Chorus Community Health Plans Request
for Authorization of Services and Reviews

Introduction: Chorus Community Health Plans (CCHP)'s Utilization Management department's Behavioral Health program has created this guide to assist providers with the process for BadgerCare Plus (Medicaid).
This guide is divided into Behavioral Health Inpatient and Partial Hospitalization Program / Intensive Outpatient Program sections.
If you have questions, please call for BadgerCare Plus at 1-877-227-1142.

I. Behavioral Health Inpatient

A. CCHP reviews clinical within one business day of submission and utilizes evidence based criteria licensed through Milliman Care Guidelines (MCG) to determine medical necessity.

B. CCHP will always attempt to render a decision on inpatient/urgent requests the day the request was received.

1. However, requests received after 1300 may not have a decision rendered the same day to allow appropriate review of the information received. CCHP follows Timeliness of UM Decisions standards as set forth by National Committee for Quality Assurance (NCQA).

C. CCHP requires all notifications of initial inpatient admissions and subsequent concurrent requests to be accompanied by a specific request for dates of service.

D. CCHP uses evidence based criteria to determine the acuity of the member's needs and may modify a request based on the clinical received. If a request is modified, CCHP will offer the opportunity to the provider to agree to terms of the modification will require a response within one business day of the request. Friday submissions will be needed by the end of that day. If agreement to the modified terms is not received, CCHP will proceed to deny any days that do not meet medical necessity per MCG.

E. For per diem services, CCHP needs a comprehensive, update via clinical documentation for each day a member is receiving services. These updates are not required to be submitted daily, but on the scheduled review date. It is important for the clinical submitted to include the date and author of each note and the member name and DOB. The documentation should clearly outline what the provider is trying to achieve with progressing the member's treatment plan and provide detailed information regarding the member's progress and discharge planning.

1. The following information is needed with each admission / review:
    a. Primary diagnosis for which the member is receiving treatment and any other concurrent diagnoses.
    b. Presenting problem/current symptoms necessitating admission or continued stay.
    c. Other factors contributing to the need for this level of care.
    d. Medications/medication changes.
    e. Labs when appropriate.
    f. Treatment interventions (planned/completed), treatment goals/discharge criteria, and progress towards treatment.
    g. Discharge planning: Estimated length of stay, recommended discharge level of care, barriers to discharge, actions steps being taken by treatment team to address barriers to discharge and discharge appointments scheduled.

2. The following information is needed for each admission/review for members admitted for detox:


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a. Clinical Institute Withdrawal Assessment for Alcohol (CIWA) and Clinical Opiate Withdrawal Scale (COWS) scoring, specific withdrawal symptoms, vitals, and medication protocol.

3. The following information is needed for each admission/review for members admitted for an eating disorder:
    a. Vitals, Orthostatic BP, BMI, Height, Weight, and Caloric intake for oral feeds and tube feeds if appropriate.

4. The following information is needed at time of discharge:
    a. Date of discharge
    b. Diagnosis and medications
    c. Confirmed contact information for member upon discharge which includes address and phone number (guardian's contact information for minors 14 and under).
    d. Aftercare plan developed by provider that has been verified to be scheduled with current in-network CCHP providers.
        i. If assistance in finding appropriate CCHP providers is needed, contact the assigned Utilization Manager.

II. Partial Hospitalization Behavioral Health Program/Intensive Outpatient Program

A. CCHP reviews clinical within one business day of submission and utilizes evidence based criteria licensed through Milliman Care Guidelines (MCG) to determine medical necessity. Urgent concurrent requests are reviewed within one business day. An urgent pre-service decisions are made within 72 hours. Non-urgent pre-service decisions within 15 calendar days.
    1. CCHP will always attempt to render a decision on urgent requests the day the request was received. However, requests received after 1300 may not have a decision rendered the same day to allow appropriate review of the information received. CCHP follows Timeliness of UM Decisions standards as set forth by National Committee for Quality Assurance (NCQA).

B. CCHP can approve up to one calendar month per request based on clinical documentation submitted (ex: 4/22/25 – 5/22/25). Please request the exact number of sessions that the member will need to attend during the month. (Example: If the IOP program is 4 days/week and duration is 4/22/17 – 5/22/17, you would count out the exact number of sessions needed, so 20 sessions).

C. CCHP requires all notifications of initial admissions and concurrent/subsequent requests to be accompanied by a specific request for dates of service.

D. CCHP uses evidence based criteria to determine the acuity of the member's needs and may modify a request based on the clinical received. If a request is modified, CCHP will offer the opportunity to the provider to agree to the terms of the modification and will require a response by the end of the next business day after the request is made. If agreement to the modified terms is not received, CCHP will proceed to deny any days that do not meet medical necessity per MCG.

E. For per diem services, CCHP needs a comprehensive, clinical documentation. It is important for the clinical submitted to include the date and author of each note and the member name and DOB. The documentation should clearly outline what the provider is trying to achieve with progressing the member's treatment plan and provide detailed information regarding the member's progress and discharge planning.

    1. The following information is needed with each admission/review:

a. Primary diagnosis for which the member is receiving treatment and any other concurrent diagnoses.
b. Presenting problem/current symptoms necessitating admission or continued stay.
c. Other factors contributing to the need for this level of care.
d. Exact treatment goals, treatment interventions, goals/discharge criteria, progress toward goals/discharge criteria.
e. Medications to include current provider's note.
f. Attendance during previous authorization period
g. Discharge planning: Estimated length of service, barriers to discharge, discharge appointments scheduled.

2. The following information is needed at time of discharge:
    a. Date of discharge
    b. Diagnosis and medications
    c. Confirmed contact information for member upon discharge.
    d. Aftercare plan developed by provider that has been verified to be scheduled with current in-network CCHP providers.
        i. If assistance in finding appropriate CCHP providers is needed, contact the assigned Utilization Manager.

III. Intensive In-home Program

A. CCHP reviews clinical dependent on the timing of the submission. Urgent concurrent requests are reviewed within one business day. An urgent pre-service decisions are made within 72 hours. Non-urgent pre-service decisions within 15 calendar days. CCHP utilizes evidence based criteria licensed through Milliman Care Guidelines (MCG) to determine medical necessity. CCHP can approve up to three calendar months per request based on clinical documentation submitted (ex: 5/22/17 to 8/22/17).

B. CCHP requires all notifications of initial admissions and concurrent/subsequent requests to be accompanied by a specific request for dates of service.

C. CCHP uses evidence based criteria to determine the acuity of the member's needs and may modify a request based on the clinical received. If a request is modified, CCHP will offer the opportunity to the provider to agree to the terms of the modification and will require a response by the end of the next business day after the request was made. If agreement to the modified terms is not received, CCHP will proceed to deny any days that do not meet medical necessity per MCG.

D. For concurrent requests, CCHP requires clinical documentation supporting medical necessity to be dated and submitted within one week of the initial proposed start date of treatment, not before as a member's unique behavioral health needs can change in short periods of time. Any clinical or requests submitted earlier than one week prior to starting treatment will be returned to the provider with an offer to resubmit in a timely manner or will be considered for denial.

1. The following information is needed with each admission/concurrent request:

    a. CCHP Assessment and Treatment Plan- Day Treatment and Intensive In-home Therapy Services.
        i. Must thoroughly address:
            1. Rationale for requested level of care at admission and with each concurrent request
            2. Goals and achievable objectives

3. Progress made toward each goal and objective
4. Attendance during previous authorization

b. Annual prescription for IIH (It is still acceptable if it expires mid-way through an authorization, but we will need a new prescription for any additional requests).

c. Annual health check has the same rules as with prescription listed above.

d. Psychiatric Evaluation- CCHP encourages a Psychiatrist or Psychologist evaluation for individuals with mental health issues severe enough to warrant in home therapy.