Chorus Community Health Plans

Medicaid Provider Manual
2024

Introduction 1
Who we are
Service Area
Contact Information

Access Standards 5
Access Standards

BadgerCare Plus Member Enrollment 6
Services
Outreach and educational programs
Healthy Mom Healthy Baby program
Cultural Awareness programs

Care4Kids 9
Covered services
Provider Network
Transportation

Provider Responsibilities 18

Quality Improvement 22

Women's Health 23
ASH Reporting

Behavioral Health 26

Case Management 27
Complex Case Management
Chronic Condition Management
Referrals

Complaints Process 28

Utilization Management 30
Program Overview
Decision Criteria
Prior Authorizations
Auto Authorizations

Prior Authorizations 42

Claims 45
Claims process

Codes and Reimbursement 47

CHORUS
COMMUNITY HEALTH PLANS

Timely Filing 51
Filing guidelines

EFT and Confirmation Portal 53
Enrollment

Appeals 56
Submitting a claim appeal

Provider Website 58

Fraud, Waste and Abuse 60

Credentialing 62
Definitions
Criteria to submit an application
Recredentialing

Provider Suspension Termination Appeals Rights 74

Telehealth Policy 83
Policy and Procedure
Definitions

Delegated Credentialing 87

Member Complaints and Appeals Process 89

Language Services Document 91

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.

The purpose of this manual is to serve as a resource for policies and procedures that affect BadgerCare Plus Managed Care. This is a supplemental manual to ForwardHealth's provider handbook for policies specific to the BadgerCare plus Product. For specific benefits under the Standard Plan please refer to the Wisconsin Medicaid web site at www.dhs.wisconsin.gov. If you have questions relating to this information, or are unable to find information that you are looking for, contact the Chorus Community Health Plans Customer Care Center.

About BadgerCare Plus with CCHP

Chorus Community Health Plans (CCHP), an affiliate of Children's Hospital of Wisconsin, is an HMO dedicated to providing access to the highest quality health care and services to our members living in Wisconsin. We are proud to serve over 120,000 members with our Badgercare Plus product. CCHP is a member of the Association for Community Affiliated Plans (ACAP), which is a national trade association representing more than 59 nonprofit safety-net health plans in 26 states. ACAP's mission is to represent and strengthen nonprofit, safety-net health plans as they work in their communities to improve the health and well-being of vulnerable populations.

About this Manual

This manual is available on our website at: choruscommunityhealthplans.org, and is updated biannually or as needed. Providers can contact CCHP Provider Relations at 1-844-229-2775 to request a paper copy or a flash-drive of the manual to be mailed to them at no charge.

Updates will also be communicated periodically through the "Provider Notes" e-newsletter and on the Provider News webpage. Providers can also receive newsletters and updates from CCHP by signing up to receive emails online.

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 service 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 cchpprovidernews@chorushealthplans.org.

CHORUS COMMUNITY HEALTH PLANS

CONTACT INFORMATION

We offer our members access to the highest quality health care and services with the combined resources of Children's Hospital of Wisconsin, Chorus Community Services, Children's specialty and primary clinics, as well as our community partners.

BadgerCare Plus service areas:

Southeast WI:

- Dodge
- Eau Claire
- Grant
- Green Lake
- Jefferson
- Kenosha
- Milwaukee
- Ozaukee
- Racine
- Walworth
- Washington
- Waukesha

Northeast WI:

- Brown
- Calumet
- Door
- Fond du Lac
- Kewaunee
- Manitowoc
- Marinette
- Oconto
- Outagamie
- Rock
- Shawano
- Sheboygan
- Waupaca
- Waushara
- Winnebago

Care4Kids service area:

- Milwaukee
- Kenosha
- Ozaukee
- Racine
- Washington
- Waukesha

CONTACT INFORMATION

CCHP PROVIDER RELATIONS TEAM

Provider Relations Manager	Jerry Pruss	JPruss@chorushealthplans.org
Senior Provider Relations Representative	Diana Schneider	CCHPProviderRelations@chorushealthplans.org
Provider Relations Representative	Lindsay Jines	CCHPProviderRelations@chorushealthplans.org
Reimbursement Configuration Analyst	Tina Travis	ttravis@chorushealthplans.org
Provider Data Manager	Stacey Martinez	smartinez@chorushealthplans.org
Provider Data Specialist	See Xiong	cchp-providerupdates@chorushealthplans.org
Provider Contracting Specialist	Rebecca Jens	cchp-contracting@chorushealthplans.org
Provider Contracting Specialist	Lauren Bergmann	cchp-contracting@chorushealthplans.org
Provider Contract Administrator	Sue Gorecki	cchp-contracting@chorushealthplans.org
Provider Network Specialist	Blia Lor	cchp-providerupdates@chorushealthplans.org
Lead Credentialing Associate	Jennifer Stewart	CCHP-Credentialing@chorushealthplans.org
Provider Communication Specialist	Kira Ward	sward2@chorushealthplans.org

CCHP Provider Relations Department *To inquire about billing, contracting, claims-related questions or other provider services, please call the CCHP Customer Service Center.*	CCHPProviderRelations@chorushealthplans.org
CCHP Customer Service Center	1-800-482-8010
CCHP Clinical Services Department *To inquire about an authorization or how to submit a request.*	414-266-5707 or 1-877-227-1142
Electronic Claims Submission *Note: CCHP currently has an Administrative Services Agreement with Dean Health Plan for customer service and claims. For claims issues, please contact our Customer Service Center at 1-800-482-8010*	EDI Payer Number: 39113 Paper claims submission address: Chorus Community Health Plan P.O. Box 56099 Madison, WI 53705
Electronic Funds Transfer (EFT) Remits *Change Healthcare through Dean Health Plan manages EFT services. If you aren't receiving your EFT remit, please call Emdeon.*	1-866-506-2830, option 1
ForwardHealth Provider Services Call Center *To inquire on member eligibility and benefits.*	1-800-947-9627
ForwardHealth Member Services *To request a replacement card.*	1-800-362-3002
HMO Enrollment Specialist *To change HMO.*	1-800-291-2002

Interpreter Services • *Telephonic interpreter services are provided to CCHP members through Cyracom and Pacific Interpreters. Please call a CCHP Provider Relations Representative to request this service.* • *For sign language services, call a CCHP Member Advocate.*	Cyracom: 833-742-4082 or X63009 Access Code: 7587 Pacific Interpreters: 800-264-1552 Access Code: 841648 CCHP Member Advocate: 877-900-2247
Member Advocate *Help members find in-network providers, schedule appointments, resolve member billing issues and review eligibility in the BadgerCare Plus program.*	1-877-900-2247
Prior Authorization/Notification of Admissions *Prior authorizations should be submitted online through the CCHP Provider Portal. Note: You must register before gaining access to the portal. For questions or problems with an electronic authorization request submission, call CCHP Clinical Services department at 414-266-5707 or 877-227-1142, option 2.*	choruscommunityhealthplans.org
Provider Portal Registration	414-266-5747
Utilization Review Department	414-266-5707 or 1-877-227-1142
Pharmacy Services *CCHP members receive covered drugs, disposable medical supplies supplied by pharmacies), and certain over-the-counter items from the state through fee-for-service Medicaid. Covered medications and prior authorization restrictions are available on the state's pharmacy website.*	www.forwardhealth.wi.gov
Routine Dental Services *Routine covered dental services (teeth cleanings, fluoride, fillings) are managed by Dental Professionals of Wisconsin to CCHP members who reside in Milwaukee, Kenosha, Ozaukee, Racine, Washington, and Waukesha counties. For CCHP members living in other counties, dental services are covered by the state of Wisconsin. Members can see a dentist that accepts their ForwardHealth card.*	414-389-9870
Transportation Services *Bus, taxi, special medical vehicle and other common carrier transportation is handled through the State of Wisconsin Department of Health Services' transportation manager.*	1-866-907-1493

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. To maintain quality standards for our providers, we promise:

- Our network providers' hours of operation do not discriminate against BadgerCare Plus Standard or
- Interpretation services if a provider does not speak the member's language
    - Language Services document on page 91.

Our definition of Primary Care Provider

CCHP defines primary care providers as:

- Advanced Practice Nurse Practitioners
- Family Nurse Practitioners
- Family Practitioners
- General Practitioners
- Internists
- Nurse Practitioners
- OB/Gynecologists
- Pediatric Nurse Practitioners
- Pediatricians
- Physician Assistants
- RNs

Appointment standards

The list below is the time limits with the providers in CCHP's network for scheduling medical, behavioral and dental appointments.

Standards	Scheduled Appointment 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 or Urgent Care Walk-in Clinic	Member is to call PCP's office first to see if PCP is available. Medical attention same day, no appointment needed.
Non-urgent Sick Visit	Medical attention within two calendar days of member's notification.
Routine Primary Care 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	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.
Behavioral Health Initial Appointment	No longer than 10 days for an initial assessment; no longer than 30 days for members discharged from an inpatient behavioral health stay.
Behavioral Health Urgent Care	Visit within 48 hours of member's request
Behavioral Health Routine Appointment	Visit within 10 days of member's request
Routine Dental Care Appointment (such as teeth cleaning and cavity fillings)	Visit within 90 days of member's request
Emergency Dental Care Appointment (severe pain, swelling or bleeding)	Visit within 24 hours of member's request

BADGERCARE PLUS MEMBER ENROLLMENT

About BadgerCare Plus
CCHP is responsible for providing all medically necessary covered services under BadgerCare Plus. Some services may require a doctor's order, a prior authorization or a copayment.

Services include, but are not limited to:

- Dental
- Disposable medical supplies
- Durable medical equipment
- Emergency room services
- Health screenings for children — HealthCheck screenings and other services for individuals under the age of 21
- Hearing services
- Home health
- Inpatient hospital
- Member Advocates
- Behavioral health and substance abuse treatment
- Nursing home
- Outpatient hospital other than emergency room
- Physical therapy, occupational therapy and speech-language pathology
- Physician, anesthesia, X-ray and laboratory
- Podiatry
- Prescription drugs — the State of Wisconsin provides and administers prescription drug benefits, not CCHP
- Reproductive health
- Transportation – ambulance, specialized medical vehicle, common carrier
- Vision

Outreach and educational programs
CCHP wants its members to receive the right care at the right time, in the right place. To help make this happen, we offer outreach and educational programs to support the providers in our network. Some of our programs and services include, but are not limited to:

- Care4Kids — out-of-home care
- Disease management
- Case management
- Healthy Mom, Healthy Baby program
- Lead testing outreach

Healthy Mom, Healthy Baby program
The Healthy Mom, Healthy Baby (HMHB) program provides a personalized approach to support and gives resources to women during all stages of their pregnancy and up to 12 months post-partum, in order to improve pregnancy outcomes and improve the overall health of women and their families. HMHB is a program that aims to assist women in having the healthiest pregnancy possible as well as a successful transition to parenthood and continued investment in their health and the health of their children. This is done by our team of nurses and advanced practice social workers who support them and their families in reaching their goals and assisting them in making informed healthcare choices.

Other services include breastfeeding support by Certified Lactation Consultants. For more information about this program, call CCHP at 414-337-BABY. We would also be happy to come to your office to discuss our various programs and CCHP incentives for each notification of pregnancy we receive. To download the Notification of Pregnancy form, go to our Provider Forms web page.

Cultural Awareness programs

CCHP is 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. For more information about the CCHP's programs and services available, call our Customer Service Center at 1-800-482-8010.

Length of enrollment

All Members residing in a mandatory HMO service area must serve an initial 12-month lock-in period. The first three months of this lock-in period are an open enrollment period. During this open enrollment period members can change their HMO. After the open enrollment period, members are locked into their selected HMO.

Primary Care

CCHP encourages all members to select a Primary Care Practitioner (PCP). Members always have a choice of providers and can contact the Customer Service department at 1-800-482-8010 for assistance in selecting a provider or to change to another provider. Members may also contact a CCHP Outreach Coordinator or Member Advocate for help with choosing a PCP.

Chorus Community Health Plan understands the importance of members establishing an on-going, interactive relationship with a primary care provider/clinic (PCP). This relationship will increase compliance with preventive care, including immunization and blood lead tests, and will reduce unnecessary emergency room utilization. PCPs coordinate care for their patients and refer them to specialists when appropriate. Primary care providers are responsible for developing a comprehensive treatment plan between themselves and the members.

Languages that providers speak are listed in the provider directory and are considered when helping members choose a PCP. All PCPs are trained to assess chronic conditions and refer to specialists if necessary. CCHP only contracts with providers who are sensitive to the cultural needs of its members and will monitor providers based on complaints. Members are permitted to change to another PCP based on the PCP's ability to provide services in a culturally competent manner. Patient centered medical homes are available throughout CCHP's network.

BadgerCare Plus ID card

BadgerCare Plus members receive a "ForwardHealth" Medicaid identification (ID) card upon initial enrollment into the Wisconsin BadgerCare Plus programs. Each individual family member receives his or her own individual ID number and card. BadgerCare Plus ID cards are in any of the following formats:

- Blue or white plastic ForwardHealth cards (standard)Green Temporary paper cards
- Express Enrollment (maternity) paper cards

Members are encouraged to always keep their cards even though they may have periods of ineligibility. It is possible a member will present a card when he or she is not eligible; therefore, it is essential providers confirm eligibility before providing services. Eligibility can be confirmed:

1. ForwardHealth Provider Portal
2. ForwardHealth website: forwardhealth.wi.gov

3. CCHP Customer Service: 1-800-482-8010

Lost or Stolen Card

If a card is lost, stolen or damaged, Wisconsin BadgerCare Plus will replace the card at no cost to the member. Members should contact the State of Wisconsin Member Services at 1-800-362-3002 for replacement cards.

CCHP will not issue members a separate ID card. The ForwardHealth card will serve as their insurance card. The ForwardHealth card includes the member's name, 10-digit Medicaid ID number, magnetic stripe, signature panel, and the State of Wisconsin Member Services telephone number. The card also has a unique, 16-digit card number on the front. This number is for internal use only and is not used for billing. The card does not need to be signed to be valid, although adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

Temporary and Presumptive Eligibility cards are issued on paper and are just a copy of the application. These members are covered by Fee-for-Service, not CCHP. Providers should make a copy of the member's temporary card in the event a claim denies.

CARE4KIDS

About Care4Kids

Care4Kids is a Medicaid benefit that provides comprehensive health care to children in out-of-home care that reflects the unique health needs of these children. To strengthen the quality, access and timeliness of care, Care4Kids creates a "medical home" for each child entering care. This "medical home" is not a physical place, but rather a philosophy that children in out-of-home care deserve coordinated and comprehensive health care that addresses their unique needs.

Care4Kids not only provides children with primary care physicians who are trained in needs of children in out-of-home care, but also offers a team of professionals who coordinate care for the child. This team works together to ensure children entering out-of-home care receive timely, individualized and developmentally appropriate care. Facilitated by the CCHP-Care4Kids Healthcare Coordination team, the comprehensive team of community stakeholders includes:

- The child's family
- County caseworkers
- Child Welfare case managers
- Health care professionals
- Out-of-home care providers

Covered services

CCHP Plan covers all medically necessary in-network services for Care4Kids enrollees. Some services may require a doctor's order or a prior authorization. Copayments do not apply to Care4Kids enrollees. Covered services include:

- Ambulance specialized medical vehicle: Full coverage of emergency and nonemergency transportation to and from a certified provider for a covered service
- Common carrier transportation (arranged through a contracted provider through the State of Wisconsin, not Care4Kids)
- Dental
- Disposable medical supplies
- Durable medical equipment
- Emergency and urgent care servicesHealth screenings for children — full coverage of HealthCheck screenings and other services for individuals under the age of 21
- Hearing services
- Home health
- Inpatient hospital
- Behavioral health and substance abuse treatment
- Nursing home
- Physical therapy, occupational therapy and speech-language pathology
- Reproductive health
- Transportation
- Vision

Members enrolled in Care4Kids will have a ForwardHealth ID card. The ForwardHealth Portal will identify members as Care4Kids, and Chorus Community Health Plan should be billed for services.

Provider network and services offered

Care4Kids members may see any provider in the CCHP Provider Network. If a member wants to see an out-of-network provider, they will need prior authorization for the services. Please refer to the CCHP website for more information on services that require notification and prior authorizations.

Pharmacy services

Care4Kids enrollees can get their prescription filled at any pharmacy that is a provider for BadgerCare Plus. Members need to show the child's ForwardHealth ID card to the pharmacist when a prescription is filled. Pharmacy benefits are covered by the State of Wisconsin, not Care4Kids. You can call Wisconsin ForwardHealth Member Services at 800-362-3002 for help filling a prescription.

Dental services

Care4Kids provides all covered dental services when provided by an in-network dental provider. As members, children have the right to a routine dental appointment within 90 days after a formal request. See the online CCHP Provider Directory or call Dental Professionals' Customer Service at 1-877-389-9870 for the names of our dentists.

Transportation

Bus, taxi, special medical vehicle and other common carrier transportation is handled through the State of Wisconsin DHS transportation manager, not Care4Kids. Please have the Care4Kids member call 1-866-907-1493 if they need a ride.

CARE4KIDS: 30-DAY EXAM GUIDELINES

Care4Kids 30-day exam guidelines

Children receive an out-of-home health screen within two business days of entering care, preferably at a Child Advocacy Center. They also receive a comprehensive initial health assessment within 30 days of enrolling, preferably at an identified Center of Excellence.

Components of exam

- MD/NP will review the information that was sent by the health care coordinator
- MD/NP reviews initial draft of the comprehensive health care plan (CHCP)
- MD performs exam, suggested components include: history, well-child components social screening; behavior assessment/mental health screen; allergies; physical exam — injury surveillance and skin exam; dental screen; immunizations; labs; age appropriate interview
- Discussion on medical home decision
- Discussion about hand-off (if necessary) and next steps

Documentation

- MD/NP will document all findings in Epic® or other electronic system as appropriate
- MD/NP will fill out medical note (template developed by Foster Care Medical Home Provider Implementation team)
- MD/NP will write referrals as necessary
- MD/NP will document on specific quality indicators
- MD/NP will highlight information that needs to be added to the comprehensive health care plan

Information sharing

Medical notes and the CHCP will be sent to the health care coordinator and other providers as necessary. Please fax this information to (414) 431-6064 as soon as possible after the comprehensive exam and each subsequent appointment.

Child Advocacy Centers or Centers of Excellence

Centers of Excellence provide a coordinated care delivery system. Centers of Excellence providers partner and share information with all parties involved in a child's care and participate in a team process to enhance communication and coordination of care.

The Centers of Excellence medical providers are specially trained in caring for children in the foster care system that have been victims of trauma, abuse and/or neglect. We've listed the Centers of Excellence on our website.

CARE4KIDS: HEALTHCHECK (EPSDT)

HealthCheck is Wisconsin's Early and Periodic Screening, Diagnosis and Treatment (EPSDT), and is mandated under federal Medicaid law. HealthCheck screenings are designed to encourage providers to provide regular, comprehensive and preventive health care to Medicaid members under the age of 21.

The State of Wisconsin requirement

The State of Wisconsin requires that at least an 80% compliance rate be attained for the completion of Health-Check exams. CCHP is required to report compliance with HealthCheck standards to the State, and will do so based upon claims data.

HealthCheck tracking and reporting

Tracking and reporting is necessary to ensure our covered members comply with the recommended preventive visits and preventive screenings. Care4Kids outreach coordinators track visits and contact members to schedule necessary appointments. Performing complete HealthChecks for *all* BadgerCare Plus eligible children keeps them healthy and provides higher reimbursement to you.

Reasons to provide HealthChecks

There are several reasons to provide HealthChecks:

- Visits ensure regular preventive health care for BadgerCare Plus members under the age of 21
- Reimburses at a higher rate than well-baby, well child visits, or HPSA bonus payments
- Through a HealthCheck referral, medically necessary services that are otherwise not covered by BadgerCare Plus may be reimbursed
- Screening exam intervals are consistent with the American Academy of Pediatrics' recommendations
- Screening requirements follow state and federal regulations and represent what most pediatric Medicaid providers see as "best practice."

HealthCheck or well-baby exam differences

The difference between the HealthCheck and a well-baby exam is the HealthCheck requires an assessment and documentation of all seven components; whereas, a well-baby exam may not.

When a patient (Guardian) refuses to let the provider do an unclothed physical exam

Federal law requires an unclothed physical exam to ensure clinicians are evaluating for potential physical abuse. This requirement does not mean the child must be totally unclothed for the entire exam. If the patient (Guardian) refuses to permit an unclothed exam, Providers may bill, but must document the refusal. Providers should alert Care4Kids of this issue for a follow-up.

When vision and/or hearing screening happens at school or somewhere else

HealthCheck providers are required to access and document vision and hearing screening, and if the member has a vision and/or hearing screening somewhere else, the provider should document that fact and it would meet the requirements.

CARE4KIDS: HEALTHCHECK SCREENING SCHEDULE

No waiting period for HealthCheck screenings

You do not need to wait a full 365 days between annual HealthCheck screenings. HealthChecks are unlimited for CCHP members enrolled in Care4Kids.

Incentives to promote HealthCheck to parents

We offer at least two incentives to help promote HealthCheck to members' parents:

1. Transportation: BadgerCare Plus pays for member transportation if it is required by members to access
2. Necessary medical care. Access to transportation is a key issue for many members in rural and central city areas in particular. Transportation can be arranged by having the member call the state's transportation broker at 1-866-907-1493.
3. Over-the-counter drugs: BadgerCare Plus also pays for medically necessary over-the-counter (OTC) drugs prescribed by physicians, as long as a Health-Check screen was done. Some prescriptions are subject to prior authorization. Please see Forward-Health's Pharmacy website for the most current list of OTC medications that *do not* require prior authorization.

More HealthCheck information

For more information on The Wisconsin BadgerCare Plus program and HealthCheck services, go to the ForwardHealth Provider Portal, and after signing in, you may print the entire HealthCheck Services handbook.

CARE4KIDS: HEALTHCHECK SCREENING SCHEDULE

The HealthCheck screening schedule

Primary Care Physicians are expected to follow the HealthCheck periodicity screening schedule for all members including women under age 21 who are pregnant. You must document in the patient's record when a parent requests an alternative immunization schedule. It's not the intent of the program to make you change your documentation system. Documentation of the listed components should be incorporated into your normal process.

Based on the federal EPSDT, the State of Wisconsin established the following periodicity screening schedule:

AGE RANGE	NUMBER OF SCREENINGS	RECOMMENDED AGES FOR SCREENINGS
Birth to first birthday	8	Birth, 1 month, 2 months, 3 months, 4 months, 5 months, 6 months, 9 months
First birthday to second birthday	3	12 months, 15 months, 18 months
Second birthday to 21st birthday	2 screening per year	Every 6 months

HealthCheck screening components

Each of the seven HealthCheck screening components listed below should be documented in the patient's medical record when a HealthCheck exam is billed.

1. Health and development history: The health and development history identifies any special risk factors, or prior conditions/treatments pertinent to future care of the patient. This history should include the following:
   - Health education/anticipatory guidance including age appropriate preventive health education
   - An explanation of screening findings and developmental behavior assessments, which include observed behavior and attainment of developmental milestones compared to age specific norms
   - A nutritional assessment
2. Unclothed physical exam/growth assessment: This assessment reviews body systems, indicating normal or abnormal findings, and includes:
   - Blood pressure must be taken on all patients beginning at age 3
   - Growth assessment: height, weight and head circumference are plotted on growth charts (head circumference must be completed up to age 2)
   - Sexual development, especially on patients who have reached puberty
   - Unclothed exams are critical to assessing children in out-of-home care to continually assess for signs of abuse
3. Vision assessment: Use of vision assessments must be attempted starting at age 4 and done annually. If attempted but unable to complete due to age, this must be documented. The general guidelines are:
   - Start on the 20/25 line (if unable to read, go up one level). If the child misses one letter on a line = pass. If the child misses two or more in one row = fail, and record vision at the previous level.
   - If the child wears glasses, a vision assessment is not necessary. Document the child wears glasses, and when the child was last seen by an optometrist/ophthalmologist for an eye exam.

4. Hearing assessment: Infancy and childhood should include otoscopic exam and/or tympanometric measurement for detection of chronic/recurrent otitis media.
5. Oral assessment: This assessment is to identify children in need of early examination by dentist. Children age 1 and older (and younger if medically necessary) must be instructed to seek dental care.
6. Immunizations: Childhood immunizations should be provided according to the Wisconsin Department of Health Immunization Guidelines. Parents declining immunizations should be documented at each visit.

Vaccines for Children Program (VFC)

A federal program intended to help raise childhood immunization levels in the U.S. by supplying *free* vaccines to private and public health care providers who administer vaccines to eligible children, which includes all BadgerCare Plus eligible children. For more information on the VFC Program, refer to the ForwardHealth Portal at forwardhealth.wi.gov

CARE4KIDS: HEALTHCHECK CLAIMS

Submitting HealthCheck claims

HealthCheck claims and other claims for children or teens enrolled in Care4Kids should be submitted to:

Chorus Community Health Plan
P.O. Box 56099
Madison, WI 53705

Claims questions

Any claims questions should be directed to our Provider Services department at 800-482-8010. CCHP asks that providers allow 45 days to pass from the date of the submission before calling to check the status of claims. Care4Kids claims will be processed the same way that CCHP claims are processed.

Provider Explanation of Payments

The explanation of Payments for Care4Kids members will have the CCHP logo. Any questions regarding claims payments can be directed to our Provider Services department at 1-800-482-8010.

Claim forms to use for HealthCheck claims

Please use the CMS-1500 claim form when billing for HealthChecks. This is the same claim form used for other BadgerCare Plus billing. Comprehensive screens are billed using CPT codes to indicate that a comprehensive HealthCheck screen was performed.

Billing for nutrition therapy

Nutrition therapy can be billed as an inter-periodic visit if the comprehensive screen identified a problem, and if the dietitian works for the HealthCheck agency. Potential problems may *not* be billed. The billing is done by the HealthCheck agency. This is for Fee-for-Service. Check with the HMO if the member is in a Medicaid HMO.

HealthCheck Billing Codes

<table>
<tr><th colspan="6">Preventive Care</th></tr>
<tr><th colspan="3">New Patient</th><th colspan="3">Established Patient</th></tr>
<tr><td>99381*</td><td>Initial preventive medicine visit</td><td>Under 1 year</td><td>99391*</td><td>Periodic preventive medicine visit</td><td>Under 1 year</td></tr>
<tr><td>99382*</td><td>Initial preventive medicine visit</td><td>Ages 1 - 4</td><td>99392*</td><td>Periodic preventive medicine visit</td><td>Ages 1 - 4</td></tr>
<tr><td>99383*</td><td>Initial preventive medicine visit</td><td>Ages 5 - 11</td><td>99393*</td><td>Periodic preventive medicine visit</td><td>Ages 5 - 11</td></tr>
<tr><td>99384*</td><td>Initial preventive medicine visit</td><td>Ages 12 - 17</td><td>99394*</td><td>Periodic preventive medicine visit</td><td>Ages 12 - 17</td></tr>
<tr><td colspan="3" rowspan="4">*These codes do not need a modifier. Note: Newborn exam in the hospital counts as the first HealthCheck if billed with either of the following CPT codes:
99460 - Initial hospital or birthing center care for evaluation and management of normal newborn
99463 - Initial hospital or birthing center care for evaluation and management of normal newborn admitted & discharged on same day</td><td>99395*</td><td>Periodic preventive medicine visit</td><td>Ages 18 - 21</td></tr>
<tr><td>99431*</td><td colspan="2">History and examination of normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records.</td></tr>
<tr><td>99432*</td><td colspan="2">Normal newborn care in other than hospital or birthing room setting, including physical examination or baby and conference(s) with parent(s).</td></tr>
<tr><td>99435*</td><td colspan="2">History and examination of normal newborn infant, including preparation of medical records.</td></tr>
</table>

CARE4KIDS: HEALTHCHECK CLAIMS

Do not apply any modifiers to the HealthCheck codes other than the ones listed below:

HealthCheck Nursing Agencies (Local Public Health Agencies)	EP TS	Indicates that periodic screens, outreach and cast management, and lead inspection services were provided as part of EPSDT Indicates follow-up services to an environmental lead inspection
Physicians, Physicians Assistants, Independent Nurse Practitioners	UA**	Medical referral

HealthCheck diagnosis codes

Use the following diagnosis codes when billing for HealthChecks:

- Z00.129 – Routine infant or child HealthCheck
- Z00.00 - Adult over 18 years of age

**In the event the member needs a referral or follow-up visit for diagnostic or corrective treatment, modifier "UA" must be attached to the above preventive care codes in the first modifier field. Modifier "UA" is a national modifier that is state defined by Wisconsin BadgerCare Plus as an indicator that the comprehensive HealthCheck exam resulted in a referral for further evaluation or treatment.

PROVIDER 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

CCHP 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 your Provider Relations Representative at 1-844-229-2775.

Notify CCHP in writing of the following events:

- Any changes in practice ownership, name, address, phone or federal tax ID numbers
- Adding a new physician — in order to treat a Medicaid/BadgerCare Plus patient, you must be a Medicaid certified provider
- 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 CCHP members
- Send written notification of any of the above events to:

  CCHP 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 tenen will be providing services
  - Locum tenens must have Medicaid certification

Referrals

- In-network specialists
  CCHP does not require written referrals for its members to any in-network provider.
- Out-of-network
  Providers must fully complete our Authorization Request form that is available on our website and fax to (414) 266-4726. CCHP will notify the provider of the approval or denial. For referral status, call 1-800-482-8010.
- Prior authorizations
  Prior authorizations are required for some CCHP covered services. Please refer to the Prior Authorization list on our website at childrenscommunityhealthplan.org. For network providers, prior authorizations should be submitted using the CCHP CareWebQI auto authorization request tool, which can be accessed through our Provider Portal.
- Providers not accepting new patients

Providers closing their panel to new patients must submit a written notice to CCHP Provider Relations that they are not accepting new patients.

- Arranging substitute coverage
  When a physician is out of the office and another provider covers his/her practice, CCHP requests:
  - Notification to include the duration of coverage, name and location of the covering provider
  - The covering practitioner must be a CCHP provider and have completed the CCHP credentialing process

- No-show policy
  A provider cannot bill a CCHP member for a no-show appointment. If a member doesn't show up for a scheduled appointment and does not notify the provider in advance of the cancellation, the provider should contact a CCHP Member Advocate at 1-877-900-2247.

  A CCHP Member Advocate must be contacted if:
  - A pattern has developed for missed appointments by a member; or
  - A provider plans on terminating a patient's care

  A CCHP Member Advocate will counsel Medicaid/BadgerCare Plus members regarding the importance of keeping appointments.

  Letters regarding termination of patient care must be sent, along with our Missed Appointment Notification form, to the CCHP Member Advocate prior to notifying the member.

  Mail termination of patient care letter and Missed Appointment Notification form to:

  Chorus Community Health Plan
  Attn: CCHP Member Advocate
  P.O. Box 1997, MS6280 Milwaukee,
  WI 53201-1997

- Member notification when a provider leaves the CCHP network

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

- Transition of patient care following termination of provider participation

  For any reason, if a CCHP 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.

Denied Services
CCHP is responsible for notifying members of denied services. As a provider you must include in your policies that CCHP is responsible for notifying members of denied services.

Moral or Religious Objections to Care

The HMO (or contracted provider) is not required to provide counseling or referral service if the HMO (or contracted provider) objects to the service on moral or religious grounds. If the HMO (or contracted provider) elects not to provide, reimburse, or cover counseling and/or referral services because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

- To the Department and Enrollment Specialist so the Department can notify members of the HMO's non-coverage of service;
- With the HMO's certification application for a BadgerCare Plus and/or Medicaid SSI contract;
- Whenever the HMO adopts the policy during the term of the contract;
- It must be consistent with the provisions of 42 CFR 438.10;
- It must be provided to potential members before and during enrollment;
- It must be provided to members within ninety (90) days after adopting the policy with respect to any particular service; and
- In written and prominent manner, the HMO shall inform members via their website and member handbook of any benefits to which the member may be entitled under BadgerCare Plus and Medicaid SSI, but which are not

available through the HMO because of an objection on moral or religious grounds

HMOs are required to provide to the Department its policies and procedures for communication with the Department, Enrollment Specialist and member whenever the HMO (or in network provider) refuses to provide, reimburse or cover counseling and/or referral services based on moral or religious objections.

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 incapacitating illness or injury 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
- If you are unable to implement the member's advance directive due to an objection of conscience, you must inform the member
- The member should contact the CCHP Customer Service Center to select a new primary care provider. As a primary care provider, you should contact the CCHP Customer Service Center if you're not able to be the member's primary care provider because of a conscionable objection to an advance directive

Medical records

As a contracted provider with CCHP, 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

CCHP 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, site significant illnesses and medical condition, and include 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

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
- Reasons for referrals documented

Members' Rights and Responsibilities

To promote effective health care, CCHP makes clear its expectations for the rights and responsibilities of its members, to foster cooperation among members, providers and CCHP.

CCHP members have the right to:

- Ask for an interpreter and have one provided while receiving any BadgerCare Plus covered service
- Receive health care services as provided for by federal and state laws. All covered services must be available and accessible to 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 practitioners 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 CCHP, its services, practitioners and providers and member rights and responsibilities
- Voice complaints or appeals with CCHP or the care it provides
- Make recommendations regarding CCHP members' rights and responsibilities policy
- A candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage

CCHP members have the responsibility to:

- Understand their health problems and participate in developing treatment goals
- Tell providers or Chorus Community Health Plan what they need to know to treat them
- Follow the treatment plan and instructions agreed upon with their provider

QUALITY IMPROVEMENT

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.

QUALITY IMPROVEMENT

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.

Abortion, Sterilization, and Hysterectomy Reporting (ASH)

Abortions

Abortion is not a covered benefit, except in cases to preserve the life of the woman or in cases of rape or incest. It's the provider's responsibility to complete the required documentation and submit that information with the claim. Physicians are required to follow the BadgerCare Plus Policy and Consent Procedures for abortions. A prior authorization is not required.

Abortion Documentation

Wis. Stats. 20.927 stipulates that physicians must affix to their claims for reimbursement written certification attesting to the direct medical necessity of the abortion or his or her belief that sexual assault or incest has occurred and has been reported to law enforcement authorities. For examples of the types of documentation that will satisfy the above requirements, go to https://www.dhs.wisconsin.gov/forms/f0/f01161.pdf

Claims and payments

All claims for abortions will be rejected unless one of the physician certification statements and the member statement are attached to the claim form. This policy is in accordance with the U.S. Supreme Court's decision of Harris vs. McRae on June 30, 1980. Payment for medical necessity of preserving the mother's behavioral health will not be made.

Required Documentation for Medicaid Reimbursement

"No service billed to Wisconsin Medicaid on the attached claim form was directly related to the performance of a non-Medicaid-covered abortion procedure. I understand that this statement is a representation of a material fact made in a claim for payment under Wisconsin Medicaid within the meaning of s.49.49, Wis. Stats., and HFS 106.6 (17), Wis. Admin. Code. Accordingly, if this statement is false, I understand that I am subject to criminal prosecution for Medicaid fraud or termination as a Medicaid provider, orboth."

____ ____________

Signed Date

____

Provider Number

Wisconsin DHS regulations for sterilization and hysterectomy procedures

CCHP is required to report all sterilizations and hysterectomies to the State of Wisconsin Department of Health Services (DHS) on a quarterly basis.

The ForwardHealth Sterilization Consent form, which is available at https://www.dhs.wisconsin.gov/library/F-01164.htm, must be signed and a copy of the form will need to be provided to CCHP with the claim for reporting purposes. At least 30 days, but not more than 180 days, must have passed between the date of informed consent and the date of sterilization. Do not count the date signed or the date of surgery in that 30- day criteria.

Informed consent

The person who obtains the informed consent must orally provide all of the requirements for informed consent as set forth on the consent form. They must offer to answer any questions and must provide a copy of the consent form to the individual to be sterilized for his or her consideration during the waiting period. An interpreter must be provided to assist the member if he or she does not understand the language used on the consent form or the language used by the person obtaining the consent. Suitable arrangements must be made to ensure that the required information is effectively communicated to members to be sterilized who are blind, deaf or otherwise disabled. A witness chosen by the member may be present when the consent is obtained. The witness may not be the person obtaining consent.

Common sterilization reporting problems

The sterilization occurs less than thirty days after the date of informed consent.

- The sterilization occurs less than 30 days after the date of informed consent and the physician has indicated a premature delivery. The physician must indicate the Estimated Date of Confinement ("EDC") for a premature delivery.
- An admission history and discharge summary must be included with the sterilization consent form if the sterilization was performed with an emergency abdominal surgery.
- On the physician's statement portion of the consent form, the signature date must be either the day of the surgery or after the surgery date. It may not be prior to the date of the sterilization.
- The member must be at least age 21 on the date he/she signs the consent form.

Hysterectomies

Hysterectomies do not require prior authorization. Hysterectomies DO require completion of the ForwardHealth Acknowledgment of Receipt of Hysterectomy Information form. This form must be in the patient's record at the time of hospitalization. The form is available online at: https://www.dhs.wisconsin.gov/ forms/f0/f01160.pdf.

The acknowledgment form for hysterectomies must be forwarded to CCHP with the claim

A hysterectomy is not covered if:

- It was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or
- Uncomplicated fibroids, a fallen uterus or retroverted uterus.

Common hysterectomy reporting problems:

1. The date the member signs the form must be prior to or match the date of the surgery.
2. The date the provider signs the form must be before the date of service on the claim.
3. Hysterectomies may be performed without the "Acknowledgment of Receipt of Hysterectomy Information" in the following circumstances:

- The hysterectomy was performed during a period of retroactive member eligibility and one of the following circumstances applied:

- The individual was already sterile prior to the hysterectomy and appropriate documentation is attached such as a prior sterilization consent form
- The individual requires a hysterectomy because of a life-threatening emergency in which the physician determines that a prior acknowledgment is not possible.
- The physician must attach the admission history and discharge summary in this case.
- The member was informed before the surgery that the procedure would make her permanently incapable of reproducing.

Outpatient behavioral health, and alcohol and other drug abuse (AODA) services

CCHP strongly encourages our BadgerCare Plus members to follow- up with an outpatient behavioral health provider within seven days of being discharged from an inpatient behavioral 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.

Authorizing outpatient behavioral health care

The Primary Care Provider (PCP) acts as the "gatekeeper" of the member's care. CCHP would like the member's PCP to be an integral part in the member's use of behavioral health services to assure appropriate utilization. Because an authorization is not required for behavioral health services; if the PCP determines behavioral health services are medically necessary and knows the plan behavioral health provider they want to refer the member to, they may do so without completing CCHP Authorization Request form. If the PCP is not certain which behavioral health practitioner is most clinically appropriate, the PCP may contact one of CCHP's Member Advocates at 877-900-2247 during normal business hours for assistance in determining the practitioner or office site that will best meet their patient's needs.

When a CCHP BadgerCare Plus patient is referred for behavior health services, they should be treated no differently than commercial patients in terms of timely access to care, either at intake or for follow-up services. The PCP will issue a written authorization only when the patient requires behavioral health services at a non- plan behavioral health clinic site or with a non-plan behavioral health provider.

Patients requiring outpatient services not offered at a plan clinic/practice

All authorizations to non-plan behavioral health providers need to be approved by CCHP. CCHP may ask the PCP to assist in determining if out-of-network services are appropriate, or if services are adequate with providers who are available within the CCHP network of providers. If you determine your patient needs specialty outpatient behavioral health services not available at your clinic/ practice, you may want to consult with CCHP Clinical Services reviewers about your assessment and recommendations.

Terminating patients from your clinic/practice

Again, CCHP BadgerCare Plus members should not be treated any differently than commercial members who receive services at your clinic/practice. As long as you apply your policies consistently, there is nothing prohibiting you from terminating a CCHP BadgerCare Plus patient from your clinic/practice. CCHP will assist the member in arranging care with another provider.

If the patient does not require or would not benefit from services

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

Concerns about coordination with county social services

The Wisconsin DHS requires CCHP to enter into a "Memorandum of Understanding" between county human services agencies and CCHP. The purpose is to develop a working relationship with community agencies involved in the provision of non-medical services to BadgerCare Plus members.

For specific information on AODA services specific to the following levels of care, please refer to the Utilization Management section, starting on page 23:

- Inpatient
- Partial Hospitalization program

- Day treatment
- Intensive In-home therapy

CASE MANAGEMENT

COMPLEX CASE MANAGEMENT

Complex 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:

- Neuromuscular condition with major impairment/deterioration
- Severe physical trauma in past 3 months, inpatient 6 or more days, transitions in level of care anticipated
- Stroke within past 3 months, major impairment
- Severe spinal cord injury within past month, major impairment
- Pediatric members with 2 or more inpatient stays in last 6 months, not connected to services
- 12 or more prescribed medications
- Other complex care situations which result in extensive use of resources (i.e. multiple uncontrolled chronic illnesses or complex medical condition and complex social situation

Services include:

- Comprehensive assessments
- Integrated goal and care planning
- Care and resource coordination
- Education about condition or disease, including self-management
- Community linkage and resources

CHRONIC CONDITION MANAGEMENT

Chronic condition 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 over the age of 18, members with Asthma between the ages of 5-17 and members with Type 2 Diabetes over the age of 18 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.

SELF-MANAGEMENT TOOLS

CCHP has self-management tools, including an online wellness portal and access to mobile applications for diabetes management and nutritional support, including telenutrition visits with registered dietitians.

- Coordinate transportation to and from appointments
- Work with pharmacies to arrange for home delivery of medications
- Assess for resource needs and social factors that may be impacting the patient's overall health and their ability to manage their condition

CCHP has self-management tools, including an online wellness portal and access to mobile applications for low back pain and diabetes management.

For more information or online resources and tools that support your patients' healthy lifestyles, visit our website at childrenscommunityhealthplan.org.

REFERRALS

If members would like help managing any concerns related to their health, please call 414-266-3173 to reach the Case Management team. Please complete a referral form on children'scommunityhealthplan.org. This form can be faxed to 414-266-1715.

COMPLAINTS PROCESS

Appeals of adverse determinations

The member's physician, member representative or health care provider acting on behalf of the member may appeal an adverse determination orally or in writing. No reviewer involved in a prior review may participate in subsequent reviews. More information regarding the appeal process is found in the UM Appeals policy. To obtain a copy, call your CCHP Provider Relations Representative at 844-229-2775.

Explanations of complaint process

CCHP provides an explanation of the complaint process to newly enrolled members upon enrollment. This process is also explained in the Member Handbook, member newsletters, and member educational fliers. All materials are produced in English, Spanish, Russian, Hmong, and additional languages as needed. Additional information regarding the process for handling complaints is found in the Quality Improvement Program Plan. To obtain a copy, please call the CCHP Manager of Clinical Quality Improvement at 414-266-3477.

New technology

CCHP evaluates and addresses updates published by ForwardHealth on a monthly basis to ensure that all additions in the covered services for BadgerCare Plus members are available to the CCHP members.

Integration with other programs

The Utilization Management (UM), Quality Improvement (QI) and Credentialing programs are closely linked in function and process.

Adverse information

Any adverse information that is gathered through interaction between the utilization management staff and the practitioner or facility staff is vital to the recredentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, pre-certification of noncovered benefits, etc. This information:

- Is forwarded to the CCHP Director of Clinical Services in the format prescribed by CCHP for review and resolution as needed.
- Is filed in the provider's QI folder and is reviewed at the time of the provider's recredentialing.

CCHP 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.

CCHP's Chief Medical Officer, Medical Directors, Executive Director of Health Plan Clinical Services, Director of Clinical Services UM/CM, Manager of Physical Health UM/CM, Manager of Behavioral Health, and Manager of Healthy Mom Healthy Baby all participate in the annual evaluation of the UM program.

The scope of the annual evaluation includes:

- Hospital days per thousand members
- Re-admission within 30 days of discharge from inpatient care
- Denials of inpatient stays/days
- Summary of criteria review updates
- Summary of new UM policies
- Inter-rater reliability
- UM trends
- Top 10 diagnoses for inpatient admits
- Top 10 ambulatory service claim types
- UM reviewer production statistics
- Member satisfaction with the UM service
- Provider satisfaction with the UM service

The above items will be assembled by the:

- Executive Director of Health Plan Clinical Services
- Director of Clinical Services UM/CM
- Manager, Clinical Services UM/CM Physical Health
- Manager, Clinical Services UM/CM Healthy Mom, Healthy Baby
  Manager, Clinical Services UM/CM Behavioral Health

Member Grievances

CCHP members can file a grievance regarding their services with CCHP or their health care provider that is not related to benefits by calling a CCHP member advocate at 1-877-900-2247 or write to us at:

Chorus Community Health Plans
Attn: Complaint/Appeal Department
P.O. Box 1997, MS6280
Milwaukee, WI 53201-1997

CCHP members can file a grievance with BadgerCare Plus to the following address:

BadgerCare Plus
Managed Care Ombuds
P.O. Box 6470
Madison, WI 53716-0470
1-800-760-0001

State of WI HMO Ombuds Program

The state has designated individuals who provide neutral, confidential, and informational assistance and can CCHP members with any questions or problems The Ombuds can help CCHP members solve problems or complaints by calling 1-800-760-0001.

Member Appeals

CCHP members have the right to appeal any benefit issues they feel were wrongly denied. Members must first appeal to CCHP. The request for an appeal must be made no more than 60 days after a notice of services being denied, limited, reduced, delayed or stopped.

If CCHP members need help writing a request for an appeal, please call a CCHP Member Advocate at 1-877-900-2247 or the BadgerCare Plus and Medicaid SSI Ombuds at 1-800-760-0001, or the HMO Enrollment Specialist at 1-800-291-2002.

If a member disagrees with the CCHP appeal decision, they can request a fair hearing with the Wisconsin Division of Hearing and Appeals. The request must be made no more than 90 days after CCHP makes a decision about the appeal.

If a member wants a fair hearing they can send a written request to:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

If a member needs help writing a request for a fair hearing, call either the BadgerCare Plus and Medicaid SSI Ombuds at 1-800-760-0001 or the HMO Enrollment Specialist at 1-800-291-2002.

UTILIZATION MANAGEMENT PROGRAM OVERVIEW

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 Plan 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

CCHP 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 1-414-266-4155. 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, 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 Plan must be medically necessary and a covered benefit.

Chorus Community Health Plan 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

CHORUS
COMMUNITY HEALTH PLANS

Retrospective reviews

A Retrospective review is an initial review of services that have been performed. Routinely, this process encompasses services performed by a non-participating provider when there was no opportunity for concurrent review, cases followed during concurrent review that could not be adequately assessed during the process because of the clinical need for a timely decision, and the consequent inability to get the medical record to a Medical Director in the required time frame. The CCHP UM/CM (utilization manager/case manager) or nurse designee reviews requests for retrospective authorization. If the supporting information meets medical necessity, the request will be authorized.

If the supporting information is questionable, the UM/ CM manager will request CCHP Medical Director review. The decision, whether to authorize or deny, is made within 30 days of obtaining all the necessary information. If approved, the appropriate authorization is entered in the system. If an adverse determination is made, the provider and member are notified of the denial in writing within five working days of the decision.

Discharge planning

Transitions in care present a risk for members. Transitional Care Management is one approach that aims to improve member outcomes and reduce potentially preventable readmissions through ensuring members receive the care they need immediately following a discharge from the hospital. Transitional Care Management is provided to all members discharging from an inpatient stay to home. Members are identified by the Utilization Management/ Case Manager (UMCM) during the utilization review process. All members discharging from a facility to home receive a phone call within (3) days post discharge by our UM/CM teams.

This is a method of coordinating care, controlling costs and arranging for the appropriate services upon discharge from the hospital. For patients who have not fully recovered or do not require the highly specialized and expensive services of acute hospital care, discharge planning ensures that the patient receives the most timely, appropriate, safe, and cost-effective discharge through home health care or appropriate placement in an extended care facility.
Discharge planning should occur as early as possible in a patient's hospital stay. The case manager reviews the post-hospital needs of the member. When necessary, the case manager works with the utilization review staff of the hospital, PCP and managing physician to arrange for services needed before the member is discharged from the hospital.

Emergency services

Emergency room services are available 24 hours a day, 7days a week. Coverage without prior authorization is provided.

Confidentiality

Confidential information is defined as any data or information that can directly or indirectly identify a patient or physician.
CCHP adheres to the following:

- All CCHP employees are required to sign a Confidentiality Statement.
- All members of the Medical Advisory Committee are required to sign a Confidentiality statement,
- All employees and practitioners are allowed to access and disclose confidential information as necessary to fulfill assigned duties and responsibilities.
- All medical information is secured under lock and key with access limited to essential personnel only.
- Medical information stored in the software system is protected under multiple levels of security by system configuration, which includes user access passwords.
- Confidential information is destroyed by inducing complete destruction when no longer needed.
- CCHP abides by all federal and state laws governing the issue of confidentiality.

Adverse determinations

In the event of an adverse determination, denied in accordance with UM policies and procedures, written notification is sent to the provider and the member.

This notification by CCHP includes the following:

- The principal reasons for the adverse determination
- The clinical basis for the adverse determination
- A description or the source of the screening criteria that were utilized as guidelines in making the determination
- The benefit provisions
- A description of the procedure for the appeal process including the address to which appeal should be sent

UTILIZATION MANAGEMENT DECISION CRITERIA

UTILIZATION REVIEW CRITERIA

Chorus Community Health Plan 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 Plan
Attention: 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 414-266-4155 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 Plan 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 Plan 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), Medical Advisory Committee (MAC), UM Committee which is a sub-committee to the MAC. The UM committee is responsible for reviewing all UM issues and related information and makes recommendations to the MAC. The UM program is reviewed and approved by the UM committee, MAC and the QOC yearly.

UTILIZATION MANAGEMENT: PRIOR AUTHORIZATIONS

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.

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. CCHP 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:

- CCHP 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.

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 CCHP does not review requests for services that have already been provided. Refer to the Appeals section of this manual.

PRIOR AUTHORIZATION FOR URGENT CARE

CCHP 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 PRE-SERVICE DECISIONS

CCHP 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

CCHP makes behavioral health care and non-behavioral health care decisions and notifications of the decision within 72 hours of the receipt of the request.

RETRO AND POST-SERVICE REQUESTS

CCHP 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.

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.

PLANNED INPATIENT HOSPITAL ADMISSIONS

CCHP requires notification of all inpatient admissions from in-network providers via our CareWebQI Auto-Authorization tool, which is available online 24 hours a day on our provider portal.

EMERGENCY CARE SERVICES

CCHP 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
- 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

Behavioral 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:

Certain services may be subject to exceptions. Contact Customer Service at 1-800-482-8010 to find out if the service needs prior authorization.

PRIOR AUTHORIZATION LIST

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

CAREWEBQI AUTO-AUTHORIZATION TOOL

Making sure you register for our Provider Portal is the key to accessing all of our services on our website. Our CareWeb QI 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.

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 CCHP 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 CCHP 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 414-266-4522 and:

- If you're a new provider to the Together with CCHP 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.
- 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 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 CCHP.
5. In approximately three business days, site administrators will receive another email from CCHP with their user login information and password.

REGISTERING ADDITIONAL USERS

Once the site administrator has registered for the CCHP Provider Portal, there are two options for registering additional users.

1. For site administrators registering individual users:
    - Go to the online registration form at togetherCCHP.org
    - Complete the fields with individual user's information

- Enter the organization's tax ID number
- 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

Designated contact

CCHP recognizes that a health care provider may designate one or more individuals as the initial contact or contacts for CCHP clinical services employees. In no event shall the designation of such an individual or individuals preclude a medical advisor from contacting a health care provider or others in his or her employment where review might otherwise be unreasonably delayed; or where the designated individual is unable to provide the necessary information or data requested.

Necessary information

When conducting routine utilization review, CCHP clinical services employees will collect only the information necessary to certify the admission, procedure or treatment, assign a length of stay goal or coordinate case management.

Second opinion

CCHP does not require a prior authorization for members to see in-network primary and specialty care providers. A member may obtain a referral from their primary care provider to a specialist (a prior authorization is not required) or make an appointment on their own to see in-network specialty care providers. If the service needed is not available within the CCHP network, CCHP staff will be available to assist the member in arranging for the service with an out-of-network provider.

Second opinion information may be required, when applicable, to support medical necessity criteria. These items will only be requested when relevant to the utilization review issue in question and as appropriate from the beneficiary, plan sponsor, health care provider or health care facility. Chorus Community Health Plan will reimburse contracted providers for second opinions.

Significant lack of agreement

Information in addition to that described in this section may be requested by the clinical services employee or voluntarily submitted by the health care provider, when there is significant lack of agreement between the clinical services employee and health care provider regarding the appropriateness of certification during the review or appeal process.

"Significant lack of agreement" means that the clinical services employee has:

- Tentatively determined that a service cannot be authorized
- Referred the case to a medical director for review
- Talked to or attempted to talk to the health care provider regarding additional information

Sharing information

CCHP clinical services employees will share all clinical and demographic information on individual patients among various divisions (e.g., certification, discharge planning, case management) to avoid duplicate requests for information from members or providers.

UM reviewers are prohibited from making adverse medical necessity determinations. Requests for services that do not meet criteria for medical necessity are referred to the CCHP Medical Director.

Concurrent review

The Concurrent review process assesses the clinical status of the member; verifies the need for continued hospitalization; facilitates the implementation of the provider's plan of care and ensures there is no delay in care; determines the appropriateness of treatment rendered and the level of care; and monitors the quality of care to ensure professional standards of care are met.

Information evaluated during the Concurrent review includes:

- Clinical information to support the appropriateness and level of service proposed
- Additional days/service/procedures proposed
- Reasons for extension
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care.

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay; with continued hospital stay approved based on the patient's condition. The need for case management or discharge planning services is evaluated during Concurrent review, meeting the objective of planning for the most appropriate and cost-effective alternative to inpatient care. If at any time, the services cease to meet inpatient or outpatient criteria, or if discharge criteria are met, or alternative care options exist, the UM/Case Management reviewer contacts the facility and obtains additional information to justify the continuation of services.

When the medical necessity for the case cannot be determined, the case is referred to the CCHP Medical Director for review. For inpatient services, a decision must be made within one working day of obtaining all the necessary information. If continuation of the service is denied, the CCHP Medical Director or designee informs the facility of the decision and their expedited appeal rights on the day of the determination. Written notification, including how to initiate an expedited appeal, will be sent to the facility and attending physician via the facility's UM department within one working day of the original verbal notification.

Inter-rater reliability

CCHP assesses the consistency with which physicians and registered nurses apply UM criteria in decision making. The assessment is performed as a periodic review by management to compare how staff members manage:

- The same case; or
- A forum in which the staff members and physician evaluate determinations; or
- Perform periodic audits against criteria.

As a result of this process, when an opportunity for improvement is identified, CCHP will take corrective action.

Out-of-network referrals

Referral requests must be completed well in advance of the service within the time frame specified by CCHP. Requests are faxed to CCHP Clinical Services at 414-266-4726 for processing. Urgent requests will have a decision and response within 24 hours of submission.

Secondary Insurance

As a CCHP provider there may be times when you are providing services or plan to provide services to a CCHP member

and you determine that CCHP is not the primary insurance carrier.

Please do not submit any request for authorization through the provider portal and/or submit medical claims for payment until you have billed the primary insurer. If a request is received and it is determined that CCHP is not the primary insurer, the request will not be processed. Providers should bill for coordination of benefits ONLY when the primary carrier has been billed and a remittance advice statement has been received showing a balance remaining. Coordination of Benefits is a process that defines which health carrier or insurance company pays as primary when a member has more than one source of coverage for health care benefits. As a Wisconsin Medicaid health plan, CCHP is considered the payer of last resort.

PRIOR AUTHORIZATIONS

Affirmative statement

CCHP 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 decision making is based only on appropriate- ness of care and service, and existence of coverage.
CCHP does 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.

Prior authorization list

CCHP maintains a list of items requiring prior authorization. You can download a current list from our Provider Resources page at childrenscommunityhealthplan.org.

Prior authorizations after the start of care

CCHP follows the Forward Health rule for submission of prior authorizations after the start of care.

- A prior authorization request may be backdated up to 14 calendar days from the first date of receipt by CCHP. For backdating to be authorized, the following criteria must be met:
  - The provider specifically requests backdating on the prior authorization request.
  - The request includes clinical justification for beginning the service before prior authorization was granted.
- CCHP receives the request within 14 calendar days of the start of the provision of services. (Submissions for non-urgent pre-service decisions — CCHP makes behavioral health and non-behavioral health decisions and notifications of the decision within 14 calendar days of receipt of the request.)
- For urgent pre-service decisions, CCHP makes behavioral health and non-behavioral health decisions and notifications of the decision within 72 hours of the receipt of the request.
- For post-service decisions, CCHP makes behavioral health and non-behavioral health decisions and notifications of the decision within 30 calendar days of the receipt of the request.
- For urgent Concurrent review, CCHP makes behavioral health and non-behavioral health decisions and notifications of the decision within 72 hours of the receipt of the request.

Prior authorization for urgent care

CCHP defines urgent care as any request for behavioral health 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:

- 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.

Planned inpatient hospital admissions

CCHP requires notification of all inpatient admissions from in-network providers via our CareWeb QI Auto-Auth tool, which is available online 24 hours a day on our provider portal

PRIOR AUTHORIZATIONS

- 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.

- Planned admissions to non-CCHP hospitals require a prior authorization. Out-of-network providers may submit their requests and supporting documentation by fax to 414-266-4726.

Emergency care services

CCHP 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 CCHP 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 CCHP within 24 hours of admission or the next business day.

Urgent or non-emergent care

Urgent or non-emergent 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 CCHP contracted facilities in the absence of the ability to see a practitioner 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.

Routine vision

- No referral is required
- Members must use Herslof opticians
- Routine vision services are covered annually
- Referral for medical conditions must be to in- plan ophthalmologists. See the CCHP Provider Directory for a list.

Durable medical equipment (DME)

- DME requires a prior authorization if the item is listed on the Prior Authorization list
- MUST USE IN-NETWORK PROVIDERS

Registering with **CCHP's** Provider Portal

Network providers must submit prior authorizations, notifications and requests through the CCHP Provider Portal. Only supporting documentation for clinical requests and submittals may be faxed to Chorus Community Health Plan at 414-266-4522.

Here's how registering with CCHP's Provider Portal works:

1. Pre-registration instructions
    - If you're a new network provider or haven't registered for the CCHP Provider Portal yet, please refer to the following instructions before you try to sign-on.
2. Choose a site administrator
    - Your organization must first designate a site administrator for the CCHP Provider Portal. You will need to use the CCHP Provider Portal in order to access other CCHP portals for services, such as prior authorizations, claim look-ups 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.
3. Obtain a registration code
    - First, site administrators will need to call our portal administrator to request a registration code at 414-266-4522, and:
    - If you're a new provider to the CCHP network, CCHP mails a letter with the registration code and instructions on how to complete portal registration. You should receive this letter within seven business days.
    - If you're an existing network provider, you'll receive your registration code by phone or email.
4. To complete online registration
    - Once the site administrator gets the registration code, they will need to complete their registration. Please see the Web Resources section of the manual for instructions on how to complete registration.

CLAIMS

Efficient processing of your claims

To allow for more efficient processing of your claims, we ask for your cooperation with the following:

- When submitting claims use the correct and complete member number. Using the correct member number on the claim helps ensure correct and timely claim payment.
- CCHP requires providers file claims in a timely manner. Claims must be submitted in accordance with the claim-filing limit outlined in your Provider Network Service 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

CCHP along with the denial for consideration. Members are required to follow CCHP's referral and prior authorization guidelines. Claims must be submitted within the timely filing guidelines along with the denial.

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

The table below indicates the list of data elements that are required on each claim submission. Listed are the appropriate box numbers from the CMS-1500 and UB- 04 claim forms for each required element.

REQUIRED INFORMATION	CMS-1500 CLAIM FORM	UB-04 CLAIM FORM	NOTES
Member Name	Box 2	Box 8	
Date of Birth	Box3	Box 12	
Member Number	Box 1.a	Box 60	10 for MA
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 State file
Federal Tax ID	Box 25	Box 5	
Total charges	Box 28		
Amount paid by other insurance (if appl.)	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	Must be registered as Performing and Billing with the State
Taxonomy code	Box 33b		

CHORUS COMMUNITY HEALTH PLANS

Corrected Claim Submission

Providers should submit corrected claims using the Corrected Claim Submittal Guide.

Prior Authorization Number

This is an optional use of Box 23 on the CMS-1500, or in the cause of UB-04 Box 63. This could also be submitted in the EDI segment 2300, Ref 02 if you would like to submit the claim via 837 EDI transaction. Please contact our Customer Service Center at 800-482-8010 with any questions regarding the required claim form fields.

Verifying your NPI and taxonomy

To verify your NPI and taxonomy, as you have them registered with the State, follow these steps:

1. Once you log into the ForwardHealth portal, you should see the information at the top that says you are logged in with: NPI 0000000000, taxonomy 111N00000X Zip 00000-0000.
2. In the right Home Page menu, click on "Check Enrollment"
3. When you use the Provider Search, you can enter your tax ID, NPI or provider name at this time. The Search Results will populate a list for each provider in group, including: NPI, Provider ID, Base ID, Financial Payer, Provider Name, Type, Specialty, Address, and taxonomy. If results don't populate, please call ForwardHealth Provider Services for assistance at 800-947-9627, Monday through Friday, 7:00 a.m. - 6:00 p.m. (Central Time, with the exception of state-observed holidays).

Claims for Qualified Treatment Trainees

Qualified Treatment Trainees (QTT's) can submit their claims on their own behalf. Chorus Community Health Plans will only allow payment for QTT's enrolled with Wisconsin Medicaid. The QTT must have a graduate degree and be working towards full clinical license. Providers must be entered in our system prior to submitting claims. The provider should send an email to the provider update mailbox CCHP-ProviderUpdates@chorushealthplans.org. Include QTT's first and last name, NPI, Group Tax ID, practice locations, practicing specialty, and effective date. You will be notified when the update is complete and you can then submit claims. Once QTT's are fully licensed they need to be credentialed. Please plan accordingly as this can take up to 90 days.

Coordination of Benefits (COBs)

BadgerCare Plus is always payer of last resort. If ForwardHealth has record of other health insurance coverage for the member during the same time frame they are effective with CCHP, the claim will be denied as other insurance primary. Please contact our Customer Care Center or Forward- Health with updates to a member's health insurance coverage should this information be incorrect.

After the primary insurance has processed the claim, the claim, along with the EOB, can be submitted to CCHP for consideration of supplemental payment.

- Should the primary insurance pay less than the CCHP allowable amount, CCHP will pay the difference, up to their allowable.
- If the primary insurance is a commercial plan and denies a Medicaid covered service, CCHP will reimburse for those covered services.
- If the primary insurance denied the entire amount to the contractual obligation-97, there is no financial responsibility to CCHP.
- In order for us to consider the charges, we would need an EOP from primary showing charges applied to patient's responsibility.

CCHP will coordinate benefits with another insurance company as long as the balance is below our allowed amount and

the member has followed their primary insurance's rules. If the member does NOT follow their primary insurance's rules, CCHP will deny the Medicaid claim.

CODES AND REIMBURSEMENT

Medicaid billing codes

Providers are expected to bill CCHP the same way they would bill Medicaid Fee- for-Service. Please continue to check the ForwardHealth website at forwardhealth.wi.gov for specific updates. This includes using the same National Provider Identifier (NPI) and taxonomy codes on our claims as those registered with the state.

Providers submitting claims to CCHP must include the corresponding modifier(s) to ensure appropriate reimbursement and reduce delays in payment. The cross references are as follows:

TYPES OF SERVICE (TOS)/DESCRIPTION	MODIFIER/DESCRIPTION
8 - Surgical Assistant	80 - Assistant Surgeon AS - Physician's Assistant
7 - Anesthesia (bill units by minutes)	AA - M.D. personally performed QX - CRNA or AA, M.D. medically directing one or more than one QZ - CRNA only, non- medically directed more than one QY - M.D. medically directing one CRNA QK - M.D. medically directing two, three, four CRNAs/AAs
P - Purchase new Durable Medical Equipment (DME)	NU
Q - Diagnostic Radiology, professional component (interpretation)	26 - Professional component
R - DME rental (per day)	RR – Rental
S - Radiation Therapy, professional component only	26 - Professional component
T - Nuclear Medicine, professional component only	26 - Professional component
U - Diagnostic Radiology, technical component only	TC - Technical component
W - Diagnostic Medical, professional component only (interpretation)	26 - Professional component
X - Diagnostic Lab, professional component	26 - Professional component

Billing multiple surgeries

Multiple procedures performed by the same provider during the same session are subject to multiple procedure reduction rules. CCHP assigns the procedures based on Relative Value Unit (RVU) assigned to each code for that place of service.

Covered procedures with the highest RVU will be reimbursed at 100% of the Medicaid Maximum Fee Schedule. Subsequent covered procedures will be reimbursed at 50%/25%/13%/13% based on the BadgerCare Plus Maximum Fee Schedule.

Modifier - 51 will be used to ensure the appropriate multiple procedure reduction is taken. All procedures should be reported at full fee to ensure appropriate reimbursement.

Co-Surgeons

CCHP reimburses each surgeon at 100 percent of Forward Health's usual surgeon rate for the specific procedure they have performed. Attach supporting clinical documentation (such as an operative report) clearly marked "co-surgeon" to each surgeon's paper claim to demonstrate medical necessity.

Surgical Assistance

CCHP reimburses surgical assistance services at 20 percent of the reimbursement rate allowed for the provider type for the surgical procedure. To receive reimbursement for surgical assistance, indicate the surgery procedure code with the appropriate assistant surgeon modifier ("80," "81," "82," or "AS") on the claim. CCHP will automatically calculate the appropriate reimbursement for assistant surgeon services based on the provider type performing the procedure.

Definitions:

1. RVU: The Physician Fee Schedule (PFS) Relative Value File assigns RVUs to most codes. Commonly known as the Medicare Physician Fee Schedule database. This file is available on the CMS website at: https://www.cms.gov/medicare/medicare-fee-for- service-payment/physicianfeesched/pfs-relative-val- ue-files.html

This also applies to ambulatory surgery claims.

- Assistant Surgeon claims will be processed following the rates dictated by the BadgerCare Plus Maximum Fee Schedule
- Multiple surgery reimbursement is 100/50/25/13/13 — based on the BadgerCare Plus Maximum Fee Schedule.

2. Ambulatory Surgery Facility claims - (bilateral procedures): Ambulatory services will be reimbursed a single facility fee (Revenue Code 510 – 516) based on the primary procedure performed. Additional reimbursement for Revenue Code 510 – 516 will not be allowed for bilateral procedures (modifier "50").

3. A bilateral procedure is defined as on which is performed on both sides of the body at the same session or on the same date of service. Bilateral surgical procedures are paid at 150% of the maximum allowable fee for the single service. When billing multiple bilateral procedures using modifier - 50 on each line, the first procedure will be reimbursed at 150%, and the second procedure at 75%.

Enhanced reimbursements for Pediatric services

Wisconsin BadgerCare Plus provides an enhanced reimbursement rate for the following services to members ages 18 and younger:

- Office and other outpatient services (CPT codes 99201-99215)
- Emergency department services (CPT codes 99281-99285)

To obtain enhanced reimbursement for members ages 18 and younger, indicate one of the applicable procedure codes and the modifier "TJ" in element 24D of the CMS-1500 claim form.

Health Professional Shortage Area

Wisconsin BadgerCare Plus provides enhanced reimbursement to primary care and emergency medicine providers that

provide care in or to members from areas designated as a Health Professional Shortage Area (HPSA). For a full list of counties and zip codes please refer to ForwardHealth's provider handbook.

CODES AND REIMBURSEMENT

The incentive payment for HPSA-eligible primary care and emergency medicine procedures is an additional 20% of the FFS Physician Maximum Allowable Fee. HPSA-eligible obstetrical procedures receive an additional 50%. Providers performing HealthCheck screenings in the HPSA areas should bill the HealthCheck modifier first since it has a higher reimbursement.

Procedure codes 99381-99385 and 99391-99395 are not eligible for HPSA incentive payments, regardless of the billing or rendering provider's or member's location, since reimbursement for these procedure codes includes enhanced reimbursement for Health Check services.

To obtain the HPSA-enhanced reimbursement

To receive additional reimbursement, providers must use the correct modifier. Indicate one of the following modifiers in element 24D of the CMS-1500 claim form:

Modifier	Description
AQ	Physicians providing services in a Rural or Urban HPSA area
AQ	Rural/Urban • Reimbursement for eligible procedure codes billed with the "AQ" modifier includes the pediatric incentive payment. • Do not bill "AQ" and "TJ" modifiers for the same procedure code.
TJ and AQ	Pediatric rate The modifier "TJ" can be billed for eligible services in situations that do not qualify for HPSA-enhanced reimbursement.
TH	Obstetrical treatment/services; prenatal* *Providers are **required to use the "TH" with procedure codes 99204 and 99213** only when those codes are used to indicate the first three antepartum care visits.

Tips to help avoid claims rejection

We understand providers want to receive prompt and accurate payments for services, so here are a few helpful hints to minimize claim rejection and/or claim payment errors.

- It's important for services to be coded accurately with valid Medicaid codes. Services are reimbursed according to BadgerCare Plus guidelines.
- CCHP will accept the two-digit place of service codes only. Contact our Customer Service Center if you would like a listing of these codes.
- Providers must bill with the same National Provider Identifier (NPI), taxonomy, and tax identifier number (TIN) that are registered with the State of Wisconsin BadgerCare Plus program. If these codes do not match, your claim will be rejected.

Claim Recoup/Refund Request Form

The purpose of the CCHP Claims Recoup/Refund Request Form (shown) is to make claim payment adjustments more efficient. When a claim has been paid incorrectly (zero payment, underpayment or overpayment), this form can be completed in lieu of resubmitting the claim or sending a refund check. When this form is used, adjustments are made on future remittances. If possible, please indicate the original claim number. This prevents resubmitted claims from being denied as a duplicate or for untimely filing. This form must be resubmitted within 60 days of the date of the denial.

Explanation of Payments

CCHP produces Explanation of Payments (EOPs) on a weekly basis. If your office would like to check the status of a claim or questions an item on the EOP, please contact our Provider Services department at 800-482-8010.

Claim adjustments

If a provider believes they were underpaid, they can contact our Customer Service Center and request an adjustment. Providers that identify they were overpaid should promptly return the overpayment to CCHP. In cases where CCHP discovers an overpayment, CCHP may offset the overpayment against other amounts due to the provider. (Please refer to your CCHP Provider Network Service Agreement for the handling of overpayments.) These adjustments will appear on the provider's EOP following the processing of future provider's claims.

Retroactive changes

Information received with retroactive effective dates will have an effective date assigned by the Wisconsin DHS as of the date the information was received by CCHP. Due to claim processing limitations, we are not able to enter retro- effective dates for any changes. This includes changes to address, TIN, NPI, name submitted directly or via any other source.

To avoid disruption in service or payment

All changes affecting a practice should be submitted at least 45 days in advance of the change to avoid disruption in service or payment. In addition to retroactive changes that affect the provider, if Wisconsin Department of Health Services (DHS) makes a change to fee schedules or processes, CCHP will not retroactively reprocess claims that have already been processed as of that date.

Providers under OIG investigation

CCHP does not pay providers who are under investigation by the Office of Inspector General (OIG). Any such provider will be termed from the network and removed from all provider directories. Also, any individual provider within a group who is under OIG investigation will have to contract independently in order to continue providing services to CCHP members. Simply requesting the TIN on a con- tract be changed is not allowed. There must be timely notification and a contract in place for the new TIN.

Medicaid certification status

All providers must be Medicaid certified at either the individual level or the group level, depending on their registration with ForwardHealth in order to participate in the CCHP provider network. If a Provider should lose certification, they will be termed immediately from the net- work. CCHP cannot pay claims for providers who are not Medicaid certified. This is a requirement of your contract. If you are a provider for CCHP via your contract with Independent Physicians Network (IPN), this is also a requirement in that contract.

TIMELY FILING

Initial Claims Submissions Timely Filing Guidelines

The initial submission of a claim is subject to the CCHP timely filing guidelines. CCHP will give providers proof of receipt and confirmation of claims via the Electronic Claims Confirmation Report. Providers should review each report received to confirm that all claims were received by CCHP and were entered in to the claims processing system.

Exceptions to Initial Claim Submission Timely Filing Guidelines

- A Provider can request, in writing, a temporary extension of the claim-filing limit for just cause as determined by CCHP. This includes computer system conversions or other short-term circumstances. These requests should be made to the CCHP Provider Relations Manager.
- Coordination of Benefit (COB) claims must be received within the timely filing limit outlined in your agreement with CCHP; beginning with the date noted on the primary payer's explanation of benefits.
    - If a provider experiences complications obtaining patient insurance information from the member, claims must be received within the timely filing limit beginning with the date the CCHP coverage is identified, but not longer than 365 days from the date of service
    - A provider must have made at least two attempts to contact the member by phone or letter requesting primary insurance information. A provider shall submit supporting documentation that demonstrates measures taken to obtain the member's insurance information. Upon receipt of such information, the provider must submit claims and supporting documentation within the timely filing limit outlined in their agreement.
    - Providers should use the Corrected Claim form, which is available online, on our Provider Forms page at childrenscommunityhealthplan.org.

- When members change physicians during their pregnancy:
    - Claims for prenatal visits that would have been normally billed as part of a global obstetrics (OB) charge, must be billed separately since the member changed physicians
    - The claims must be submitted within the timely filing limit beginning with the date of delivery. CCHP will not accept a global obstetrical charge from a provider in this situation.

Resubmitting a claim

For each claim that doesn't pass the initial editing process:

- There's an associated rejection reason that shows why the claim didn't pass
- Based on the rejection reason, providers will need to make any necessary changes and resubmit the claim

Beginning with the date CCHP receives the claim, CCHP requires providers make any necessary changes and resubmit the claim within the allotted time frame agreed upon in their contract.

Claims resubmissions/corrections Timely Filing Guidelines

All resubmitted/corrected claims need to be received by CCHP within the filing limit.

- The first day of the filing limit for resubmissions/ corrections begins with the date CCHP notifies the provider a claim has failed processing. You will find this date on the Explanation of Payment (EOP) or Rejected Claims Report.

Exceptions to Timely Filing Guidelines on claim resubmissions:

- When a claim is rejected or denied as a result of CCHP's error, the submitted/corrected claim must be reviewed within one year of the EOP date.
- When the provider discovers new or additional information and requests additional payment on a processed and paid claim, such information must be received within 60 calendar days of provider's receipt of information.
- When a claim is rejected or denied as a result of CCHP's error, the submitted/corrected claim must be reviewed within one year of the EOP date.

Electronic Claims Transmission confirmation

CCHP provides 100% confirmation on all new claim submissions. Confirmation of receipts are generated and sent to providers for all claims received by CCHP, whether it is filed on paper or through Electronic Claims Transmission.

EFT AND CONFIRMATION PORTAL

Enrolling in the EFT program

Provider's option to initiate enrollment:

1. Enroll online at changehealthcare.com. Please fill out the Epayment Enrollment Authorization Form and submit the required validation paperwork with your Enrollment Form.

Questions? If you're already receiving your payments and EOPs electronically and encounter a problem, please call Change Healthcare at 866-506-2830, option 3.

To complete EFT enrollment

After the information is verified, Change Healthcare emails a Welcome Kit to the provider with account information and instructions for completing enrollment, including setting payer preferences and adding bank accounts. For more information about Change Healthcare ePayment, providers can visit changehealthcare.com.

Providers can also find more EFT information on the Frequently Asked Questions section of CCHP's Provider Tool Kit, which is available on the Provider Resources page at childrenscommunityhealthplan.org.

The CCHP Confirmation Portal

CCHP provides confirmation on all new claim submissions for network providers. For every claim received by CCHP, whether it is filed on paper or through EDI, a receipt confirmation is generated and available to the provider of service.
Registering for the Claims Confirmation Portal Providers will need to register before they can access the Claims Confirmation Portal:

- A CCHP Provider Relations Representative will need to verify the provider is an in-network provider
- Once verified, the Provider Relations Representative emails the provider instructions for registering
- To register, please contact your Provider Relations Representative at 844-229-2775

Benefits of Claims Confirmation Portal
Providers who have access to the Claims Confirmation Portal can:

- Confirm all their claims were received by CCHP and were entered into the claims processing system, whether submitted on paper or electronically
- Receive an electronic report of rejected claims through this portal

Printed confirmations
Providers who don't have access to the Claims Confirmation Portal, receive:

- A printed letter listing the specific claim that didn't pass the initial editing process, as well as an associated rejection reason
- A printed copy of the claim

Resubmitting a claim
For each claim that doesn't pass the initial editing process:

- There's an associated rejection reason that shows why the claim didn't pass
- Based on the rejection reason, providers will need to make any necessary changes and resubmit the claim
- Beginning with the date CCHP receives the claim, CCHP requires providers make any necessary changes and resubmit the claim within the allotted time frame agreed upon in their contract

Electronic Claims Transmission Confirmation Reports

Providers who submit claims electronically can access a Confirmation Report through our Claims Confirmation Portal. Providers should review each report received to confirm all claims were received by CCHP and entered into the claims processing system. The Confirmation Report confirms the number of claims received and the total dollar amount associated with those claims.

- Claims submitted on a CMS-1500 form will be listed alphabetically and totaled.
- Claims submitted on a UB-04 will be listed together alphabetically and totaled.

If the totals on the report do not match the provider's totals, this may indicate that there was a problem with the transmission. If you have questions or are experiencing problems with transmitting, contact CCHP's third-party administrator at 800-356-7344 (ext. 4320).

Electronic HIPAA transactions

According to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, conducting certain transactions "electronically" are subject to the HIPAA regulations. In addition to or instead of paper EOPs, many providers prefer to receive and post their payments via our 835 HIPAA transactions, which is avail- able through our third-party administrator. Chorus Community Health Plan providers may sign-up to receive 835 transactions at http://www.deancare.com/health-insurance/quality/hipaatransactions.

Electronic HIPAA transactions

According to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, conducting certain transactions "electronically" are subject to the HIPAA regulations. In addition to or instead of paper EOPs, many providers prefer to receive and post their payments via our 835 HIPAA transactions, which is avail- able through our third-party administrator. Chorus Community Health Plan providers may sign-up to receive 835 transactions at https://www.deancare.com/health-insurance/quality/hipaatransactions.

Types of HIPAA transactions

- A Health Care Claim Payment/Advice (835) transaction is mainly used for health care insurance plan institutions to make payments to health care providers, and to give Explanations of Payment (EOP). It has charges that were paid, reduced, or changed, and how the payment was made (such as through a clearinghouse).
- Health Care Claim Institutional & Professional (837) uses both NPI Type 1 and NPI Type 2, whichever is applicable to the appropriate claim form being used.
- A Health Care Claim Status Inquiry (276) transaction is used by health care providers to check on the status of a submitted claim.
- A Health Care Status Response (277) transaction is used by payers to report on the status of previously submitted claims.

Getting started with EDI transactions

To set up Electronic Data Interchange (EDI) transactions with CCHP, please enroll with your clearinghouse first. Once enrolled, please provide us with your clearinghouse information by completing CCHP's EDI Setup Form. This form and a 276/277 Companion Guide are online at childrenscommunityhealthplan.org.

CHORUS COMMUNITY HEALTH PLANS

EFT AND CONFIRMATION PORTAL

If you have questions on how set up EDI transactions or are experiencing problems, please contact CCHP's third-party administrator at 800-356-7344 (ext. 4320).

Electronic payments/Remit Advices

Emdeon® through Dean Health Plan (DHP) manages providers' electronic payments (ePayments) from various payers. Emdeon ePayment replaces paper- based claims payments with electronic funds transfer (EFT) payments that are directly deposited into the provider's bank account.

APPEALS

The CCHP provider appeals process

We no longer accept paper appeals and will return paper appeals to providers instructing providers to submit appeals via the portal. Portal access and information can be found on our website at chorushealthplans.org.

No punitive action is taken by a CCHP provider against anyone who requests an expedited resolution of an appeal or supports a member's appeal.

How to submit appeals via the portal

1. Select "Providers," then provider portal in the dropdown.
2. Choose Badgercare Plus Claims Look-Up Tool and select "sign up."

The registration guide and user guide can also be found on the portal page.

**Please note: Administrators will be responsible for setting up their organizations prior to individual providers registering. Once Chorus Community Health Plans approves the administrator they can then have their individual providers register. The administrators will be responsible for approving their individual providers. Individual providers will not have access until their administrator approves. If you have any questions, please send a detailed email with your user name, NPI number, and tax ID number to: CCHPProviderRelations@ChorusHealthPlans.org.

Final determination appeals

CCHP 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.

Providers must use this form when submitting a provider appeal for State review. All elements of the form must be completed and all of the required documents (i.e., copy of the claim, copy of the payment denial remittance, copy of the appeal letter and response, and medical records for appeals regarding medical necessity) must be included with the appeal or it will be returned to the provider.

- Appeals to the DHS must be submitted in writing within 60 days of CCHP's response. In the case of no response, within 60 days from the 45-day timeline allotted the HMO to respond.
- DHS will accept comments from both parties and has 45 days from the date of receipt of all written comments to respond.

APPEALS

Wisconsin DHS final determination appeal requirements
If you disagree with this determination, you may appeal the decision to the Department of Health Services through the Provider Appeals portal at https://wi-appeals.entellitrak.com/ within 60 days of this letter.

Providers are required to submit appeals with legible copies of all supporting documentation as outlined in the Appeals to BadgerCare Plus HMOs and Medicaid SSI HMOs (#384) and Appeals to ForwardHealth (#385) topics of the ForwardHealth Online Handbook.

The decision to overturn an HMO's/PIHP's denial must be clearly supported by the documentation the provider submits. Submitting incomplete or insufficient documentation may lead to ForwardHealth upholding the HMO's/PIHP's denial.

PROVIDER WEBSITE

Our website address is childrenscommunityhealthplan.org, and we continually monitor its functionality to improve usability, accuracy and timeliness of content, as well as processes for posting.

Finding helpful links, tools and guides
Our website at childrenscommunityhealthplan.org, offers our providers the resources they need to be efficient in providing excellent care to our members.

We have compiled links, forms, documents, and guidelines frequently requested by our providers, including:

- Provider Directory
- Corrected Claim Submittal Guide
- Clinical and patient forms
- Referral for case or disease management forms
- CCHP Electronic Data Interchange (EDI) Setup form with 276/277 Companion Guide
- Provider Demographic Update/Change form
- The CareWeb QI authorization portal and the Emdeon claims look-up portal

Accessing Provider Directory Information
CCHP offers a Provider Directory to ensure our members are receiving the most current information about their providers, and finding the best possible care for their health care needs. You can access the Provider Directory on our Provider Resources page at childrenscommunityhealthplan.org. You can search by provider's name, location, and specialty.

The Provider Directory 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 Demographic Update/ Change form, which is available on the Provider Forms page at childrenscommunityhealthplan.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 (Up to 100 characters)
- 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

PROVIDER WEBSITE

For questions or if you need assistance completing the online Provider Demographic Update/Change form, please contact your Provider Relations Representative by phone at 844-229-2775 or by email at cchp-providerupdates@chw.org.

FRAUD, WASTE AND ABUSE

Chorus Community Health Plan is required to cooperate with regulatory, administrative, 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 (FWA) and to comply with the Centers for Medicare and Medicaid Services (CMS) mandatory requirement that providers receive this training and education. CCHP regularly performs claims audits to monitor billing practices as part of its anti-fraud, waste and abuse efforts. Regardless of the time period that has elapsed since a payment was made and within statute guidelines, if CCHP finds that it overpaid Provider on any claim or paid a claim in error due to FWA, CCHP has the right to recoup payments from Provider or offset unrelated payments to correct for any payment errors or audit findings.

Regulatory definitions

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, client-directed/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.

DHS is not a party to complaints, lawsuits, or other actions taken due to action taken by the HMO, because the contract between the HMO and the network provider is between two private entities.

If the HMO makes or receives annual payments under the contract of at least $5,000,000, written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about right of employees to be protected as whistleblowers.

Whistleblowers should report program integrity concerns to the DHS OIG. Whistleblowers may make a report through the hotline (877-865-3432) or through the online portal: (https://www.reportfraud.wisconsin.gov/RptFrd).

CREDENTIALING

This policy outlines Chorus Community Health Plan's (CCHP) process for Credentialing and Re-credentialing 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 – 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 process it uses 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 Providers – 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.

CREDENTIALING

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 behavioral 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:

a. 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
b. 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 at the sole discretion of CCHP

c. Doctors of Chiropractic Medicine (DC) must graduate from a chiropractic school
d. Doctors of Dental Surgery (DDS) or Doctors of Medicine in Dentistry (DMD) must graduate from dental school
e. Doctors of Podiatric Medicine (DPM) must graduate from podiatry school and successfully complete a hospital residency program
f. 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:
    1. 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:
    b. Doctoral degree in clinical, counseling psychology or equivalent field of study from an institution accredited by the American Psychological Association (APA)
    c. 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
    d. 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 behavioral-health field
4. Clinical Nurse Specialist (Psychiatry)
    e. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and Behavioral Health nursing
    f. 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
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
    a. 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, which are Effective: 2/1/06 Reviewed: Revised: 9/26/19 Policy Owner: Provider Relations/Credentialing Manager 7 reviewed by the CMO and at their discretion, may be reviewed by the Credentialing Committee for a determination of LIP's acceptance into CCHP network
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

CHORUS COMMUNITY HEALTH PLANS

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/recredentialing
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.

Credentialing System Controls

A. Primary Source Verification (PSV)
    a. Receive
        i. Electronically credentialing staff queries the applicable verification site
    b. Store
        i. Information is printed to hard copy and placed in practitioner file and stored into locked file cabinet
    c. Review
        i. Reviewed by credentialing staff and CMO in hardcopy
    d. Track & date
        i. Credentialing staff utilizes a checklist to track PSVs and initial and date each verified form
B. Tracking Modification
    a. Credentialing staff will initial and date on application when modified
    b. Modifications are made manually to the file
    c. When e-mail confirmation is available from practitioner the credentialing staff will attach into the file
    d. If application is not complete the credentialing staff will reach out to the practitioner for additional information and modify per direction of practitioner
    e. When checking Medicaid certification number the credentialing staff will edit the application after checking Forward Health if the number was submitted incorrectly

C. Authorization to modify
  a. Credentialing specialist/associate and CMO have authority to access, modify and delete information when circumstances for modification are deemed appropriate such as:
    - Discrepancies are identified by practitioner, credentialing staff, or CMO

D. Securing Information
  a. Credentialing staff only, have access to the locked file cabinets where practitioner files are stored. The credentialing specialist keeps the key for the locked storage cabinets

E. Credentialing Process Audit
  a. Quarterly the credentialing specialist will choose a random sample of credentialed practitioner files that were completed in that quarter. The sample will be 5% from each credentialing associate

PROCEDURE

Practitioner Credentialing Process

A. Chief Medical Officer Review:
  a) The CMO conducts a preliminary review of all credentialing and re-credentialing application files
  b) The CMO documents approval of "clean files, with his/her signature and date. Clean files are presented to the Credentialing Committee for review
  c) If the CMO has questions about a file or it appears that the applicant does not meet clean file criteria the CMO shall forward the application to the Credentialing Committee for recommendation, denial or deferral

B. Credentialing Committee Review
  a) The information provided to the Credentialing Committee shall include the applicant's profile and documentation related to the issue(s) in question. If the file contains sufficient information that meets established eligibility criteria in the Credentialing Committee's discretion, the committee may issue a vote to recommend enrollment of the applicant and document such approval in the meeting minutes. If the Credentialing Committee denies an applicant for failure to provide sufficient information, such discussions and vote are documented in the meeting minutes
  b) The Credentialing Committee may request further information from any persons or organizations, including the applicant, in order to assist the evaluation process. If the applicant does not provide the requested information by specified due date, the application or credentialing request will be closed. An application closed due to failure to provide requested information when due will not be considered a denial that triggers appeal rights
  c) The Credentialing Committee may approve, deny, or defer an application for further review
  d) The Credentialing Committee shall review the applicant's profile and documentation. If the Credentialing Committee determines that an applicant meets established eligibility criteria, the Credentialing Committee may issue a vote to accept the applicant and document such approval in the meeting minutes. If the Credentialing Committee denies and applicant for failure to provide sufficient information or otherwise meet specified criteria, such discussions and vote are documented in the meeting minutes. The Credentialing Committee may defer any matter to the CMO for further review
  e) The Credentialing Committee may request further information from any person or organizations, including the applicant, in order to assist with the evaluation process. If the applicant does not provide the requested information by the specified due date, the application or credentialing request is closed. An application closed due to failure to provide requested information when due will not be considered a denial that riggers appeal rights.

C. Applicants are notified via signed letter from the CMO of the acceptance or denial of their credentialing or re-credentialing request within 30 days of the Credentialing Committee
D. CCHP will verify and approve or deny an application within 60 days from the date of receipt of the completed application. If CCHP requires additional information from the applicant, CCHP shall send a written request to the applicant. If the applicant does not respond within the timeframe specified, the application will deemed incomplete and closed with no further action. Such actions does not trigger appeal rights
E. Acceptance of an applicant into CCHP's network is conditioned upon the applicant's signature on the applicable network agreement. Indication by the Credentialing Committee that the applicant meets the credentialing criteria does not create a contract between the applicant and CCHP. The applicant is not considered a network provider and is not entitled to treat covered persons or receive payment from CCHP until the network agreement is signed by both parties with a specified effective date

Re-credentialing Process for Practitioners

A. CCHP re-credentials practitioners and organizational providers at least every 36 months to assure that the practitioner or organizational provider is in good standing with state and federal regulatory bodies, has been reviewed and approved by an accrediting body (as applicable), and continues to meet CCHP participation and quality improvement requirements. CCHP's Provider Relations & Contracting Representative is responsible for notifying the credentialing staff of any potential contracts with organizational providers
B. CCHP will send notification via e-mail, fax or by US postal service two months prior to the re-credentialing due date to the credentialing contact of the clinic/group. CCHP will send a final notice one month prior to the due date of the re-credentialing application. The notice will state that if the required information is not provided by the due date that the applicant will be terminated from CCHP's network effective on the due date of the re-credentialing applicants are informed at the time of termination that they are eligible to re-apply at any time
C. All terms, criteria requirements, and process set forth above, relating to initial credentialing shall apply to re-credentialing unless otherwise stated in those sections
D. In addition, the following information shall be provided at re-credentialing:
    a. The applicant will update CCHP with any changes in work history, current board certification and additional education
    b. The applicant must have demonstrated compliance with all terms of the network agreement, specifically including completion of individual improvement plans requested by CCHP
    c. A new attestation must be submitted within two months of re-credentialing due date
E. The applicant is required to complete the requested updates and send notification to such to credentialing staff by the specified due date
F. Re-credentialing applications or requests will be reviewed by the Credentialing Committee including but not limited to, the malpractice history of potential quality of care or service concerns found, the Credentialing Committee will conduct a thorough review of these findings. CCHP will verify current board certification and additional education, if applicable
G. The Credentialing Committee has the authority to approve an applicant's participation in CCHP's network. If the Credentialing Committee is unable to approve a practitioner or organizational provider, it may deny participation in CCHP's network.

PROVIDER SUSPENSION TERMINATION APPEAL RIGHTS

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, and 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.

   A. 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

   B. 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

CHORUS COMMUNITY HEALTH PLANS

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;
        i. illegal drugs;
        i. 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 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.

PROVIDER SUSPENSION TERMINATION APPEAL RIGHTS

RIGHT TO APPEAL/PRE-APPEAL PROCESS

A. Right to an Appeal. 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:
   1. Termination of participation in CCHP's Network; or
   2. Restricting participation in CCHP's Network.
   3. The appeal shall be heard via telephone conference unless an in-person format is agreed upon in writing by the QOC.

B. 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:
   1. The action proposed to be taken;
   2. The reasons for the proposed action;
   3. That the Practitioner has a right to an appeal and that the
   4. Practitioner may appear in person or by telephone;
   5. That the Practitioner has thirty (30) days after receipt of the notice within which to submit a written request for an appeal;
   6. A summary of the Practitioner's rights in the appeal;
   7. 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
   8. 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.

C. 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:
   1. Issuance of a letter of guidance, correction, counsel, warning, or reprimand;
   2. Failing to meet contractual obligations or qualifications specified in CCHP's Credentialing policies or in the Practitioner's network agreement;
   3. Summary suspension, unless it exceeds fourteen (14) days in duration;
   4. Determination that an application is incomplete;
   5. Determination that an application will not be processed due to a misstatement or omission;
   6. Determination of ineligibility based on a failure to meet eligibility criteria, upon initial credentialing, re-credentialing or during the term of participation; or a lack of need for the Practitioner's specialty services.

D. 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

E. 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:
   i. copies of, or reasonable access to, all patient medical records referred to in the statement of reasons at the individual's expense;
   i. reports of experts relied upon by the Credentialing Committee
   i. copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
   iv. 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 (10) 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

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's 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.

a. 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.
b. 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
c. Before the close of the appeal, each side may briefly summarize its position for the Appeals Committee if it chooses.
d. 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

e. 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.

f. 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.

g. 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

<u>REPORTING TO AUTHORITIES</u>

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.

TELEHEALTH POLICY

To ensure that services provided to Chorus Community Health Plan (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.

Practitioners cannot provide telehealth services to CCHP members until a site visit of the originating site is conducted.

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 islocated.

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 behavioral 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, 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 behavioral 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, causing 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 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.

Compliance

A provider group shall ensure that its providers, employees and other personnel comply with all applicable federal and state laws, regulations, and rules including, without limitation, rules and regulations of the Wisconsin Department of Health Services ("DHS") governing services rendered to BadgerCare Plus HMO program beneficiaries. DHS rules include its Civil Rights Compliance ("CRC") Plan requirements. Information about these CRC requirements can be found at https://www.dhs.wisconsin.gov/civil-rights/index.htm.

Americans with Disabilities Act of 1990

Section 12182 of the Americans with Disabilities Act of 1990 prohibits discrimination against individuals with disabilities in everyday activities, including health care services. Similarly, Section 504 of the Rehabilitation Act of 1973 prohibits discrimination against individuals with disabilities on the basis of their disability in programs or activities that receive federal financial assistance, including health care programs and services. These statutes require health care providers make their services available in an accessible manner.

DELEGATED CREDENTIALING

PURPOSE OR DESCRIPTION:

When Chorus Community Health Plan (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 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.

MEMBER COMPLAINTS AND APPEALS PROCESS

A complaint defined

A complaint is a general term used to describe if the CCHP member is not satisfied with their health plan or provider. A complaint may be oral or written, and may include:

- Access to care problems, such as the member can't get a service, treatment or medicine they need
- The member's plan denies a service and says it's not medically necessary
- The member has to wait too long for an appointment
- The member got poor care or were treated rudely
- The member's plan does not pay them back for emergency care that they had to pay for
- The member received a bill they believe they should not have to pay

An appeal defined

An appeal is an oral or written expression of dissatisfaction with the decision CCHP gave the member when the member complained, or when they are dissatisfied with CCHP's decision to deny or limit authorization or coverage of a requested service. The member or their authorized representative can file an appeal within 90 days or our decision concerning any matter.

These matters may include, but are not limited to:

- Quality of care or services provided
- Rudeness by a provider or employee
- Failure to respect your member rights
- The type or level of service
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of a payment for service

CCHP would like to know if the member has a complaint or wants to appeal a decision about their care or services they receive from CCHP.

The member can call us if they have a complaint or appeal, or write to us at:

Chorus Community Health Plan
Attn.: Complaint/Appeal
Department P.O. Box 1997, MS6280
Milwaukee, WI 53201-1997

An expedited complaint or appeal

If the CCHP member complaint or appeal needs action right away because a delay in treatment would greatly increase the risk to their health, call CCHP as soon as possible at 800-482-8010. CCHP cannot treat the CCHP member differently from other members because they file a complaint or appeal. The CCHP member's health care benefits will not be affected.

A fair hearing

The member has the right to appeal to the State of Wisconsin Division of Hearings and Appeals for a fair hearing if the member believes their benefits are wrongly denied, limited, reduced, delayed or stopped by CCHP.

- An appeal of this type must be made no later than 45 days after the date of the action being appealed. If the member makes an appeal before the effective date, the service may continue.
- The member may need to pay for the cost of services if the hearing decision is not in the member's favor.
- If the member wants a fair hearing, they can send a written request to:

  Department of Administration Division of Hearings and Appeals
  P.O. Box 7875
  Madison, WI 53707-7875

Language Services Resources

LANGUAGE SERVICES RESOURCES

If you or someone you're helping has questions about Chorus Community Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-482-8010.

ALBANIAN
Nëse ju, ose dikush që po ndihmoni, ka pyetje për Chorus Community Health Plans, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-800-482-8010 (TTY: 711)

GERMAN
Falls Sie oder jemand, dem Sie helfen, Fragen zum Chorus Community Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-482-8010 an (TTY: 711)

POLISH
Jeśli Ty lub osoba, której pomagasz macie pytania odnośnie Chorus Community Health Plans, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-482-8010 (TTY: 711)

ARABIC
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Chorus Community Health Plans فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب) 1-800-482-8010 (TTY: 711)

HINDI
यदि आपके ,या आप दवारा सहायता ककए जा रहे ककसी वयकतत के Chorus Community Health Plans के बारे में परशन है ,तो आपके पास अपनी भाषा में मुफत में सहायता और सूचना परापत करने का अधधकार है। ककसी दुभाषषए से बात करने के लिए 1-800-482-8010 पर कॉल करें। (TTY: 711)

RUSSIAN
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Chorus Community Health Plans то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-482-8010 (TTY: 711)

BURMESE
Chorus Community Health Plans နှင့်ပတ်သက်၍ သင် သို့မဟုတ် သင်အကူအညီပေးနေသူ တစ်ဦးတွင် မေးမြန်းစရာများ ရှိမည်ဆိုပါက၊ အကူအညီနှင့် သတင်းအချက်အလက်များကို အခမဲ့သင် ရယူပိုင်ခွင့် ရှိပါသည်။ စကားပြန်ဆိုသူ တစ်ဦးထံသို့စကားပြောဆိုရန်၊ 1-800-482-8010 တွင် ဖုန်းခေါ်ဆိုပါ။ (TTY: 711)

HMONG
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Chorus Community Health Plans, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-800-482-8010 (TTY: 711)

SOMALI
Haddii adiga iyo qof aad caawinaysaa su'aalo qabaan ku saabsan Chorus Community Health Plans, waxaad leedahay xaqa aad caawimo ku hesho iyo macluumaadka luqaddaada iyaddoon kharash kugu fadhiyin. Lahadal turjubaan wac 1-800-482-8010 (TTY: 711)

CHINESE
如果您，或是您正在協助的對象，有關於[插入項目的名稱面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯，請撥電話［在此插入數字 1-800-482-8010 (TTY: 711)

KOREAN
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Chorus Community Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 애기하기 위해서는 1-800-482-8010 로 전화하십시오 (TTY: 711)

SPANISH
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Chorus Community Health Plans tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-482-8010 (TTY: 711)

ENGLISH
If you or someone you're helping has questions about Chorus Community Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-482-8010 (TTY: 711)

LAOTIAN
ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມີຄໍາຖາມກ່ຽວກັບ Chorus Community Health Plans ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການເວົ້າກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-800-482-8010 (TTY: 711)

TAGALOG
Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Chorus Community Health Plans, may karapatan ka na makakuha nga tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-482-8010 (TTY: 711)

FRENCH
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Chorus Community Health Plans vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-482-8010 (TTY: 711)

PENNSYLVANIA DUTCH
Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Chorus Community Health Plans, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-800-482-8010 uffrufe (TTY: 711)

VIETNAMESE
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Chorus Community Health Plans quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-482-8010 (TTY: 711)

Revised 8/6/2024

CHORUS COMMUNITY HEALTH PLANS