Thank you for choosing to participate in the provider network of Children’s Community Health Plan (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 Children’s Community Health Plan Customer Care Center.

About BadgerCare Plus with CCHP
Children’s Community Health Plan (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: childrenscommunityhealthplan.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 be mailed to them at no charge.

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

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

The use of the term “Provider” in this manual
CCHP acknowledges that the National Committee for Quality Assurance (NCQA) differentiates between a practitioner (person) and a provider (facility). We follow this guidance on this manual’s cover. However, to simplify the text within this manual, we have decided to use the term “provider” as an all-encompassing term that includes facilities as well as physicians, practitioners, and any other staff who are directly or indirectly contracted to provide 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@chw.org.
Service Area
We offer our members access to the highest quality health care and services with the combined resources of Children’s Hospital of Wisconsin, Children’s Community Services, Children’s specialty and primary clinics, as well as our community partners.

BadgerCare Plus service area:
- Brown
- Door
- Calumet
- Jefferson
- Kenosha
- Manitowoc
- Milwaukee
- Oconto
- Outagamie
- Ozaukee
- Racine
- Shawano
- Sheboygan
- Walworth
- Washington
- Waukesha
- Waupaca
- Winnebago

Care4Kids service area:
- Milwaukee,
- Kenosha
- Ozaukee
- Racine
- Walworth
- Washington
- Waukesha

CHILDREN’S COMMUNITY HEALTH PLAN POLICY CHANGES:
POLICY CHANGES CAN BE FOUND ON CCHP’S WEBSITE.
# CCHP PROVIDER RELATIONS TEAM

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations Manager</td>
<td>Dawn Rady</td>
<td><a href="mailto:drady@chw.org">drady@chw.org</a></td>
</tr>
<tr>
<td>Senior Provider Relations Rep.</td>
<td>Diana Schneider</td>
<td><a href="mailto:dschneider2@chw.org">dschneider2@chw.org</a></td>
</tr>
<tr>
<td>Provider Relations Rep.</td>
<td>Tina Powell</td>
<td><a href="mailto:tpowell@chw.org">tpowell@chw.org</a></td>
</tr>
<tr>
<td>Provider Relations Rep.</td>
<td>Stacey Martinez</td>
<td><a href="mailto:smartinez@chw.org">smartinez@chw.org</a></td>
</tr>
<tr>
<td>Provider Contracting Specialist</td>
<td>Sue Gorecki</td>
<td><a href="mailto:sgorecki@chw.org">sgorecki@chw.org</a></td>
</tr>
<tr>
<td>Provider Network Specialist</td>
<td>Blia Lor</td>
<td><a href="mailto:blor@chw.org">blor@chw.org</a></td>
</tr>
<tr>
<td>Provider Network Specialist</td>
<td>Lauren Bergmann</td>
<td><a href="mailto:lbergmann@chw.org">lbergmann@chw.org</a></td>
</tr>
</tbody>
</table>

# CCHP Provider Relations Representatives

To inquire about billing, contracting or other provider services. For claims-related questions, please call the CCHP Customer Service Center.

<table>
<thead>
<tr>
<th>CCHP Customer Service Center</th>
<th>1-800-482-8010</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCHP Clinical Services Department</td>
<td>414-266-5707 or 1-877-227-1142</td>
</tr>
</tbody>
</table>

# 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

<table>
<thead>
<tr>
<th>Electronic Funds Transfer (EFT) Remits</th>
<th>1-866-506-2830, option 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change Healthcare through Dean Health Plan manages EFT services. If you aren’t receiving your EFT remit, please call Emdeon.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ForwardHealth Provider Services Call Center</th>
<th>1-800-947-9627</th>
</tr>
</thead>
<tbody>
<tr>
<td>To inquire on member eligibility and benefits.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ForwardHealth Member Services</th>
<th>1-800-362-3002</th>
</tr>
</thead>
<tbody>
<tr>
<td>To request a replacement card.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HMO Enrollment Specialist</th>
<th>1-800-291-2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>To change HMO.</td>
<td></td>
</tr>
</tbody>
</table>
| **Interpreter Services** | **Phone:** 414-607-8766  
**Fax:** 414-607-8767  
**PAGER:** 414-201-0014  
**Email:** schedule@langsourc.com  
**Wisconsin VRS:** 1-800-947-3529 (or 711) |
|---|---|
| • On-site interpreter services are provided to CCHP members through Language Source.  
• Telephonic interpreter services are provided to CCHP members through Pacific Interpreters. Please call a CCHP Provider Relations Representative to request this service.  
• For sign language services, call a CCHP Member Advocate | |
| **Member Advocate** | **1-877-900-2247** |
| Help members find in-network providers, schedule appointments, resolve member billing issues and review eligibility in the BadgerCare Plus program. | |
| **CCHP on Call Nurseline** | **1-877-257-5861** |
| Nurses are on duty 24 hours a day, seven days a week to help answer healthcare questions. | |
| **Prior Authorization/Notification of Admissions** | **childrenscommunityhealthplan.org** |
| 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. | |
| **Provider Portal Registration** | **414-266-5747** |
| | |
| **Utilization Review Department** | **414-266-5707 or 1-877-227-1142** |
| | |
| **Pharmacy Services** | **www.forwardhealth.wi.gov** |
| 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. | |
| **Routine Dental Services** | **414-389-9870** |
| 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. | |
| **Transportation Services** | **1-866-907-1493** |
| Bus, taxi, special medical vehicle and other common carrier transportation is handled through the State of Wisconsin Department of Health Services transportation manager. | |
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

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.

<table>
<thead>
<tr>
<th>Standards</th>
<th>Scheduled Appointment Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td>For a life-threatening situation, members are instructed to go to the nearest emergency room or call 911 for immediate medical attention</td>
</tr>
<tr>
<td>Urgent Care Clinic or Urgent Care Walk-in Clinic</td>
<td>Member is to call PCP’s office first to see if PCP is available. Medical attention same day, no appointment needed.</td>
</tr>
<tr>
<td>Nonurgent Sick Visit</td>
<td>Medical attention within two calendar days of member’s notification</td>
</tr>
<tr>
<td>Routine Primary Care Routine Well-Baby Visits</td>
<td>Visit within 30 calendar days of member’s request</td>
</tr>
<tr>
<td>Preventive Care – Immunizations, Routine Physical Exam</td>
<td>Visit within 30 calendar days of member’s request</td>
</tr>
<tr>
<td>High-risk Prenatal</td>
<td>Visit Appointment Visit within two weeks of member’s request or within three weeks if the member’s request is with a certain doctor</td>
</tr>
<tr>
<td>After-hours Access Standards — 24-Hour Accessibility</td>
<td>All network providers must be available, either directly or through coverage arrangements 24 hours a day, 7 days a week, 365 days a year</td>
</tr>
<tr>
<td>Primary Care Office Wait Time</td>
<td>Members with scheduled appointments should be seen within 30 minutes of their check-in time</td>
</tr>
<tr>
<td>Behavioral Health Initial Appointment</td>
<td>No longer than 10 days for an initial assessment; no longer than 30 days for members discharged from an inpatient mental health stay</td>
</tr>
<tr>
<td>Behavioral Health Urgent Care</td>
<td>Visit within 48 hours of member’s request</td>
</tr>
<tr>
<td>Behavioral Health Routine Appointment</td>
<td>Visit within 10 days of member’s request</td>
</tr>
<tr>
<td>Routine Dental Care Appointment (such as teeth cleaning and cavity fillings)</td>
<td>Visit within 90 days of member’s request</td>
</tr>
<tr>
<td>Emergency Dental Care Appointment (severe pain, swelling or bleeding)</td>
<td>Visit within 24 hours of member’s request</td>
</tr>
</tbody>
</table>
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
- Mental 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
- Physical therapy, occupational therapy, and speech-language pathology
- Physician, anesthesia, X-ray, and laboratory services
- 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
CCHP’s Healthy Mom, Healthy Baby program helps pregnant women get the support and services they need to have a healthy pregnancy and baby. Participants receive services in her home or over the phone from social workers or nurses who are specially trained in maternal/infant health. Other services include high-risk pregnancy services and 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 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 at childrenscommunityhealthplan.org. 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. 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.

Children’s Community Health Plan’s 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 culturally sensitive 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.
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 services
- Health screenings for children — full coverage of HealthCheck screenings and other services for individuals under the age of 21
- Hearing services
- Home health
- Inpatient hospital
- Mental 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 Children’s 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
Children receive an out-of-home care health screen within two business days of entering care, preferably at a Child Advocacy Center or Child Protection 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 online at: childrenscommunityhealthplan.org.
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 of care to Medicaid members under the age of 21 to provide regular, comprehensive, and preventive health care.

The State of Wisconsin requirement
The State of Wisconsin requires that a least an 80% compliance rate be attained for the completion of HealthCheck 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 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.

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 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 can print the entire HealthCheck Services handbook from this site.

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:

<table>
<thead>
<tr>
<th>AGE RANGE</th>
<th>NUMBER OF SCREENINGS</th>
<th>RECOMMENDED AGES FOR SCREENINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to first birthday</td>
<td>8</td>
<td>Birth, 1 month, 2 months, 3 months, 4 months, 5 months, 6 months, 9 months</td>
</tr>
<tr>
<td>First birthday to second birthday</td>
<td>3</td>
<td>12 months, 15 months, 18 months</td>
</tr>
<tr>
<td>Second birthday to 21st birthday</td>
<td>2 screening per year</td>
<td>Every 6 months</td>
</tr>
</tbody>
</table>

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 agespecific 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](https://forwardhealth.wi.gov).
Submitting HealthCheck claims
HealthCheck claims and other claims for children or teens enrolled in Care4Kids should be submitted to:
Children’s 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 (not a potential problem), and if the dietitian works for the HealthCheck agency. 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>
<thead>
<tr>
<th>Preventive Care</th>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381*</td>
<td>Initial 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>
</tr>
<tr>
<td>99383*</td>
<td>Initial 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>
</tr>
<tr>
<td>99391*</td>
<td>Periodic preventive medicine visit</td>
<td>Under 1 year</td>
</tr>
<tr>
<td>99392*</td>
<td>Periodic preventive medicine visit</td>
<td>Ages 1 - 4</td>
</tr>
<tr>
<td>99393*</td>
<td>Periodic preventive medicine visit</td>
<td>Ages 5 - 11</td>
</tr>
<tr>
<td>99394*</td>
<td>Periodic preventive medicine visit</td>
<td>Ages 12 - 17</td>
</tr>
<tr>
<td>99395*</td>
<td>Periodic preventive medicine visit</td>
<td>Ages 18 - 21</td>
</tr>
<tr>
<td>99431*</td>
<td>History and examination of normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records.</td>
<td></td>
</tr>
<tr>
<td>99432*</td>
<td>Normal newborn care in other than hospital or birthing room setting, including physical examination or baby and conference(s) with parent(s).</td>
<td></td>
</tr>
<tr>
<td>99435*</td>
<td>History and examination of normal newborn infant, including preparation of medical records.</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Modifier</th>
<th>Modifier Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthCheck Nursing Agencies (Local Public Health Agencies)</td>
<td>EP, TS</td>
<td>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.</td>
</tr>
<tr>
<td>Physicians, Physicians Assistants, Independent Nurse Practitioners</td>
<td>UA**</td>
<td>Medical referral</td>
</tr>
</tbody>
</table>

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.
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 (available on our website on the Provider Forms page) 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 (from our website), to the CCHP Member Advocate prior to notifying the member.

  Mail termination of patient care letter and Missed Appointment Notification form to:
  - Children’s 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 timely 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.

**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 for, or provide coverage of, counseling or referral service 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;
PROVIDER RESPONSIBILITIES

- 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 for, or provide coverage of counseling or referral service 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, 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 (Continued.)

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 Children’s Community Health Plan what they need to know to treat them
• Follow the treatment plan and instructions agreed upon with their provider
The Quality Improvement (QI) program of Children’s Community Health Plan provides a framework for continuous performance improvement of the health care provided to its members, ensuring the provision of appropriate, affordable, and accessible care. This is accomplished by identifying, evaluating, and monitoring the quality of health care services provided to or proposed for plan members.

**GOALS AND OBJECTIVES**

Children’s Community Health Plan strives to continuously improve the care and service provided by our health care delivery system.

Our Quality Improvement program:
- Establishes the standards that encompass all quality improvement activities within the health plan.
- Promotes and incorporates quality into the health plan’s organization structure and processes.
- Facilitates a partnership between members, practitioners, providers and health plan staff for the continuous improvement of quality health care delivery.
- Continuously improves communication and education in support of these efforts.
- Considers and facilitates achievement of prevention goals in the areas of health promotion and early detection and treatment.
- Provides effective monitoring and evaluation of patient care and services to ensure that care provided by health plan practitioners/providers meets the requirements of good medical practice and is positively perceived by health plan members and health care professionals.
- Evaluates and disseminates clinical and preventive practice guidelines.
- Monitors performance of practitioners and providers against evidence-based medical guidelines.
- Develops guidelines for quality improvement activities (e.g. access and availability, credentialing/re-credentialing, peer review, etc.).

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)

Abortion
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 mental 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 106.06 (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, or both.”

______________________________  __________________________
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 mental health or AODA facility. There is no question that rapid outpatient follow-up is consistent with standard practice guidelines and leads to better patient care.

Authorizing outpatient mental 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 authorizing of behavioral health services to assure appropriate utilization. Because an authorization is not required for mental health services; if the PCP determines mental health services are medically necessary and knows the plan mental 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 mental 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 mental health clinic site or with a non-plan mental 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 mental 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
Case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual’s complex health needs, using communication and available resources to promote quality, cost effective outcomes.

Criteria for eligibility includes:
- Members with Cystic Fibrosis who have at least one emergency department visit or hospital admission in the past 6 months
- Members with Multiple Sclerosis and who are experiencing major impairment and deterioration
- Members with polypharmacy of 17 or more prescribed medications
- Members experiencing severe physical trauma within the past 3 months who have had an inpatient length of stay greater than 6 days and for whom transitions in levels of care are anticipated
- Members with Sickle Cell Disease who have had 2 or more hospital admissions in the past 12 months
- Members with severe spinal cord injury within the past 3 months and who are experiencing major impairment
- Other complex care situations will be considered

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

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

Members with Major Depression 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.

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

The CCHP Medical Directors, Executive Director of Health Plan Clinical Services, Director of Clinical Services UM / CM, Manager of Medical 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 Medical
- Manager, Clinical Services UM / CM Healthy Mom, Healthy Baby
- Manager, Clinical Services UM/CM Behavioral Health
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
Children’s 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 1-844-450-1926. Messages are confidential and may be left 24 hours per day. Communications received after normal business hours are responded to on the following business day.

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

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

Children’s 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
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
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, 7 days 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 REVIEW CRITERIA
Children’s 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:
Children’s 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 414-266-5707 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. Children’s 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 Children’s 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) and the Medical Advisory Committee (MAC).

The MAC is responsible for reviewing all UM issues and related information and making recommendations to the QOC. The UM program is reviewed and approved by the MAC and the QOC yearly.
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 24 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

Mental health services, including the following levels of care:
• Inpatient stays require notification within 24 hours of admission
• Partial hospitalization / day treatment
• Intensive outpatient

Substance use disorder services, including the following levels of care:
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 414-266-5747 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:
   o Go to the online registration form at togetherCCHP.org
   o Complete the fields with individual user’s information
   o Enter the organization’s tax ID number
   o Enter the registration code provided in the portal welcome letter
   o Go to the drop-down menu “What type of user are you registering?” and select “A general user”

2. For individual users to register:
   o Go to the online registration form
   o Complete the fields with individual user’s information
   o Enter the organization’s tax ID number
   o 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. Children’s 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.
**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 appropriateness 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 24 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.

- 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.

24/7 nurse triage line
CCHP offers a nurse triage line, which is available 24 hours a day, 7 days a week. Providers can get information about alternative care available in and outside of the CCHP provider network. The number to contact is 877-257-5861.

Urgent or nonemergent care
Urgent or nonemergent 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 nonemergent 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 Children’s Community Health Plan at 414-266-4726.

Here’s how it works:
1. Preregistration 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
   1. 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.
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
2. First, site administrators will need to call our portal administrator to request a registration code at 414-266-5747, and:
3. 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.
4. 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 this manual for instructions on how to complete registration.
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.

<table>
<thead>
<tr>
<th>REQUIRED INFORMATION</th>
<th>CMS-1500 CLAIM FORM</th>
<th>UB-04 CLAIM FORM</th>
<th>NOTES</th>
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<tr>
<td>Member Name</td>
<td>Box 2</td>
<td>Box 8</td>
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</tr>
<tr>
<td>Date of Birth</td>
<td>Box 3</td>
<td>Box 12</td>
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<tr>
<td>Member Number</td>
<td>Box 1.a</td>
<td>Box 60</td>
<td>10 for MA</td>
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<tr>
<td>Diagnosis Code</td>
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<td>Box 42</td>
<td>4-digit revenue code on UB-92</td>
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<td>Box 47</td>
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<tr>
<td>Units</td>
<td>Box 24.G</td>
<td>Box 46</td>
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<td>Provider NPI &amp; Taxonomy code</td>
<td>Box 24 J</td>
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<td>Amount paid by other insurance (if appl.)</td>
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<td>Box 56</td>
<td>Must be registered as Performing and Billing with the State</td>
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<tr>
<td>Taxonomy code</td>
<td>Box 33b</td>
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</table>

Optional fields for special purposes
Additional fields may be used for special purposes or submission types. For example, if a claims submission is a corrected claim, providers are required to use Box 22 on the CMS-1500 or box 64 on the UB-04, which are equal to EDI location Loop 2300, Segment REF, Element REF02 if submitting electronically. Claim frequency code 7 or 8 is a must, and should be included here.
Another example is submitting the prior authorization number if one was secured prior to the service being performed. 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 (QTTs) may not submit claims on their own behalf. Services should be reported under the name and NPI of the qualified supervising provider with the U6 modifier appended to each CPT code. No other professional level modifiers should be indicated on the claim or it will deny. Children’s Community Health Plan 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.

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 ForwardHealth 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.

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 into the claims processing system.

**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:

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

**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:
   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 one 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.

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:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AQ</td>
<td>Physicians providing services in a Rural or Urban HPSA area</td>
</tr>
<tr>
<td>AQ</td>
<td>Rural/Urban</td>
</tr>
<tr>
<td></td>
<td>• Reimbursement for eligible procedure codes billed with the “AQ” modifier includes the pediatric incentive payment.</td>
</tr>
<tr>
<td></td>
<td>• Do not bill “AQ” and “TJ” modifiers for the same procedure code.</td>
</tr>
<tr>
<td>TJ and AQ</td>
<td>Pediatric rate</td>
</tr>
<tr>
<td></td>
<td>The modifier “TJ” can be billed for eligible services in situations that do not qualify for HPSA-enhanced reimbursement.</td>
</tr>
<tr>
<td>TH</td>
<td>Obstetrical treatment/services: prenatal*</td>
</tr>
<tr>
<td></td>
<td>*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.</td>
</tr>
</tbody>
</table>

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.
Rejected Claims Reports
During claims processing, claims go through an initial editing phase that checks for valid patient information, correct identification numbers, provider information, etc. If the claim fails initial editing, it is rejected. The provider is notified of the rejection via the Rejected Claims Report.

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 Appeal/ 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.
- Providers can resubmit the claim and/or corrections by indicating on claim in Box 19 “Corrected Claim” and putting the claim number in Box 22 of the CMS-1500 form. For UB-04 form users, this information should be in Box 64. Claim frequency code 7 or 8 is a must, and should be included here.

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.

**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 contract 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 network. 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.

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 available through our third-party administrator. Children’s Community Health Plan providers may sign-up to receive 835 transactions at http://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.

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.
Enrolling in the EFT program
Providers have two options 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
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 http://dhs.wisconsin.gov/civilrights/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.

The CCHP provider appeals process
Providers are entitled to make a claim appeal if they believe a denial or payment determination is unsatisfactory or incorrect. Providers must submit their appeal in writing to CCHP within the number of days specified in their contract (under Provider Group Appeals and Dispute Resolution), from the date the provider receives the denial or payment determination.

Submitting a claim appeal
Providers can submit a written request or utilize the Appeal/Corrected Claim form, which is available on our website at childrenscommunityhealthplan.org. The appeal cannot be faxed.

1. If a provider submits a written appeal request, it should be marked with “Appeal”, and include the following information:
   - Provider’s name
   - Date of service
   - Date of billing
   - Date of rejection or offsetting, as applicable
   - Member’s name, BadgerCare Plus number
   - Reason[s] for reconsideration
   - Original claim number

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

3. Submit the written request or Appeal/Corrected Claim form, along with any supporting documentation to:
   - Provider Appeals
   - P.O. Box 56099
   - Madison, WI 53705

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.

Wisconsin DHS final determination appeal requirements
The Wisconsin DHS requires providers to use the Wisconsin Medicaid and BadgerCare Plus Managed Care Program Provider Appeal form to file the final determination appeal, which is available online at http://dhs.wisconsin.gov/forms/F1/F12022.doc.
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 to Wisconsin DHS must be sent to:
  BadgerCare Plus and Medicaid SSI Managed Care Unit
  P.O. Box 6470
  Madison, WI 53716-0470
  Fax: 608-224-6318
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

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

### Regulatory definitions

**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** 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** 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

### 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/
This policy outlines Children’s Community Health Plan’s (CCHP) process for Credentialing and Recredentialing of Practitioners and Organizational Providers for inclusion in CCHP’s Network.

CREDENTIALING DEFINITIONS

- “Applicant” means the Practitioner or Organizational Provider seeking to become credentialed or recredentialed to participate in CCHP’s Network.
- “Credentialing” is the process of assessing and validating the applicable criteria and qualifications of a Practitioner or Organizational Provider for participation in the CCHP Health Plan.
- “Credentialing Authority” means 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” is a subcommittee of the Quality Oversight Committee that uses a peer review process to evaluate and make recommendations regarding credentialing decisions.
- “Committee Members” means members of the Credentialing Committee appointed by the QOC and which includes Network participating health care professionals, such as physicians, allied health providers, and other medical and surgical specialties to provide advice and expertise for credentialing decisions.
- “Covered Persons” means individuals who have insurance through CCHP.
- “Credentialing Verification Organization” means 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 Restriction” means any limitation or limiting condition imposed on a Practitioner’s ability to practice medicine.
- “Medical Director” means the licensed physician appointed by CCHP to serve as the Chair of the Credentialing Committee and fulfill various duties related to CCHP administration.
- “Mental Health Organizational Providers” means inpatient, residential, and ambulatory facilities, which provide mental health services to Covered Persons.
- “Organizational Providers” includes 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 mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.
- “Practitioner” is a licensed or certified professional who provides medical care or behavioral healthcare services.
- “Primary Source Verification” means verification of credentialing information directly from the entity (e.g., state licensing board) that conferred or issued the original credential.
- “Quality Oversight Committee” refers to 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, recredentialing, and related administration of the credentialing process.
- “Recredentialing” is the process of re-assessing and validating the applicable qualifications of a Practitioner or Organizational Provider to allow for participation in CCHP’s Network.
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;
- The following behavioral health providers: Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists, Clinical Nurse Specialists, Clinical Substance Abuse Counselors

CCHP credentials the following Organizational Providers:

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

CREDENTIALING COMMITTEE

The Credentialing Committee is responsible for reviewing the credentials of Practitioners and Organizational Providers and making decisions whether to accept, retain, deny or terminate a Practitioner and Organizational Provider’s participation in CCHP’s Network. A Medical Director serves as the Committee Chairperson. The Credentialing Committee will meet the 3rd Thursday of every month unless otherwise determined by the Committee Chairperson. The presence of a majority of voting Credentialing Committee members constitutes a quorum. The Medical Director or a designee will chair the Credentialing Committee and serve as a voting member. The Credentialing Committee will include the Director of Health Plan Clinical Services and at least seven (7) Practitioners. The Committee is composed of participating Network Practitioners and includes Practitioners who practice in the specialty type that most frequently provides services to Covered Persons. The Medical Director may appoint Practitioners whose expertise is deemed appropriate for the efficient and effective functioning of the Credentialing Committee.

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 (i) believes there is a conflict of interest, such as direct economic competition with the Practitioner; or (ii) feels his or her judgment might otherwise be compromised. A Credentialing Committee member will also disclose if he or she has been professionally involved with the Practitioner. Determinations to deny an 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 recredentialing 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 appropriately authorized staff. 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 Recredentialing 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 the Applicant’s race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or types of patients the Practitioner Applicant specializes in. CCHP ensures non-discrimination by having 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.

CCHP CREDENTIALING AND REcredentialing CRITERIA

Initial Credentialing
Each Practitioner Applicant must submit a standardized application for review when applying for initial participation in CCHP's Network. If the Applicant meets CCHP's 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 sixty (60) calendar days from the date of the signature on the application/attestation. During the credentialing process, CCHP will review the verification elements shown in “Criteria for Selecting Practitioners” unless otherwise required by applicable regulatory or accrediting bodies.

Recredentialing
The recredentialing 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.

Recredentialing of Practitioners occurs every three (3) 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 (3) years are not considered an action or determination that triggers appeals rights. Each Practitioner applying for continued participation in CCHP's Network must submit all required supporting documentation.
Organizational Provider Credentialing and Recredentialing

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 the 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 the 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 credentialing process, CCHP will review the verification elements shown in “Criteria for Selecting Providers” unless otherwise required by applicable regulatory or accrediting bodies.

Recredentialing of Organizational Providers occurs every three (3) 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.

Eligibility Criteria for Practitioners:

1. Initial Applicants must submit the following information in order to be considered for participation: 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. The Application must include information on the type of professional license(s) or certification(s) held, state where issued, certification and/or license number, effective date, and date of expiration.
4. Applicants must provide current Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substance Certificate (CDS) in each state where the Applicant intends to practice, if applicable.
5. A 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 the Applicant’s area of practice, licensure, or certification, including dates of receipt. Not required at the time of recredentialing unless it has changed and impacts the LIP’s specialty.
7. A listing of degrees or certifications 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 recredentialing unless it has changed and impacts the LIP’s specialty.
8. A listing 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.
9. 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.
10. 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, other health care delivery setting, medical review board, licensing board, or other administrative body or government agency.
11. A completed Application, including a signed statement, which may be in an electronic format, providing information and attesting to.
12. Applicant’s current professional liability policy, including the name of the 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.
13. Limitations on ability to perform essential functions of the position with or without accommodation.
14. History of loss of license or any loss or limitations of privileges or disciplinary activity.
15. Absence of current, substance abuse use or active alcoholism.
16. 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.
17. Completeness and accuracy of the information provided in the Application.
18. 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.

19. Any other documents or information that CCHP determines are necessary for it to effectively and/or efficiently review the Applicant’s qualifications.

20. No current medical staff membership or clinical privilege restrictions.

The following Credentialing Criteria must be verified and approved within 60 days of the date of the signature on the Attestation form, to be eligible to become a Participating Practitioner.

The required medical or professional education and training are:

1. Medical Doctors (MD’s) and Doctors of Osteopathic Medicine (DO’s) must graduate from medical school and successfully complete a residency training program approved by the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA) in the specialty in which the applicant will be practicing.

2. Alternatives to Residency Programs. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the residency program requirement:
   - 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 that clinical specialty or subspecialty; or
   - 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 is at the sole discretion of CCHP.

3. Doctors of Chiropractic Medicine (DC) must graduate from a chiropractic school.

4. Doctors of Dental Surgery (DDS) or Doctor of Medicine in Dentistry (DMD) must graduate from dental school.

5. Doctors of Podiatric Medicine (DPM) must graduate from podiatry school and successfully complete a hospital residency program.

6. All advanced practice practitioners (e.g. nurse practitioner, nurse mid-wife, etc.) must graduate from an accredited professional school and successfully complete a training program.

7. If Applicant indicates board certification, CCHP Primary Source Verifies board certification from the most current edition of an NCQA-accepted source, but need not Primary Source Verify each level of education and training if the certifying board has already Primary Source Verified it. If the Applicant is not board certified, then Primary Source Verification of the highest level of education listed on the Application is required, except that each level of education must be Primary Source verified for dentists.

8. Verification of Board Certification must be completed prior to the decision date.

9. Verification of postgraduate education or training not listed in (1) above. CCHP Primary Source Verifies any postgraduate education or training disclosed in the Application and not considered in (1) above if relevant to LIP’s scope of practice (e.g., Fellowship). Verification and approval within accordance of the time frame as specified by Credentialing Authority from the Application Date to the Decision Date is not required for this element however verification must be completed prior to the decision date.

10. Current licensure or certification. CCHP Primary Source Verifies that the Applicant maintains current, valid unrestricted licensure or certification in all states where the applicant provides care to CCHP members. Any findings that result in sanctions or restrictions on the LIP from any state licensing authority results in closing the Applicant’s credentialing file. Time limit for verification is 180 calendar days.

11. A valid Drug Enforcement Agency DEA Certificate, unless the Applicant’s practice does not require it, the Applicant must have a current, valid DEA in each state where the Applicant intends to practice; or if the Applicant has a pending DEA application, an agreement with a Participating LIP with a valid DEA certificate in each state where the Applicant intends to practice to write prescriptions for the Applicant with the pending DEA application. CCHP verifies that the Applicant meets this requirement by obtaining a copy of the Applicant’s DEA in each state where the Applicant intends to practice, visually inspecting the certificate, or confirming with NTIS that the certificate is in force at the Decision Date. Verification of the element must be complete prior to the Decision Date.

12. Medicare/Medicaid program participation eligibility. The Applicant must not be ineligible, excluded, or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state’s Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG), the General Services Administration (GSA), System for Award Management (SAM), Social Security Death Master File (SSDMF)
or other disciplinary action by any federal or state entities identified by CMS. CCHP verifies reported sanction information from an NCQA-accepted source.

13. Work History. CCHP obtains a five-year work history. Gaps longer than sixty days, must be explained by the practitioner in writing and found acceptable by the Credentialing Committee.

14. Insurance or state-approved alternative. CCHP requires a copy of the Applicant’s current Certificate of Coverage or may allow the Applicant’s attestation coverage that exceeds the minimum established by this Credentialing Policy. 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.

15. Malpractice History. CCHP must obtain written confirmation of history of malpractice settlements from the malpractice carrier or must query the NPDB. Any Practitioner with a malpractice history exceeding an established threshold is referred to the Credentialing Committee for review.

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

17. Hospital Clinical Privileges. For MDs and DOs who provide inpatient care, the Applicant must have unrestricted hospital clinical privileges at a hospital accredited by the one of the following: The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP) or the National Integrated Accreditation for Healthcare Organizations (NIAHO/DNV), or a hospital previously approved by CCHP. The Applicant shall list the hospitals where it has privileges on the application. Some clinical specialties may function exclusively in the outpatient setting, and the Credentialing Committee may at its discretion deem hospital clinical privileges not relevant to these specialties. These Applicants may be requested to identify their plan for coverage of inpatient care.

18. Other Credentialing requirements such as WDSPS if the practitioner is not board certified as required by Credentialing Authorities.

19. No affirmative responses to Disclosure Questions on Credentialing Application. Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application, which are reviewed by the Medical Director and at the discretion of the Medical Director, may be reviewed by Credentialing Committee for a determination of LIP’s acceptance into CCHP Network.

CRITERIA FOR SELECTING PRACTITIONERS:
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:

1. Applicants must have an active and unrestricted license without limitations or sanctions from the state(s) in which they practice.
2. Applicants cannot be excluded from participating in Medicare or Medicaid programs (lack of sanctions or debarment).
3. No prior denials or termination. The applicant must not have been denied participation (for reasons other than network need) by CCHP within the previous 24 months.

If the Applicant fails to meet these criteria, CCHP will not process the application further. An Applicant may reapply when he/she meets all of the eligibility criteria.

Recredentialing Applicants must provide and/or will be primary source verified the following information:

1. A complete recredentialing application and required supplemental information/attachments without material omissions or misrepresentations.
2. A 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 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.

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 of similar specialty at a Network Organizational Provider who provides inpatient care to Covered Persons needing hospitalization.

8. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism.

9. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.

10. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest.

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 an HMO or PPO.

13. No QA/PI data or other patient care related performance data, including complaints, above set thresholds.

The following are exception criteria for specific practitioners:

1. Licensed Clinical Social Workers (LCSW) or other master level social work license types:
   - 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:
   - Doctoral degree in clinical, counseling psychology or equivalent field of study from an institution accredited by the APA.
   - 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.

3. Licensed Professional Counselors:
   - Master’s or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field.

4. Clinical Nurse Specialists (Psychiatry):
   - Master’s degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
   - Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing.
   - Certification by the American Nurses Association (ANA) in psychiatric nursing.
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 affect quality of care or patient safety.

General Criteria for Organizational Providers:
1. Valid, current and unrestricted license 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 any of the following programs: Medicare or Medicaid.
4. General/comprehensive liability insurance as well as errors and omissions (malpractice) 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. Accredited Organizational Providers must provide proof of current accreditation status conducted during the previous three (3) 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 Laboratory 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

If not appropriately accredited, Organizational Provider must submit a copy of its CMS or state site survey for review by the Credentialing Committee to determine if CCHP’s quality and certification criteria standards have been met.

PRACTITIONER CLEAN FILE CRITERIA
To qualify as a Practitioner “clean file” the following criteria must be met:
• 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.
• No sanctions (license, Medicare or Medicaid).
• Current active DEA with no restrictions or limitations (if applicable).
• 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.
• 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 a CCHP participating Network hospital, if CCHP determines that Applicant’s practice requires such privileges.
• No unexplained gaps in work in work history greater than sixty days
• Lack of present, illegal drug use.
• Ability to perform the essential functions of the position, with or without accommodation.
• No felony or misdemeanor convictions.
• No professional liability settlements within five (5) years for initial Credentialing and three (3) years for Recredentialing.
• No adverse actions or disciplinary activity by another health plan.
• A Practitioner’s eligibility for Board Certification is defined by no fewer than three (3) years and no more than seven (7) years following the successful completion of accredited training. This follows the American Board of Medical Specialties (ABMS) Board Eligibility Policy.
• Minimum credentialing guidelines met for education and training if Board Certification not available for specialty.
• 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.

CREDENTIALING PROCESS

1. Medical Director Review:
   a. The Medical Director conducts a preliminary review of all credentialing and Recredentialing application files.
   b. The Medical Director documents approval of Clean Files, as described below, with his/her signature and date. Clean Files are presented to the Credentialing Committee for review.
   c. If the Medical Director has questions about a file or it appears that the Applicant does not meet certain criteria, the Medical Director shall forward the application to the Credentialing Committee for recommendation, denial or deferral.

2. 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 with the evaluation process. If the Applicant does not provide the requested information by the 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 an 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 Medical Director for further review.
   e. The Credentialing Committee may request further information from any persons 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 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.

3. Applicants are notified via signed letter from the Medical Director of the acceptance or denial of their Credentialing or Recredentialing request within thirty (30) days of the Credentialing Committee.

4. 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 be deemed incomplete and closed with no further action. Such action does not trigger appeal rights.

5. Acceptance of an Applicant into CCHP’s Network is conditioned upon the Applicant’s signature on the applicable Network Agreement (“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.

RECREDENTIALING PROCESS

- CCHP recredentials Practitioners and Organizational Providers at least every thirty-six (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.
- CCHP will send notification via email, fax or by US postal service two (2) months prior to the Recredentialing due date to the Credentialing contact of the clinic/group or to the individual of an independent practice. CCHP will send a final notice one (1) month prior to the due date of the Recredentialing 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.
- All terms, criteria, requirements, and process set forth above, relating to initial Credentialing shall apply to Recredentialing unless otherwise stated in those Sections.
- In addition, the following information shall be provided at Recredentialing:
  - The Applicant will update CCHP with any changes in work history, current Board Certification, and additional education.
  - The Applicant must have demonstrated compliance with all terms of the Network Agreement, specifically including completion of Individual Improvement Plans requested by CCHP.
  - A new attestation must be submitted within two (2) months of Recredentialing due date.
  - The Applicant is required to complete the requested updates and send notification
  - of such to Credentialing staff by the specified due date.
  - Recredentialing applications or requests will be reviewed by the Credentialing Committee, including, but not limited to, the malpractice history and history of potential Quality of Care/Quality of Service concerns within the recredentialing cycle. If a history of malpractice claims and Quality of Care/Quality of Service concerns are found, the Credentialing Committee will conduct a thorough review
  - of these findings. CCHP will verify current Board Certification and additional education, if applicable.
  - 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.

ONGOING SANCTION MONITORING

CCHP has an ongoing monitoring program for the purpose of monitoring complaints, adverse events and quality of care issues. The CCHP credentialing personnel 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 will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General (OIG)
- Federal Medicare/Medicaid Reports
- State licensing Boards/Agencies
- Covered Persons/Practitioner and Organizational Provider patient/customer service departments
- CCHP’s Quality Dept. (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal and affiliated CCHP departments
- Any other verified information received from appropriate sources when a Practitioner or Organizational Providers 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 Medical Director, referral to the Credentialing Committee, or termination. CCHP will report Practitioners or Organizational Providers to the appropriate authorities as required by applicable law.
RIGHTS OF PRACTITIONERS
Confidentiality of Credentialing File:
Ongoing access to credentialing files and related information is restricted to authorized personnel only, including CCHP credentialing personnel. Physical files with documents are only accessible to Credentialing Staff, including Credentialing Coordinators, Credentialing Managers, the Medical Director and others who oversee credentialing functions.

Rights of Practitioners with Respect to CCHP Credentials File:
Practitioners and Applicants to CCHP's 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 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 (10) business days. Proposed corrections should be submitted to CCHP by Practitioners in writing within thirty (30) day of receipt.
- Each Practitioner is notified when information the Practitioner has submitted on an application varies substantially from that received during the verification process. CCHP personnel will provide written notification to the Practitioner and the Practitioner will be given at least thirty (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 recredentialing application status.

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

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

POLICY:
A. A Practitioner or Organizational Provider's participation in CCHP's Network or programs may be terminated for any lawful reason, including but not limited to a failure to meet eligibility criteria, matters related to professional conduct and competence, credentialing and recredentialing 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 Recredentialing 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:
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.

A summary suspension or restriction may be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Director, Credentialing Committee or QOC.

2. A summary suspension or restriction will become effective immediately upon imposition, will immediately be reported in writing to the Credentialing Committee and will remain in effect unless it is modified by the Medical Director, pertinent committee or designee.

3. The Practitioner will be provided a written basis for the summary suspension, including the names and medical record numbers of the patient(s) involved (if any), within a reasonable period of time following imposition of the suspension.

4. Credentialing Committee Procedure:
   a. The ad hoc committee appointed by the Chair of the Credentialing Committee will review circumstances related to the summary suspension or restriction (or voluntarily refrain) within a reasonable time under the circumstances, generally not to exceed 14 days. Prior to, or as part of, this review, the Practitioner shall be given an opportunity to provide information relevant to the summary suspension or restriction to the Credentialing Committee or ad hoc committee.
   b. After considering the circumstances resulting in the suspension or restriction and the Practitioner's response, if any, the Credentialing Committee will determine whether there is sufficient information to warrant a recommendation or whether to commence an investigation. The Credentialing Committee will also determine whether the summary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and appeal, if applicable).

AUTOMATIC TERMINATION

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

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

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

RIGHT TO APPEAL / PRE-APPEAL PROCESS:

A. Right to an Appeal. 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 Practitioner may appear in person or by telephone;
     4. That the Practitioner has thirty (30) days after receipt of the notice within which to submit a written request for an appeal;
     5. A summary of the Practitioner’s rights in the appeal;
     6. 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;
     7. 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, recredentialing 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. Appointment of QOC as the Appeals Committee
   • The QOC or designated ad hoc committee shall serve as the Appeals Committee. All subsequent references to the Appeals Committee shall refer to the QOC or designated ad hoc committee. Individuals who are in direct economic competition with the Practitioner shall not participate as part of the Appeals Committee. Knowledge of the matter involved shall not preclude an individual from serving on the Appeals Committee, but an individual who previously considered and voted on the matter, has a family, professional or business relationship with the Practitioner requesting an appeal that creates an actual conflict of interest shall not be eligible to serve on the Appeals Committee. One member of the Appeals Committee shall be appointed as Chairperson. The Chairperson shall conduct the appeal, any pertinent pre-appeal matters, maintain decorum, and rule on all evidentiary and witness matters. The Chairperson shall ensure that all participants have a reasonable opportunity to present relevant oral and documentary evidence and shall determine the order of procedure during the appeal.

F. 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:**
  a. 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.
  b. 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;
    ii. reports of experts relied upon by the Credentialing Committee;
    iii. 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.
  c. The provision of this information is not intended to waive any privilege under the Wisconsin peer review / health care services review protection statute.
  d. No later than ten (10) 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 or information at the appeal that are not timely disclosed to the other party.

**APPEAL**

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

B. **Admissibility of Evidence:** The appeal shall not be conducted according to the rules of law or procedures relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted if it’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.

Reporting to Authorities
CCHP shall report professional review actions based on reasons related to professional competence or conduct that adversely affect credentialing to the National Practitioner Data Bank and appropriate state licensing boards in accordance with the Healthcare Quality Improvement Act.
PURPOSE OR DESCRIPTION:
To insure that services provided to Children’s 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 Forward Health requirements for certification by ForwardHealth and the requirements established by Children’s Community Health Plan. Services provided via telehealth must be of sufficient audio and visual fidelity and clarity to be functionally equivalent to a face-to-face encounter where both the rendering practitioner and the member are in the same physical location. Both the distant and the originating sites must have the requisite equipment and staffing necessary to provide telehealth services.

Definitions:
1. 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.”
2. Originating Site: The site where the patient (member) is physically located when receiving telehealth services.
3. Distant Site: The location at which the practitioner providing telehealth services is located.

Procedure:
1. Services must be provided by a network practitioner within the practitioner’s scope of practice
2. Services must be provided to a member at an approved “originating site” within an eligible location
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 Noncovered Services below).
6. Meets coding eligibility criteria, conditions of payment, and billing methodology requirements

Noncovered 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

Eligible Distant Site Practitioners
- Physicians
- Psychiatrists
- Nurse Practitioners
- Physician Assistants
- Nurse Midwives
- Clinical Psychologists
- Clinical social Workers
- Audiologists
- Professionals providing services in mental health or substance abuse program certified by the Division of Quality Assurance

Authorized Originating Sites
1. Office of a physician or practitioner
2. Hospitals
3. Federally Qualified Health centers
4. Skilled Nursing Facilities
5. Community Mental Health Centers
6. Emergency Department
7. Local health department
Not Eligible Originating Sites
1. Member’s home
2. Independent Renal dialysis facilities
3. Any site not specifically listed under Authorized Originating Sites

Additional ForwardHealth Requirements:
Medicaid covered services provided by telehealth are reimbursed provided:
1. The agency is a certified program under one of the following program standards: WIS Admin. Code DHS 34, 35, 36, 40, 61, 63, or 75 (except for the provision of opioid treatment under DHS 75.15). Persons providing mental health or substance abuse services via telehealth must be a staff member of one of these certified programs.
2. The certified program also is certified for telehealth by the Division of Quality Assurance.

Documentation Requirements:
All services provided via telehealth must be thoroughly documented in the member’s medical record 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.

Orientation and Training: All practitioners using telehealth for service provision shall receive orientation and on-going training 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.

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.

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.
PURPOSE OR DESCRIPTION:
When Children’s Community Health Plan (CCHP) delegates credentialing to entities that meet credentialing delegation eligibility requirements, CCHP must ensure 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 of 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:

Children’s 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