoing monitoring and evaluation
- Continuous quality improvement
- Customer satisfaction
- Practitioner/provider credentialing
- Utilization management

The goals of the program are to:

- Continuously improve the quality of clinical care and service that members receive from participating health care providers who are contracted with CarePartners of Connecticut
- Increase member satisfaction
- Improve the quality of service that providers receive
- Increase provider satisfaction
- Improve the health of identified segments of the member community

A Board of Directors has overall responsibility for the QI program. A Care Management Committee (CMC) is responsible for overseeing the implementation of the QI program (including the annual QI Work Plan) and for determining that funding is adequate to support program activities and goals.

Specific positions, committees, and organizational units play a significant role in QI activities, including:

- Care Management Committee (CMC)
- Quality of Care Committee (QOCC)
- Quality Performance Improvement Team (QPIT)
- QI work groups
- QI project teams (providers offer input into the QI program by participating in committees such as QOCC and MSPAC)

Medical Care Access Goals for Primary Care

Access to medical care is a key component of health care quality. Members must have access to their providers, although, in a life-threatening situation, members are expected to obtain care at the nearest medical facility.

CarePartners of Connecticut recognizes the diversity with which providers handle member calls, arrange urgent care, and schedule routine care. CarePartners of Connecticut does expect that members will be heard and their medical needs met in a manner that is reasonable and provides quality medical care.

CarePartners of Connecticut understands that providing medical care is not a completely predictable experience. Emergencies and episodic increases in the demand for services at times may overwhelm the ability of an individual office to meet the expectations for medical care access. However, in the normal course of providing medical care, provider offices should regularly meet these expectations.

CarePartners of Connecticut has developed medical care access goals that all provider offices are expected to adopt and review with their office staff. The goals include suggestions for PCPs to provide better service to their patients. Many providers may have already included these suggestions in their telephone triage system.

Members may periodically contact CarePartners of Connecticut with concerns about office waiting times, appointment availability, and similar issues. CarePartners of Connecticut uses these guidelines to determine whether member concerns are reasonable and provides feedback to the members and providers, as necessary.

All medical care access goals are evaluated at least annually and revised, as necessary, based on the results of access surveys and provider input.

Office Visit Appointments

- **Emergency care:** Appointments are scheduled on the same day with an available clinician
- **Urgent care:** Appointments are scheduled within 24 hours with an available clinician; if the office has more urgent cases than it can handle, the staff arranges for urgent care at another site
- **Nonurgent symptomatic care:** Appointments are scheduled within one week with an available clinician for nonurgent episodic illness
- **Preventive care:** For history and physical checkups with no acute illness, the provider or other appropriately licensed clinician sees the member within 30 days from the date of the request. (**Note**: Members are covered for one routine physical exam per year)

Telephone Callbacks

During Office Hours

The office determines if the member's call is urgent and the following procedures are followed:

- Urgent calls will be returned within one hour
- Nonurgent calls will be returned on the same day

After Office Hours

Members are expected to exercise appropriate judgment about urgent needs for service when contacting their providers outside normal office hours.

An answering service or machine answers telephones after hours. For urgent problems, an answering service offers to contact the provider or a covering provider, as necessary. An answering machine provides a number through which a provider can be contacted for urgent problems. Providers normally return urgent calls within one hour.

If a provider uses a triage service for telephone screening after hours, the provider must instruct the nursing staff to identify themselves as a nurse who is covering for a provider.

The nurse must also communicate to the member that during a life-threatening situation, the member must hang up and either call 911 or go to the nearest emergency department (ED), as appropriate. At the completion of the call, the nurse must verify that the member is comfortable with the nurse's advice and tell the member of his or her right to speak to the covering provider. All providers used for covering purposes must be licensed as required by law.

Note: Routine use of an ED to supply after-hours care is not an acceptable coverage arrangement.

Office Waiting Time

In most situations, members should not have to wait more than 30 minutes past their appointment time to be seen. If a longer wait is anticipated, office staff should explain the reason for the delay and offer to book the member for another appointment.

Credentialing Site Visit Requirements

Tufts Health Plan performs credentialing responsibilities for CarePartners of Connecticut. Provider site visits may be conducted for any of the following reasons:

- When more than one complaint/grievance is received about a provider's office regarding physical accessibility, physical appearance or the adequacy of waiting and examining room space within six months
- Member satisfaction results indicate an office site may not meet Tufts Health Plan standards
- Employee reports, other concerning data and information is received from a member or provider indicating a site may not meet Tufts Health Plan standards
- Other data is required for quality improvement purposes and cannot be reasonably collected using alternative methods

- Other circumstances, as deemed necessary

Tufts Health Plan personnel or a designated representative with the appropriate training will perform the site visit within two weeks of Tufts Health Plan's determination that a site visit is warranted.

Of the 32 components, at least 28 must be present to obtain a passing score (85%). Select components may be considered not applicable for some types of offices.

Site visits resulting in deficiencies requiring corrective action will require the practitioner to submit a corrective action plan within 30 days to the Quality Management (QM) Department. All sites receiving a failing score will be subject to a follow-up site visit within six months of the visit.

If the site still does not receive a passing score or does not demonstrate adequate improvements in the deficient areas from the previous visit, the results will be documented and the site will continue to be visited every six months until the deficiencies are remedied, or the site receives a passing score, or if it is determined that further action is required by Tufts Health Plan.

CarePartners of Connecticut participating providers must comply with CarePartners of Connecticut medical policies, including Tufts Health Plan policies that are made applicable to the CarePartners of Connecticut provider network, the Quality Administrative program, and medical management programs that are developed in consultation with participating providers.

Practice guidelines and utilization management guidelines:

- Are based on reasonable medical evidence or a consensus of health care professionals in a particular field
- Consider the needs of the enrolled population
- Are developed in consultation with contracting health professionals
- Are reviewed and updated periodically
- The guidelines are communicated to providers and, as appropriate, to members.
- Decisions with respect to utilization management, member education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines.

For additional information, refer to the sample credentialing site visit checklist:

Provider name:_____		Provider unit:_____	
Address: _____		Other providers at same site (attach additional sheet if necessary:_____	
Telephone: _____			
Provider ID:_____		_____	
Date and time of site visit:_____		Office contact:_____	
Physical Accessibility		**Physical Appearance**	
Handicapped accessible with signage	Y ☐ N ☐	Visual cleanliness	Y ☐ N ☐
Ramp from parking into building	Y ☐ N ☐	Adequate lighting	Y ☐ N ☐
Elevator (if office is not on 1st floor)	Y ☐ N ☐	Free of odor	Y ☐ N ☐
Doorknobs are pull-down	Y ☐ N ☐	Refuse disposal available	Y ☐ N ☐
Doorways are at least 3.5 feet wide	Y ☐ N ☐	Office hours posted	Y ☐ N ☐
At least one bathroom has adequate space for a wheelchair or assistant	Y ☐ N ☐	Exit signs readily visible	Y ☐ N ☐
Entrance is safely accessible (e.g., free of snow and ice)	Y ☐ N ☐	Policies/procedures for patient confidentiality available	Y ☐ N ☐
Stairs have handrails	Y ☐ N ☐	Adequate seating	Y ☐ N ☐
At least one examining room has adequate space for a wheelchair	Y ☐ N ☐	Smoke detectors present	Y ☐ N ☐
Adequacy of Medical/Treatment Record Keeping		**Adequacy of Appointments**	
Staff has immediate access to key health information/data (e.g., diagnoses, allergies,	Y ☐ N ☐	Routine office visit within 1 week of request with an available clinician	Y ☐ N ☐

test results, treatments, medications)			
Office has a scheduling system(s) for booking appointments and record keeping is orderly	Y ☐ N ☐	Urgent care within 24 hours with an available clinician	Y ☐ N ☐
Office utilizes a reminder system(s) to prompt and alert the staff to ensure regular screenings and preventative practices	Y ☐ N ☐	24-hour coverage	Y ☐ N ☐
File area locked when unattended	Y ☐ N ☐		
Legible file markers	Y ☐ N ☐		
Legible documentation	Y ☐ N ☐		
Adequacy of Waiting and Examining Room Space			
Sharps disposal	Y ☐ N ☐	**Score of 32 = %**	
Biohazard waste disposal	Y ☐ N ☐	(Score of 85% or greater is passing)	
Provisions for universal precautions (wearing gloves, masks, hand washing)	Y ☐ N ☐		
Medications and prescription pads locked/ restricted access	Y ☐ N ☐		
Use of clean linen and/or paper on exam tables	Y ☐ N ☐		

Medical Record Maintenance Procedures and Review

CarePartners of Connecticut requires medical records to be maintained in a manner that is current, detailed, complete, accurate, and organized, and permits effective and confidential patient care and quality review. As a Medicare Advantage Organization, CarePartners of Connecticut agrees to do the following:

- Maintain records for at least 10 years from the end of the final contract period or completion of audit, whichever is later, unless there is a special need to retain longer
- Provide medical record access to federal entities, such as the Department of Health and Human Services (HHS) and the Comptroller General, which is head of the Government Accountability Office (GAO), or their designees
- The medical record, whether electronic or paper, communicates the member's past medical treatment, past and current health status, and treatment plans for future health care. Well-documented medical records facilitate communication and the coordination and continuity of care while promoting efficiency and effectiveness of treatment.

CarePartners of Connecticut considers all records to be confidential and requires that all CarePartners of Connecticut providers do the following:

- Maintain medical records in a space staffed by office personnel
- Maintain medical records in a locked office when staff is not present
- Permit review or removal of medical records only with member's authorization
- Release medical and behavioral health records, other member health information, and other member information regarding CarePartners of Connecticut members, only in accordance with state and federal laws regarding confidentiality and disclosure

In addition, as a CMS contractor, CarePartners of Connecticut participates in QM activities through Tufts Health Plan. These activities often involve medical record reviews. CarePartners of Connecticut, through Tufts Health Plan, requires that providers provide access to medical records when requested as part of QM activities and maintain confidentiality during medical record review.

Outpatient Behavioral Health/Substance Use Disorder Treatment Access Standards

All contracting inpatient and outpatient behavioral health and substance use disorder providers are expected to meet the standards described below.

Temporal Access

Emergency care will be made available to all CarePartners of Connecticut members at any CarePartners of Connecticut contracting facility with emergency services available. Emergency care must be available 24 hours a day, 7 days a week at each CarePartners of Connecticut BH/SUD facility.

A member with life-threatening needs must be seen immediately. A member with nonlife-threatening needs must be seen within six hours. Each facility is a licensed hospital with a full-time specific BH/SUD emergency and triage team. CarePartners of Connecticut also covers emergency BH/SUD care at any licensed facility when medically necessary.

Urgent care must be available within 48 hours of a member's request and may be provided by any CarePartners of Connecticut behavioral health provider. Nonurgent care must be available within 10 business days of a member's request.

Transplants

Medicare-covered transplants do not require prior authorization from CarePartners of Connecticut or from the PCP/medical group. Members may be referred for evaluation of appropriateness for transplant by either the PCP, or by a specialist to whom the PCP initially referred the member.

Once a member is deemed to be appropriate for a transplant, the inpatient notification process must be performed according to CarePartners of Connecticut's timeframe guidelines. Refer to the CarePartners of Connecticut Prior Authorization and Inpatient Notification List for more information.

All solid organ heart, lung, heart-lung, liver, intestinal, kidney, and pancreas transplants must be performed at a Medicare-approved facility. CarePartners of Connecticut will not compensate services rendered at a non-Medicare-approved facility. Refer to the CarePartners of Connecticut Medicare-Approved Facilities List for additional information.

Note: Providers/facilities must report any changes in certification or accreditation to CarePartners of Connecticut and Tufts Health Plan, which handles CarePartners of Connecticut credentialing.

For more information regarding transplants, refer to the Transplant Facility Payment Policy.

In addition to the preventive health and disease management programs described above, CarePartners of Connecticut also works on several other quality initiatives specific to preventable hospital admissions, discharge planning, appropriate nursing facility institutionalization, and identification of abuse/neglect.

Serious Reportable Events

The National Quality Forum (NQF) defines serious reportable events ("never events") as "errors in medical care that are of concern to both the public and health care professionals and providers, clearly identifiable and measurable, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization". Tufts Health Plan, which performs credentialing for the CarePartners of Connecticut provider network, considers the following types of events as never events:

- **SREs and SRAEs:** Unambiguous, serious, preventable adverse incidents involving death or serious harm to a patient resulting from a lapse or error in a healthcare facility. SREs are developed and endorsed by the NQF. SRAEs are defined by CMS.
- **PPCs:** Conditions that meet the definition of a "health care acquired condition (HCAC)" or a "provider preventable condition (PPC)" as defined by CMS in federal regulations at 42 CFR 447.26(b).

Nonpayment for SREs, SRAEs and PPCs

CarePartners of Connecticut's policy and regulatory obligation is to deny or retract payment for services related to care that meets the definition of SREs, SRAEs and/or PPCs once they have been identified. CarePartners of Connecticut will not compensate providers or permit providers to bill members for services related to the occurrence of a SRE, SRAEs and/or PPCs.

Providers are required to notify Tufts Health Plan of SREs, SRAEs and PPCs that occur when providing services to CarePartners of Connecticut members.

Reporting SREs, SRAEs, and PPCs

To report a SRE, SRAEs or PPCs to CarePartners of Connecticut, providers should fax their report to the QM Department at 617.673.0973.

CarePartners of Connecticut and/or Tufts Health Plan on CarePartners of Connecticut's behalf, works directly with the involved provider to review the event, identify opportunities for quality improvement and determine how the nonpayment issue will be resolved.

Reference Sources:

- Refer to the National Quality Forum and to the CMS Medicare Part C Reporting Requirements for information on reporting SREs and SRAEs
- CMS: Hospital-Acquired Conditions

Refer to the SRE, SRAE and PPC Payment Policy for more information.

UTILIZATION REVIEW DETERMINATION TIME FRAMES

The purpose of this chart is to reference utilization review (UR) determination time frames.

Written notice of authorization will be sent to members or providers upon request. In all instances, CarePartners of Connecticut strives to conduct utilization review determinations and provide notice of these determinations within a reasonable period of time, appropriate to the medical circumstances.

Note: A provider is defined as a health care professional, facility or vendor.

Note: For the purposes of this document, verbal and written notices to providers and members must occur as expeditiously as the member's health requires, but no longer than the time frames specified below.

Review Type: Whether to Expedite a Request for a Determination

Any request for coverage for medical care or treatment with respect to which the member or a provider believes applying standard organization timeframes could seriously jeopardize the member's life, health or ability to regain maximum function.

Decision Timeframe	A decision must be made within 24 hours whether or not to expedite. CarePartners of Connecticut must automatically expedite the determination if a provider makes or supports the request. **Note:** Requests for payment of services the member has already received cannot be expedited.
Extension Rules	N/A
Notice of Authorization Determination	N/A
Notice of Denial Determination	If CarePartners of Connecticut denies the request for an expedited determination, it must automatically transfer the request to the standard time frame. The member will be given oral notice of the denial, including member rights, and subsequently deliver written notice within 3 calendar days of the notice of denial determination that: • Explains that the organization will automatically transfer and process the request using the 14 days standard time frame • Informs the member of the right to file an expedited grievance if they disagree with the denial • Provides instructions about the expedited grievance process and its timeframes • Informs the member of the right to resubmit a request for an expedited determination and that if the member gets provider support applying standard organizational time frames could seriously jeopardize the member's life, health or ability to regain maximum function, the request will automatically be expedited.

Review Type: Prospective Expedited (Urgent)

UR performed prior to an admission or other course of treatment in which the application of the time period for making nonurgent determinations could seriously jeopardize the member's life, health or ability to regain maximum function.

Decision Timeframe	Determination and notification must occur within 72 hours of receipt of the request. Total time including decision on whether to expedite a request is 72 hours.

Extension Rules	The time frame may be extended up to14 calendar days if: • The enrollee requests the extension; or • The extension is justified, in the enrollee's interest, and additional medical evidence from a non-contracted provider is needed in order to make a decision favorable to the enrollee (i.e., the MA plan should not extend the timeframe to get evidence to deny the coverage request); or • The extension is justified due to extraordinary, exigent or other non-routine circumstances and is in the enrollee's interest If extended, the enrollee must be notified in writing of the reasons for the delay and inform the enrollee of the right to file an expedited grievance if they disagree with the MA plan's decision to grant an extension.
Notice of Authorization Determination	Verbal notification must occur within 72 hours of receipt of request (or an additional 48 hours if an extension was granted). The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented.
Notice of Denial Determination	• Verbal notification must occur to the requesting provider within 72 hours of receipt of request (or an additional 48 hours if an extension was granted). • Written notification must be sent within 3 calendar days of verbal notice. • The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented. • Written notification must be sent to the requesting provider within 72 hours of receipt of request (or an additional 48 hours if an extension was granted). Simply mailing the letter within the time frame is insufficient.

Review Type: Concurrent Expedited (Urgent)

UR that is performed during a hospital stay or other course of treatment in which the application of the time period for making non-urgent determinations could seriously jeopardize the member's life, health or ability to regain maximum function.

Decision Timeframe	Determination and notification must occur as expeditiously as the member's health requires but no later than 24 hours of the receipt of request.
Extension Rules	N/A
Notice of Authorization Determination	• Verbal notification must occur within 24 hours. • The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented. • Written notification must be sent to the member and the requesting provider within 24 hours of the receipt of request.
Notice of Denial Determination	• Verbal notification to the requesting provider must occur within 24 hours of receipt of request. Notification must be sent within 72 hours of the verbal notice. • The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented. • Written notification must be sent to the member and the requesting provider within 24 hours after receipt of request (or an additional 48 hours if an extension was granted). Simply mailing the letter within the time frame is insufficient.

Review Type: Standard Prospective and Concurrent (Nonurgent)

Prospective nonurgent is UR that is performed prior to an admission or other course of treatment. Concurrent nonurgent is UR that is performed during a hospital stay or other course of treatment.

Decision Timeframe	Determination and notification must be completed as expeditiously as the member's health condition requires, but no later than 14 calendar days after receipt of request.

Extension Rules	The time frame may be extended up to 14 calendar days from the receipt of the request for coverage. The member must then be notified of the extension in writing using CMS approved template.
Notice of Authorization Determination	• Verbal notice to provider must occur within 14 calendar days after receipt of request (or an additional 14 days if an extension was granted.) • The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented. • Written notification must be sent to the member within 14 calendar days after receipt of request (or an additional 14 days if an extension was granted.)
Notice of Denial Determination	• Verbal notice to provider must occur within 14 calendar days after the receipt of request (or an additional 14 days if extended.) • The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented. • Written notification must be sent to the member and provider within 14 calendar days after the receipt of request (or an additional 14 days if an extension was granted.)

Review Type: Retrospective Review

UR of services after they have been provided to the member.

Decision Timeframe	Determination and notification must be made within 30 calendar days of the receipt of request.
Extension Rules	An extension may be granted once for 15 calendar days due to lack of information. If within 30 calendar days the information received is inadequate a written notice must be sent to the member and provider with the information required to complete the coverage determination, specifying that additional information is needed within 45 calendar days. The time frame for making the determination is suspended from the date of written noticed until the earlier of: 1. Date response received 2. Date established for furnishing requested information. Once the information is received, or the 45 days expire, the review determination must be completed within 15 calendar days.
Notice of Authorization Determination	An optional written notification may be sent to the provider and member within 60 calendar days of the request or an additional 15 calendar days if an extension was granted.
Notice of Denial Determination	Written notification authorizations must be sent to the provider within 60 calendar days of the request unless an extension was granted. Written notification denials must be sent to the provider and member within 60 calendar days of the request unless an extension was granted.

OBSERVATION PROGRAM

The CarePartners of Connecticut Observation Program was introduced to ensure that medically necessary care is provided in the most appropriate setting. Utilization experience has shown that inpatient admissions often may be avoided in cases where short-term, intensive outpatient management interrupts the progression of an illness, successfully stabilizes and improves the patient's conditions, and permits the patient to return home.

CarePartners of Connecticut does not expect observation services to be used as a replacement for medically appropriate inpatient admissions, as noted in the following definition:

> Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.
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> Observation services are covered only when provided on the order of a physician or another individual authorized under state law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Observation services must also be reasonable and necessary to be covered by Medicare. Only in rare and exceptional cases do reasonable and necessary outpatient services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

The following information highlights important points of this program:

- When medically appropriate, observation care is an option for patients whose problems are reasonably expected to be resolved within 24 to 48 hours. Members must be released or admitted by the 49th hour of observation care.
- Hospitals must follow inpatient notification procedures for members admitted to inpatient status after receiving observation services.
- Behavioral health and substance use disorder (BH/SUD) observation services must be provided or coordinated by a member's designated BH facility, or by a CarePartners of Connecticut Behavioral Health Department Program Manager
- CarePartners of Connecticut may retrospectively review observation services for medical necessity to ensure compliance with CarePartners of Connecticut guidelines.
- Hospitals will no longer be reimbursed at the contracted rate for both observation care and an inpatient admission if a decision is made that results in an inpatient admission from the observation stay. If the observation services and admissions commence on the same calendar day, CarePartners of Connecticut will only pay for the admission.
- When other outpatient services are provided, all reasonable and necessary observation services are packaged in the ambulatory payment classification (APC) payment for the procedure or visit with which it was furnished. Separate APC payments made only for outpatient observation services involving three specific conditions (chest pain, asthma, and congestive heart failure) will not apply. However, hospitals may receive payment for "direct admission" to observation services in accordance with Medicare guidelines. See the CMS Medicare Claims Processing Manual, Chapter 4, §290 for additional payment criteria.
- As required by CMS and the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, hospitals must provide written notification and a verbal explanation to individuals receiving observation services in an outpatient setting for more than 24 hours. This notice must be issued using the standard CMS Medicare Outpatient Observation Notice (MOON) form to provide notification to affected individuals. Providers must submit the form no later than 36 hours after observation services are initiated and the notification must be signed by the individual or proxy to acknowledge receipt. For more information about the NOTICE Act and for the current version of the MOON form, refer to CMS.
  Note: As outlined in the MOON notice, certain portions do not apply to CarePartners of Connecticut members; members are instead covered in accordance with their member benefit documents. Providers should include this information in their verbal explanations to members receiving

observation services for more than 24 hours and advise members to contact Customer Relations at 888.341.1507 (TTY 711) with any coverage-related questions:

- Members are not required to meet the 3-day minimum inpatient stay for admission to a skilled nursing facility (SNF)
- Member cost-sharing may apply but be capped

Refer to the Observation Services Payment Policy for additional information.