Chorus Community Health Plans
Individual and Family Plan
Provider Manual
2024

CHORUS
COMMUNITY HEALTH PLANS

INTRODUCTION

Thank you for choosing to participate in the provider network of Chorus Community Health Plans (CCHP). We are committed to partnering with you and your staff to improve the health of our members.

About Chorus Community Health Plans
Chorus Community Health Plans is a Wisconsin-based health plan that has offered health insurance to individuals and families in our community for over 12 years.

In 2017, we expanded to offer Chorus Community Health Plans health insurance coverage, available both on and off the Marketplace in southeastern Wisconsin. We are proud to be affiliated with Children's Wisconsin and to offer individuals and families access to high-quality health care through a variety of plan options in Kenosha, Milwaukee, Ozaukee, Racine, Washington, Waukesha , Brown, Calumet, Door, Manitowoc, Oconto, Outagamie, and Winnebago counties.

About this Manual
This Provider and Practitioner Manual has essential information about our policies and procedures, and serves as an extension of your Provider Network Agreement. This manual and other provider resources are available on our website at chorushealthplans.org.

This manual is updated biannually or as needed. Providers can contact the Provider Services team at 1-844-202-0117 to request a paper copy.

Manual Updates
Updates will also be communicated periodically through the "Provider Notes" e-newsletter and through the portal. Providers can also receive newsletters and updates by signing up to receive emails from Provider Relations online at chorushealthplans.org.

The use of the term "Provider" in this manual
CCHP acknowledges that the National Committee for Quality Assurance (NCQA) differentiates between a practitioner (person) and a provider (facility). We follow this guidance on this manual's cover. However, to simplify the text within this manual, we have decided to use the term "provider" as an all-encompassing term that includes facilities as well as physicians, practitioners, and any other staff who are directly or indirectly contracted to provide services to our members.

We welcome your feedback
We value your feedback on this manual. Please forward any corrections, questions, and comments to us by email at cchp-providernews@chorushealthplans.org.

Criteria for selecting providers to participate in our network
For practitioners – CCHP does not use quality measures, member experience measures or cost-related measures to select practitioners.

For hospitals – CCHP does not use quality measures, member experience measures, patient safety measures or cost-related measures to select hospitals. After several years of experience offering individual and family plans, we may begin utilizing these measures to select practitioners and/or hospitals.

Policy changes
Policy changes can be found on Chorus Community Health Plan's website.

SERVICE AREA

Our fifteen-county service area not only includes some of the area's top providers, but also in-network specialists, pharmacists, and chiropractors. Please view our northeast and southeast service areas below:

A provider search tool for all your needs

Please visit our website at **chorushealthplans.org/find-a-doc,** select the Individual and Family Plans option and search our Provider Directory to see all current in-network providers.

Network hospitals in our NORTHEAST WISCONSIN service area include:

BROWN COUNTY
- Bellin Hospital
- Bellin Psychiatric Center
- HSHS St. Mary's Hospital - Green Bay
- HSHS St. Vincent Children's Hospital - Green Bay
- HSHS St. Vincent Hospital - Green Bay

CALUMET COUNTY
- Ascension Calumet Hospital

DOOR COUNTY
- Door County Medical Center

MANITOWOC COUNTY
- Froedtert Holy Family Memorial Hospital

OCONTO COUNTY
- Bellin Health Oconto Hospital
- HSHS St. Clare Memorial Hospital - Oconto Falls

OUTAGAMIE COUNTY
- Ascension NE Wisconsin - St. Elizabeth Campus

SHEBOYGAN COUNTY
- HSHS St. Nicholas Hospital - Sheboygan

WINNEBAGO COUNTY
- Ascension NE Wisconsin - Mercy Campus
- Children's Wisconsin - Fox Valley Hospital

Network hospitals in our SOUTHEAST WISCONSIN service area include:

KENOSHA COUNTY
- Froedtert South
- Froedtert Pleasant Prairie Hospital
- Rogers Behavioral Health

MILWAUKEE COUNTY
- Ascension Columbia St. Mary's Hospital
- Ascension SE Wisconsin Hospital - Franklin Campus
- Ascension SE Wisconsin Hospital - Greenfield Campus
- Ascension SE Wisconsin Hospital - St. Joseph Campus
- Ascension St. Francis Hospital
- Children's Wisconsin Milwaukee Hospital
- Froedtert Hospital & The Medical College of Wisconsin
- Froedtert Community Hospital - Oak Creek
- Midwest Orthopedic Specialty Hospital - Franklin
- Orthopaedic Hospital of Wisconsin - Glendale
- Ascension Sacred Heart Rehabilitation Hospital
- Select Specialty Hospital
- Rogers Behavioral Health - Brown Deer
- Rogers Behavioral Health - West Allis

OZAUKEE COUNTY
- Ascension Columbia St. Mary's Hospital – Ozaukee Campus
- Ascension Sacred Heart Rehabilitation Hospital
- Froedtert Community Hospital - Mequon

RACINE COUNTY
- Ascension All Saints Hospital - Spring Street Campus
- Ascension All Saints Hospital - Wisconsin Avenue Campus
- Lakeview Specialty Hospital and Rehab

WASHINGTON COUNTY
- Froedtert West Bend Hospital

WAUKESHA COUNTY
- Ascension SE Wisconsin Hospital - Elmbrook Campus
- Ascension SE Wisconsin Hospital - Menomonee Falls Campus
- Ascension SE Wisconsin Hospital - Waukesha Campus
- Froedtert Menomonee Falls Hospital
- Froedtert Community Hospital - Pewaukee
- ProHealth Oconomowoc Memorial Hospital
- ProHealth Rehabilitation Hospital of Wisconsin
- ProHealth Waukesha Memorial Hospital
- Rehabilitation Hospital of Wisconsin
- Rogers Behavioral Health

ACCESS STANDARDS

To maintain the best possible care for our members, we have established standards — ensuring our members have continuous access to quality health care services.

Our promise

To maintain quality standards for our members, we promise:

- Our network providers' hours of operation do not discriminate against members
- Interpreter services if a provider does not speak the member's language

After hours care

Chorus Community Health Plans network providers must provide 24 hours a day/7 days a week coverage through telephone service or other on-call systems. Please see the Urgent Care section of this manual for additional details.

Primary Care Provider

CCHP defines primary care providers, who must be licensed by the state in which care is rendered and performed, as:

- Family Practitioners
- Internists
- Nurse Practitioners
- Pediatricians

Appointment standards

The list below includes the time limits for the providers in Chorus Community Health Plan's network for scheduling medical and behavioral health care appointments.

Standards	Scheduled Appointed Time Frame
Emergency Care	For a life-threatening situation, members are instructed to go to the nearest emergency room or call 911 for immediate medical attention
Urgent Care Clinic / Urgent Care Walk-in Clinic	Medical attention same day, no appointment needed
Non-urgent Sick Visit	Medical attention within two calendar days of member's notification
Routine Primary Care and Routine Well-Baby Visits	Visit within 30 calendar days of member's request
Preventive Care – Immunizations, Routine Physical Exam	Visit within 30 calendar days of member's request
High-risk Prenatal Visit Appointment	Visit within two weeks of member's request or within three weeks if the member's request is with a certain doctor
After-hours Access Standards — 24-hour Accessibility	All network providers must be available, either directly or through coverage arrangements 24 hours a day, 7 days a week, 365 days a year
Primary Care Office Wait Time	Members with scheduled appointments should be seen within 30 minutes of their check-in time

ACCESS STANDARDS

Standards	Scheduled Appointed Time Frame
Behavioral Health Care Initial Appointment	No longer than 10 days for an initial assessment; no longer than 30 days for members discharged from an inpatient mental health stay
Behavioral Health Care Urgent Care	Visit within 48 hours of member's request
Behavioral Health Care Routine Appointment	Visit within 10 days of member's request
Emergency Dental Care Appointment *(Severe pain, swelling or bleeding due to a dental accident. Dental coverage is limited to dental accidents.)*	Visit within 10 days of member's request

MEDICAL CLAIMS

Participating providers in the Chorus Community Health Plans network agree to accept payment made by CCHP as payment in full. Any discounts a provider agrees to cannot be billed to a member or secondary insurance company. Members may be billed for copayments, coinsurance, deductible amounts, and non-covered services.

CLAIMS SUBMISSION

A correct and complete member number must be submitted on the claim. Using the correct member number on the claim helps ensure correct and timely claim payment. Important items to remember when submitting claims:

- Submit claims electronically or type claims. Handwritten claims may be returned
- Claims with eraser marks or whiteout corrections may be returned.
- Only clean claims (defined on page 7) containing all required information will be processed within the required time limits. Rejected claims that have missing or incorrect information may not be resubmitted. A new claim form must be generated for resubmission.
- Use proper place-of-service codes
- Use modifier code "25" when it's necessary to indicate that the member's condition required a significant, separately identifiable evaluation and management service above and beyond the other procedure or service performed on the same date by the same provider.
- Bill anesthesia claims with the correct codes from the American Society of Anesthesiologists with appropriate anesthesia modifiers and time units, if applicable.
- Submit only one payee address per tax identification number.
- If provider submits an error on the claim, the provider should submit a corrected claim, clearly marking the claim as "corrected."
- Services for the same patient with the same date of service may not be unbundled. For example, an office visit, a lab work-up, and a venipuncture by the same provider on the same day must be billed on the same claim.
- Submit all provider appeals within the time frame outlined in your Provider Network Agreement.

CORRECTED CLAIMS

- SHOULD BE STAMPED AS A CORRECTED CLAIM.
- UB04: CORRECTED CLAIMS SHOULD BE BILLED WITH THE CORRECT BILL TYPE

TIMELY FILING

Chorus Community Health Plans requires providers file claims in a timely manner. Claims must be submitted in accordance with the claim filing limit outlined in your Provider Network Agreement. Claims related to work related injuries or illness should be submitted to the Worker's Compensation carrier. Claims denied by the Worker's Compensation carrier, should be submitted to us, along with the denial for consideration. Members are required to follow all referral and/or prior authorization guidelines. Claims must be submitted within the timely filing guidelines along with a copy of the denial.

TIMELY FILING DEADLINES

Please reference your Provider Network Agreement for the submission of new claims timely filing limits. Claims submitted after the time frame outlined in your Provider Network Agreement, will be denied for untimely filing. Members cannot be billed for Chorus Community Health Plan's portion of the claims submitted after these deadlines. Members may be billed for copayments, coinsurance, and/or deductibles.

Subrogation claims should be sent to our office for processing. We will pursue recovery of those expenses from the at-fault party and/or their liability insurer. Members are required to follow our referral and prior authorization guidelines. Claims must be submitted within the timely filing guidelines along with the denial.

MEDICAL CLAIMS

MEDICAL RECORDS POLICY
Chorus Community Health Plans requires that all services billed be appropriately documented in the patient's medical records in accordance with CCHP's Medical Records Policy. If the services billed are not documented in the patient's medical record, in accordance with the policy, they will not be considered reimbursable by Chorus Community Health Plans.

CLAIMS FOR QUALIFIED TREATMENT TRAINEE
Qualified Treatment Trainees (QTT) may not submit claims on their own behalf. Services should be reported under the name and NPI of the qualified supervising provider with the U6 modifier appended to each CPT code. No other professional level modifiers (HO) should be indicated on the claim or it will deny. Chorus Community Health Plans will only allow payment for QTTs with a graduate degree working towards full clinical licensure.

COORDINATION OF BENEFITS CLAIMS
Coordination of Benefits is administered according to the member's benefit plan and applicable laws. If a member has a primary carrier:

1. Please submit their claim to the primary carrier first.
2. After the primary carrier pays, submit claim to Chorus Community Health Plans for consideration within the timely filing limit outlined in your Provider Network Agreement. Please include the primary carrier's Explanation of Benefits (EOBs)

CLAIMS FILING METHODS
Claims can be filed electronically in the following ways:

- *Electronic Data Interchange (EDI)*
  Chorus Community Health Plans accepts electronic claims in data file transmissions. Electronic claim files sent directly to CCHP are permitted only in the HIPAA standard formats. Providers who have existing relationships with the following clearinghouses can send claims electronically using the payer ID: 251CC, and may continue to transmit claims in the format produced by their billing software.
    - Change HealthCare (Emdeon)
    - RelayHealth (McKesson)
    - Gateway (Trizetto)

  These clearinghouses are then responsible for reformatting these claims to meet HIPAA standards and passing claims on to CCHP.

- *Paper claims*
    - CMS-1500 Form – These forms are used for billing professional services performed in a provider's office, hospital, or ancillary facility. (We do accept provider specific billing forms.)
    - UB-04 forms – These forms are for inpatient hospital services or ancillary services performed in the hospital. (CCHP doesn't accept hospital-specific billing forms.)

<u>Late charges on the CMS-1500 forms</u>
Please write "late charges" on a CMS-1500 form when submitting late charges. This allows us to route the claims to the appropriate processing area. Late charges are subject to the timely filing limit.

Submit claim forms to:
Chorus Community Health
Plans P.O. Box 106013
Pittsburgh, PA 15230-6013

MEDICAL CLAIMS

Clean claims

Chorus Community Health Plans defines a "clean" claim as a claim that is complete in its entirety and does not contain any defects or incorrect information. Only clean claims that have the required correct information will be processed in a timely manner. The table below indicates the list of data elements that are required on each claim submission.

Listed on the next page are the appropriate box numbers from the CMS-1500 and UB-04 claim forms for each required element.

Clean claims

Required Information	**CMS-1500 Claim Forms**	**UB04 Claim Form**	**Notes**
Member Name	Box 2	Box 8	
Date of Birth	Box3	Box 12	
Member Number	Box 1.a	Box 60	
Diagnosis Code	Box 21	Box 67	
Date of Service	Box 24.A	Box 6	
Place of Service	Box 24.B	N/A	2-digit
Type of Bill	N/A	Box 4	
Service Code	Box 24.D	Box 42	4-digit revenue code on UB-92
Billed amounts	Box 24.E	Box 47	
Units	Box 24.G	Box 46	
Provider NPI & Taxonomy code	Box 24 J		Must match
Federal Tax ID	Box 25	Box 5	
Total charges	Box 28		
Amount paid by other insurance *(if app.)*	Box 29	Box 54	
Balance Due	Box 30		
Provider Name	Box 31	Box 1	
Provider Billing Address	Box 33	Box 1	
Billing Provider NPI	Box 33 a	Box 56	
Taxonomy code	Box 33b		

CODING POLICIES AND PROCEDURES

DIAGNOSIS CODES

The diagnosis codes submitted on the claims must indicate the member's medical condition or circumstances requiring evaluation or treatment. The documentation within the member's medical record must correlate to the diagnosis codes submitted on claims.

Diagnosis should be coded using ICD-10-CM, and the primary diagnosis should describe the main reason for the visit to the provider. Keep in mind the following regarding diagnosis codes:

- All diagnosis codes on the claim should be valid and coded to the highest level of specificity. Make sure the diagnosis code is valid and complete.
- The primary diagnosis indicates the principal reason for the member's visit.
- Diagnosis codes should be appropriate for the patient's gender and age.
- Specific conditions or multiple conditions should be coded and reported as specifically as possible
- When coding for both acute and chronic conditions, be sure to assign codes to all conditions for which the member is seeking medical care.
- When coding ongoing or chronic conditions, do not assume the code used at the previous visit is appropriate for the current visit.
- When coding injuries, identify each as specifically as possible.
- If a preventive visit was scheduled, but symptoms of illness or injury exist at the time of the visit, code the primary diagnosis as "preventive." The condition(s) for which the member is being treated should be coded as a secondary diagnosis

PLACE-OF-SERVICE CODES

When submitting the CMS-1500 claim form, the CMS standard two-digit Place-of-Service code is required in Box 24B. Claims submitted without a Place-of-Service code will be rejected and need to be resubmitted.

Commonly used Place-of-Service codes:

11	Office	50	Federally Qualified Health Center
12	Home	51	Inpatient Psychiatric Facility
15	Mobile	52	Psychiatric Facility Partial Hospitalization
20	Urgent Care Facility	53	Community Mental Health Center
21	Inpatient Hospital	54	Intermediate Care Facility / Individuals with Intellectual Disabilities
22	Outpatient Hospital	55	Residential Chemical Dependency Treatment Facility
23	Emergency Room	56	Psychiatric Residential Treatment Facility
24	Ambulatory Surgical Center	60	Mass Immunization Center
25	Birthing Center	61	Comprehensive Inpatient Rehabilitation Facility
26	Military Treatment Facility	62	Comprehensive Outpatient Rehabilitation Facility
31	Skilled Nursing Facility	65	End-Stage Renal Disease Treatment Facility
32	Nursing Facility	71	State or Local Public Health Clinic
33	Custodial Care Facility	72	Rural Health Clinic

34 Hospice

49 Independent Clinic

81 Independent Laboratory

CODING POLICIES AND PROCEDURES

CODES AND MODIFIERS

- Unlisted codes
  In some circumstances, it is appropriate for a provider to bill for a procedure that does not have an existing CPT/ HCPCS code. The provider should bill with the "miscellaneous" or "not otherwise classified" code that is most appropriate for the service provided. Chorus Community Health Plans may ask providers for supporting documentation.

- Modifiers
  Listed below are physician modifiers that are billed frequently.

Modifier	Description
24	Unrelated evaluation and management service by the same physician during a postoperative period
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
33	Preventive services
50	Bilateral procedure
57	Decision for surgery
59	Distinct procedural service
62	Two surgeons
76	Repeat procedure by same physician or other qualified health care professional
77	Repeat procedure by another physician or other health care professional
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
80	Assistant surgeon
82	Assistant surgeon (when qualified resident and surgeon not available)
91	Repeat clinical diagnostic laboratory test
LT	Left side
RT	Right side

- Anesthesia modifiers
  - Claims for anesthesia should be billed with the correct codes from the American Society of Anesthesiologists (ASA) – 00100-01999. These codes are included in the CPT manual.
  - Certified Registered Nurse Anesthetist (CRNA) are eligible for reimbursement and can be billed in conjunction with the anesthesiologists' charges when the appropriate modifier is used.
  - Appropriate anesthesia modifiers also should be billed, including but not limited to the following:

Anesthesia Modifier	Description
AA	Anesthesia services performed personally by anesthesiologist
AD	Medical supervision by a provider; more than four concurrent anesthesia procedures
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QS	Monitored anesthesia care service
QX	Certified Registered Nurse Anesthetist (CRNA) service with medical direction by a provider
QY	Medical direction of one CRNA by an anesthesiologist
QZ	CRNA service without medical direction by a physician

HOME MEDICAL EQUIPMENT MODIFIERS

Home medical equipment (HME) modifiers include, but are not limited to the following:

Modifier	Description
MS	Six-month maintenance and servicing
RA	Replacement of a DME, orthotic or prosthetic
RR	DME rental
NU	New equipment
UE	Used durable medical equipment

CODE SPECIFIC POLICIES

- Blood draw/venipuncture: We do not reimburse for blood draw/venipuncture when that service is provided in conjunction with any other laboratory or evaluation and management service on the same date of service.
- Surgical procedures: Providers must note surgical procedures performed during the same operative session by the same provider on a single claim form. Billing on separate claim forms may result in delayed payments, incorrect payments, or payment denial.
- Reimbursement: We process all clean claims within 30 days from the date they are received. Please reference your Provider Network Agreement for reimbursement information.
- Multiple payee addresses: We require providers to submit a single payee address per tax ID number. Chorus Community Health Plan does not honor multiple payee addresses.

CODING POLICIES AND PROCEDURES

CLAIMS EDITING SOFTWARE

Chorus Community Health Plans follows standard coding procedures as outlined in CPT, ICD10-CM, and HCPCS, as well as certain guidelines developed by CMS and/or a commercially available coding review software package used by CCHP. Payment to provider shall be based upon such industry standard coding procedures, as adopted by CCHP. In addition, CCHP may limit the codes certain providers may submit to CCHP for reimbursement.

EXPLANATION OF PAYMENT (REMITTANCE ADVICE)

The Explanation of Payment (EOP), referred to on the statement as a "remittance advice," is a summary of claims submitted by a specific provider. It shows the date of service, diagnosis, and procedure performed as well as all payment information. This includes money applied to the member's deductible or copayment, and denied services.

For additional questions pertaining to the EOP, please contact Provider Services at 1-844-202-0117, Monday through Friday from 8:00 a.m. to 5:00 p.m.

- Process for refunds or returned checks
  Chorus Community Health Plans accepts overpayments in two ways – provider may refund additional money directly to us or we will take deductions from future claims.

- Refunds
  If Chorus Community Health Plans made a payment in error, providers may return the check or write a separate check from their account for the full amount paid in error. Providers should include a copy of the remittance advice, supporting documentation noting the reason for the refund, and the explanation of benefits (EOB) from other insurance carriers, if applicable.
  Refund should be mailed to:
  Chorus Community
  Health Plans
  P.O. Box 106014
  Pittsburgh, PA 15230-6014

- Overpayment
  Please refer to your Provider Network Agreement regarding the return of overpayments. If Chorus Community Health Plan has paid in error and the provider has not sent a refund or returned the check, the money will be deducted from future claims paid. The related claim information will be shown on the remittance advice as a negative amount.

- Claim follow-up
  To view claim status on the Provider Portal, go to our website at chorushealthplans.org. New users will be asked to register. For login information, contact Provider Services. To check the status of a claim without going online, call Chorus Community Health Plan Providers Services at 1-844-202-0117, Monday through Friday from 8:00 a.m. to 5:00 p.m.

ELECTRONIC CLAIMS SUBMISSION (EDI)

Electronic Data Interchange (EDI), also known as Electronic Claims Submission, enables health care providers to send and receive medical claims information.

Chorus Community Health Plans supports all HIPAA-compliant electronic transactions. EDI transactions also eliminate paper checks being sent through the mail, which allows providers to receive payments sooner. For more information on the standards for EDI or to purchase copies of different EDI companion guides, visit the Washington Publishing Company website at http://www.wpc-edi.com. To set-up EDI transactions with us, please have your clearinghouse submit claims with our payer ID number 251CC. See Claims Filing Methods on page 5 for more details.

BILATERAL SERVICES

Chorus Community Health Plans will reimburse contracted providers for covered, medically necessary bilateral services.

What are bilateral services?
Bilateral services are procedures that are performed on both sides of the body during the same procedure or on the same day. Services in this category are generally radiology procedures or other diagnostic tests. Payments are made based on the member's benefit and the provider agreement.

Billing information:
When the bilateral indicator is "3," the standard bilateral reduction does not apply and Medicare allows the procedure to be reported with modifier 50 (1 unit) or with RT and LT modifiers (1 unit each). The bilateral "3" procedures are configured in our claim system to reimburse with the RT and LT modifiers only. If modifier 50 is used for one of these codes, the claim is held for manual pricing causing potential delays or manual errors.

Example of acceptable methods of billing bilateral:

Billing Scenario	Industry Standard Billing Methods	Chorus Community Health Plans Preferred Billing
1	One claim line and code 73630-RT, LT (2 units)	Yes
2	One claim line and code 73630-50 (1 unit)	No
3	Two claim lines: Claim line 1: 73630-RT (1 unit) Claim line 2: 736360-LT (1 Unit)	Yes

GRACE PERIOD

Except for the first premium, any premium not paid to Chorus Community Health Plans by the due date is in default. The member's grace period is 30 days from the due date, unless the member is receiving an advanced premium tax credit from the federal government, in which case the member will have a three-month grace period. If the member is receiving an advance premium tax credit from the federal government, Chorus Community Health Plans reserves the right to pend payment of all applicable claims that occur in the second and third month of the grace period.

> ***Important**: Partial premium payments will not extend the duration of the grace period. The member must pay all past due amounts in order to bring their account into good standing.*

If the member does not pay the past due premiums before the end of the grace period, the member's coverage will be terminated retroactively to the end of the first grace period month. If this happens, any pending claims will not be paid and it will become the member's responsibility to pay providers directly for the services received during months two and three of the grace period.

If claims were paid during the grace period, and the member terminates, Chorus Community Health Plans will recoup payments from the provider and the provider will bill the member for any outstanding balances on his/her account. It will be the member's financial responsibility to pay for those services.

	SILVER			SILVER SELECT			STANDARD SILVER		
	200	150	100	200	150	100	200	150	100
Individual medical and prescription deductible	$2,750	$750	$250	$3,000	$750	$100	$4,000	$1,000	$250
Individual medical and prescription maximum out-of-pocket	$6,950	$2,900	$1,650	$6,950	$2,900	$1,000	$6,950	$2,900	$1,350
Family medical and prescription deductible	$5,500	$1,500	$500	$6,000	$1,500	$200	$8,000	$2,000	$500
Family medical and prescription maximum out-of-pocket	$13,900	$5,800	$3,300	$13,900	$5,800	$2,000	$13,900	$5,800	$2,700
Primary care office visit	$40 copay	$20 copay	$5 copay	$35 copay	$30 copay	$25 copay	$30 copay	$20 copay	$10 copay
Specialty/specialist office visit	$80 copay	$40 copay	$10 copay	$75 copay	$70 copay	$50 copay	$60 copay	$50 copay	$20 copay
Inpatient and outpatient services	35% after deductible	20% after deductible	10% after deductible	40% after deductible	20% after deductible	10% after deductible	20% after deductible	10% after deductible	5% after deductible
Outpatient lab services	35% after deductible	20% after deductible	10% after deductible	40% after deductible	20% after deductible	10%after deductible	$35 copay per visit	$35 copay per visit	$20 copay per visit
Urgent care	35%after deductible	20% after deductible	10% after deductible	40% after deductible	20% after deductible	10% after deductible	20% after deductible	10% after deductible	5% after deductible
Emergency room	35% after deductible	20% after deductible	10% after deductible	40% after deductible	20% after deductible	10% after deductible	20% after deductible	10% after deductible	5% after deductible
Prescription drugs									
Tier 1: Generic	$10 copay	$5 copay	$5 copay	$15 copay	$10 copay	$10 copay	$15 copay	$10 copay	$5 copay
Tier 2: Preferred brand	35% after deductible	20% after deductible	10% after deductible	$55 copay	$50 copay	$40 copay	$40 copay	$25 copay	$15 copay
Tier 3: Non-preferred brand	35% after deductible	20% after deductible	10% after deductible	40% after deductible	20% after deductible	10% after deductible	20% after deductible	10% after deductible	5% after deductible
Tier 4: Specialty prescriptions	35% after deductible	20% after deductible	10% after deductible	40% after deductible	20% after deductible	10% after deductible	20% after deductible	10% after deductible	5% after deductible
Tier 5: ACA preventive prescriptions	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tier 6: Select generics, including select insulin	$0	$0	$0	$0	$0	$0	$0	$0	$0
Case management programs	✔	✔	✔	✔	✔	✔	✔	✔	✔
CCHP on Call nurse line	✔	✔	✔	✔	✔	✔	✔	✔	✔

CONFIDENTIALITY

HIPAA & PERSONAL HEALTH INFORMATION (PHI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is designed to make health coverage more portable for individuals who change jobs or health plans by limiting the coverage exclusions that can be imposed when such a change occurs. HIPAA also contains privacy provisions designed to protect the confidentiality and security of Protected Health Information (PHI).

Title II of HIPAA is issued by the Department of Health and Human Services and has a section entitled "Administrative Simplification Rules," which includes provisions designed to reduce health care costs by standardizing claims processing, as well as provisions designed to improve the privacy and security of members' personal health information.

In accordance with HIPAA and NCQA requirements, Chorus Community Health Plans has a set of standards that help safeguard the confidentiality of member information. The following is a brief summary of how we use, disclose, and safeguard member information:

- Technological and administrative protections are in place to safeguard the privacy of our members' PHI, including race, ethnicity, and language data.
- There is mandatory staff training on how to protect and secure PHI.
- PHI is secured on our computers with firewalls and passwords.
- Member PHI Authorization and PHI Accounting Disclosure forms are available on our Member Forms website page.

OFFICIAL NOTICE OF PRIVACY PRACTICES

Providers can find more information in our official Notice of Privacy Practices on our website at chorushealthplans.org. Chorus Community Health Plans reserves the right to change our privacy practices and the contents of this Notice of Privacy Practices as allowed by law. When we make a significant change in our privacy practices, we will change this Notice and send it to our members or post it on our website at chorushealthplans.org.

RELEASE OF PHI WITHOUT MEMBER AUTHORIZATION

Chorus Community Health Plans may disclose a member's PHI without written authorization pursuant to a valid court order or subpoena, or as otherwise required by law, as well as health care operations and payments, such as:

- Payment of practitioners and providers
- Measurement of care and services
- Health or disease management programs
- Investigation of complaints and appeals
- Other purposes needed to administer benefits

MEDICAL RECORD ACCESS TO MEMBERS

Original medical records are not maintained by Chorus Community Health Plans. Members will contact their health care provider for access to their medical records. The member has the right to:

- Inspect and copy their protected health information maintained by their providers.
- Request an account of such information and to place limitations on the disclosure of such information.

COVERAGE

BEHAVIORAL HEALTH CARE, AND ALCOHOL AND OTHER DRUG ABUSE (AODA) SERVICES

Behavioral health care and AODA benefits are the same as for all other medical conditions, and are subject to deductible, coinsurance and copayments.

Referrals and prior authorizations

Chorus Community Health Plans would like the members' primary care providers (PCP) to play an integral part in meeting their comprehensive health care needs. We do not require referrals or prior authorizations for routine, in-network outpatient behavioral health care services.

We're here to help

If assistance is requested in locating an in-network provider to meet a covered member's needs, please contact Customer Service at 1-844-201-4672. You may also request assistance from our Clinical Services department at 414-266-5707.

Outpatient follow-up care

We strongly encourage our members to follow-up with an outpatient behavioral health provider within seven days of being discharged from an inpatient mental health or AODA facility. There is no question that rapid outpatient follow-up is consistent with standard practice guidelines and leads to better patient care.

If on the basis of a thorough bio-psychosocial evaluation, your clinic determines either a member does not require or would not benefit from specific behavioral health care services, your staff needs to document this conclusion in writing to us, with a notification to the member. We will stand by your recommendation or, in special circumstances, seek a second opinion. In all cases such as these, we assume that you will communicate your recommendations directly to the member.

Non-covered services

The following is a list of behavioral health care services that are not covered. This exclusion list does not apply for Mental Health Disorder services provided as the result of an emergency detention, commitment or court order. Please refer to the member's Evidence of Coverage (EOC) for a complete list. Please contact Provider Services at 1-844-202-0117 with questions about coverage.

Non-covered behavioral health care services include but are not limited to:

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Services that extend beyond the period necessary for evaluation, diagnosis, and the application of evidence-based treatments or crisis intervention to be effective
- Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders, and other disorders with a known physical basis.
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias, and other Mental Health Disorders that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practices, as reasonably determined by the Practitioner. This exclusion does not apply for Mental Health Disorder services provided as the result of an Emergency detention, commitment or court order.
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
- Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

- Intellectual disability with Autism Spectrum Disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Benefits for Autism Spectrum Disorder as a primary diagnosis are described under Autism Spectrum Disorder Services in Covered Services.
- Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Practitioner. If services for a nervous or Mental Health Disorder occur as a result of an Emergency detention, commitment or court order, the services will be covered.
- Services or supplies for the diagnosis or treatment of a Mental Health Disorder that, in the reasonable judgment of the Practitioner, are any of the following:
- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Practitioner's level of care guidelines or best practices as modified annually.
- Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Health Disorder, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks

DIALYSIS SERVICES

The Chorus Community Health Plans Dialysis Diagnosis Code List includes but is not limited to the following diagnosis codes: I12.0; I13.11; I13.2;

- E09.22; E11.22;
- N18; N18.4; N18.5; N18.6; N18.9; N19.

Dialysis limitations:

- Dialysis services must be provided by our contracted providers.

A case manager from Chorus Community Health Plans is available to assist members with care coordination. Please complete the Case/Disease Management Referral Form for the member, which is available on our Provider Forms page at chorushealthplans.org.

DURABLE MEDICAL EQUIPMENT (DME) (INCLUDING HEARING AIDS)

Chorus Community Health Plans benefit plan authorizes DME based on the retail price of the individual item or the monthly rental price. We will determine whether the item will be purchased or rented. Multiple items may appear on an authorization, but only the items with the check box for retail price/monthly rental price of greater than $500 will require prior authorization (completion of this field is mandatory).

- For each item that requires a prior authorization, clinical documentation to support the need must be submitted with the request.
- Items not meeting the retail price criteria for prior authorization will be assigned a No Prior Authorization Required code status.

Please note that there is a list of DME items that always require prior authorization despite their retail price, and these items are covered by our internal medical policies. The Prior Authorization List has more information such as, codes requiring authorization, a link to non-covered procedure codes, and those procedure codes that do not require a prior authorization.

DME exclusions:

- Devices used specifically as safety items including car seats or booster seats or to affect performance in sports-related activities.
- Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. These exclusions do not apply for covered members who are at risk of neurological or vascular disease arising from disorders such as diabetes.
- The following items are excluded, even if prescribed by a provider:
    - Blood pressure cuff/monitor

    - Enuresis alarm
    - Non-wearable external defibrillator
    - Trusses
- Devices and computers to assist in communication and speech except for speech aid devices and tracheoesophageal voice devices for which benefits are provided as described under Durable Medical Equipment in the Covered Services section of the member's Evidence of Coverage insurance contract
- Corrective appliances primarily intended for athletic purposes or related to a sports medicine treatment plan, and other appliances/devices, and any related services, including but not limited to:
    - Children's corrective shoes
    - Arch supports
    - Special clothing or bandages of any type
    - Back braces
    - Lumbar corsets
    - Hand splints
    - Knee braces
    - Shoe inserts and orthopedics shoes except as described under Prosthetic Devices in the Covered Services section of the member's Evidence of Coverage insurance contract
- Oral appliances for snoring
- Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
- Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
- Wearable robotic exoskeleton systems.

HEARING AIDS

Benefits are available for hearing aids for covered members who are certified as deaf or hearing impaired by either a physician or audiologist licensed under Wisconsin law. Related treatment includes services, diagnoses, surgery, and therapy provided in connection with the hearing aid and/or cochlear implant.

- Coverage of hearing aids is subject to the limit listed in the member's Schedule of Benefits.
- Covered services do not include the cost of batteries or cords.
- Benefits for hearing services are limited to one hearing aid per ear every three years

Bone anchored hearing aids are a covered service available under the applicable medical/surgical covered services categories for covered members who have either of the following:

- Craniofacial anomalies which preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Bone anchored hearing aids are limited to one per lifetime and require Prior Authorization.

COVERAGE

COCHLEAR IMPLANTS

Benefits are available for the following:

- The cost of cochlear implants that are prescribed by a physician or a licensed audiologist for a covered member under this benefit who is certified as deaf or hearing impaired by a physician or a licensed audiologist.
- The cost of treatment related to cochlear implants, including procedures for the implantation of cochlear devices.
- The cost of cochlear implants may not exceed the cost of one implant per covered member more than once every three years.
- Requires prior authorization.

HOME HEALTH CARE

Home Health Care is covered when a covered member is confined to his/her home, and if not provided, would require the covered member to be placed in a skilled nursing facility or hospitalized. It must also be deemed medically necessary and a formal home care program must provide the services.

To get reimbursed for Home Health Care services, the in-network practitioner must:

- Obtain a prior authorization
- Order, supervise and review the Home Health Care every two months. However, the practitioner may determine that a longer period between reviews is sufficient
- Render services in our service area

Home Health Care limitations:

- Home Health Care is limited to 60 visits per calendar year. One home care visit equals up to four consecutive hours in a 24-hour period
- The Home Health Care visit maximum applies to physical, occupational and speech therapy rendered in the home

You can verify the type of plan and coverage a member has by calling Provider Services at 1-844-202-0117.

HOME INFUSION THERAPY

Home infusion therapy is included in the home health care benefit. Home infusion therapy will be considered if hospitalization or confinement in a skilled nursing facility would be necessary if home infusion therapy services were not provided.

Home Infusion Therapy limitations**:**

- Nonprescription supplies are not a covered benefit.
- Pumps and medically necessary supplies are covered under the DME benefit.

HOSPICE CARE

Hospice Care is covered if the covered member's practitioner certifies that the covered member or covered dependent's life expectancy is six months or less; the care is palliative; and, the Hospice Care is received from a licensed hospice agency.

Hospice Care services are provided according to a written care delivery plan developed by an in-network Hospice Care practitioner and by the recipient of the Hospice Care services.

Hospice Care services include but are not limited to:

- Physician services
- Nursing care
- Respite care
- Medical and social work services
- Counseling services
- Nutritional counseling
- Pain and symptom management
- Medications

- Medical supplies and DME
- Occupational, physical, or speech therapies
- Volunteer services
- Home Health Care services
- Bereavement services

Respite care may be provided only on an occasional basis (once per 60 days) and may not be reimbursed for more than five consecutive days at a time. Prior Authorization is required for Hospice Care services whether in home or in a respite care facility.

SKILLED NURSING FACILITY

Coverage applies only when skilled nursing or skilled rehabilitation services are required on a daily basis. Skilled Nursing care means care that can only be performed by or under the supervision of licensed nursing personnel.

Skilled rehabilitation services include such services as physical therapy performed by or under the supervision of a professional. Benefits are available for:

- Room and board in a semi-private room (a room with two or more beds)
- Ancillary services and supplies — services received during the inpatient stay including prescription drugs, diagnostic and therapy services

Skilled Nursing Facility limitations:

- Benefits are limited to 30 days per stay.
- Benefits are available only if both of the following are true:
  - If the initial confinement in a Skilled Nursing Facility or Inpatient Acute Medical Rehabilitation Facility was or will be a cost-effective alternative to an inpatient stay in a hospital
  - The member will receive skilled care services that are not primarily custodial care

TRANSPLANTS

Benefits are provided for the following transplants and related costs with a prior authorization:

- Heart
- Liver
- Liver/small bowel
- Pancreas
- Bone marrow (autologous self to self, or allogenic other to self)
- Kidney
- Heart/lung
- Single lung
- Bilateral sequential lung
- Corneal (prior authorization not required)
- Kidney/pancreas
- Intestinal
- Re-transplantation for the treatment of organ failure or rejection.
- Immunosuppressive or anti-rejection medications. These drugs must be for an approved transplant. Cost sharing may apply, as described in the member's Scheduled of Benefits.
- Donor costs that are directly related to organ removal are covered services for which benefits are payable through the organ recipient's coverage under the covered member's Evidence of Coverage (EOC).
- Transplant criteria

Chorus Community Health Plans contracts with a transplant coordinator. The covered member's condition must meet the following criteria and be approved by both our designated transplant provider and us:

- The potential benefit of the transplant must outweigh the potential risk.
- The specific type of transplant must provide more benefit than other therapies, given the covered member's

medical condition
- The covered member must not have a terminal disease that the transplant would not correct or cure
- The specific type of transplant must improve the covered member's quality of life and health or functional status. To determine this, we will rely only on scientifically designed and controlled research studies. We will rely only on such studies published in peer reviewed medical publications that are accepted as appropriate by the transplant or oncology academic communities

Transplant exclusions:

- Any experimental or investigational transplant or any other transplant-like technology not listed in the member's Evidence of Coverage (EOC) insurance contract.
- Any resulting complications from these, and any services and supplies related to such experimental or investigational transplantation or complications, including but not limited to:
    - High-dose chemotherapy
    - Radiation therapy
    - Immunosuppressive drugs

Case management

A case manager from Chorus Community Health Plans will be available to assist the member with care coordination/ case management. Please complete the Case / Disease Management Referral Form for the member, which is available on the Provider Forms page at chorushealthplans.org.

CREDENTIALING

This policy outlines Chorus Community Health Plan's (CCHP) process for Credentialing and Recredentialing of Practitioners and Organizational Providers for inclusion in CCHP's Network.

CREDENTIALING DEFINITIONS

- **Applicant** – the Practitioner or Organizational Provider seeking to become credentialed or re-credentialed to participate in CCHP's network
- **Credentialing** – the process of assessing and validating the applicable criteria and qualifications of a Practitioner or Organizational Provider for participation in the CCHP network
- **Credentialing Authority** – the National Committee for Quality Assurance (NCQA); the Centers for Medicare and Medicaid Services (CMS) as applicable, and any other federal or state authority
- **Credentialing Committee** – a subcommittee of the Quality Oversight Committee (QOC) that uses a peer review process to evaluate and make recommendations regarding credentialing decisions
- **Covered Persons** – individuals who have insurance through CCHP
- **Credentialing Verification Organization (CVO)** – an organization that conducts primary source verification of practitioner credentials for other organizations. The NCQA CVO Certification program evaluates CVO management of many aspects of its credentials verification operations, as well as the processes it used for continuous improvement of services
- **Material Restrictions** – any limitation or limiting condition imposed on a Practitioner's ability to practice medicine
- **Licensed Independent Practitioner (LIP)** – any health care professional who is permitted by law to practice independently within the scope of the individual's license or certification, and includes but is not limited to audiologists (AUDs), certified nurse midwives (CNMs), certified registered nurse anesthetist (CRNAs), medical doctors (MDs), doctors of osteopathy (DOs), oral surgeons (DDS or DMD), chiropractors (DCs), doctors of podiatric medicine (DPMs), psychiatrists (MDs), psychologists (PsyD or PhD), nurse practitioners (NP or APNP), allied behavioral health practitioners (CSAC, LPC, LCSW, LMFT) and all other non- physician practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision), have an independent relationship with CCHP and provide care under a Benefit Plan
- **Chief Medical Officer** – the licensed physician appointed by CCHP to serve as the Chair of Credentialing Committee and fulfill various duties related to CCHP administration
- **Medical Director** – the licensed physician appointed by CCHP to serve as a member of the Credentialing Committee and fulfill various duties related to CCHP administration
- **Behavioral Health Organizational Providers** – inpatient, residential, and ambulatory facilities, which provide Behavioral Health services to Covered Persons
- **Organizational Provider** – an institution or organization that provides services such as hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers, and Behavioral health facilities that provide Behavioral Health and/or substance abuse treatment in an inpatient, residential or ambulatory setting (CCHP only organizationally credentials County ambulatory agencies and medication assisted treatment centers)
- **Practitioner** – a licensed or certified professional who provides medical care or behavioral healthcare services
- **Primary Source Verification** – verification of credentialing information directly from the entity (e.g. state licensing board) that conferred or issued the original credential
- **Quality Oversight Committee (QOC)** – the committee delegated the authority by the CCHP Board of Directors to implement, oversee, and make final decisions regarding CCHP credentialing functions. The QOC may delegate to the Credentialing Committee the responsibility for selection, credentialing, re-credentialing and related administration of the credentialing process
- **Re-credentialing** – the process of re-assessing and validating the applicable qualifications of a Practitioner or Organizational Provider to allow for participation in CCHP's network

CREDENTIALING COMMITTEE

The Credentialing Committee is responsible for reviewing the credentials of Practitioner and Organization Providers and making decisions whether to accept, retain, deny or terminate a Practitioner and Organizational Provider's participation in CCHP's network.

The Chief Medical Officer (CMO) serves as the committee chairperson. The Credentialing Committee will meet the 3rd Thursday of every month unless otherwise determined by the committee chair. The presence of a simple majority of voting members constitutes a quorum. The voting members of the Credentialing Committee include the CMO, CCHP Medical Directors, and at least seven (7) practitioners representing CCHP's participating network. The CMO may appoint additional voting members, network practitioners or otherwise, whose expertise is deemed appropriate for the efficient and effective functioning of the Credentialing Committee. The committee shall also include the Executive Director of Health Plan Clinical Services and the Executive Director of Health Plan Operations as non-voting members. Their role is to represent the interests of CCHP's clinical, quality, and provider contracting functions as well as health plan operations.

The Credentialing Committee will access various specialists for consultation, as needed to review an applicant's credentials. Credentialing Committee members shall disclose and abstain from voting on a Practitioner if the member:

- Believes there is a conflict of interest
- Feels his/her judgment might otherwise be compromised

A committee member will also disclose if he/she has been professionally involved with the Practitioner. Determinations to deny and applicant's participation, or terminate a practitioner from participation in CCHP's network, requires a majority vote of the voting members of the Credentialing Committee in attendance. All information obtained during the credentialing and re-credentialing process is strictly confidential and privileged. All Credentialing Committee meeting minutes and Practitioner and Organizational Provider credentialing files shall be securely stored and only accessible by credentialing staff, in locked file cabinets. Documents and information in these files may not be reproduced or distributed, except for credentialing and quality review purposes.

Non-Discrimination

CCHP conducts all Practitioner and Organizational Provider credentialing and re-credentialing in a non-discriminatory manner and takes steps to monitor for and prevent discriminatory practices. CCHP does not make credentialing decisions in any way based upon an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or types of patients the Practitioner applicant specializes in. CCHP ensures non-discrimination by having the Credentialing Committee members sign an affirmative statement that all decisions are made in a non-discriminatory manner. CCHP conducts periodic audits of Practitioner and Organizational Provider complaints to determine if there are any complaints alleging discrimination and reports the findings to the QOC.

SCOPE OF CREDENTIALING

CCHP credentials the following Practitioners:

- Medical doctors and doctors of osteopathic medicine;
- Doctors of podiatry;
- Oral surgeons;

- Psychiatrists;
- Chiropractors;
- Nurse practitioners;
- Certified registered nurse midwives;
- Certified nurse anesthetists;
- Audiologists;
- Psychologists;
- Behavioral health providers as follows:
    - Licensed marriage and family therapists
    - Licensed clinical social workers
    - Licensed professional counselors
    - Clinical nurse specialists
    - Clinical substance abuse counselors

CCHP credentials the following Organizational Providers:

- Hospitals;
- Skilled nursing facilities;
- Home health agencies;
- Free-standing surgical centers; and
- Behavioral health facilities that provide mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting

INITIAL CREDENTIALING

Each practitioner applicant must register with the Council for Affordable Quality Healthcare (CAQH) to submit an application for review when applying for initial participation in CCHP's network. If the applicant meets CCHP screening criteria, the credentialing process will commence. CCHP will verify those elements related to an applicant's legal authority to practice, relevant training, experience and competency from the primary source where applicable, during the credentialing process. All verifications must be current and verified within ninety (90) calendar days from the date the application is deemed complete to begin processing. During the credentialing process, CCHP will review the verification elements shown in Credentialing Criteria for Practitioners unless otherwise required by applicable regulatory or accrediting bodies.

CRITERIA TO SUBMIT AN APPLICATION

CCHP requires practitioners who submit an application to meet three criteria in order for the credentialing application to be processed:

- An active and unrestricted license without limitations or sanctions from the state(s) in which they practice
- Cannot be excluded from participating in Medicare or Medicaid programs (lack of sanctions or debarment) where such participation is required

- No prior denials or termination from participation by CCHP (for reasons other than network need) within the previous 24 months.

If the applicant fails to meet these criteria, CCHP will not process the application further. The applicant may reapply when they meet all of the eligibility criteria.

CREDENTIALING CRITERIA FOR PRACTITIONERS

Initial applicants must submit the following information in order to be considered for participation:

1. A release granting CCHP permission to review the records of and to contact any professional society, hospital, insurance company, present or past employer, professional peer, clinical instructor, or other person, entity, institution, or organization that does or has records or professional information about the applicant
2. A release from legal liability for any such person, entity, institution, or organization that provides information as part of the application process
3. Information on the type of processional license(s) or certification(s) held, state issued, certification and/or license number, effective date, and date of expiration
4. Current Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substance Certificate (CDS) in each state where applicant intends to practice, if applicable
5. Professional liability claims history that resulted in settlements or judgments paid by or on behalf of the applicant, and history of liability insurance coverage, including any refusals or denials to cover applicant or cancellations of coverage
6. Educational history and degrees received relevant to applicant's area of practice, licensure, or certification, including dates of receipt. Not required at the time of re-credentialing unless it has changed and impacts the LIP's specialty

The required medical or professional education and training are as follows:

1. MDs and DOs must graduate from medical school and successfully complete a residency training program approved by the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA) in the specialty in which the applicant will be practicing.
2. Alternative to residency programs, MDs and DOs meeting any one of the following criteria will be viewed as meeting the residency program requirement:
    i. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in the clinical specialty or subspecialty OR
    ii. CCHP will take into consideration the successful completion of equivalent accredited training programs, in the specialty in which the applicant will be practicing. The determination of whether such programs are equivalent or not are the sole discretion of CCHP
3. Doctors of Chiropractic Medicine (DC) must graduate from a chiropractic school.

4. Doctors of Dental Surgery (DDS) or Doctors of Medicine in Dentistry (DMD) must graduate from dental school.
5. Doctors of Podiatric Medicine (DPM) must graduate from podiatry school and successfully complete a hospital residency program.
6. All advanced practice practitioners (e.g. nurse practitioner, nurse midwife, etc.) must graduate from an accredited professional school and successfully complete a training program.

The following are exceptions for specific Behavioral Health practitioners:

1. Licensed Clinical Social Workers (LCSW) or other master level social work license types:
    a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education
2. Clinical Psychologists:
    a. Doctoral degree in clinical, counseling psychology or equivalent field of study from an institution accredited by the American Psychological Association (APA)
    b. Education and/or training deemed equivalent by the Credentialing Committee for a practitioner with a doctoral degree not from an APA accredited institution but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology. The determination of whether such programs are equivalent or not are at the sole discretion of CCHP
3. Licensed Professional Counselors
    a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field
4. Clinical Nurse Specialist (Psychiatry)
    a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and Behavioral Health nursing
    b. Registered Nurse license and any additional licensures as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing
5. Listing of degrees or certification received from appropriate professional schools, residency training programs, or other specialty training programs appropriate for the type of participation sought, if applicable. Not required at the time of re-credentialing unless it has changed and impacts the LIPs specialty
6. List of professional licenses received, whether current or expired, and licensing history, including any challenges, restrictions, conditions, limitations, or other disciplinary action taken against such license or voluntary relinquishment of such licensure

7. Current certifications, where such certification is required, for participation in Medicare, Medicaid or other federal programs and certification history for such participation, including restrictions, conditions, or other disciplinary actions
8. A five year employment history, including periods of self-employment and the business names used during this time, and a history of voluntary or involuntary terminations from employment, professional disciplinary action or other sanction by a managed care plan, hospital, or other health care delivery setting, medical review board, licensing board, or other administrative body or government agency
9. Completed application, including a signed statement, which may be in an electronic format, providing information and attesting to
10. Current professional liability policy, including the name of insurer, policy number, expiration date and coverage limits (even if $0); Practitioners with federal tort coverage must submit a copy of their federal tort letter, or a signed attestation that they have federal tort coverage
11. Limitations on ability to perform essential functions of the position with or without accommodation
12. History of loss of license of any loss or limitations of privileges or disciplinary activity
13. Absence of current, substance abuse or active alcoholism
14. No felony convictions or pleas of no contest to a felony that the Credentialing Committee deems would make the applicant inappropriate for inclusion in CCHP's network
15. Completeness and accuracy of the information provided in the application
16. Authorization to allow CCHP to conduct a review, satisfactory to CCHP, of the applicant's practice including office visits, staff interviews, and medical record keeping assessments, in accordance with Credentialing Authority
17. Any other documents or information that CCHP determines are necessary for it to effectively and or efficiently review applicant's qualifications (i.e. collaborating physician form for nurse practitioners)
18. No current medical staff membership or clinical privilege restrictions

CCHP RECREDENTIALING CRITERIA

RE-CREDENTIALING CREDENTIALING

The re-credentialing process incorporates re-verification and the identification of changes in a practitioner's licensure, sanctions, certification, health status and/or quality and performance information (including but not limited to, malpractice experience, sanction history, hospital privilege related or other actions) that may reflect, as applicable, on the practitioner's professional conduct and competence. This information is reviewed in order to assess whether practitioners continue to meet CCHP credentialing standards.

Re-credentialing of practitioners occurs every three years unless otherwise required by regulatory or accrediting bodies or a shorter term as determined by the Credentialing Committee. Credentialing terms of less than three years are not considered an action of determination that triggers appeals rights. Each practitioner applying for continued participation in CCHP's network must submit all required supporting documentation.

Re-credentialing Criteria for Practitioners

Re-credentialing applicants must provide and/or will be primary source verified the following information:

1. A complete re-credentialing application and required supplemental information/attachments without material omissions or misrepresentations
2. Signed and dated attestation, consent and release
3. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to covered persons
4. No current federal sanction and no new history of federal sanctions (per OIG reports or on NPDB report)
5. Current DEA and/or state controlled substance certification without history of or current restrictions if applicable
6. Current professional liability policy, including the name of insurer, policy number, expiration date and coverage limits (even if $0). Practitioners with federal tort coverage must submit a copy of their federal tort letter, or a signed attestation that they have federal tort coverage
7. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions, OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a network provider who provides inpatient care to covered persons needing hospitalization
8. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest
9. No impairment or other condition which would negatively impact the ability to perform essential functions in their professional filed
10. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism
11. Malpractice case history reviewed since the last Credentialing Committee review, if no new cases are identified since last review, malpractice history will be reviewed as meeting criteria, if new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used
12. No new (since previous credentialing review) involuntary terminations from another health plan
13. No QA/PI data or other patient care related performance data, including complaints, above set thresholds

VERIFICATION

The credentialing criteria must be verified and approved within 90 days from the date the application is deemed complete to be eligible to become a participating practitioner.

1. No prior denials or terminations. At the discretion of CCHP, the applicant must not have been denied participation by CCHP (for reasons other than network need) within the preceding 24 months.

2. No affirmative responses to disclosure questions on credentialing application. Provide details on all affirmative responses to disclosure questions.
3. Other credentialing requirements such as WDSPS if the practitioner is not board certified as required by credentialing authorities

PRACTITIONER CLEAN FILE CRITERIA INITIAL AND RE-CREDENTIALING

To qualify as a practitioner "clean file" the following criteria must be met:

1. Current active license with no restrictions or limitations. During any time period in which the practitioner's license is suspended, CCHP will initiate immediate action to terminate the provider from the network
2. No sanctions (license Medicare or Medicaid)
3. Current active DEA with no restrictions or limitations (if applicable)
4. Current professional liability insurance of not less than $1,000,000 per occurrence and $3,000,000 in the general aggregate with an insurer licensed to provide medical malpractice insurance in Wisconsin, or show similar financial commitments made through an appropriate Wisconsin approved alternative, as determined by CCHP and appropriate secondary coverage by the Wisconsin Injured Patients and Families Compensation Fund. The pertinent network agreement may require coverage that exceeds the minimum level described above
5. Current full hospital admitting privileges, without material restrictions, conditions, or other disciplinary actions, at a CCHP participating network hospital, or arrangements with a participating practitioner to admit and provide hospital coverage to covered persons at CCHP participating network hospital, if CCHP determines that applicant's practice requires such privileges
6. No unexplained gaps in work history greater than ninety days
7. Lack of present, illegal drug use
8. Ability to perform the essential functions of the position with or without accommodations
9. No felony or misdemeanor convictions
10. No professional liability settlements within five years for initial credential and three years for re-credentialing
11. No adverse findings on NPDB other than malpractice reports from greater than five years, before the application, for initial credential and three years for re-credentialing
12. No restricted hospital privileges or other disciplinary activity
13. No adverse actions or disciplinary activity by another health plan
14. Practitioner must be board certified or board eligible in specialty of practice. If not board eligible, practitioner must have no adverse events within the past five years and be in practice greater than ten years.
15. Practitioner's eligibility for board certification is defined by no fewer than three years and no more than seven years following the successful completion of accredited training. This follows the ABMS board eligibility policy.
16. Minimum credentialing guidelines met for education and training if board certification not available for

specialty

17. No miscellaneous credentialing red flags, to include but not limited to, interruption of training and history of liability coverage canceled for any reason or frequent changes in insurers

If these criteria are not met the file will be considered "unclean" and will be reviewed by the Credentialing Committee.

ORGANIZATIONAL PROVIDERS

Scope of Credentialing

- Hospitals
- Skilled nursing facilities
- Home Health Agencies
- Free standing surgical centers
- Behavioral health facilities that provide behavioral health and/or substance abuse treatment in an inpatient, residential or ambulatory setting

Organizational Provider Credentialing Criteria

Initial and Re-credentialing Organizational Credentialing

Organizational provider applicants must submit a standardized application for review when applying for initial participation in CCHP's network. If the applicant meets pertinent CCHP screening criteria, the credentialing process will commence. In addition to licensure and other eligibility criteria for organizational providers, as described in detail below, all organizational providers are required to maintain accreditation by an appropriate, recognized accrediting body or, in absence of such accreditation, CCHP may evaluate the most recent site survey by Medicare or applicable Wisconsin oversight agency performed within the past 36 months for a given organizational provider. During the re-credentialing process, CCHP will review the verification elements shown in "Criteria for Selecting Providers" unless otherwise required by applicable regulatory or accrediting bodies.

Re-credentialing of organizational providers occurs every three years unless otherwise required by regulatory or accrediting bodies. Each organizational provider applying for continued participation in CCHP's network must submit all required supporting documentation.

Organizational Provider Eligibility Criteria

All organizational providers must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, CCHP may evaluate the most recent site survey by Medicare or the appropriate state oversight agency performed within the past 36 months. Non-accredited organizational providers are subject to individual review by the Credentialing Committee and will be considered for covered individual access need, only when the Credentialing Committee review indicates compliance with CCHP standards and there are no federal or state level deficiencies or sanctions that would adversely quality of care or patient safety.

Credentialing/Re-credentialing Criteria for Organizational Providers

1. Valid, current and unrestricted license or certification to operate in Wisconsin. The license must be in good standing with no sanctions
2. Valid and current Medicare and Medicaid certification
3. Must not be currently debarred or excluded from participation in Medicare or Medicaid
4. General/comprehensive liability insurance as well as errors and omissions (malpractice) of not less than $1,000,000 per occurrence and $3,000,000 in the general aggregate with an insurer licensed to provide medical malpractice insurance in Wisconsin, or show similar financial commitments made through an appropriate Wisconsin approved alternative, as determined by CCHP and appropriate secondary coverage by the Wisconsin Injured Patients and Families Compensation Fund. The pertinent network agreement may require coverage that exceeds the minimum level described above
5. Accredited organizational providers must provide proof of current accreditation status conducted during the previous three year period and active federal or state licensure as applicable. CCHP will accept accreditation results from:
    - AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities
    - AAAHC – Accreditation Association for Ambulatory Health Care
    - ACHC – Accreditation Commission for Health Care
    - CARF/CCAC – Commission on Accreditation of Rehabilitation Facilities/Continuing Care Accreditation Commission
    - CHAP – Community Health Accreditation Program
    - CCAC - Continuing Care Accreditation Commission
    - CIHQ – Center for Improvement in Healthcare Quality
    - COA – Council on Accreditation
    - COLA – Commission on Office Accreditation
    - HFAP – Healthcare Facilities Accreditation Program
    - NCQA – National Committee for Quality Assurance
    - NIAHO/DNV – GL – National Integrated Accreditation for Healthcare/Det Norske Veritas and Germanischer Lloyd
    - TJC – The Joint Commission
    - Other – CMS Division of Quality Assurance

Confirmation and Clean File Criteria of Organizational Providers

1. Current, active license appropriate for facility type, if applicable, with no restriction, limitation, or disciplinary action by any federal or state entities identified by CMS or State Medical or Pharmacy boards
2. Unrestricted and non-probationary Medicare/Medicaid participation
3. No sanctions (license, Medicare, Medicaid, OIG or other)
4. Current general/comprehensive liability and malpractice insurance coverage for at least the limits established by CCHP for each facility type
5. Not ineligible, excluded, or debarred from participating in Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program
6. Current accreditation by an accrediting entity recognized by CCHP for type of facility
    a. If not appropriately accredited, organizational provider must submit a copy of its CMS or state survey for review by the Credentialing Staff to determine if CCHP's quality and certification criteria standards have been met

ONGOING SANCTION MONITORING

CCHP has an ongoing monitoring program for the purpose of monitoring complaints, adverse events and quality of care issues. CCHP credentialing staff perform ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department reviews periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

A. Office of Inspector General (OIG)
B. Federal Medicare/Medicaid Reports
C. State Licensing Boards/Agencies
D. Covered persons/practitioner and organization provider patient/customer service departments
E. CCHP Quality Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
F. Other internal and affiliated CCHP departments
G. Any other verified information received from appropriate sources when a practitioner or organizational provider within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response including but not limited to: review by the chairperson of the Credentialing Committee, review by the CCHP CMO, referral to the Credentialing Committee, or termination. CCHP will report practitioners or organizational providers to the appropriate authorities as required by applicable law.

Data Audits

A. Practitioner information, including education, training, certification and specialty listings in practitioner directories and other materials for members will be consistent with the practitioner information verified at the time of credentialing/re-credentialing
B. On a quarterly basis, ten percent of approved files are reviewed for accuracy between the online directory and credentialing system

Confidentiality of Credentialing Files

Ongoing access to credentialing files and related information is restricted to authorized personnel only including CCHP credentialing staff. Physical files with documents are only accessible to credentialing associates, credentialing specialist, credentialing manager, the CMO and other staff who oversee credentialing functions.

Rights of Practitioners with Respect to CCHP Credentials File

Practitioners and applicants to CCHP network have certain rights with respect to their credentials:

- Each practitioner has the right to review and correct erroneous information in their credentialing application file and their electronic profile in CCHP's credentialing management system. The practitioner should send a written request to CCHP, specifying the format (photocopy of paper file, electronic profile run from the credentialing management system, or both). CCHP credentialing staff will then furnish the practitioner with a photocopy of their paper application file, and/or an electronic profile from the credentialing management system within ten business days. Proposed corrections should be submitted to CCHP by practitioners in writing within 30 days of receipt.
- Each practitioner is notified when information the practitioner has submitted on an application varies substantially from that received during verification process. CCHP credentialing staff will provide written notification to the practitioner and the practitioner will be given at least 30 days to respond and correct the discrepancy. The practitioner application file will be considered incomplete until the discrepancy is corrected. Once correction is received, the file will proceed through the application process as usual.
- Each practitioner has the right to request credentialing and re-credentialing application status. The practitioner can contact the Credentialing department by phone or e-mail.

Notification to Authorities/Reporting Requirements

When CCHP takes a professional review action with respect to a practitioner's participation in CCHP's network, CCHP may have or assume an obligation to report such to the National Practitioner Data Bank (NPDB). Once CCHP receives a verification of the NPDB report, the verification report will be sent to the applicable licensing board. CCHP will comply with all state and federal regulations with regard to the reporting of adverse actions or recommendations relating to professional conduct and competence. These reports will be made to the appropriate, designated agencies or authorities.

Appeal Rights/Process

CCHP has established policies and procedures related to CCHP's monitoring, investigation and formal appeal process, if applicable, when CCHP makes determinations regarding practitioner and organizational provider eligibility and continued participation in CCHP's network. See policy entitled Practitioner Suspension, Termination and Appeal Rights.

PROVIDER SUSPENSION TERMINATION APPEAL RIGHTS

PURPOSE OR DESCRIPTION:
This policy sets forth the procedures for restricting, suspending or terminating a Practitioner or Organizational Provider's participation in CCHP's Network, notifying the Practitioner or Organizational Provider of this action and, if applicable, offering appeal rights and notifying appropriate authorities in compliance with applicable law.

Any inability to implement an applicable provision of this policy, inclusive of any further updates, revision and amendments, due to a conflict with the applicable state or federal law, state law and federal law shall control and take precedence over this policy.

POLICY:

A. A Practitioner or Organizational Provider's participation in CCHP's Network or programs may be terminated for any lawful reason, including but not limited to a failure to meet eligibility criteria, matters related to professional conduct and competence, credentialing and re-credentialing criteria including matters involving patient complaints and identified performance issues, and any basis set forth in the Practitioner's or Organizational Provider's participation agreement with CCHP.
B. Additionally, a Practitioner or Organizational Provider's participation in CCHP's Network or programs may be evaluated when information is received relative to professional conduct and competence including, but not limited to professional disciplinary actions, malpractice history and claim events, sanctions under Medicare, Medicaid or other healthcare programs, unprofessional conduct, moral turpitude, criminal convictions, reportable malpractice actions, loss or surcharge of malpractice insurance or other events
C. The definitions set forth in the CCHP Credentialing and Re-credentialing Policy apply to this policy, unless otherwise indicated.

PROCEDURE:

1. Investigation. CCHP has the following process for inquiry into an investigation of any complaint, allegation or concerns regarding a Practitioner and Organizational Provider. This includes, but is not limited to, inquiry into and investigation of complaints and identified adverse event reports involving a Practitioner or Organizational Provider. A preliminary inquiry may be undertaken by the Medical Director or designee on behalf of the Quality Oversight Committee (QOC), into any matter to assess whether an investigation should be requested or commenced. A preliminary inquiry is permitted but not required prior to a request for or commencement of an investigation. Any request for an investigation should be submitted in writing to, or initiated by, the Medical Director or designee.

2. If the Credentialing Committee or QOC determines an investigation is warranted, an individual or ad hoc committee may be appointed to conduct the investigation. The Practitioner should be notified that an investigation is being commenced and afforded the opportunity to participate in the investigative process. Investigations should be concluded within a reasonable time following receipt of the request for investigation. Upon completion of the investigation, the responsible individual(s) or committee shall submit a written report of their findings to the Credentialing Committee or QOC.

3. Following completion of an investigation, the Credentialing Committee may determine that further review and action is required, or make a determination regarding whether corrective action is warranted based on the findings of the investigation.

PROVIDER SUSPENSION TERMINATION APPEAL RIGHTS

Corrective Action

1. After reviewing the investigating individual or committee's or designee's report, the Credentialing Committee may take one or more of (but not be limited to) the following actions:
    A. Determine that corrective action is not warranted;
    B. Direct that further investigation occur;
    C. Accept the investigation report and recommendation;
    D. Place the Practitioner on probation;
    E. Issue a letter of instruction, correction, reprimand or warning to the Practitioner;
    F. Determine that the Practitioner's participation in CCHP's Network be restricted or terminated, or;
    G. Recommend or take such other action as the Credentialing Committee determines is appropriate under the circumstances

Summary Suspension

1. Grounds for Summary Suspension or Restriction:
    a. Whenever, the conduct or continuation of treating Covered Persons by a Practitioner constitutes or may result in an immediate danger to Covered Person(s) or the general public, the Medical Director or designee, acting on behalf of the Credentialing Committee, has the authority to (1) afford the individual an opportunity to voluntarily refrain from providing services to Covered Persons pending an investigation; or (2) suspend or restrict the Practitioner's participation in CCHP Network or programs, whichever is most appropriate under the circumstances.
    b. A summary suspension or restriction may be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Director, Credentialing Committee or QOC.
2. A summary suspension or restriction will become effective immediately upon imposition, will immediately be reported in writing to the Credentialing Committee and will remain in effect unless it is modified by the Medical Director, pertinent committee or designee.
3. The Practitioner will be provided a written basis for the summary suspension, including the names and medical record numbers of the patient(s) involved (if any), within a reasonable period of time following imposition of the suspension.
4. Credentialing Committee Procedure:
    a. The ad hoc committee appointed by the Chair of the Credentialing Committee will review circumstances related to the summary suspension or restriction (or voluntarily refrain) within a reasonable time under the circumstances, generally not to exceed 14 days. Prior to, or as part of, this review, the Practitioner shall be given an opportunity to provide information relevant to the summary suspension or restriction to the Credentialing Committee or ad hoc committee.

b. After considering the circumstances resulting in the suspension or restriction and the Practitioner's response, if any, the Credentialing Committee will determine whether there is sufficient information to warrant a recommendation or whether to commence an investigation. The Credentialing Committee will also determine whether the summary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and appeal, if applicable).

AUTOMATIC TERMINATION

A. Any action taken by a licensing board, accreditation organization, professional liability insurance company, court or government agency regarding any of the matters set forth in section B below, or failure to satisfy any of the threshold eligibility criteria set forth in this policy, must be reported to the Medical Director within five (5) days of occurrence or receipt of notification by the Practitioner.

B. A Practitioner's participation in CCHP's Network will automatically terminate should any of the following occur:

1. Licensure: Revocation, expiration, suspension, limitation, or the placement of restrictions on a Practitioner's license
2. Controlled Substance Authorization: Revocation, expiration, suspension, or the placement of restrictions on a Practitioner's DEA or controlled substance registration if required for their practice of medicine
3. Insurance Coverage: Termination or lapse of a Practitioner's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by CCHP
4. Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs
5. Criminal Activity: Conviction, plea of guilty, or no contest pertaining to any felony, or to any misdemeanor involving:
    i. controlled substances
    ii. illegal drugs
    iii. Medicare, Medicaid, or insurance or health care fraud or abuse
    iv. violence against another
    v. abuse or neglect of a child
    vi. any other offense that serves as a bar to the individual acting as a caregiver pursuant to the Wisconsin Caregiver Law
6. Requested Information: A failure to provide adequate information within thirty (30) days pertaining to a Practitioner's qualifications or compliance with this policy or participation agreement or in response to a written request from the Medical Director, Credentialing Committee, QOC or any committee authorized to request such information.
7. Fails to satisfy any of the other threshold eligibility criteria set forth in this policy.

C. Automatic termination will take effect immediately upon notice to the Practitioner or such other date as specified in the notice. The Practitioner has 10 days from the date of notice to request a waiver. Any waiver request must be accompanied by a complete written explanation and supporting information. All determinations regarding whether a waiver should be granted and back dating a reinstatement date will be in the sole discretion of the Credentialing Committee.

RIGHT TO APPEAL/PRE-APPEAL PROCESS:

A. **Right to an Appeal**

B. Practitioners shall be entitled to an appeal should the Credentialing Committee recommend or take any of the following actions in furtherance of quality healthcare based on the competency or professional conduct of the Practitioner:

   a. Termination of participation in CCHP's Network; or
   b. Restricting participation in CCHP's Network
   c. he appeal shall be heard via telephone conference unless an in-person format is agreed upon in writing by the QOC

C. **Notice of Adverse Action**

The Medical Director or designee shall give notice to the Practitioner of any adverse action that provides for an appeal right. This notice of appeal shall include the following:

   a. The action proposed to be taken
   b. The reasons for the proposed action
   c. That the Practitioner has a right to an appeal and that the Practitioner may appear in person or by telephone

d. That the Practitioner has thirty (30) days after receipt of the notice within which to submit a written request for an appeal
e. A summary of the Practitioner's rights in the appeal
f. That a failure to request an appeal within the above time period, and in the proper manner, constitutes a waiver of any rights to an appeal on the matter that is the subject of the notice
g. That upon the Medical Director's receipt of the Practitioner's appeal request, the Practitioner shall be notified of the date, time and place of appeal, which unless otherwise provided for shall not be less than thirty (30) days nor more than ninety (90) days after the notice, and shall provide the Practitioner with a list of the witnesses expected to testify at the appeal on behalf of the QOC

D. Actions Not Grounds for an Appeal

None of the following actions will constitute grounds for an appeal, and they will take effect without appeal. However, the Practitioner will be entitled to submit a written explanation to be placed into his or her file:

a. Issuance of a letter of guidance, correction, counsel, warning, or reprimand

b. Failing to meet contractual obligations or qualifications specified in CCHP's Credentialing policies or in the Practitioner's network agreement
c. Summary suspension, unless it exceeds fourteen (14) days in duration
d. Determination that an application is incomplete
e. Determination that an application will not be processed due to a misstatement or omission
f. Determination of ineligibility based on a failure to meet eligibility criteria, upon initial credentialing, recredentialing or during the term of participation; or a lack of need for the Practitioner's specialty services

E. Request for Appeal/Waiver

All requests for an appeal must be in writing to the attention of the Medical Director and be received by certified mail within the thirty (30) calendar days following the Practitioner's receipt of the notice of proposed adverse action. If the Practitioner does not request an appeal within the time and in the manner specified, he or she shall be deemed to have waived his or her right to appeal.

F. Appointment of QOC as the Appeals Committee

The QOC or designated ad hoc committee shall serve as the Appeals Committee. All subsequent references to the Appeals Committee shall refer to the QOC or designated ad hoc committee. Individuals who are in direct economic competition with the Practitioner shall not participate as part of the Appeals Committee. Knowledge of the matter involved shall not preclude an individual from serving on the Appeals Committee, but an individual who previously considered and voted on the matter, has a family, professional or business relationship with the Practitioner requesting an appeal that creates an actual conflict of interest shall not be eligible to serve on the Appeals Committee. One member of the Appeals Committee shall be appointed as Chairperson. The Chairperson shall conduct the appeal, any pertinent pre-appeal matters, maintain decorum, and rule on all evidentiary and witness matters. The Chairperson shall ensure that all participants have a reasonable opportunity to present relevant oral and documentary evidence and shall determine the order of

procedure during the appeal.

G. Pre-Appeal Process

Time Frames

The following time frames, unless otherwise agreed to in writing by the Credentialing Committee and Practitioner, will govern the timing of pre-appeal procedures:

1. The pre-appeal conference will be scheduled at least fourteen (14) days prior to the appeal;
2. The Credentialing Committee and Practitioner will exchange witness lists and proposed documentary exhibits at least ten (10) days prior to pre-appeal conference; and
3. Any objections to witnesses and / or proposed documentary exhibits must be provided at least five (5) days prior to the pre-appeal conference.

Provision of Relevant Information

1. By requesting participation in CCHP's Network and an appeal under this policy, prior to receiving any confidential documents, the Practitioner requesting the appeal must agree in writing, that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the appeal process. The Practitioner must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements, if applicable, in connection with any Protected Health Information contained in any documents provided.
2. Upon receipt of the above agreement and representation, the Practitioner requesting the appeal will be provided with a copy of the following, if applicable:
    - copies of, or reasonable access to, all patient medical records referred to in the statement of reasons at the individual's expense
    - reports of experts relied upon by the Credentialing Committee copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted)
    - and copies of any other documents relied upon by the Credentialing Committee
3. The provision of this information is not intended to waive any privilege under the Wisconsin peer review/health care services review protection statute.
4. No later than ten (1O) days prior to the appeal, the Practitioner and the Credentialing Committee shall furnish to the other party a written list of the names and addresses of the witnesses he or she intends to call at the appeal. Neither the Practitioner, nor his or her legal counsel, nor any other person on behalf of the practitioner, shall contact CCHP employees or staff or individuals' appearing on the Credentialing Committee's witness list concerning the subject matter of the appeal, unless specifically and mutually agreed upon by and among the Practitioner and Medical Director.

There is no right to discovery in connection with the appeal. Each party, however, shall provide the other party within ten days copies of all documents (including, but not limited to patient medical records, incident reports, redacted committee minutes, memoranda, correspondence, books, or articles) that will be offered as evidence or relied upon by witnesses at the appeal, and which are pertinent to the basis for which the action is recommended or imposed. The Chairperson may address,

and rule upon, any objections or other issues raised in connection with the exchange of documents. All documents shall be treated by the parties as confidential peer review information, shall not be disclosed to third parties not involved in the appeal and shall remain subject to the applicable peer review protections available under Wisconsin and federal law. Unless the parties agree otherwise, or unless a party demonstrates good cause for its noncompliance as determined by the Chairperson, a party will not be permitted to utilize documents or information at the appeal that are not timely disclosed to the other party.

Appeal

A. *Right to Counsel*

CCHP and the Practitioner are each entitled to representation by personal legal counsel and/or other person of choice who may present evidence call, examine, and cross-examine witnesses. If the Practitioner is represented by legal counsel, such representation is at his or her sole expense.

B. *Admissibility of Evidence*

The appeal shall not be conducted according to the rules of law or procedures relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Evidence or testimony that is not relevant and/or is repetitious in the determination of the Chairperson be excluded. The Appeals Committee may ask questions of the witnesses and may, on its own initiative, request the presence of expert or other witnesses, as it deems appropriate. All determinations of evidentiary appropriateness shall be made by the Chairperson. If the Practitioner does not testify on his or her own behalf, he or she may be called and examined by the QOC as if under cross-examination.

C. *Record of Appeal*

The Appeals Committee shall maintain a record of the hearing by a court reporter who is present during the proceedings. The Appeals Committee shall require evidence to be taken only on sworn oath or affirmation administered by any person authorized to administer such oaths in the State of Wisconsin.

D. *Hearing Procedure*

The chairperson of the Appeals Committee will open the appeal by stating the purpose and protocol of the appeal.

1. During the appeal, the Practitioner will have the ability to exercise any or all of the rights as set forth in the Notice of Adverse Action. A CCHP representative will present the reasons for the decision to reject or terminate the Practitioner.
2. It is the Practitioner's burden to demonstrate, by a preponderance of the evidence, that there is no reasonable basis for the adverse recommendation or decision. The Practitioner will present reasons why his/her participation should not be rejected or terminated.
3. Before the close of the appeal, each side may briefly summarize its position for the Appeals Committee if it chooses.
4. The maximum duration of the appeal will be two hours unless the Chairperson, in his or her discretion, determines that the appeal cannot reasonably be concluded in that time period.
5. The appeal is closed upon conclusion of the presentation of oral and written evidence, and receipt of

the appeal transcript. The Practitioner shall have the right to submit a written statement to the Appeals Committee for its consideration in final deliberations. Such statement or submission is due to the Appeals Committee with copy to the Medical Director within seven (7) days following receipt of the hearing transcript by each party, unless otherwise extended by agreement of the parties. The Appeals Committee shall conduct its deliberations in private. If the Appeals Committee finds that the Practitioner has not met his or her burden of proof, then it shall either recommend that the action recommended or taken by the Credentialing Committee be initiated or affirmed, as the case may be; or it may recommend some lesser or greater action as is appropriate in light of the evidence. All decisions must be reached by a majority vote.

6. Within twenty-one (21) days after receipt of the appeal transcript, the Appeals Committee shall submit its written findings and recommendations to the Medical Director for notification to the Credentialing Committee and Practitioner.
7. If the Practitioner fails to appear, participate or timely respond after notice and without sufficient cause as determined by the Appeals Committee, the Practitioner will be deemed to have waived the right to a hearing.

E. Notice regarding Appeals Committee Decision: The Medical Director shall notify the Practitioner by certified mail, return receipt requested, within five (5) calendar days of receiving notification of the Appeals Committee's decision.

Reporting to Authorities
CCHP shall report professional review actions based on reasons related to professional competence or conduct that adversely affect credentialing to the National Practitioner Data Bank and appropriate state licensing boards in accordance with the Healthcare Quality Improvement Act.

PURPOSE OR DESCRIPTION:

When Chorus Community Health Plans (CCHP) delegates credentialing to entities that meet credentialing delegation eligibility requirements, CCHP must ensures that prospective delegate's policies, procedures, and processes meet National Committee for Quality Assurance (NCQA) credentialing standards prior to signing a credentialing delegation agreement. Periodic and on-going oversight is conducted to assure continuing compliance with NCQA credentialing standards.

POLICY:
Entities that request authority to credential CCHP network practitioners through a delegation agreement must submit that request to the Manager of Clinical Quality Improvement. The decision to delegate is based on:

1. The prospective delegate meeting eligibility requirements
2. Successful completion of an audit of policies and procedures that address applicable NCQA credentialing standards
3. Successful completion of an audit from a sample of initial credentialing files and re-credentialing files
4. Fully executing a Credentialing Delegation Agreement between CCHP and the prospective delegate
5. CCHP does not sub-delegate credentialing roles and responsibilities.

PROCEDURE
Pre-Delegation Auditing

1. Requests from eligible entities to conduct delegated credentialing of CCHP network practitioners on behalf of CCHP should refer the request to the Manager of Clinical Quality Improvement.
2. A staff member of CCHP's Credentialing Department will contact the requesting entity to arrange a pre-delegation audit. The requesting entity will be asked to provide:
   a. Policies and procedures that address NCQA credentialing standards
   b. Names and titles of Credentialing Committee members
   c. A roster of practitioners that were initially credentialed in the previous 12 months and a list of practitioners that were re-credentialed in the previous 12 months
3. The entity requesting credentialing delegation authority will be provided with:
   a. CCHP's current Credentialing Program Description
   b. A copy of the audit tool used to assess credentialing policies and procedures
   c. A copy of the template Credentialing Delegation Agreement
4. Upon receipt of the requested information, CCHP will provide the requesting entity a list of randomly selected practitioners from the roster provided whose credentialing documentation has been selected for the file audit.
5. CCHP credentialing staff will review policies submitted using an audit tool that incorporates current, applicable NCQA credentialing standards.
   a. A summary of the audit scoring will be provided to the prospective delegate.
   b. The threshold for successfully completing the audit is 100%
   c. Any results less than 100% will be discussed between CCHP and the prospective delegate and remedial action will be required to achieve 100% compliance.
6. Once a successful document audit is completed, credentialing files selected for audit will be requested and submitted to CCHP.
7. The selected credentialing files will be audited in conformance with NCQA's auditing methodology and utilizing the NCQA file auditing tools for initial credentialing and for re-credentialing.

8. The threshold for successful completion of the pre-delegation file audit is 100%. A score less than 100% must be addressed by a Corrective Action Plan.
9. When the audits of documents and credentialing files achieve a score of 100%, a Credentialing Delegation Agreement can be signed by both parties, and an "Effective Date" for implementing the agreement will be determined.
10. Practitioners cannot provide services to CCHP members prior to execution of a Credentialing Delegation Agreement signed by both parties with the "Effective Date" specified.

On-going Delegation Auditing

1. At least annually, CCHP will conduct a Credentialing Delegation Oversight Audit.
2. CCHP will contact the delegate and request current copies of the information required for the pre-delegation audit.
3. After reviewing documents for compliance with NCQA credentialing standards, an audit of credentialing files will be conducted.
4. A summary of audit findings and scoring will be provided to the delegate along with any opportunities for improvement that are identified in the audit process.
5. Scores that are below a 90% threshold will require a Corrective Action Plan. Elements that require a Corrective Action Plan will be re-audited by CCHP.
6. Prospective delegates have sixty (60) days to complete implementation of the corrective action plan.
7. More frequent Oversight Audits may also be scheduled at the discretion of CCHP.
8. Failure to achieve an audit score of 90%, or to implement the Corrective Action Plan will result in termination of the Credentialing Delegation Agreement.
9. The results of Delegation Oversight audits are reported to CCHP's Credentialing Committee, and are included in a report to CCHP's Quality Oversight Committee.

DELEGATED CREDENTIALING ELIGIBILITY POLICY

PURPOSE OR DESCRIPTION

Credentialing is a foundational quality assurance responsibility that ensures the participating practitioners who provide care and service to members of Chorus Community Health Plans (CCHP) have the education and training required to see our members, and are monitored for any sanctions or changes in status that could adversely affect the quality of care provided. This policy describes the requirements for an organization to be eligible to conduct credentialing on behalf of CCHP through a delegation agreement.

POLICY

CCHP's credentialing delegation process is intended to ensure quality and efficiency and to minimize the risk of jeopardizing CCHP's accreditation status. CCHP only delegates credentialing roles and responsibilities to entities that:

- Uniquely credential 200 or more network practitioners or;
- That are accredited by The Joint Commission (TJC) or the National Council for Quality Assurance (NCQA)

Entities that meet these requirements to be eligible for delegation of credentialing must sign a credentialing delegation agreement.

PROCEDURE

CCHP will process requests for delegated credentialing from organizations that meet the minimum eligibility requirements. To process the request CCHP will:

- Provide the prospective delegate with NCQA standards, elements, and factors that CCHP will be auditing for compliance.
- The prospective delegate organization will provide policies and documents that demonstrate compliance with applicable NCQA Credentialing Standards.
- CCHP Credentialing Staff will audit randomly selected files of practitioners who have been initially credentialed and practitioners that have been re-credentialed by the prospective delegate.
- The results of the policy and procedure audit and the file audit must demonstrate 100% compliance with applicable NCQA standards prior to signing a credentialing delegation agreement.
- Upon completion of a successful credentialing pre-delegation audit, CCHP and the prospective delegate will sign a mutually agreed upon Credentialing Delegation Agreement, and indicate the effective date of the agreement.

TELEHEALTH POLICY

To ensure that services provided to Chorus Community Health Plans (CCHP) members by telehealth providers receive the same quality of services that would be provided in a face-to- face contact, that the originating and the distant sites meet established standards, that there are adequate protections for Protected Health Information that comply with HIPAA regulations, and that the member is informed and consents to receive services by telemedicine.

POLICY

Telehealth services must meet all applicable Wisconsin regulations (Ch. Med. 24, Wis. Admin. Code), applicable Forward Health requirements, and any other requirements established by CCHP as set forth in this policy. Services provided via telehealth must be of sufficient audio and visual fidelity and clarity to be functionally equivalent to a face-to-face encounter where both the rendering practitioner and the member are in the same physical location. Both the distant and the originating sites must have the requisite equipment and staffing necessary to provide telehealth services.

Definitions

- **Telehealth services:** Services provided remotely using a combination of interactive video, audio, and externally acquired images through a networking environment between a CCHP member and a participating practitioner. Telehealth services are provided in "real time."
- **Originating Site:** The site were the patient (member) is physically located when receiving telehealth services.
- **Distant Site:** The location at which the practitioner providing telehealth services is located.

Procedure

1. Services must be provided by a CCHP network practitioner within the practitioner's scope of practice
    a. Eligible Distant Site Practitioners
        - Physicians
        - Psychiatrists
        - Nurse Practitioners
        - Physician Assistants
        - Nurse Midwives
        - Clinical Psychologists
        - Clinical Social Workers
        - Audiologists
        - Professionals providing services in mental health or substance abuse program certified by the Division of Quality Assurance
2. Services must be provided to a member at an approved "originating site" within an eligible location
    a. Authorized Originating Sites
        - Office of a physician or practitioner
        - Hospitals
        - Federally qualified health centers
        - Skilled nursing facilities
        - Community mental health centers
        - Emergency department
        - Local health department

    b. Not Eligible Originating Sites
        - Member's home
        - Independent renal dialysis facilities
        - Any site not specifically listed under Authorized Originating Sites

3. Services must be provided using a real-time telecommunications system.
4. The system must be interactive.
5. The patient must be present and participating (i.e., not "store and forward"—see Non-covered Services below).
6. Meets coding eligibility criteria, conditions of payment and billing methodology requirements

Non-covered Services
The following are not covered as telehealth services:

1. Telephone conversations
2. Written electronic communications such as e-mails and text messages
3. Store and forward services (transmission of medical information to be reviewed by a practitioner at a later time)
4. Services that are not covered when delivered face-to-face

ORIENTATION AND TRAINING

All practitioners using telehealth for service provision shall receive orientation and on-going training from their facility on the use of telehealth equipment, the clinical application of telehealth, safety and security during telehealth visits, privacy and confidentiality, and back-up procedures if there is equipment failure and patient preparation for telehealth.

Requirements:

1. Any physician who uses telemedicine in the diagnosis and treatment of a patient located in Wisconsin must be licensed to practice medicine and surgery in Wisconsin
2. *ForwardHealth*
   Medicaid covered services provided by telehealth are reimbursed provided:
   a. The agency is a certified program under one of the following program standards: WIS Admin. Code DHS 34, 35, 36, 40, 61, 63, or 75 (except for the provision of opioid treatment under DHS 75.15). Persons providing mental health or substance abuse services via telehealth must be a staff member of one of these certified programs.
   b. The certified program also is certified for telehealth by the Division of Quality Assurance.
3. *Documentation*
   All services provided via telehealth must be thoroughly documented in the member's medical record at the originating site in the same manner as services provided face-to-face. Documentation for originating sites must support the member's presence in order to submit a claim for the originating site facility.
4. *Member Consent*
   Practitioners must obtain patient consent to receive their treatment and care via telehealth. Other available treatment or care cannot be denied in the event that the patient refuses consent for telehealth services. Patients shall be informed about the provision of services provided through telehealth; the success rate of telehealth services, how telehealth sessions are conducted, and the extent to which the program is able to provide treatment service face-to-face versus via telehealth. This information shall be provided in language that can be easily understood by the member especially in the discussion of technical issues such as encryption or technical failure. The organization shall have an on-going method for measuring

patient satisfaction with telehealth visits and evaluating the results.

5. *HIPAA Compliance*
   Practitioners providing telehealth services should have policies and procedures that demonstrate compliance with HIPAA regulations and requirements.

   Practitioners providing telehealth services shall ensure that workspaces are secure, private, reasonably soundproof, and have a lockable door to prevent unexpected entry.

   Privacy shall be ensured so that practitioner/patient discussion cannot be overheard by others outside the room where the service is provided.

   Organizations that provide telehealth services shall conduct an assessment of the potential risks and vulnerabilities to the confidentiality of Protected Health Information, its integrity, and availability. The assessment will determine the reasonable and appropriate security measures for the conditions under which telehealth services are provided.

Policies and procedures should be adopted that address the steps to be taken in the event of a technology breakdown that would cause a disruption of the session.

Site Visit:

1. Site visits will be conducted every three (3) years for providers rendering telehealth services.
2. A staff member of CCHP's Credentialing Department will contact the originating site to arrange a site visit. The originating site will be asked to provide:
   a. Telehealth Policy
   b. HIPPA Policy
3. The originating site will be provided with a copy of the audit tool used for the site visit.
4. CCHP credentialing staff will review policies submitted using the Telehealth Credentialing Application Site Assessment audit tool prior to the site visit.
5. A Utilization Case Manager and Credentialing Staff member will conduct the site visit using the Telehealth Credentialing Application Site Assessment audit tool.
6. The threshold for successful completed of the site visit is 98%. A score less than 98% must be addressed by a Corrective Action Plan.
   a. The originating site will have sixty (60) days to complete implementation of the corrective action plan, unless otherwise indicated by the Credentialing Committee.
   b. Failure to achieve a passing score or fulfill the Corrective Action Plan will result in denial of telehealth services.
   c. More frequent site visits may also be scheduled at the discretion of CCHP.
7. The results of the site visit are reported to the Credentialing Committee. The Committee can make additional requests/recommendations for the originating site.

EMERGENCY AND URGENT CARE

Out-of-network providers will be reimbursed for emergency and urgent care services based on the maximum allowed amount as defined in the Evidence of Coverage.

EMERGENCY DEFINED

A condition of sudden onset for a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one or more of the following:

- Placing the health of the individual (or with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Other serious medical consequences

URGENT CARE DEFINED

Treatment or services provided for a sickness or an injury that develops suddenly and unexpectedly that requires immediate treatment, but is not of sufficient severity to be considered emergency treatment.

An urgent care facility provides for the delivery of urgent care services. An urgent care facility generally provides unscheduled, walk-in care. An urgent care facility may be hospital-based or non-hospital based within the service area.

Urgent care limitations:

- We will cover urgent care furnished by an urgent care facility when billed as an urgent care.
- Any required follow-up care must be furnished by an in-network provider.

HEALTH MANAGEMENT PROGRAMS

CASE MANAGEMENT

Case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's complex health needs, using communication and available resources to promote quality, cost effective outcomes.

Criteria for eligibility includes:

- Members with Cystic Fibrosis who have at least one emergency department visit or hospital admission in the past 6 months
- Members with Multiple Sclerosis and who are experiencing major impairment and deterioration
- Members with polypharmacy of 15 or more prescribed medications
- Members experiencing severe physical trauma within the past 3 months who have had an inpatient length of stay greater than 6 days and for whom transitions in levels of care are anticipated
- Members with Sickle Cell Disease who have had 2 or more hospital admissions in the past 12 months
- Members with severe spinal cord injury within the past 3 months and who are experiencing major impairment

Other complex care situations will be considered Services include:

- Comprehensive assessment
- Integrated goal and care planning
- Crisis intervention
- Care and resource coordination
- Education about condition or disease, including self-management
- Medication Reconciliation
- Community linkage opportunities
- Advocacy through a strength-based, trauma-sensitive approach

HEALTH MANAGEMENT

Health Management programs within CCHP are designed to improve the health of individuals with specific chronic conditions and to reduce health care service use and costs associated with avoidable complications, such as emergency room visits and hospitalizations.

Members with Major Depression or Type 2 Diabetes over the age of 18 and/or members with Asthma between the ages of 5-17 years old are provided an introductory letter explaining the program, including how to opt out if desired, as well as newsletter communications and preventative care reminders throughout the year.

REFERRALS

If members would like help managing any concerns related to their health, please call 414-266-3173 to reach the Health Management team. Please complete a referral form on children'scommunityhealthplan.org. This form can be faxed to 414- 266-1715. For more information or online resources and tools that support your patient's healthy lifestyle, visit our website at chorushealthplans.org

HEALTH MANAGEMENT PROGRAMS

Healthy Mom, Healthy Baby
Healthy Mom, Healthy Baby provide personalized support and resources to women during all stages of their pregnancy and up to 12 months post-partum. The Healthy Mom, Healthy Baby program is designed to improve the health and well-being of women by pairing expectant and new mothers with a case manager. Our team will provide this service over the phone. Other services include breast feeding support, behavioral health support, nutritional education and high-risk family case management. Please call 414-337-BABY (2229) for more information.

SMOKING CESSATION PROGRAMS
Chorus Community Health Plans members have access to the following benefits to help quit smoking:

- *Medications* – There are medications that can help members quit smoking. Some of these medications are available at no-cost to the member. Review the Pharmacy Benefit Guide online at chorushealthplans.org or call Customer Service to see if the prescription is covered.
- *QuitLine* – The Wisconsin Tobacco Quit Line offers telephone counseling to members who smoke.
- *Online Tools* – Members have access to an online action plan that will support and guide, step-by-step, in members' efforts to quit smoking. These tools can be accessed online through CCHP Connect (member portal)

Call 414-266-3173 for guidance on quitting smoking.

PREVENTIVE SERVICES
Chorus Community Health Plans covers many preventive services at no cost to its members, including screening tests and immunizations in accordance with the Patient Protection and Affordable Care Act of 2010 (ACA). We have an online guide of preventive services, which may be covered without a copayment or applying to the member's deductible or coinsurance, as long as the services are recommended as preventive by their provider and are delivered by an in-network provider. Providers can find this list on our website at chorushealthplans.org.

- Please be aware that this list may be amended from time to time to comply with federal requirements.
- A complete listing of recommendations and guidelines can always be found at http://www.healthcare.gov/center/regulations/prevention.html

PREVENTIVE EXAMS
Sometimes a routine preventive exam may result in a specific diagnosis from the provider or the need for additional follow- up care. If the member requires follow-up care or if they're being treated for an injury or illness, those additional services may not be covered at 100%. If you have any questions, call Provider Services at 1-844-202-0117.

PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Advocacy Statement

CCHP does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his/her patient, including any of the following:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions

PROVIDER RIGHTS

Our Chorus Community Health Plans Providers have the right to:

- Be treated by their patients and other health care workers with dignity and respect.
- Receive accurate and complete information and medical histories for members' care.
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
- Expect other network providers to act as partners in members' treatment plans.
- Expect members to follow their directions, such as taking the right amount of medication at the right times.
- Help members make decisions about their treatment, including the right to recommend new or experimental treatments.
- Make a complaint or file an appeal against Chorus Community Health Plans and/or a member (see Provider Claims Appeals section).
- Receive payments for copayments, coinsurance, and deductibles as appropriate.
- File a grievance with Chorus Community Health Plans on behalf of a member, with the member's consent (see Provider Claims Appeals section).
- Have access to information about Chorus Community Health Plan's Quality Improvement programs, including program goals, processes, and outcomes that relate to member care and services. This includes information on safety issues.
- Contact Chorus Community Health Plans Provider Services with any questions, comments, or problems, including suggestions for changes in the Quality Improvement program's goals, processes, and outcomes related to member care and services.

PROVIDER RESPONSIBILITIES

Chorus Community Health Plans offers the support, resources, and education providers need to ensure they are in compliance with our policies as well as the state's policies.

Title III of the Americans with Disabilities Act (ADA) prohibits discrimination against individuals with disabilities by places of public accommodation. 42 U.S.C. §§ 12181 - 12189. Private health care providers are considered places of public accommodation. The U.S. Department of Justice issued regulations under Title III of the ADA at 28 C.F.R. Part 36. The Department's Analysis to this regulation is at 56 Fed. Reg. 35544 (July 26, 1991). The provider is responsible to follow these policies. For questions about these policies, please contact the Provider Relations Representative at 1-844-229-2775.

Notify Chorus Community Health Plans in writing of the following events:

- Any changes in practice ownership, name, address, phone or federal tax ID numbers
- Loss or suspension of your license to practice
- Bankruptcy or insolvency
- Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program
- Any indictment, arrest or conviction of a felony or any criminal charge related to your practice
- Material changes in cancellation or termination of liability insurance
- When a provider is no longer available to provide care to members
- Send written notification of any of the above events to:

  Chorus Community Health Plans – Provider Relations P.O. Box 1997, MS 6280
  Milwaukee, WI 53201-1997

- Providers with locum tenens have the following responsibilities:
  - Notify us in advance when locum tenens will be providing services
  - Locum tenens must be in-network

PROVIDER RIGHTS AND RESPONSIBILITIES

PROVIDER RESPONSIBILITIES (*continued*)

Referrals
In-network specialists: Chorus Community Health Plans plans do not require written referrals for its members to any in-network provider.

Out-of-network: Providers must contact Chorus Community Health Plans at 1-844-450-1926 to submit a prior authorization request. Out- of-network services are generally not covered.

Arranging substitute coverage
When a physician is out of the office and another provider covers his/her practice, Chorus Community Health Plans requests:

- Notification to include the duration of coverage, name, and location of the covering provider
- The covering practitioner must be an in-network provider and have completed our credentialing process.

Providers closing their practice to new patients must submit a written notice to the Provider Relations team that they are not accepting new patients.

- Letters regarding termination of patient care must be sent, along with our Missed Appointment Notification form (available on the website) to the Provider Relations prior to notifying the member.
- Mail termination of patient care letter and Missed Appointment Notification Form to:
  Chorus Community Health
  Plans Attn: Provider Relations
  P.O. Box 1997, MS6280
  Milwaukee, WI 53201-1997

Member notification when a provider leaves the Chorus Community Health Plans network:

- The provider is required to notify us as outlined in the Provider Network Agreement.
- At least 30 days prior to the effective date of termination, we will send members a letter notifying them of the change, provided we were notified timely of the change.

Transition of patient care following termination of provider participation:

- For any reason, if a provider terminates, the provider must participate in the transition of the patient to ensure timely and effective care. This may include providing service(s) for a reasonable time at the contracted rate.

ADVANCE DIRECTIVES
The federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make decisions about their medical care in advance of an injury or incapacitating illness through an advance directive. Physicians and providers, including home health agencies, skilled nursing facilities and hospices, must provide patients with written information on state laws about a patient's right to accept or refuse treatment and the provider's own policies regarding advance directives.

AS A PROVIDER, YOU MUST:

- Inform patients about their right to have an advance directive.
- Document in the patient's medical record any results of a discussion on advance directives. If a patient has or completes an advance directive, their patient file should include a copy of the advance directive.
- Inform patients if you are unable to implement the member's advance directive due to an objection of conscience, you must inform the member.
- Inform patients if you're not able to be the member's primary care provider because of a conscionable objection to an advance directive. You can reach Customer Service at 1-844-201-4672.

PROVIDER RIGHTS AND RESPONSIBILITIES

MEDICAL RECORDS

As a contracted provider with Chorus Community Health Plans, we expect that you have policies to address the following:

- Maintain a single, permanent medical record for each patient that is available at each visit.
- Protect patient records from destruction, tampering, loss or unauthorized use.
- Maintain medical records in accordance with state and federal regulations.
- Maintain patient signature of consent for treatment/screening

GENERAL DOCUMENTATION GUIDELINES

Chorus Community Health Plans expects you to follow these commonly accepted guidelines for medical record information and documentation:

- Date all entries and identify the author.
- Make entries legible.
- On a problem list cite significant illnesses and medical condition, including dates of onset and resolution
- Make notes on medication allergies and adverse reactions. Also note if the patient has no known allergies or adverse reactions.
- Make it easy to identify the medical history, and include serious illnesses, injuries and operations for patients seen three or more times.

Document these items:

- Alcohol use, tobacco habits and substance abuse for patients ages 11 and older, including cessation counseling
- Immunization record
- Family and social history
- Preventive screenings and services
- Blood pressure, height, and weight

To document demographic information the patient medical record should include:

- Patient name and/or member ID number on every page
- Gender
- Age or date of birth
- Address
- Marital status
- Occupational history
- Home and work phone numbers
- Name and phone number of emergency contact
- Name of spouse or relative
- Health insurance information

To document patient hospitalization the patient medical record should include:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information

PROVIDER RIGHTS AND RESPONSIBILITIES

GENERAL DOCUMENTATION GUIDELINES (CONTINUED)

To document patient encounters the patient medical record should include:

- Patient's complaint or reason for the visit
- Physical assessment
- Unresolved problems from previous visit(s)
- Diagnosis and treatment plans consistent with your findings
- Growth chart for pediatric patients
- Development assessment for pediatric patients
- Patient education, counseling or coordination of care with other providers
- Date of return visit or other follow-up care
- Review by the primary care provider (initialed) on consultation, lab, imaging, special studies, outpatient and inpatient records
- Consultation and abnormal studies including follow-up plans
- Discharge note for any procedure performed in the provider's office
- Documented reasons for referrals

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBERS HAVE THE RIGHT TO:

- Ask Chorus Community Health Plans for an interpreter and have one provided to them during any covered service.
- Receive the information provided in their Evidence of Coverage in another language or another format.
- Receive health care services as provided for by federal and state laws. All covered services must be available and accessible to our members. When medically appropriate, services must be available 24 hours a day, seven days a week.
- Receive information about treatment options including the right to request a second opinion regardless of the cost or benefit coverage.
- Participate with providers in making decisions about their health care regardless of the cost or benefit coverage.
- Be treated with dignity and respect. Members have a right to privacy regarding their health.
- Be free from any form of restraint or seclusion used as a means of force, control, ease or reprisal.
- Receive information about Chorus Community Health Plans, our services, practitioners and providers, and member rights and responsibilities.
- Voice complaints or appeals with Chorus Community Health Plans or the care Chorus Community Health Plans provides.
- Make recommendations regarding our member rights and responsibilities policy.
- A candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.

MEMBERS HAVE THE RESPONSIBILITY TO:

- **Read their contract** – Members must read and understand to the best of their ability all materials concerning their health benefits and ask for help if they need it.
- **Be enrolled and pay required contributions** – Benefits are available to members only if they are enrolled for coverage under the contract. Their enrollment options and the corresponding dates that coverage begins are listed in the "When Coverage Begins and Ends" section in their Evidence of Coverage.
- **Be aware their contract does not pay for all health services** – A member's right to benefits is limited to Medically Necessary Covered Services. The extent of their contract's payments for those Covered Services and any obligation that they may have to pay for a portion of the cost of these covered services is set forth in the Schedule of Benefits sent to the member.
- **Choose their practitioner** – It is a member's responsibility to select the health care professionals who will deliver care to them. We arrange for practitioners and other health care professionals and facilities to participate in our network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.
- **Participate in their own health care** – Decisions are between the provider and the member. We encourage members to talk to their doctor about what he or she needs to know to treat them and supply information (to the extent possible) that our organization needs in order to provide care. Members have the responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible. We ask they follow the treatment plan agreed upon by the provider and the patient.
- **Pay their share** – A member must pay an annual deductible, copayment and/or coinsurance for most covered services. These payments are due at the time of service or when billed by the network provider. Deductible, copayment and coinsurance amounts are listed in the member's Schedule of Benefits. They may also be required to pay the difference between the actual charge and the Maximum Allowed Amount plus any deductible and/or coinsurance/copayments.
- **Pay the cost of excluded services** – A member must pay the cost of all excluded services and items. The member should review the Exclusions section of their contract to become familiar with our exclusions.
- **Show their identification card** – Members should show their identification card (ID) every time they request health services. If they do not show their ID card, you as the provider may not know to bill the correct insurance company for the services delivered, and any resulting delay may mean that they will be unable to receive benefits.

PHARMACY BENEFITS

The Pharmacy Benefit Guide provides an overview of members' pharmacy benefits with Chorus Community Health Plans. It tells members the process for getting certain drugs covered, options for filling prescriptions, important phone numbers, and more.

For a complete listing of benefits, exclusions, and limitations, members can refer to the Schedule of Benefits for their plan. In the event there are discrepancies with the information in the Pharmacy Benefit Guide, the terms and conditions of the coverage documents will govern.

LOCATE A PARTICIPATING PHARMACY

Our pharmacy network includes participating pharmacies, such as CVS, Walgreens, Target and Walmart. Providers can use the Express Scripts Pharmacy Location Search to find a participating pharmacy.

PRESCRIPTION DRUG FORMULARY

Our formulary is the list of Food and Drug Administration (FDA) approved drugs that are covered with the plan. Chorus Community Health Plan's Pharmacy and Therapeutics (P&T) Committee researches and evaluates drugs it may cover. Committee members include doctors and pharmacists who meet regularly during the year to review and update the formulary.

Committee members base their decision on the drug's safety, effectiveness, and cost. Members can choose from six different levels, or "tiers". Each tier has a different copayment or coinsurance.

The six formulary tiers:

- Tier 1 includes a majority of generic medications: We require members to use a generic version of the drug if one is available.
- Tier 2 is for preferred-brand medications: We classify these drugs as "preferred" because of their value and effectiveness.
- Tier 3 is for non-preferred brand medications.
- Tier 4 is for specialty medications: For which members will have the highest level of cost sharing. Specialty drugs require close management by a physician.
- Tier 5 is for zero cost-share preventive drugs. is for select generic medications: Select generic medications are offered at no additional cost share to members.
- Tier 6 is for select generic medications: Select generic medications are offered at no additional cost share to members.

PREVENTIVE MEDICATIONS

In accordance with the Patient Protection and Affordable Care Act of 2010 (PPACA), many select preventive medications are covered at no cost to members. Please note there are other drugs that Chorus Community Health Plans covers in addition to the ones listed in the Pharmacy Benefit Guide. For the latest information on the complete formulary and other pharmacy benefits, visit our website's pharmacy services section. (Select "Chorus Community Health Plans to access the searchable drug list.)

GETTING PRESCRIPTIONS FILLED

Retail

- Chorus Community Health Plan's network of retail pharmacies includes hundreds of locations, independent pharmacies, as well as multi-store chains throughout the region. Members can take their prescription to any pharmacy in the network. Members must use 75 percent of their drug before getting a refill.

- Go to chorushealthplans.org/Find-a-pharmacy for specific pharmacy names, locations, and telephone

numbers. Members can also call Customer Service at 1-844-201-4672.

PHARMACY BENEFITS

Mail order

- Mail-order prescriptions are written for a 90-day supply. If the doctor writes for a 30-day supply with two refills, the mail order facility may combine the prescription to make a 90-day supply. If members do not want a 90-day supply, they should write, "Do Not want a 90-day Supply" on the mail-order form.

- For a new medication the first time members get a prescription or a new drug, we recommend that trying a 30-day supply of the drug from a retail pharmacy. That way the practitioner has a chance to make sure that it is the right dose and that it does not cause any side effects.

- Members can ask for a mail-order form by calling Customer Service at 1-844-201-4672, or by requesting the form through chorushealthplans.org.

- If members will be away from home for a long period of time, they may want to use our mail-order service to get a 90-day supply before they leave.

SPECIALTY MEDICATIONS

Specialty drugs must be obtained through our designated specialty provider, Accredo or Froedtert Pharmacy. When members are prescribed a specialty drug and use a specialty provider, they get mail-order delivery and better access to drugs, since many retail pharmacies do not have these types of drugs.

- Specialty drugs that require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy must be obtained through our designated specialty provider. A specialty provider offers cost-saving health care, drug management and compliance programs.

DRUG SUPPLIES NOT COVERED

- No authorizations will be provided for drugs reported by the member, provider, or pharmacy to be lost, misplaced, stolen, destroyed, or damaged.
- Drugs received at no charge to the member (workers' compensation, drugs purchased with a manufacturer's coupon) will not be covered.
- Prescriptions that are written more than a year ago will not be covered. The member's provider will need to write a new prescription.

MEDICATIONS NOT COVERED

The following medications are benefit exclusions and will not be covered under the pharmacy benefit:

- Antimalarial agents when used for prevention
- Anti-obesity medications, including, but not limited to appetite suppressants and lipase inhibitors
- Blood or blood plasma products*
- Compounded products containing excluded ingredients (examples are compounded hormone replacement therapies and compounded narcotic analgesics)
- Drugs labeled for investigational use
- Fertility agents
- Legend vitamins (other than prenatal, fluoride, and certain therapeutic vitamins)
- Most over-the-counter (OTC) medications**
- Needles/Syringes (other than insulin)*
- Nutrition and dietary supplements*
- Therapeutic devices/appliances*
- Urine strips. (Because our doctors feel blood glucose strips are more accurate than urine test strips in measuring blood glucose, urine strips are not a covered benefit.)

This is not a complete list and there may be other medications that are not covered. For more information, contact Customer Service at 1-844-201-4672.

***Please note that, under certain circumstances, medical benefits may cover the items marked with an asterisk (*). For information on these items, members can contact our Customer Service at 1-844-201-4672.*

***Additional OTC medications may be covered in accordance with the Patient Protection and Affordable Care Act. The Chorus Community Health Plans Preventive Services Guide, which is available on our website, contains information regarding this coverage.*

FILLING PRESCRIPTION WHEN TRAVELING

When members travel outside of the network area, many pharmacies across the country will accept their member ID card. To find a participating pharmacy, members can call Customer Service at 1-844-201-4672.

To fill a prescription at a participating out-of-area pharmacy, members should show their member ID card. Some pharmacies may ask the member to pay the full price of the drug. If that happens and the claim is approved, the member will be refunded the amount that they paid for the drug, less the copayment.

Members can request a Pharmacy Program Direct Reimbursement Claim Form by calling Customer Service at 1-844-201-4672, or by obtaining the form through CCHP Connect (the Member Portal).

NON-FORMULARY EXCEPTIONS

If the prescribed medication the member takes is not on the list of covered drugs for their benefit plan (also called a "formulary"), the member can ask Chorus Community Health Plans to cover it. This is called a "non-formulary exception." A request for a non-formulary exception will only be approved if:

- There is documented evidence that the formulary alternatives are not effective in treating the member's condition, or;
- The formulary alternatives would cause adverse side effects, or;
- A contraindication exists such that the member cannot safely try the formulary drug.

As a first step, providers can contact Customer Service at 1-844-201-4672 for a list of similar drugs that are covered by the member's plan or they can go to chorushealthplans.org/formulary for this information.

If members need to request a non-formulary exception, they should contact Customer Service or access the Exception Request Form in CCHP Connect. When members make this request, we may contact the prescriber or physician for information to support the request. After we receive the member request, we will make our decision within 72 hours. Members can request a faster (expedited) decision if they or their doctor believe that waiting up to 72 hours for a decision could seriously harm their health. If the member's request to expedite is granted, we must give a decision no later than 24 hours from when we received the request.

If we deny the member's request for a non-formulary exception, the member may first request an internal review of that decision by contacting Customer Service. If the denial of the non-formulary exception request is upheld through an internal review, the member may then request an external review by an Independent Review Organization (IRO). The member can also request an external review by contacting Customer Service at 1-844-201-4672.

Medications that fall under the Pharmacy or Medical Benefits

The Medication List indicates whether a prior authorization is needed through the pharmacy or medical benefit. Further instruction may be provided in the notes section of the list. The list can be found on the Chorus Community Health Plans website.

Pharmacy benefit:
Medications that require a prior authorization, and are covered under the pharmacy benefit must be completed by downloading an authorization form from Chorus Community Health Plan's website. After filling out this form, please fax it to CCHP Pharmacy Services at 844-201-4675.

If you have questions regarding medications that are covered under the pharmacy benefit, please contact Pharmacy Services at 844-201-4677. After authorization is received the provider needs to request the medication from Accredo Specialty Pharmacy or Froedtert Pharmacy. Providers can contact Accredo Specialty Pharmacy at 866-759-1557 or Froedtert Pharmacy at 844-249-2435 for prescriptions and renewals after authorization has been received.

A provider can check the status of a prescription by calling 844-516-3319. Specialty Pharmacy will mail the prescription and will bill Express Scripts.

Medical benefit:
Medications that require a prior authorization, and are covered under the medical benefit must be completed through the Guiding Care Authorization Tool which can be found in the CCHP Provider Portal.

Providers that are not registered on the portal will need to contact their organization's designated site administrator to obtain a registration code. Site administrators can call CCHP's Provider Portal administrator at 414-266-5747 to request their registration code.

After submitting the prior authorization request through the Guiding Care Authorization Tool, CCHP's Utilization Staff will review the request. The assigned UM Staff member may reach out for additional clinical information through the Guiding Care Authorization Tool. Providers can view the status of their request in the Guiding Care Authorization Tool.

PHARMACY BENEFITS

MEDICATION PRIOR AUTHORIZATION
If a drug requires prior authorization, the Chorus Community Health Plans Pharmacy Services department must authorize the use of this drug before it will be covered. Drugs that require prior authorization are often:

- Newer drugs for which we want to track usage
- Drugs not used as a standard first-line option in treating a medical condition
- Drugs with potential side effects that we want to monitor for patient safety
- Drugs categorized as specialty medications

STEP THERAPY
Step therapy is built into the electronic system that checks a member's medication history. A drug with step therapy will be automatically approved if there is a record that the member has already tried the preferred drug(s). If there is no record that the member tried the preferred drug(s) in their drug history, the member's physician must submit relevant clinical information to the Pharmacy Services Department before it will be covered. Drugs that are subject to step therapy requirements include:

- Newer drugs for which we want to track usage
- Drugs not used as a standard first-line option in treating a medical condition
- Drugs with potential side effects that we want to monitor for patient safety and drugs categorized as specialty medications

QUANTITY LIMITS
Quantity limits are based on FDA guidelines, clinical literature, and the manufacturer's instructions. Quantity limits promote appropriate use of the drug, prevent waste, and help control costs.

For some drugs, the dosing guidelines may recommend that patients take the drug one time a day in a larger dose instead of several times a day in smaller doses. The quantity limits follow the guidelines and cover one larger dose per day. The member's physician can request an exception to the quantity limit through the Pharmacy Services Department. Prescriptions for controlled substances and specialty medications are limited to a 30-day supply.

Please see the Pharmacy Benefit Guide for more detailed information on prior authorization, step therapy requirements and quantity limits.

PROVIDER APPEALS PROCESS

PROVIDER APPEALS PROCESS
Providers have the right to file an appeal to Chorus Community Health Plans within the time frame outlined in your Provider Network Agreement.

In the event of an adverse medical necessity determination the practitioner has the right to discuss the decision with the Medical Director. The practitioner may contact the health plan within 2 business days of notification to set up a time with additional pertinent medical information. This information will be noted in the denial letter.

In the event of an adverse medical necessity determination the practitioner has the right to discuss the decision with the Medical Director. The practitioner may contact the health plan within 2 business days of notification to set up a time with additional pertinent medical information.

To file a formal appeal:

- First complete the Provider Appeal Form, which is available on the Provider Forms page at togetherCCHP.org.
- Mail it along with copies of any supporting documents.
- Submit your written appeal to:

  Chorus Community Health Plans
  Attn.: Appeals Department P.O. Box 1997,
  MS 6280 Milwaukee, WI 53201-1997 CCHP-appeals@chorushp.org

We will send you a letter within five business days notifying you that the appeal was received. We will review the appeal, investigate, and provide you with a decision within 30 calendar days of receiving the appeal.

APPEALING A DECISION
You may try to resolve your problem by taking the steps outlined above in the complaint and appeal process. You may also contact the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the Office of the Commissioner of Insurance by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

You can also call 1-800-236-8517 or visit ocicomplaints@wisconsin.gov to request a complaint form.

URGENT APPEALS
A request for an urgent appeal will be considered if the application of the length of time allowed for making a non-urgent determination:

- Could seriously jeopardize the member's life or health, or the member's ability to regain maximum function based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the member's medical condition subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

The request for an urgent appeal does not have to be in writing. Urgent appeals will be resolved within 72 hours after receipt, or sooner as needed to accommodate the urgency of the situation. The member will receive both verbal and written notification of the decision.

PROVIDER APPEALS PROCESS

SUBMITTING A CLAIM APPEAL

Providers can submit a written request or utilize the Provider Appeal Form, which is available on the Provider Forms page at chorushealthplans.org.

1. If a provider submits a written appeal request, it should be marked with "Appeal", and include the following information: Provider's name; Date of service; Date of billing; Date of rejection or offsetting, as applicable; Member's name, member ID number; and Reason(s) for reconsideration.

2. If provider's complaint is medical (emergency, medical necessity and/or prior authorization), we will indicate if medical records are required and need to be submitted with the appeal.

3. Submit the written request or the Provider Appeal Form, along with any supporting documentation to: Chorus Community Health Plans Attn:
   Appeals Department P.O. Box 1997, MS 6280
   Milwaukee, WI 53201-1997
   CCHP- ProviderAppeals@chorushealthplans.org

Chorus Community Health Plans will respond to the appeal request in writing within 45 days of receipt. If CCHP does not respond within 45 days or if the provider is not satisfied with CCHP's response, the provider may appeal to the Wisconsin Department of Health Services (DHS) for a final determination.

Notification will include when the resolution may be expected and why additional time is needed. The total time for resolution will be no more than 45 days from the date the appeal was filed. If the provider is not satisfied with CCHP's response, the provider may appeal to the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin's insurance laws, and file a complaint.

Member complaints: If you have a member complaint, please contact Customer Service at 1-844-201-4672. Provider Services representatives are available to take your call during regular business hours, Monday through Friday. After we receive your complaint, the member will be notified of our decision within 30 days.

PLAN DESCRIPTIONS

AFFORDABLE CARE ACT COMPLIANT

Chorus Community Health Plans plans are all Affordable Care Act (ACA) compliant, meaning they conform to the Healthcare Reform regulations, and are available to purchase on the Marketplace or directly with Chorus Community Health Plans Each plan option covers the ACA's essential health benefits without annual or lifetime coverage maximums, and is guaranteed issue during Open Enrollment and with a Qualifying Life Event.

PLAN OPTIONS

Chorus Community Health Plans offers catastrophic, bronze, silver, and gold plans, which can be purchased on or off- Marketplace. The plans includes a high deductible health plan which offers the option of a Health Savings Account. We also offer multiple cost-share reduction plans that are available based on the customer's income. Limited- and zero-cost sharing plans are also available for customers who are members of the federally recognized tribes of Alaska Native Claims Settlement Act Corporation Shareholders.

MEMBER ID CARDS

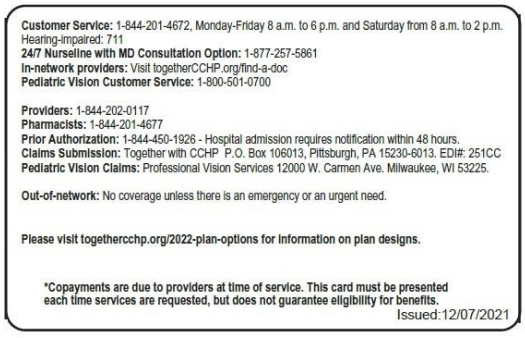
MEMBER ID CARDS

All Chorus Community Health Plans members receive one individualized identification card. We require members to show their ID cards before they receive services or care.

- Only a covered member who has paid their premiums under their plan's contract has the right to plan services or benefits.
- If a member receives services or benefits to which they are not entitled to under the terms of their plan's contract, the member is responsible for the actual cost of the services or benefits.

The member identification (ID) card includes the following enrollment related information:

- Plan name
- Full name of the member: Each member/dependent is listed under "member name"
- 11-digit member ID number
- Issue date (the date the ID card was printed)
- Identifies the subscriber's most current benefits
- Cost sharing amounts: This lists benefit coverage, including any office visit copayments and prescription drug coverage
- Pharmacy information
- Pediatric vision Customer Service information
- Claims submission information
- Customer Service information



PROVIDER RESOURCES

Chorus Community Health Plans PROVIDER RELATIONS REPRESENTATIVES – 1-844-229-2775

Jerry Pruss	Mgr Provider Relations & Contracting	JPruss@chorushealthplans.org
Stacey Martinez	Mgr Provider Data	SMartinez@chorushealthplans.org
Diana Schneider	Provider Relations Rep Sr	DSchneider2@chorushealthplans.org
Lindsay Jines	Provider Relations Rep	LJines@chorushealthplans.org
Lauren Bergmann	Provider Contract Spec	LBergmann@chorushealthplans.org
Becky Jens	Provider Contract Spec	RJens@chorushealthplans.org
Susan Gorecki	Payer Contract Administrator	SGorecki@chorushealthplans.org
Lynn Marie Love	Data Analyst Sr	LLove@chorushealthplans.org
Blia Lor	Provider Data Mgmt Spec Ld	BLor@chorushealthplans.org
Qiana Irving	Provider Data Mgmt Spec	QIrving@chorushealthplans.org
See Xiong	Provider Data Mgmt Spec	SXiong3@chorushealthplans.org
Yolonda Collins	Provider Data Mgmt Spec	YCollins@chorushealthplans.org

Additional contact information:

Provider Services We have a team dedicated to serve your specific needs. Call us, we're happy to help.	1-844-202-0117
Prior Authorizations Please see the Prior Authorization list on our website for the most up-to-date listing of services that require a prior authorization.	Phone: 1-844-450-1926 Fax: (414) 266-4726
Credentialing	Email: cchp-credentialing@chorushealthplans.org Phone: 1-844-229-2776 Fax: (414) 266-5797
Customer Service for members Monday through Friday, 8:00 a.m. to 5:00 p.m. Saturdays, 8:00 a.m. to 2:00 p.m.	Phone: 1-844-201-4672 Fax: 1-844-201-4673
Pharmacy Questions Please see the Pharmacy Benefit Guide for the latest listing of prescriptions drugs that are covered or not covered.	1-844-201-4677 Fax 1-844-201-4675
Provider Appeals Address Please see Provider Appeals Process page in this manual for more information on the appeals processes.	Provider Appeals Attn: Appeals Department P.O. Box 1997, MS 6280 z Milwaukee, WI 53201
Claims Address Please see the Provider Appeals Process page in this manual for more information on the claims process. Mail check or money order to the claims address.	Chorus Community Health Plans P.O. Box 106013 Pittsburgh, Pennsylvania 15230-6013 EDI#: 251CC
Provider Manual	chorushealthplans.org
Fraud, Waste, and Abuse	1-877-659-5200

PROVIDER RESOURCES

INTERPRETER SERVICES
CCHP provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and who have language service needs or who require information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

If a member you're helping has questions about Chorus Community Health Plans, they have the right to get help and information in their language at no cost.

Interpreter services, call 1-844-201-4672
TTY users, call 1-844-531-4856

CULTURAL AWARENESS PROGRAMS
We are committed to creating and sustaining an environment that welcomes everyone. Educational and enrichment materials, resources and community organizations links related to diversity and inclusion are available on our Cultural Awareness page at chorushealthplans.org. For more information about our programs and services available, call Customer Service at 1-844-201-4672.

CCHP PROVIDER PORTAL
Registering with our Provider Portal is the key to accessing the auto-authorization tool and other services.
If you're a new provider to the Chorus Community Health Plans network or haven't registered for our Provider Portal yet, your organization's designated site administrator will need to obtain a registration code before they can complete the online portal registration form. Site administrators can call our portal administrator at (414) 266-5747 to request their registration code. Go to chorushealthplans.org for more information about accessing the Guiding Care Auto Authorization tool through the CCHP Provider Portal.

CHORUS COMMUNITY HEALTH PLAN'S PROVIDER TOOL
The Chorus Community Health Plans Provider Tool is used to check member eligibility, search and submit claims and chat with Customer Service. Registration instructions and instructions on how to use the tool can be found inside CCHP's Provider Portal. If have additional questions you can call 844-202-0117.

ACCESSING PROVIDER DIRECTORY INFORMATION
Chorus Community Health Plans offers a Provider Directory to ensure our members are receiving the most current information about their providers. You can access the Provider Directory at chorushealthplans.org. You can search by provider's name, location, and specialty.

THE PROVIDER UPDATE/CHANGE FORM
To ensure we meet the Centers for Medicare & Medicaid Services (CMS) online provider directory requirements, CCHP updates its Provider Directory regularly. To make sure the provider information we have in our Provider Directory is accurate, review your information often. If any of your information has changed, or is not listed accurately or at all, please make the appropriate changes quickly and easily by downloading the Provider Update/Change Form, which is available on the Provider Forms page at chorushealthplans.org. Once you have saved the form to your desktop, please complete and email it to: cchp-providerupdates@chw.org.

Providers should make sure they have the following required information in our Provider Directory:

- Name
- Gender
- Specialty
- Hospital affiliation
- Medical group affiliation
- Board certification
- Accepting new patients (PCP only)
- Languages spoken (by provider and staff)
- Office location and phone number

FRAUD, WASTE AND ABUSE

Chorus Community Health Plans is required to cooperate with regulatory and law enforcement agencies in reporting any activity that appears to be suspicious in nature. According to the law, any information that we have concerning such matters must be turned over to the appropriate governmental agencies. This section of the provider manual is intended to educate providers on fraud, waste, and abuse and to comply with the Centers for Medicare and Medicaid Services (CMS) mandatory requirement that providers receive this training and education.

FRAUD

Fraud is defined as intentional deception or misrepresentation made by an entity or person, including but not limited to a subcontractor, vendor, provider, member, or other customer with the knowledge that the deception could result in some unauthorized benefit to a person or an entity. Fraud includes any attempt to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the custody or control of, any health care benefit program. It includes any act that constitutes fraud under applicable state and federal laws. For example, fraud may exist when a provider bills for services not rendered, and the service cannot be substantiated by documentation.

WASTE

Waste is defined as an act involving payment or the attempt to obtain payment for items or services where there was no intent to deceive or misrepresent, but where the outcome of poor or inefficient methods resulted in unnecessary costs to the plan.

ABUSE

Abuse is defined as incidents or practices that are inconsistent with accepted, sound business, fiscal, or medical administrative practices. Abuse may, directly or indirectly, result in unnecessary costs to the health plan, improper payment, or payment for services that fail to meet professional standards of care or are medically unnecessary. Abuse consists of payment for items or services when there is no legal entitlement and the recipient has knowingly misrepresented the facts to receive the benefit or payment. Abuse often takes the form of claims for services not medically necessary or not medically necessary to the extent provided. Abuse also includes practices by subcontractors, providers, members, or customers that result in unnecessary costs to the health plan. For example, abuse may exist when the provider fails to appropriately bill new and established patient office codes. The provider bills a "new" patient code both on the initial visit and subsequent visits.

More fraud, waste, and abuse examples, include but are not limited to:

- Submitting false or misleading information about services performed
- Misrepresenting the services performed (e.g., up- coding to increase reimbursement)
- Retaining and failing to refund and report overpayments (e.g., if your claim was overpaid, you are required to report and refund the overpayment, and unpaid overpayments also are grounds for program exclusion)
- A claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act
- Treating all patients weekly regardless of medical necessity
- Inserting a diagnosis code not obtained from a physician or other authorized individual
- Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded health care programs
- Lying about credentials, such as degree and licensure

EXTRAPOLATION

We may review paid claims to help ensure payment integrity. If reviewing all medical records for a procedure would burden you, we may select a statistically valid random sample (SVRS) or smaller subset of the SVRS. This gives an estimate of the proportion of claims we paid in error. The estimated proportion, or error rate, can be projected across all claims to determine overpayment. You may appeal the initial findings. You must supply all requested medical records. Failure to do so may result in a failure of the entire SVRS and all claims submitted within the review.

You must handle overpayment disagreements as outlined in this guide and in your Agreement. Provider claim reviews may be conducted through a phone call, on-site visit, internal claims review, clientdirected/regulatory investigation and/or compliance reviews. We ask that you provide us, or our designee, during normal business hours, access to examine, review, scan and copy any and all records necessary to determine compliance.

If you refuse to allow access to your facilities, we reserve the right to recover the full amount paid or due to you.

HOW TO REPORT FRAUD, WASTE AND ABUSE

Contact the CCHP Special Investigations Unit online compliance reporting at ethicspoint.com, and click on:

- File a New Report via Ethicspoint", then "Submit"
- "CCHP", then "Submit"
- You will be directed on how to file the report

You can also report anonymously at 877-659-5200 or visit CMS' State Contacts Database at: www.cms.gov/apps/contacts.

UTILIZATION MANAGEMENT

UTILIZATION MANAGEMENT PROGRAM
The goal of the Utilization Management (UM) Program is to ensure that services provided are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting, and meet professionally recognized standards of care. In addition, UM seeks to facilitate the use of alternative settings when the above circumstances are not met, or when a quality of care concern arises.

Utilization Management Program goals:

- Ensure that the enrollee is accessing medical care in the most appropriate setting. Actively monitor utilization to guard against over or under utilization of services.
- Provide feedback to the providers who demonstrate inappropriate utilization patterns using approved standards and practice guidelines.

AFFIRMATIVE STATEMENT
Chorus Community Health Plans wants its members to get the best possible care when they need it most. To ensure this, we use a prior authorization process, which is part of our UM program. Utilization Management decision-making is based only on appropriateness of care and service, and existence of coverage. We do not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

ANNUAL EVALUATION OF THE UM PROGRAM
Chorus Community Health Plans seeks to ensure that the UM program is up-to-date by completing an annual evaluation of the structure and scope of the program. Processes are reviewed and updated, as indicated, at least annually.

You may contact the UM department from 8:00 a.m. to 5:00 p.m., Monday through Friday at 1-844-450-1926. Messages are confidential and may be left 24 hours per day. Communications received after normal business hours are responded to on the following business day.

CRITERIA FOR DECISIONS
Milliman Care Guidelines (MCG) are used to determine medical necessity and are clinical decision support tools used for treating specific patient conditions with appropriate levels of care and optimal progression toward discharge or transition.

MILLIMAN CARE GUIDELINES
Clinical documentation is reviewed for admission and extended-stay criteria, or the UM staff is available to assist in optimizing the discharge plan with the resources available through plan providers. All services provided by Chorus Community Health Plans must be medically necessary and a covered benefit.

Chorus Community Health Plans adheres to the Milliman Care Guidelines' definition of medical necessity: a medical assistance service required to prevent, identify or treat a member's illness, injury or disability.

Such services must be:

- Consistent with professionally recognized standards of care with respect to quality, frequency, and duration
- Performed in the least costly setting available where the services and treatments can be safely and appropriately provided
- Not provided primarily for the convenience of the patient, the practitioner, or the facility providing the care

UTILIZATION MANAGEMENT

UTILIZATION REVIEW CRITERIA

Chorus Community Health Plans selects criteria, which aligns the interests of the member, provider and health plan, and have evidence-based development including input from recognized medical experts and of which are applied to a broad number of members.

- Utilization review criteria are a screening guide and are not intended to be a substitute for physician judgment
- Utilization review decisions are made in accordance with evidenced-based practice. Criteria are used for the approval of medical necessity but not for the denial of services. The CCHP Medical Director reviews all potential denials for medical necessity
- Criteria are reviewed and updated annually

AVAILABILITY OF CRITERIA

Contracted credentialed providers may request a copy of specific clinical criteria used in making UM decisions by faxing (414) 266-4726 or by writing to:

Chorus Community Health Plans
Attn.: Manager of Utilization Management
P.O. Box 1997, MS6280
Milwaukee, WI 53201-1997

The criteria requested must be specified in detail to insure the appropriate information is returned. A fax number, email or mailing address for return must be included. Providers may also call 1-844-450-1926 to request a copy of the specific clinical criteria.

PROCESSES USED TO MAKE DETERMINATIONS

Utilization Management staff members review concurrent inpatient admissions with the exception of obstetrical delivery admissions for medical necessity. Specifically identified services as outlined on the prior authorization list of services are also reviewed. Chorus Community Health Plans licenses MCG for medical necessity determinations. The licensed guidelines include:

- Ambulatory care
- Inpatient/surgical care
- General recovery care
- Home care
- Behavioral health care
- Chronic conditions
- Recovery facility guidelines

Documentation from the patient medical records including but not limited to: progress/treatment notes; intake information; history and physical; laboratory and imaging reports; medication administration; orders; consultations; and operative reports may be reviewed as indicated by the specific guideline to determine medical necessity. When requested, peer-to-peer discussions are provided.

AUTHORITY

The Chorus Community Health Plans Board of Directors is ultimately responsible for UM activities, and delegates the responsibility for the UM program (including the review and appropriate approval of the UM policies and procedures) to the Quality Oversight Committee (QOC) and the Medical Advisory Committee (MAC).

The MAC is responsible for reviewing all UM issues and related information and making recommendations to the QOC. The UM program is reviewed and approved by the MAC and the QOC yearly.

PRIOR AUTHORIZATIONS

PRIOR AUTHORIZATIONS

Chorus Community Health Plans wants its members to get the best possible care when they need it most. To ensure this, we use a prior authorization process, which is part of the Utilization Management (UM) Program.

Our contracted providers are responsible for obtaining prior authorization before they provide services to covered members. Providers may not bill the member if the prior authorization is not obtained.

There is NO coverage available for providers who are not in our network, unless prior authorization is received or unless it is an emergency.

- In some situations, the covered member may need medical attention before the prior authorization process can take place.
- Please note that in urgent or emergency hospital inpatient admissions, though prior authorization is not required, we must be notified within 24 hours of the Inpatient admission.

Prior Authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of benefits are subject to all terms and conditions of the covered member's contract.

If the provider chooses to provide a service that has been determined not to be medically necessary, and is not a covered service, or has not been prior authorized though prior authorization is required, the covered member will not be responsible for paying any charges. Covered services performed without prior authorization are not allowed to be billed to the member.

PROCESS FOR OBTAINING PRIOR AUTHORIZATIONS

Providers should start the prior authorization process as soon as possible, before the beginning of treatment. The provider must submit a prior authorization request online through the Provider Portal at chorushealthplans.org. If you have questions about the prior authorization process, please contact Chorus Community Health Plans Customer Service at 1- 844-201-4672.

URGENT PRE-SERVICE REQUESTS

If the member or a health care professional with knowledge of the member's medical condition has an urgent request for prior authorization, the provider must submit the request via the Provider Portal. Chorus Community Health Plans will make a decision on the request and notify the provider via the portal within 72 hours of receipt of a correctly submitted, completed request, or as soon as possible if the member's condition requires a shorter time frame.

URGENT CONCURRENT REQUESTS

An urgent request is any request for prior authorization for medical care or treatment with respect to the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the covered member or; the ability of the covered member to regain maximum function; or in the opinion of a physician with actual knowledge of the covered member's medical condition, would subject the covered member to severe pain that cannot be adequately managed without the care or treatment that is being requested.

If the request is incomplete:

- Chorus Community Health Plans will notify the submitting provider of the specific information needed as soon as possible, but no later than 24 hours after receiving the urgent request.
- If the submitting provider fails to provide the information requested, we will provide the submitting provider with our decision based on the current information that we have by the end of the business day following the date of initial submission of request.

PRIOR AUTHORIZATIONS

NON-URGENT PRIOR AUTHORIZATION REQUESTS

We will make a decision on the non-urgent requests within 15 days of our receipt of a correctly submitted request. If the request does not contain sufficient clinical information to make a medical necessity decision, we will request the required information, which must be submitted within the initial 15 days for making the decision. Prior authorizations after the start of care Chorus Community Health Plans does not review requests for services that have already been provided. Refer to the Appeals section of this manual.

PRIOR AUTHORIZATION FOR URGENT CARE

Chorus Community Health Plans defines urgent care as any request for behavioral health care or non-behavioral health care with respect to which the application of the time periods for making non-urgent care determinations could result in the following circumstances. If the request is determined as not meeting this definition:

- If it could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state
- In the opinion of a practitioner with knowledge of the member's medical condition or behavioral health condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request

URGENT CARE

Urgent care services are needed in order to treat an unforeseen medical problem that is not life-threatening, but requires prompt diagnosis and/or treatment in order to preserve the member's health.

- Members with non-emergent conditions should be directed to our contracted facilities in the absence of the ability to see a provider at their primary care clinic.
- In all cases of emergency or urgent care situations, providers should instruct members to contact their primary care clinic for follow-up services that may be needed.

URGENT PRE-SERVICE DECISIONS

Chorus Community Health Plans makes behavioral health care and non-behavioral health care decisions and notifications of the decision within 72 hours of the receipt of the request.

URGENT CONCURRENT REVIEW

Chorus Community Health Plans makes behavioral health care and non-behavioral health care decisions and notifications of the decision within 24 hours of the receipt of the request.

RETRO- AND POST-SERVICE REQUESTS

Chorus Community Health Plans does not review requests for services that have already been provided. Post-service requests will be returned to the provider to be adjudicated on appeal, except for emergency or urgent care services. If the submitting provider fails to follow our procedure for prior authorization requests:

- Chorus Community Health Plans will notify the submitting provider within 24 hours of our receipt of the request.
- The notice will include the reason why the request failed and the proper process for obtaining prior approval or precertification.

PLANNED INPATIENT HOSPITAL ADMISSIONS

Chorus Community Health Plans requires notification of all inpatient admissions from in-network providers via our Guiding Care Auto-Authorization tool, which is available online 24 hours a day on our provider portal at chorushealthplans.org.

- All in-network providers must use the provider portal for reporting of inpatient admissions and submission of clinical documentation supporting those admissions.
- All inpatient admissions are reviewed for medical necessity.

PRIOR AUTHORIZATIONS

EMERGENCY CARE SERVICES
Chorus Community Health Plans provides emergency care services for all members with in-network and out-of-network providers for behavioral and non-behavioral health emergencies.

Emergency service claims indicating a place of service (POS) (23/emergency department) are approved for screening and stabilization of our members without prior approval — where a prudent layperson, acting responsibly, would believe that an emergency medical condition exists.

Approval will also be granted if an authorized representative, acting for the organization, authorized the provision of emergency services.

All out-of-network providers, including outside the state of Wisconsin, will receive approval for these emergency services based on the same criteria. Emergency inpatient admissions must be reported to us within 24 hours of admission or the next business day

COVERED SERVICES THAT REQUIRE PRIOR AUTHORIZATION
The list below has some of the covered services that require a prior authorization. Please review CCHP's website for a full list of services requiring prior authorization.

- Ambulance — nonemergency air and ground
- Anesthesia for facility services
- Any procedure that could be considered cosmetic, including: breast reduction and mastectomy for gynecomastia
- Autism Spectrum Disorder services
- Cochlear implants
- Dental/anesthesia and facility service for dental services
- Dialysis
- Durable Medical Equipment (DME): We will decide if the equipment should be purchased or rented. Prior Authorization is required for a retail purchase price $500 or greater for a single item whether a purchase price or a monthly rental price.
- EEG, video monitoring
- Intensive outpatient PET scans
- Hearing Aids
- Prosthetic devices
- Proton beam therapy (PBT)
- Pain management procedures (including but not limited to: epidural steroid injections and radio frequency ablation and spinal cord stimulators)
- Radiation oncology
- Reconstructive procedures, excluding breast reconstruction surgery following mastectomy skilled nursing facility
- Specialty medications

Elective surgeries, including but not limited to:
- Knee arthroplasty, total
- Elbow arthroplasty
- Shoulder arthroplasty
- Shoulder hemiarthroplasty
- Hip arthroplasty
- Hysterectomy

PRIOR AUTHORIZATIONS

- Wrist arthroplasty
- Cervical and lumbar laminectomy, discectomy / micro discectomy
- Sympathectomy by thoracoscopy or laparoscopy
- Urethral suspension procedures
- Electrophysiologic study and implantable cardioverter-defibrillator (ICD) insertion, transvenous
- Genetic testing, including BRCA genetic testing
- Home Health care
- Hospice care
- Inpatient hospital stays require notification within 24 hours of admission
- Inpatient rehabilitation

Mental health services, including the following levels of care:

- Inpatient stays require notification within 24 hours of admission
- Partial hospitalization / day treatment
- Intensive outpatient

Substance use disorder services, including the following levels of care:

- Inpatient
- Partial hospitalization / day treatment
- Intensive outpatient

Certain services may be subject to exceptions. Contact Customer Service at 1-844-201-4672 to find out if the service needs prior authorization.

Chorus Community Health Plans PRIOR AUTHORIZATION LIST

Before submitting your prior authorization request, go to our website at chorushealthplans.org to review the most recent Prior Authorization List. It has a full listing, including exclusions, procedure codes, and other important information.

AUTO AUTHORIZATIONS

Guiding Care AUTO-AUTHORIZATION TOOL

Making sure you register for our Provider Portal is the key to accessing all of our services on our website. Our Guiding Care Auto Authorization tool allows providers to submit notifications, prior authorizations, and check authorization status. Network providers must submit their notifications and requests using this tool through our Provider Portal. Documentation supporting the medical necessity of an inpatient admission or a prior authorization request should be uploaded into the authorization request when it's created. There are Portal user's guides available on the Provider Resources page at chorushealthplans.org.

Preregistration instructions

If you're registered for the Provider Portal with the CCHP Medicaid plan, the same login and password can be used. If you're a new network provider or haven't registered for the Chorus Community Health Plans Provider Portal yet, please refer to the following instructions before you try to sign-on.

Choose a site administrator

Your organization must first designate a site administrator for the Chorus Community Health Plans Provider Portal. You will need to use the Provider Portal in order to access other portals for services, such as prior authorizations, claim lookups and claim confirmations. Each facility may have two site administrators. You may choose to have one site administrator for all the portals, or your site administrator may assign users. The first person to register for an organization is considered the site administrator.

Obtain a registration code

First, site administrators will need to call our portal administrator to request a registration code at (414) 266-5747, and:

(415) If you're a new provider to the Chorus Community Health Plans network, we will mail a letter with the registration code and instructions on how to complete portal registration. You should receive this letter within seven business days.

(416) If you're an existing network provider, you'll receive your registration code by phone or email.

To complete online registration

Once the site administrator gets the registration code, they will need to complete their Provider Portal registration using the following steps:

1. Go to our Provider Portal Registration page at chorushealthplans.org to complete our registration form. Site administrators will need their facility's tax ID number and registration code.
2. Confirm the online registration form was submitted. Within a few minutes of submitting the registration form, site administrators should receive a confirmation email.
3. Verify the email address. Within 30 minutes of submitting the online registration form site administrators should receive an email to verify the email address they provided — they should click on the link in that email.
4. Next, site administrators will receive an "Email Verification Completed" email from Chorus Community Health Plans.
5. In approximately three business days, site administrators will receive another email from Chorus Community Health Plans with their user login information and password.

REGISTERING ADDITIONAL USERS

Once the site administrator has registered for the Chorus Community Health Plans Provider Portal, there are two options for registering additional users.

1. For site administrators registering individual users:
    - Go to the online registration form at chorushealthplans.org
    - Complete the fields with individual user's information
    - Enter the organization's tax ID number

AUTO AUTHORIZATIONS

- Enter the registration code provided in the portal welcome letter
- Go to the drop-down menu "What type of user are you registering?" and select "A general user"

2. For individual users to register:
    - Go to the online registration form
    - Complete the fields with individual user's information
    - Enter the organization's tax ID number
    - Enter the registration code provided to the organization's site administrator Go to the drop-down menu "What type of user are you registering?" and select "A general user" Note: Each facility may have two site administrators.

To register additional users, site administrators will need to complete their registration first, and then individual users can follow the administrator's steps for email verification and login.

QUALITY IMPROVEMENT PROGRAM

THE QUALITY IMPROVEMENT PROGRAM

The Quality Improvement Program provides a framework for continuous performance improvement of the health care and services provided to CCHP members, assuring the provision of appropriate, affordable, and accessible care. This is accomplished by identifying, evaluating, and monitoring the quality of and access to health care services provided for plan members.

GOALS AND OBJECTIVES

CCHP strives to continuously improve the care and service provided by the health care delivery system. CCHP's Quality Improvement Program establishes the standards that encompass all quality improvement activities within the health plan. The following goals guide the program:

1. Promote and incorporate quality into the health plan's organization structure and processes.
   - Facilitate a partnership between CCHP's members, practitioners, and health plan staff for the continuous improvement of quality health care delivery.

   Continuously improve communication and education in support of these efforts.
   Consider and facilitate achievement of public health goals in the areas of health promotion and early detection and treatment.
2. Provide effective monitoring and evaluation of patient care and services to ensure that care provided by health plan practitioners meets the required standard of care of good medical practice and is positively perceived by health plan members and health care professionals.
   - Evaluate and disseminate clinical and preventive practice guidelines
   - Monitor performance of practitioners against evidence-based medical guidelines
   - Develop guidelines for quality improvement activities (e.g. access and availability, peer review, etc.)
   - Survey health plan members' and practitioners' satisfaction with the quality of care and services provided
   - Develop, define, and maintain data systems to support quality improvement activities
3. Ensure prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up.
   - Identify and monitor important aspects, problems, and concerns regarding health care services provided to members
   - Provide ongoing feedback to health plan members and practitioners regarding the measurement and outcome of quality improvement activities
4. Conduct quality improvement, risk management, and patient safety activities.
   - Aggregate and use data to develop, implement, and evaluate quality improvement activities
   - Provide a means to minimize and reduce risks to members
   - Identify issues, develop initiatives, and monitor key aspects of patient safety
5. Maintain compliance with local, state, and federal regulatory requirements and accreditation standards.
   - Monitor compliance with regulatory requirements for quality improvement and risk management opportunities and respond as needed
   - Ensure that reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies

A copy of our detailed Quality Improvement program is available upon request.

For more information about our QI program, including details about our activities and progress toward goals, please call the Quality Improvement department at 1-844-229-2776.