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Access Standards

We recently surveyed providers to determine if they were meeting CCHP's access standards. To maintain the best possible care for our members, we have established standards — ensuring our members have
continuous access to quality health care services. Listed below are the access standards for behavioral health:

- Behavioral Health Initial Appointment: No longer than 10 days for an initial assessment; no longer than 30 days for members discharged from an inpatient mental health stay
- Behavioral Health Urgent Care: Visit within 48 hours of member’s request
- Behavioral Health Routine Appointment: Visit within 10 days of member’s request

You can view a full list at our website of the time limits with in-network providers for scheduling medical, behavioral health, and BadgerCare Plus dental appointments.

Get more information online

We would like to remind you about important information available on our website. You can view and/or download information about the following topics on the website:

- Our Quality Improvement Program including goals, processes, and outcomes as related to care and service.
- The process to refer members to Case Management.
- The process to refer members to Disease Management.
- Our Medicaid member rights and responsibilities statement.
- Our Together with CCHP member rights and responsibilities statement.
- Our Provider Manuals.

**Credentialing and Contracting on the website**

In an effort to make it easier for new providers and current providers to find information on contracting and credentialing, we have reorganized this section on the website. Previously the Get Contracted section, contained all of credentialing and contracting information. Today this section is split between Becoming a Provider and Current Provider. If you are a current provider wishing to add a new provider to your group, interested in Telehealth, or recredentialing please look under the Current Provider tab. CCHP’s Credentialing policies and provider manual can be found under this section.

Appeals
Tips for filing appeals

When filing an appeal please make sure you are using the correct appeal form and sending it to the address that is on the form. Here are the two version of the forms:

- [Together with CCHP appeal form](#)
- [BadgerCare Plus with CCHP appeal form](#)

Here are some more tips for filing appeals:

1. Please contact customer service regarding claims payments issues before appealing. You can reach Together with CCHP Provider Services at 844-202-0117, and BadgerCare Plus Provider Services at 1-800-482-8010.
2. We do not accept faxed appeals. Appeals that are faxed will be returned.
3. The comments on the appeal form should have detailed information as to why you are appealing. Please do not notate "Please review medical records attached."
4. Corrected claims are not appeals. These should be sent to the claims address. For BadgerCare Plus corrected claims please review this [guide](#). For Together with CCHP claims please stamp and notate that it is a corrected claim before mailing it in.
5. Sending a primary insurance EOB with claims is not an appeal. This should be sent to the claims address.
6. If you have multiple claims for the same member denying for the same reason they can all go on the same appeal form. Put a list of claim numbers and detailed information in the comment area or on a separate sheet of paper if necessary.
7. Please wait 30 days to follow up on appeals. Status questions can be emailed to [DSchneider2@chw.org](mailto:DSchneider2@chw.org). Please include in the email: member name, member ID number, date of service, and claim number.

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CCHP Provider Portal

CareWeb Provider Manual Updated

In an effort to help providers use the CareWeb's Provider Manual, it has been updated with a new design and new content. This guide covers inpatient admission notifications and prior authorization submissions. In addition, it covers how to clear the providers queue and check for prior authorizations that are not submitted.

[Read CareWeb’s Provider Manual](#)
BadgerCare Plus and Together with CCHP CareWeb Training

This summer, Provider Relations hosted training sessions on how to use the CareWeb Authorization Tool. If you missed this summer's training, watch this video of webinar.

The Provider Relations team will be hosting two more training sessions this year on CareWeb Authorization Tool.

- November 2 -- Provider Relations will be joined by the Utilization Management department to discuss submitting a prior authorization, checking pending authorizations, and much more on prior authorizations!
- December 6 -- We will be hosting a training session on Inpatient Notifications in the CareWeb Authorization tool. Please save the dates and keep an eye out for invitations in your email inbox!

Notifying CCHP of Inpatient Admission

Please reference your provider agreement with CCHP that outlines providers are required to notify CCHP within 24 hours of an inpatient admission; and prior authorize elective services and/or procedures prior to providing services.

Please make sure to attach clinical information to the request within 24 hours. Without clinical information to review for medical necessity, your request for services may be denied.

- We recommend that you check each day for authorizations that are in the draft status and have not been submitted.
- CCHP will not be notified until the authorization has been submitted
- You can check by filtering the submission status to draft

Watch a tutorial video to learn more about this process
Authorization Lists

Children's Community Health Plan has updated the Prior Authorization and No Prior Authorization lists.

- **Effective 09/15/2018:** The following codes for Cardiac Mechanical Support were removed from the No Prior Authorization list and added to the Prior Authorization list: 33975; 33976; 33977; 33978; 33979; 33980; 33981; 33982; 33983; 33990; 33991; 33992; 92970; 92971; Q0478; Q0479; Q0480; Q0481; Q0482; Q0483; Q0484; Q0485; Q0486; Q0487; Q0489; Q0490; Q0491; Q0492; Q0493; Q0494; Q0495; Q0496; Q0497; Q0498; Q0499; Q0500; Q0503; Q0504; Q0506; Q0507; and Q0508. This is effective September 15, 2018. The cosmetic CPT codes 36470 and 36471 were removed from the No Prior Authorization list and added to Prior Authorization list.

- **Effective 09/01/2018:** The cosmetic CPT codes 36475 and 36476 were removed from the No Prior Authorization list and added to Prior Authorization list. This is effective September 1, 2018.

- **Effective 08/06/2018:** These codes were added to the prior authorization required list for Specialty Medications: J7320; J7321; J7322; J7323; J7324; J7325; J7326; J7327; J7328. These codes were removed from the No Prior Authorization list and added to the Prior Authorization list: J7320; J7321; J7322; J7323; J7324; J7325; J7326.

For questions or assistance with your authorization request, call:

Children's Community Health Plan - Clinical Services Department

Toll free: 877-227-1142, option 2

Local: (414) 266-5707

View BadgerCare Plus Authorization Lists

Together with CCHP

Authorization Lists

Together with CCHP's No Prior Authorization and Non Covered lists were updated for genetic codes, radiation and proton beam therapy, influenza virus vaccine, and shingles vaccine.

- These codes were removed from the Prior Authorization list and added to the No Prior Authorization list: 81528; 77427; 77431; 77432; 77435; 774700.

- These codes were removed from the Non-Covered Codes list and moved to the No Prior Authorization list: 90674; 90682; and A0998.
Balance Billing
Payments made by CCHP to providers should be accepted as paid in full. The Provider Group should not balance bill the member. Providers should only charge members for deductibles, coinsurance and copayments. This would only apply to in-network providers. If prior authorization is required and the provider does not obtain the prior authorization the member is not held responsible.

Explanation of Payment Tool Released
Providers can now access Explanation of Payment (EOP) documents in the Together with CCHP Provider Portal. This offers providers the opportunity to view these EOPs online instead of waiting for a printed mailing.

Administrators must grant a user access to view EOP documents. EOPS can be searched for by date, EFT or check number, and specific dollar amount. The documents are sorted by run date, time, and EOP type. The EOPs are sorted in descending order.

Adobe Acrobat Reader or other software that permits the user view to view a document in PDF format is required. The documents can be saved or printed.

EOPs created after January 1, 2018 are available online. If a user requires an EOP older than this date, the documents are available by contacting Provider Services at 1-844-202-0117.

If the results of an EOP search yield no results, this could be due to any of the following factors:

- No EOPs match the search criteria.
  
  **Resolution:** Examine the search criteria carefully to confirm input exactly matches the intended sort criteria.
How can an administrator modify a user's permissions to allow the user to see EOP documents?

Certain sections of Together with CCHP's portal require administrators to allow access. Administrators must grant a user access to view EOP documents.

This can be done by going to the Security Management component of the Together with CCHP Portal and choosing a user to modify permissions.

Once the user is located, click on the Select link next to the name to open the user’s security profile for modification. The user’s current access privileges will be displayed.

To permit a user to view Explanation of Payment documents, click on the box across from this option, which populates a checkmark in the box.
Get paid faster and save money!
What are EFT, ERA and Electronic EOPs?

- Electronic funds transfer (EFT) allows providers to receive payment electronically.
- Electronic remittance advice (ERA) is an alternative to the paper version of the explanation of payments (EOPs).
- Explanation of payments can be accessed through the Together with CCHP Provider Portal.

Electronic funds transfer (EFT)
Claims payments are deposited directly into your bank account. If you are interested in receiving EFT’s, please complete the EFT Authorization Form and fax to: 1-844-549-3744

Electronic remittance advice (ERA)
Provides explanation of payment in HIPAA complaint files. While Together with CCHP offers the option to generate 835 formatted ERA files and make them available for direct download from the Together with CCHP Provider Portal many automated billing systems interface with payers via a clearinghouse. To request a direct interface of an 835 formatted ERA file, from our Portal or via PGP encrypted file transfer, please complete the ERA/835 Request Form and send to: HPEDIRequest@upmc.edu

Electronic explanation of payment (eEOP)
Allows providers to view claim payments created after January 1, 2018 electronically through the Together with CCHP Provider Portal. Read more about our electronic EOP Tool

Have Questions? You can reach Together with CCHP Provider Services at: 1-844-202-0117

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Synagis

**Synagis Season**

Synagis (Palivizumab) is used to help prevent RSV infection in infants and children at high risk.

Children’s Community Health Plan is working with CVS Caremark for the 2018-2019 season to distribute Synagis to BadgerCare Plus with CCHP and Care4Kids members.

Here is the process:

1. Providers should submit the prior authorization request in the CareWeb Qi portal. (Here are instructions on how to submit in the portal). Please contact 414-266-5747 if you do not have access to the portal.
2. CCHP's Utilization Management team will review the prior authorization request and notify the provider if Synagis is approved or denied. The parent or guardian will, also, be notified if it is denied.

3. Once approved, the provider will need to fax this form to CVS Caremark. Please include a fax cover sheet with the authorization approval number.

   **Care4Kids Members:**
   - Please indicate on the form if the patient is a Care4Kids member.
   - CVS Caremark will only reach out to the provider for a Care4Kids member.

4. CVS Caremark will contact the BadgerCare Plus member's family if Synagis is approved. CVS will attempt three times to reach the parent for delivery. If unable to reach either, the case will be closed out 48 hours later and lost to contact letters will be sent out.

5. CVS Caremark will then reach out to the provider to set up the delivery date.

6. Upon delivery, the provider will receive a refill form that will need to be sent back to CVS Caremark for the future doses.

Prescribing providers and billing providers may amend approved prior authorizations for Synagis if a member's weight changes, resulting in an increase in Synagis units during a treatment season.

Providers have 30 days from the date of administering each dose change to amend an approved prior authorization.

A maximum of five doses of Synagis will be approved. Fewer than five monthly doses will be needed for children born during the RSV season.

Prior authorization is available for both the 100mg and 50mg vial.

If you have questions about this process, please contact the Healthy Mom, Healthy Baby team at 414-337-BABY (2229).

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**Download the Synagis Form**

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**Health Programs**

**Z Codes: Social Determinants of Health**

Since January 2017, BadgerCare Plus with CCHP providers have included z codes on claims over 177,000 times. Z codes notate social and economic factors that contribute greatly to our members' health including:

- High BMI
- Tobacco abuse
- Drug abuse
- Alcohol abuse
- Psychosocial circumstances
- Homelessness
- Family conflict
- Employment issues
Z codes may be used as either a first-listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter.

By providers notating on claims these social determinants of health through Z codes, CCHP community health navigators and case managers can use these codes to assess resource needs and connect members with resources and programs in the community.

Transplant and Mechanical Cardiac Support Requests

CCHP is requesting that providers create evaluation and transplant requests through CareWeb Auto Authorization Tool to ensure the Utilization Management Department is notified properly.

To begin the process in the CareWeb Auto Authorization Tool, providers will select Transplant Services under the request type.

As of September 20, 2018, providers will not be able to send this request through a secured message.

If you have questions on this policy please contact 414-266-5747.
If you do not have access to CareWeb Auto Authorization Tool, please contact your site's administrator. If you have questions on how to register please contact 414-266-5747.

CCHP on Call Nurseline

If you have patients that could benefit from a free nurseline, please refer them to CCHP on Call.

Members can speak directly to knowledgeable registered nurses who are available 24/7. The nurses may provide symptom assessment and help find the appropriate level of care to help keep costs down.

Members can call 1-877-257-5861.

Breast Cancer Screening

With October being breast cancer awareness month, we would like to remind our providers and members about the recommendations for breast cancer screening.
About one in eight U.S. women (about 12.4%) will develop invasive breast cancer over the course of her lifetime. In 2018, an estimated 266,120 new cases of invasive breast cancer are expected to be diagnosed in women in the U.S., along with 63,960 new cases of non-invasive (in situ) breast cancer (Jan 9, 2018).

The United States Preventive Service Task Force (USPSTF) and American Cancer Society Breast Cancer screening recommendations - 2018 are as follows:

- Women age 50 to 74 years should have mammography screening every 2 years.
- Women age 40 to 49 years decision to start screening mammography should be an individual one.
- Women with a parent, sibling, or child with breast cancer are at higher risk for breast cancer and thus may benefit more than average-risk women beginning screening in their 40s.

HEDIS Measure Definition: The percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer. Numerator: One or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

CCHP 2017 Measurement Year HEDIS Reported rate 64.92%.

References:
U.S. Breast Cancer Statistics | Breastcancer.org

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**Cervical Cancer Screening**

In 2015 in Wisconsin, there were 214 new cases of Cervical Cancer. For every 100,000 women, seven Cervical Cancer cases were reported. In the same year, there were 69 women who died of Cervical Cancer. For every 100,000 women in Wisconsin, two died of Cervical Cancer.

The American Cancer Society estimates there will be 13,240 new cases of invasive cervical cancer diagnosed in the United States in 2018. As you know:

- Cervical cytology (Pap test) looks for precancerous and cancerous cells.
- High-risk HPV test looks for the DNA or RNA of the types of the HPV virus (16 and 18) that can cause these cellular changes. High-risk HPV types are detected in 99% of cervical cancers.

**HEDIS Specifications:**

Women 21-64 years of age have cervical cytology (PAP) performed every three years. According to the Center for Disease Control, HPV co-testing is not recommended for women under 30 years of age, because most infections in this age group are transient. Women 30-64 years of age should have cervical cytology/HPV co-testing regardless performed every five years. The American College of Obstetricians and Gynecologists (ACOG) continues to recommend co-testing (cytology in combination with hrHPV) as a primary screening modality in this population:

- Reflex testing does not count. “Order- HPV regardless” HPV after cytology is considered reflex testing and will not count for HEDIS CCS measure.
- According to The American College of Obstetricians and Gynecologist- Screening is still needed
for women who have been vaccinated against HPV.

CCHP 2017 Measurement Year HEDIS Reported rate 71.34%.

References:

Division of Cancer Prevention and Control, (http://www.cdc.gov/cancer/dcpc/about/) Centers for Disease Control and Prevention (http://www.cdc.gov/)


Postpartum Care

The American College of Obstetricians and Gynecologists (ACOG) has redesigned Postpartum Care. Doctors are urged by ACOG to help patients develop a postpartum care plan while still pregnant.

ACOG had previously recommended a comprehensive postpartum visit take place within the first six weeks after birth.

It is now recommended that women have contact with their ob-gyns or other obstetrical care providers within the first three weeks postpartum on an ongoing basis. According to ACOG, "More than half of maternal deaths occur after the baby is born, according to a new CDC Foundation report.”

This plan should include a team of family and friends to provide social and other support.

Per the National Committee for Quality Assurance (NCQA) technical specification guidelines; Post-partum exam must occur 21-56 days after delivery of live birth.

To meet NCQA Compliancy the following documentation is required:

1. Required Notation of – “PPV, 6 week visit, or Postpartum”
2. Pelvic Exam- Pap exam counts toward measure
3. Weight, BP, Breast (notation of breastfeeding counts), and Abdomen exam- must have all four together if other components not present.

Providers should use CPT category II code of 0503F to help meet Quality of Care guidelines. This helps capture this compliant visit.

CCHP does not pay anything extra for use of this code, but it helps CCHP capture compliant visits, thus decreasing the need to request medical records via fax or onsite visits.
Adolescent Well-Care Visits Components

When performing well child visits, please document these five components that most closely align with Early Period Screening, Detection, and Treatment (EPSDT) guidelines as defined by Medicaid.

Healthcare Effectiveness Data and Information Set (HEDIS) states these five components are vitally important:

1. Health history
2. Physical exam
3. Health education or anticipatory guidance
4. Current physical development
5. Current mental development

On chart reviews, we frequently find that documentation on the last three are missing. All five components must be present if the visit is going to be useful for HEDIS counts.

Project ECHO hopes to reduce opioid-related complications

A new initiative has started in the State of Wisconsin to connect clinical experts with primary care providers and medication-assisted treatment prescribers in an effort to reduce opioid-related complications.

Project ECHO (Extension for Community Healthcare Outcomes) is sponsored by the Wisconsin Department of Health Services (DHS), Division of Care and Treatment Services, the University of Wisconsin Department of Family Medicine and Community Health.

Providers can earn continuing education (CE) credit through this program. For more information about the program and how to earn CE credit, refer to the Project ECHO website.

An additional tool available to help providers combat the opioid epidemic is the University of Wisconsin Addiction Consultation Hotline. Aided by a DHS grant, UW’s hotline offers daily on-call help to providers who seek support and direction to deal with their patients with substance-abuse problems.

The hotline is available Monday through Friday, 8 a.m. to 5 p.m. Providers may call the hotline at the UW Health Access Center at 800-472-0111 or 608-263-3260.
Paramedics visiting Members in Milwaukee County Hospitals

CCHP and Milwaukee Fire Department’s Community Paramedics recently announced a joint partnership program to help improve outcomes after hospital discharge and reduce readmissions. The program focuses on helping members transition from hospital to home.

Members will receive an initial visit with one of the Community Paramedics during their hospital stay to introduce themselves and explain the program. Once the member has been discharged, the Community Paramedics will visit the member at home two to three more times to assure the member is following their discharge instructions, taking medications and have scheduled a primary care visit. At the home visit any other needs will be addressed, including home safety.

On the last visit a staff member of the CCHP Clinical Services team will partner with the Community Paramedics and visit the member together in their home. Based on the member's needs the Clinical Services staff member may enroll the member in ongoing Case Management.

If you have questions, please contact CCHP’s Clinical Services team at 877-227-1142.

Decreasing Unnecessary Antibiotic Use in Children

Thank you for demonstrating excellence by helping to decrease unnecessary antibiotic use in children with upper respiratory tract infections.

According to our records, you have provided antibiotics for 6% or fewer of the children you diagnosed with an Upper Respiratory Infection this year. You are among a group of our network physicians performing above the 75th percentile for this standard, nation-wide.

We appreciate your quality care for our patients.

Below is a list of providers that are demonstrating this excellence:

- Dr. Andrew Swietlik
- Dr. Ma Fe Francia Visaya
- Dr. Roberta Ashby
- Stacy Boden, APNP
- Dr. Rica Canseco
- Dr. John Dunn
- Dr. DeVang Gandhi
- Dr. George Milonas
- Dr. Samir Mullick
- Fabiola Boche, PA
- Megan Bucaro, APNP
- Dr. Marcos De La Cruz
- Mary Ford, NP
- Dr. Elizabeth Hagen
Lab Monitoring for Children Prescribed Atypical Antipsychotics

Submitted by: Kelly Hodges, MD and Lisa Zetley, MD

Over the last decade the number of atypical antipsychotics prescribed to children has increased dramatically. Despite concerns for overprescribing, there are many cases where atypical antipsychotics coupled with high quality evidence-based therapy services is the best option for a child with complex mental health concerns. It is important for all providers who care for children with complex needs to understand the side effects of these medications, and the laboratory monitoring that is necessary to ensure that development of metabolic abnormalities is detected and addressed early.

Atypical antipsychotics (also known as second-generation antipsychotics) generally have a more tolerable side effect profile than their predecessors, the first-generation antipsychotics. However, these drugs have the potential to cause metabolic side effects which include weight gain and the development of dyslipidemia and/or hyperglycemia. Because of these risks, it is important that all children prescribed these medications have their BMI, lipid profile, and fasting glucose and/or HbA1C checked within 30 days of initiating these meds, and every 6 months thereafter. This way metabolic changes can be detected early, and the prescriber can discuss the risks and benefits of continuing the medication at the current dose with the child and family.

Literature shows that children in foster care are prescribed atypical antipsychotics at a rate higher than children not in foster care. For those children enrolled in the Care4Kids program the care coordination team may help facilitate the ordering of these labs, either with the mental health prescriber or the primary care provider. Using a team approach is often necessary to ensure these high-risk children have appropriate monitoring for metabolic side effects.

Pediatric mental health is a complex problem that requires an array of tools to manage most effectively. Atypical antipsychotics are one of these tools, so ensuring that providers are aware of the potential side effects and the monitoring that is needed is one way to assure children remain in optimal physical and mental health while taking these medications.
Children’s Community Health Plan (CCHP), owned by Children’s Hospital of Wisconsin, is an HMO dedicated to providing access to the highest quality health care and services to BadgerCare Plus and Together with CCHP members.

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