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CareWeb QI Auto-Authorization Tool
CareWeb Qi Auto-Authorization Tool

Quality Improvement Program
Goals and Objectives
Thank you for choosing to participate in the provider network of Together with Children’s Community Health Plan (CCHP). We are committed to partnering with you and your staff to improve the health of our members.

**About Together with CCHP**
Children’s Community Health Plan is a Wisconsin-based health plan that has offered health insurance to individuals and families in our community for over 12 years.

In 2017, we expanded to offer Together with CCHP health insurance coverage, available both on and off the Marketplace in southeastern Wisconsin. We are proud to be affiliated with Children’s Hospital of Wisconsin and to offer individuals and families access to high-quality health care through a variety of plan options in Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties.

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

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

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

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

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

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

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

**Policy changes**
Policy changes can be found on Together with CCHP’s website.
Our six-county service area not only includes some of the area’s top providers, but also in-network specialists, pharmacists, and chiropractors.

Network hospitals in our service area include:

WASHINGTON COUNTY
- St. Joseph’s Hospital, West Bend

OZAUKEE COUNTY
- Columbia St. Mary’s Hospital – Ozaukee

WAUKESHA COUNTY
- Community Memorial Hospital
- Wheaton Franciscan – Elmbrook Memorial
- Rogers Memorial Hospital

MILWAUKEE COUNTY
- Wheaton Franciscan – St. Joseph Campus
- Children’s Hospital of Wisconsin
- Froedtert Memorial Lutheran Hospital
- Rogers Memorial Hospital – West Allis
- Medical College of Wisconsin
- Columbia St Mary’s
- Wheaton Franciscan Healthcare – St. Francis
- Wheaton Franciscan Healthcare – Franklin
- Rogers Memorial Hospital – Brown Deer

RACINE COUNTY
- Wheaton Franciscan Healthcare – All Saints (Spring Street Campus)
- Wheaton Franciscan Healthcare – All Saints (Wisconsin Avenue Campus)

KENOSHA COUNTY
- United Hospital System – Kenosha Medical Center Campus
- United Hospital System – St. Catherine’s Medical Center Campus
- Rogers Memorial Hospital
To maintain the best possible care for our members, we have established standards — ensuring our members have continuous access to quality health care services.

**Our promise**
To maintain quality standards for our members, we promise:

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

**After hours care**
Together with CCHP network providers must provide 24 hours a day/7 days a week coverage through telephone service or other on-call systems. Members may also seek care after hours at an in-network urgent care facility or through CCHP on Call, our 24/7 nurseline at 1-877-257-5861. Please see the Urgent Care section of this manual for additional details.

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

- Family Practitioners
- Internists
- Nurse Practitioners
- Pediatricians

**Appointment standards**
The list below includes the time limits for the providers in Together with CCHP’s network for scheduling medical and behavioral health care appointments.

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<thead>
<tr>
<th>Standards</th>
<th>Scheduled Appointed Time Frame</th>
</tr>
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<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 / Urgent Care Walk-in Clinic</td>
<td>Medical attention same day, no appointment needed</td>
</tr>
<tr>
<td>Non-urgent Sick Visit</td>
<td>Medical attention within two calendar days of member’s notification</td>
</tr>
<tr>
<td>Routine Primary Care and 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 Visit Appointment</td>
<td>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>Standards</td>
<td>Scheduled Appointed Time Frame</td>
</tr>
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<td>-----------------------------------------------</td>
<td>-------------------------------------------------------------------</td>
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<tr>
<td>Behavioral Health Care 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 Care Urgent Care</td>
<td>Visit within 48 hours of member’s request</td>
</tr>
<tr>
<td>Behavioral Health Care Routine Appointment</td>
<td>Visit within 10 days of member’s request</td>
</tr>
<tr>
<td>Emergency Dental Care Appointment (Severe pain, swelling or bleeding due to a dental accident. Dental coverage is limited to dental accidents.)</td>
<td>Visit within 10 days of member’s request</td>
</tr>
</tbody>
</table>
Participating providers in the Together with CCHP network agree to accept payment made by CCHP as payment in full. Any discounts a provider agrees to cannot be billed to a member or secondary insurance company. Members may be billed for copayments, coinsurance, deductible amounts, and non-covered services.

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

CORRECTED CLAIMS
- Should be stamped as a corrected claim.
- UB04: Corrected claims should be billed with the correct bill type

TIMELY FILING
Together with 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 Agreement. Claims related to work related injuries or illness should be submitted to the Worker’s Compensation carrier. Claims denied by the Worker’s Compensation carrier, should be submitted to us, along with the denial for consideration. Members are required to follow all referral and/or prior authorization guidelines. Claims must be submitted within the timely filing guidelines along with a copy of the denial.

TIMELY FILING DEADLINES
Please reference your Provider Network Agreement for the submission of new claims timely filing limits. Claims submitted after the time frame outlined in your Provider Network Agreement, will be denied for untimely filing. Members cannot be billed for Together with CCHP’s portion of the claims submitted after these deadlines. Members may be billed for copayments, coinsurance, and/or deductibles. Subrogation claims should be sent to our office for processing. We will pursue recovery of those expenses from the at-fault party and/or their liability insurer. Members are required to follow our referral and prior authorization guidelines. Claims must be submitted within the timely filing guidelines along with the denial.

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

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

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

1. Please submit their claim to the primary carrier first.
2. After the primary carrier pays, submit claim to Together with CCHP for consideration within the timely filing limit outlined in your Provider Network Agreement. Please include the primary carrier’s Explanation of Benefits (EOBs)

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

• Electronic Data Interchange (EDI)
  Together with CCHP accepts electronic claims in data file transmissions. Electronic claim files sent directly to CCHP are permitted only in the HIPAA standard formats. Providers who have existing relationships with the following clearinghouses can send claims electronically using the payer ID: 251CC, and may continue to transmit claims in the format produced by their billing software.
  • Change HealthCare (Emdeon)
  • RelayHealth (McKesson)
  • Gateway (Trizetto)
  These clearinghouses are then responsible for reformatting these claims to meet HIPAA standards and passing claims on to CCHP.

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

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

Submit claim forms to:
  Together with CCHP
  P.O. Box 106013
  Pittsburgh, PA 15230-6013

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

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

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<th>CMS-1500 Claim Forms</th>
<th>UB04 Claim Form</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Member Nameycle</td>
<td>Box 2</td>
<td>Box 8</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Box 3</td>
<td>Box 12</td>
<td></td>
</tr>
<tr>
<td>Member Number</td>
<td>Box 1.a</td>
<td>Box 60</td>
<td></td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Box 21</td>
<td>Box 67</td>
<td></td>
</tr>
<tr>
<td>Date of Service</td>
<td>Box 24.A</td>
<td>Box 6</td>
<td></td>
</tr>
<tr>
<td>Place of Service</td>
<td>Box 24.B</td>
<td>N/A</td>
<td>2-digit</td>
</tr>
<tr>
<td>Type of Bill</td>
<td>N/A</td>
<td>Box 4</td>
<td></td>
</tr>
<tr>
<td>Service Code</td>
<td>Box 24.D</td>
<td>Box 42</td>
<td>4-digit revenue code on UB-92</td>
</tr>
<tr>
<td>Billed amounts</td>
<td>Box 24.E</td>
<td>Box 47</td>
<td></td>
</tr>
<tr>
<td>Units</td>
<td>Box 24.G</td>
<td>Box 46</td>
<td></td>
</tr>
<tr>
<td>Provider NPI &amp; Taxonomy code</td>
<td>Box 24 J</td>
<td></td>
<td>Must match</td>
</tr>
<tr>
<td>Federal Tax ID</td>
<td>Box 25</td>
<td>Box 5</td>
<td></td>
</tr>
<tr>
<td>Total charges</td>
<td>Box 28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount paid by other insurance (if app.)</td>
<td>Box 29</td>
<td>Box 54</td>
<td></td>
</tr>
<tr>
<td>Balance Due</td>
<td>Box 30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Name</td>
<td>Box 31</td>
<td>Box 1</td>
<td></td>
</tr>
<tr>
<td>Provider Billing Address</td>
<td>Box 33</td>
<td>Box 1</td>
<td></td>
</tr>
<tr>
<td>Billing Provider NPI</td>
<td>Box 33 a</td>
<td>Box 56</td>
<td></td>
</tr>
<tr>
<td>Taxonomy code</td>
<td>Box 33b</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CODING POLICIES AND PROCEDURES

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

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

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

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

Commonly used Place-of-Service codes:

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Place of Service Code</th>
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<tr>
<td>Home</td>
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</tr>
<tr>
<td>Mobile</td>
<td>15</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>20</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
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</tr>
<tr>
<td>Outpatient Hospital</td>
<td>22</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>23</td>
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<tr>
<td>Ambulatory Surgical Center</td>
<td>24</td>
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<tr>
<td>Birthing Center</td>
<td>25</td>
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<tr>
<td>Military Treatment Facility</td>
<td>26</td>
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<tr>
<td>Skilled Nursing Facility</td>
<td>31</td>
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<tr>
<td>Nursing Facility</td>
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<tr>
<td>Custodial Care Facility</td>
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<tr>
<td>Hospice</td>
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<tr>
<td>Independent Clinic</td>
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<tr>
<td>Federally Qualified Health Center</td>
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<td>Inpatient Psychiatric Facility</td>
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<tr>
<td>Psychiatric Facility Partial Hospitalization</td>
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<tr>
<td>Community Mental Health Center</td>
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<tr>
<td>Intermediate Care Facility / Individuals with Intellectual Disabilities</td>
<td>54</td>
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<tr>
<td>Residential Chemical Dependency Treatment Facility</td>
<td>55</td>
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<tr>
<td>Psychiatric Residential Treatment Facility</td>
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<tr>
<td>Mass Immunization Center</td>
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<td>Comprehensive Inpatient Rehabilitation Facility</td>
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<td>Comprehensive Outpatient Rehabilitation Facility</td>
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<td>End-Stage Renal Disease Treatment Facility</td>
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<td>State or Local Public Health Clinic</td>
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<td>Rural Health Clinic</td>
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<td>Independent Laboratory</td>
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Effective 01/01/18
In some circumstances, it is appropriate for a provider to bill for a procedure that does not have an existing CPT/HCPCS code. The provider should bill with the “miscellaneous” or “not otherwise classified” code that is most appropriate for the service provided. Together with CCHP may ask providers for supporting documentation.

Listed below are physician modifiers that are billed frequently.

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

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

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

**HOME MEDICAL EQUIPMENT MODIFIERS**

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

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS</td>
<td>Six-month maintenance and servicing</td>
</tr>
<tr>
<td>RA</td>
<td>Replacement of a DME, orthotic, or prosthetic</td>
</tr>
<tr>
<td>RR</td>
<td>DME rental</td>
</tr>
<tr>
<td>NU</td>
<td>New equipment</td>
</tr>
<tr>
<td>UE</td>
<td>Used durable medical equipment</td>
</tr>
</tbody>
</table>

**CODE SPECIFIC POLICIES**

- Blood draw/venipuncture: We do not reimburse for blood draw/venipuncture when that service is provided in conjunction with any other laboratory or evaluation and management service on the same date of service.
- Surgical procedures: Providers must note surgical procedures performed during the same operative session by the same provider on a single claim form. Billing on separate claim forms may result in delayed payments, incorrect payments, or payment denial.
- Reimbursement: We process all clean claims within 30 days from the date they are received. Please reference your Provider Network Agreement for reimbursement information.
- Multiple payee addresses: We require providers to submit a single payee address per tax ID number. Together with CCHP does not honor multiple payee addresses.
CLAIMS EDITING SOFTWARE
Together with CCHP follows standard coding procedures as outlined in CPT, ICD10-CM, and HCPCS, as well as certain guidelines developed by CMS and/or a commercially available coding review software package used by CCHP. Payment to provider shall be based upon such industry standard coding procedures, as adopted by CCHP. In addition, CCHP may limit the codes certain providers may submit to CCHP for reimbursement.

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

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

• Process for refunds or returned checks
  Together with CCHP accepts overpayments in two ways – provider may refund additional money directly to us or we will take deductions from future claims.

• Refunds
  If Together with CCHP made a payment in error, providers may return the check or write a separate check from their account for the full amount paid in error. Providers should include a copy of the remittance advice, supporting documentation noting the reason for the refund, and the explanation of benefits (EOB) from other insurance carriers, if applicable.

  Refund should be mailed to:

  Together with CCHP
  P.O. Box 106014
  Pittsburgh, PA 15230-6014

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

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

ELECTRONIC CLAIMS SUBMISSION (EDI)
Electronic Data Interchange (EDI), also known as Electronic Claims Submission, enables health care providers to send and receive medical claims information. Together with CCHP supports all HIPAA-compliant electronic transactions. EDI transactions also eliminate paper checks being sent through the mail, which allows providers to receive payments sooner. For more information on the standards for EDI or to purchase copies of different EDI companion guides, visit the Washington Publishing Company website at http://www.wpc-edi.com. To set-up EDI transactions with us, please have your clearinghouse submit claims with our payer ID number 251CC.
Together with CCHP will reimburse contracted providers for covered, medically necessary bilateral services.

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

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

**Example of acceptable methods of billing bilateral:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>One claim line and code 73630-RT, LT (2 units)</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>One claim line and code 73630-50 (1 unit)</td>
<td>No</td>
</tr>
</tbody>
</table>
| 3                | Two claim lines: Claim line 1: 73630-RT (1 unit)  
Claim line 2: 736360-LT (1 Unit) | Yes                                      |
GRACE PERIOD

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

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

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

If claims were paid during the grace period, and the member terminates, Together with CCHP will recoup payments from the provider and the provider will bill the member for any outstanding balances on his/her account. It will be the member’s financial responsibility to pay for those services.
HIPAA & PERSONAL HEALTH INFORMATION (PHI)

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

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

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

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

OFFICIAL NOTICE OF PRIVACY PRACTICES

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

RELEASE OF PHI WITHOUT MEMBER AUTHORIZATION

Together with CCHP may disclose a member’s PHI without written authorization pursuant to a valid court order or subpoena, or as otherwise required by law, as well as health care operations and payments, such as:

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

MEDICAL RECORD ACCESS TO MEMBERS

Original medical records are not maintained by Together with CCHP. Members will contact their health care provider for access to their medical records. The member has the right to:

• Inspect and receive a copy their protected health information maintained by their providers.
• Request an account of such information and to place limitations on the disclosure of such information.
BEHAVIORAL HEALTH CARE, AND ALCOHOL AND OTHER DRUG ABUSE (AODA) SERVICES

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

Referrals and prior authorizations
Together with CCHP would like the members’ primary care providers (PCP) to play an integral part in meeting their comprehensive health care needs. We do not require referrals or prior authorizations for routine, in-network outpatient behavioral health care services.

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

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

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

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

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

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Services that extend beyond the period necessary for evaluation, diagnosis, and the application of evidence-based treatments or crisis intervention to be effective
- Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders, and other disorders with a known physical basis.
- Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias, and other Mental Health Disorders that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practices, as reasonably determined by the Practitioner. This exclusion does not apply for Mental Health Disorder services provided as the result of an Emergency detention, commitment or court order.
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
• Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
• Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
• Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Practitioner. If services for a nervous or Mental Health Disorder occur as a result of an Emergency detention, commitment or court order, the services will be covered.
• Services or supplies for the diagnosis or treatment of a Mental Health Disorder that, in the reasonable judgment of the Practitioner, are any of the following:
  • Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
  • Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
  • Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
  • Not consistent with the Practitioner’s level of care guidelines or best practices as modified annually.
  • Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient’s Mental Health Disorder, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks
• Treatment and services received at a residential treatment center

DIALYSIS SERVICES
The Together with CCHP Dialysis Diagnosis Code List includes but is not limited to the following diagnosis codes:
• I12.0; I13.11; I13.2;
• E09.22; E11.22;
• N18; N18.4; N18.5; N18.6; N18.9; N19.

Dialysis limitations:
• Dialysis services must be provided by our contracted provider.

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

DURABLE MEDICAL EQUIPMENT (DME) (INCLUDING HEARING AIDS)
Together with CCHP benefit plan authorizes DME based on the retail price of the individual item or the monthly rental price. We will determine whether the item will be purchased or rented. Multiple items may appear on an authorization, but only the items with the check box for retail price/monthly rental price of greater than $500 will require prior authorization (completion of this field is mandatory).
• For each item that requires a prior authorization, clinical documentation to support the need must be submitted with the request.
• Items not meeting the retail price criteria for prior authorization will be assigned a No Prior Authorization Required code status.

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

- Devices used specifically as safety items including car seats or booster seats or to affect performance in sports-related activities.
- Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. These exclusions do not apply for covered members who are at risk of neurological or vascular disease arising from disorders such as diabetes.
- The following items are excluded, even if prescribed by a provider:
  - Blood pressure cuff/monitor
  - Enuresis alarm
  - Non-wearable external defibrillator
  - Trusses
- Devices and computers to assist in communication and speech except for speech aid devices and tracheoesophageal voice devices for which benefits are provided as described under Durable Medical Equipment in the Covered Services section of the member’s Evidence of Coverage insurance contract
- Corrective appliances primarily intended for athletic purposes or related to a sports medicine treatment plan, and other appliances/devices, and any related services, including but not limited to:
  - Children’s corrective shoes
  - Arch supports
  - Special clothing or bandages of any type
  - Back braces
  - Lumbar corsets
  - Hand splints
  - Knee braces
  - Shoe inserts and orthopedics shoes except as described under Prosthetic Devices in the Covered Services section of the member’s Evidence of Coverage insurance contract
- Oral appliances for snoring
- Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
- Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
- Wearable robotic exoskeleton systems.

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

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

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

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

Bone anchored hearing aids are limited to one per lifetime and require Prior Authorization.
COCHLEAR IMPLANTS
Benefits are available for the following:
• The cost of cochlear implants that are prescribed by a physician or a licensed audiologist for a covered member under this benefit who is certified as deaf or hearing impaired by a physician or a licensed audiologist.
• The cost of treatment related to cochlear implants, including procedures for the implantation of cochlear devices.
• The cost of cochlear implants may not exceed the cost of one implant per covered member more than once every three years.
• Requires prior authorization.

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

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

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

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

HOME INFUSION THERAPY
Home Infusion Therapy is included in the Home Health Care benefit. Home Infusion Therapy will be considered if hospitalization or confinement in a skilled nursing facility would be necessary if Home Infusion Therapy services were not provided.

Home Infusion Therapy limitations:
• Nonprescription supplies are not a covered benefit.
• Pumps and medically necessary supplies are covered under the DME benefit.

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

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

Hospice Care services include but are not limited to:
• Physician services
• Nursing care
• Respite care
• Medical and social work services
Counseling services
• Nutritional counseling
• Pain and symptom management
• Medications
• Medical supplies and DME
• Occupational, physical, or speech therapies
• Volunteer services
• Home Health Care services
• Bereavement services

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

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

Skilled rehabilitation services include such services as physical therapy performed by or under the supervision of a professional.
• Benefits are available for:
  • Room and board in a semi-private room (a room with two or more beds)
  • Ancillary services and supplies — services received during the inpatient stay including prescription drugs, diagnostic and therapy services

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

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

Transplant criteria
Together with CCHP contracts with a transplant coordinator. The covered member’s condition must meet the following
criteria and be approved by both our designated transplant provider and us:
• The potential benefit of the transplant must outweigh the potential risk.
• The specific type of transplant must provide more benefit than other therapies, given the covered member’s
medical condition.
• The covered member must not have a terminal disease that the transplant would not correct or cure.
• The specific type of transplant must improve the covered member’s quality of life and health or functional
status. To determine this, we will rely only on scientifically designed and controlled research studies. We will rely
only on such studies published in peer reviewed medical publications that are accepted as appropriate by the
transplant or oncology academic communities;

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

Case Management
A case manager from Together with CCHP will be available to assist the member with care coordination/case
management. Please complete the Case / Disease Management Referral Form for the member, which is available on
the Provider Forms page at togetherCCHP.org.
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 Counselor

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 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:
   a. 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
   b. 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 Credentials 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:
   a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education.

2. Clinical Psychologists:
   a. Doctoral degree in clinical, counseling psychology or equivalent field of study from an institution accredited by the APA.
   b. Education and/or training deemed equivalent by the Credentialing Committee for a Practitioner with a doctoral degree not from an APA accredited institution but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.

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

4. Clinical Nurse Specialists (Psychiatry)
   a. Master’s degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
   b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing.
   c. 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/Deit 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 time frame 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.
REREDENTIALING 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 recredentialing. 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:**
      
      a. Whenever, the conduct or continuation of treating Covered Persons by a Practitioner constitutes or may result in an immediate danger to Covered Person(s) or the general public, the Medical Director or designee, acting on behalf of the Credentialing Committee, has the authority to (1) afford the individual an opportunity to voluntarily refrain from providing services to Covered Persons pending an investigation; or (2) suspend or restrict the Practitioner's participation in CCHP Network or programs, whichever is most appropriate under the circumstances.
      
      b. A summary suspension or restriction may be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Director, Credentialing Committee or QOC.

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

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

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

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

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

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

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

A. Right to an Appeal. 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.

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.

a. 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 on the matter that is the subject of the notice;
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

1. None of the following actions will constitute grounds for an appeal, and they will take effect without appeal. However, the Practitioner will be entitled to submit a written explanation to be placed into his or her file:
   a. Issuance of a letter of guidance, correction, counsel, warning, or reprimand;
   b. Failing to meet contractual obligations or qualifications specified in CCHP’s Credentialing policies or in the Practitioner’s network agreement; Summary suspension, unless it exceeds fourteen (14) days in duration;
   c. Determination that an application is incomplete;
   d. Determination that an application will not be processed due to a misstatement or omission;
   e. 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

a. 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

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

2. Provision of Relevant Information:
   • 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.
   • 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 copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted);
     iii. and copies of any other documents relied upon by the Credentialing Committee
   • The provision of this information is not intended to waive any privilege under the Wisconsin peer review / health care services review protection statute.
   • 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 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.

1. During the appeal, the Practitioner will have the ability to exercise any or all of the rights as set forth in the Notice of Adverse Action. A CCHP representative will present the reasons for the decision to reject or terminate the Practitioner.

2. It is the Practitioner’s burden to demonstrate, by a preponderance of the evidence, that there is no reasonable basis for the adverse recommendation or decision. The Practitioner will present reasons why his/her participation should not be rejected or terminated.

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

4. The maximum duration of the appeal will be two hours unless the Chairperson, in his or her discretion, determines that the appeal cannot reasonably be concluded in that time period.

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

6. Within twenty-one (21) days after receipt of the appeal transcript, the Appeals Committee shall submit its written findings and recommendations to the Medical Director for notification to the Credentialing Committee and Practitioner.

7. If the Practitioner fails to appear, participate or timely respond after notice and without sufficient cause as determined by the Appeals Committee, the Practitioner will be deemed to have waived the right to a hearing.

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

Reporting to Authorities

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

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. 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.
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. A copy of the audit tool used to assess credentialing policies and procedures
   b. A copy of the template Credentialing Delegation Agreement
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.
DELEGATED CREDENTIALING ELIGIBILITY POLICY

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

POLICY:
CCHP’s credentialing delegation process is intended to insure quality and efficiency and to minimizes the risk of jeopardizing CCHP’s accreditation status. CCHP only delegates credentialing roles and responsibilities to entities that:

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

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

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

- Provide the prospective delegate with NCQA standards, elements, and factors that CCHP will be auditing for compliance.
- The prospective delegate organization will provide policies and documents that demonstrate compliance with applicable NCQA Credentialing Standards.
- CCHP Credentialing Staff will audit randomly selected files of practitioners who have been initially credentialed and practitioners that have been re-credentialed by the prospective delegate.
- The results of the policy and procedure audit and the file audit must demonstrate 100% compliance with applicable NCQA standards prior to signing a credentialing delegation agreement.
- Upon completion of a successful credentialing pre-delegation audit, CCHP and the prospective delegate will sign a mutually agreed upon Credentialing Delegation Agreement, and indicate the effective date of the agreement.
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 were 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.
Out-of-network providers will be reimbursed for emergency and urgent care services based on the maximum allowed amount as defined in the Evidence of Coverage.

**EMERGENCY DEFINED**
A condition of sudden onset for a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one or more of the following:
- Placing the health of the individual (or with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Other serious medical consequences

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

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

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

Members may contact the provider’s office, “CCHP on Call” the 24-hour nurseline at 1-877-257-5861, or seek services from an urgent care facility. You can locate an urgent care facility on our website at togetherCCHP.org/find-a-doc.
HEALTH MANAGEMENT PROGRAMS

CASE MANAGEMENT

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

Criteria for eligibility includes:

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

Other complex care situations will be considered

Services include:

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

HEALTH MANAGEMENT

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

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

REFERRALS

If members would like help managing any concerns related to their health, please call 414-266-3173 to reach the Health Management team. Please complete a referral form on children’scommunityhealthplan.org. This form can be faxed to 414-266-1715. For more information or online resources and tools that support your patients healthy lifestyle, visit our website at togetherwithcchp.org
HEALTHY MOM, HEALTHY BABY
Healthy Mom, Healthy Baby provide personalized support and resources to women during all stages of their pregnancy and up to 12 months post-partum. Healthy Mom, Healthy Baby program is designed to improve the health and well-being of women by pairing expectant and new mothers with a case manager.

Our team will provide this service over the phone. Other services include breast feeding support, behavioral health support, nutritional education and high-risk family case management. Please call [1-414-337-BABY] for more information.

SMOKING CESSATION PROGRAMS
Together with CCHP members have access to the following benefits to help quit smoking:

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

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

CCHP NURSE LINE – CCHP ON CALL
CCHP on Call which is our system for answering health care questions.

When should members use CCHP on Call?

- Before going to the emergency room. If the emergency is life threatening, call 911.
- For any general health questions or concerns.
- If a child has a fever.
- If a child sprains an ankle.
- For help deciding where to go for help.
- For skin irritation or rash.
- Child has a scrape or cut.
- Anytime there is a question about where to go for Your health care.

We have nurses on duty 24 hours a day, seven days a week to help answer questions. Simply call 1-877-257-5861. This is a free phone call.

PREVENTIVE SERVICES
Together with CCHP covers many preventive services at no cost to its members, including screening tests and immunizations in accordance with the Patient Protection and Affordable Care Act of 2010 (ACA).

We have an online recommendation and guide of preventive services, which may be covered without a copayment or applying to the member’s deductible or coinsurance, as long as the services are recommended as preventive by their provider and are delivered by an in-network provider. Providers can find this list on our website at togetherCCHP.org.

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

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

Our Together with CCHP Providers have the right to:

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

PROVIDER RESPONSIBILITIES

Together with 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 the Provider Relations Representative at 1-844-229-2775.

Notify Together with CCHP in writing of the following events:

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

Referrals
In-network specialists: Together with CCHP plans do not require written referrals for its members to any in-network provider.

Out-of-network: Providers must contact Together with CCHP at 1-844-450-1926 to submit a prior authorization request. Out-of-network services are generally not covered.

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

Providers not accepting new patients Providers closing their panel to new patients must submit a written notice to the Provider Relations team that they are not accepting new patients.
• Letters regarding termination of patient care must be sent, along with our Missed Appointment Notification form (on the website), to the Provider Relations prior to notifying the member.
• Mail termination of patient care letter and Missed Appointment Notification Form
• Appointment Notification form to:
  Together with CCHP
  Attn.: Together with CCHP Member Advocate
  P.O. Box 1997, MS6280
  Milwaukee, WI 53201-1997

Member notification when a provider leaves the Together with CCHP network:
• The provider is required to notify us as outlined in the Provider Network Agreement
• At least 30 days prior to the effective date of termination, we will send members a letter notifying them of the change, provided we were notified timely of the change

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

ADVANCE DIRECTIVES
The federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make decisions about their medical care in advance of an 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
• If you’re not able to be the member’s primary care provider because of a conscionable objection to an advance directive. You can reach Customer Service at 1-844-201-4672.
MEDICAL RECORDS
As a contracted provider with Together 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
Together with 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

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 HAVE THE RIGHT TO:

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

MEMBERS HAVE THE RESPONSIBILITY TO:

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

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

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

PRESCRIPTION DRUG FORMULARY
Our formulary is the list of Food and Drug Administration (FDA)-approved drugs that are covered with the plan. Together with CCHP’s Pharmacy and Therapeutics (P&T) Committee researches and evaluates drugs it may cover. Committee members include doctors and pharmacists who meet regularly during the year to review and update the formulary.

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

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

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

GETTING PRESCRIPTIONS FILLED
- Retail
  - Together with CCHP’s network of retail pharmacies includes hundreds of locations, independent pharmacies, as well as multi-store chains throughout the region. Members can take their prescription to any pharmacy in the network. Members must use 75 percent of their drug before getting a refill.
  - Go to togetherCCHP.org/Find-a-pharmacy for specific pharmacy names, locations, and telephone numbers. Members can also call Customer Service at 1-844-201-4672.
• Mail order
  • Mail-order prescriptions are written for a 90-day supply. If the doctor writes for a 30-day supply with two refills, the mail order facility may combine the prescription to make a 90-day supply. If members do not want a 90-day supply, they should write, “Do Not want a 90-day Supply” on the mail-order form.
  • For a new medication, the first time, members get a prescription or a new drug, we recommend that trying a 30-day supply of the drug from a retail pharmacy. That way the practitioner has a chance to make sure that it is the right dose and that it does not cause any side effects.
  • Members can ask for a mail-order form by calling Customer Service at 1-844-201-4672, or by requesting the form through togetherCCHP.org.

SPECIALTY MEDICATIONS
Specialty drugs must be obtained through our designated specialty provider, Accredro. When members are prescribed a specialty drug and use a specialty provider, they get mail-order delivery and better access to drugs, because many retail pharmacies do not have these types of drugs.
  • Specialty drugs that require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy must be obtained through our designated specialty provider. A specialty provider offers cost-saving health care, and drug management and compliance programs.

DRUG SUPPLIES NOT COVERED
• If members will be away from home for a long period of time, they may want to use our mail-order service to get a 90-day supply before they leave.
• No authorizations will be provided for drugs reported by the member, provider, or pharmacy to be lost, misplaced, stolen, destroyed, or damaged.
• Drugs received at no charge to the member (workers’ compensation, drugs purchased with a manufacturer’s coupon) will not be covered.
• Prescriptions that are written more than a year ago will not be covered. The member’s provider will need to write a new prescription.

MEDICATIONS NOT COVERED
The following medications are benefit exclusions and will not be covered under the pharmacy benefit:
• Antimalarial agents when used for prevention
• Anti-obesity medications, including, but not limited to appetite suppressants and lipase inhibitors
• Blood or blood plasma products*
• Compounded products containing excluded ingredients (examples are compounded hormone replacement therapies and compounded narcotic analgesics)
• Drugs labeled for investigational use
• Fertility agents
• Legend vitamins (other than prenatal, fluoride, and certain therapeutic vitamins)
• Most over-the-counter (OTC) medications**
• Needles/Syringes (other than insulin)*
• Nutrition and dietary supplements*
• Therapeutic devices/appliances*
• Urine strips. (Because our doctors feel blood glucose strips are more accurate than urine test strips in measuring blood glucose, urine strips are not a covered benefit.)
This is not a complete list and there may be other medications that are not covered. For more information, contact Customer Service at 1-844-201-4672.

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

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

FILLING PRESCRIPTION WHEN TRAVELING

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

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

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

NON-FORMULARY EXCEPTIONS

If the drug the member takes is not on the list of covered drugs for their benefit plan (also called a “formulary”), the member can ask Together with CCHP to cover it.

This is called a “non-formulary exception.” A request for a non-formulary exception will only be approved if:

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

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

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

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

A medications grid that lists all the medications which require prior authorization as well as if the medication is considered a medical or pharmacy benefit. This can be found on the Together with CCHP’s website.

The Medication List grid will indicate whether a prior authorization is needed through the pharmacy or medical benefit. Further instruction may be provided in the notes section of the grid.

**Pharmacy benefit:**

Medications covered under the pharmacy benefit and that require prior authorization must be completed by downloading an authorization form from Together with CCHP’s website. After filling out this form, please fax it to CCHP Pharmacy Services at 844-201-4675.

If you have questions regarding medications that are covered under the pharmacy benefit please contact Pharmacy Services at 844-201-4677. After authorization is received the provider needs to request the medication from Accredo Specialty Pharmacy. Providers can contact Accredo Specialty Pharmacy at 866-759-1557 for prescriptions and renewals after authorization has been received. In addition, a provider can check the status of a prescription by calling 844-516-3319. Accredo Specialty Pharmacy will mail the prescription. Accredo Specialty Pharmacy will bill Express Scripts.

**Medical benefit:**

Medications covered under the medical benefit and require prior authorization must be completed through the CareWeb Qi Authorization Tool which can be found in the CCHP Provider Portal.

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

After submitting the prior authorization request through the CareWeb Qi Authorization Tool, CCHP’s Utilization Staff will review the request. The assigned UM Staff member may reach out for additional clinical information through the CareWeb Qi Authorization Tool. Providers can view the status of their request in the CareWeb Qi Authorization Tool.
MEDICATION PRIOR AUTHORIZATION

If a drug requires prior authorization, the Together with CCHP Pharmacy Services department must authorize the use of this drug before it will be covered. Drugs that require prior authorization are often:

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

STEP THERAPY

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

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

QUANTITY LIMITS

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

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

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

Providers have the right to file an appeal to Together with CCHP within the time frame outlined in your Provider Network Agreement.

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

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

To file a formal appeal:

• First complete the Provider Appeal Form, which is available on the Provider Forms page at togetherCCHP.org.
• Next, mail it to us, along with copies of any supporting documents.
• Submit your written appeal to:
  Together with CCHP
  Attn.: Appeals Department
  P.O. Box 1997, MS 6280
  Milwaukee, WI 53201-1997

We will send you a letter within five business days notifying you that the appeal was received. We will review the appeal, investigate, and provide you with a decision within 45 calendar days of receiving the appeal. If appealing on behalf of the member, the member needs to authorize the provider to do so.

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

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

You can also call 1-800-236-8517 or email complaints@ociwi.state.us and request a complaint form.

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

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

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

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

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

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

3. Submit the written request or the Provider Appeal Form, along with any supporting documentation to:
   Together with CCHP
   Attn.: Appeals Department
   P.O. Box 1997, MS 6280
   Milwaukee, WI 53201-1997

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

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

Member complaints If you have a member complaint, please contact Customer Service at 1-844-202-4672. Provider Services representatives are available to take your call during regular business hours, Monday through Friday. After we receive your complaint, the member will be notified of our decision within 30 days.
### AFFORDABLE CARE ACT COMPATIBLE

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

### PLAN OPTIONS

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

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<tr>
<th>PLAN DESCRIPTIONS</th>
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<th>BRONZE</th>
<th>SILVER</th>
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| Primary care office visit | 2 free visits, then 0% after deductible | $60 copay | 0% after deductible | $50 copay | $35 copay | $30 copay | $30 copay |
| Specialty/specialist office visit | 0% after deductible | 50% after deductible | 0% after deductible | $50 copay | $80 copay | $65 copay | $60 copay |
| Inpatient and outpatient services | 0% after deductible | 50% after deductible | 0% after deductible | 40% after deductible | 40% after deductible | 20% after deductible | 20% after deductible |
| Urgent care | 0% after deductible | 50% after deductible | 0% after deductible | $10 copay than deductible/coinsurance | $80 copay than deductible/coinsurance | $65 copay than deductible/coinsurance | $60 copay than deductible/coinsurance |
| Emergency room | 0% after deductible | 50% after deductible | 0% after deductible | 40% after deductible | 40% after deductible | 20% after deductible | 20% after deductible |

### Prescription Drugs

| Tier 1: Generic | 0% after deductible | $20 copay | 0% after deductible | $10 copay | $15 copay | $15 copay | $10 copay |
| Tier 2: Preferred brand | 0% after deductible | 60% after deductible | 0% after deductible | 40% after deductible | 55 copay | $50 copay | $55 copay |
| Tier 3: Non-preferred brand | 0% after deductible | 50% after deductible | 0% after deductible | 40% after deductible | 30 copay than deductible/coinsurance | $30 copay than deductible/coinsurance | $20 copay than deductible/coinsurance |
| Tier 4: Specialty prescriptions? | 0% after deductible | 50% after deductible | 0% after deductible | 40% after deductible | 30 copay than deductible/coinsurance | $30 copay than deductible/coinsurance | $20 copay than deductible/coinsurance |
| Tier 5: ACA preventive pharmaceuticals | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Tier 6: Select generics | $0 | $0 | $0 | $0 | $0 | $0 | $0 |

### Award-winning customer service

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MEMBER ID CARDS

All Together with CCHP members receive one individualized identification card. We require members to show their ID cards before they receive services or care.

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

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

- Plan name
- Full name of the member: Each member / dependent is listed under “member name.”
- 11-digit member ID number
- Issue date: This is the date the ID card was printed.
- It identifies the subscriber’s most current benefits.
- Cost sharing amounts: This lists benefit coverage, including any office visit copayments and prescription drug coverage.
- Pharmacy information
- Pediatric vision Customer Service information
- Claims submission information
- Customer Service information
**TOGETHER WITH CCHP PROVIDER RELATIONS REPRESENTATIVES – 1-844-229-2775**

<table>
<thead>
<tr>
<th>Provider Services</th>
<th>1-844-202-0117</th>
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<tr>
<td>We have a team dedicated to serve your specific needs. Call us, we’re happy to help.</td>
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<tr>
<th>Prior Authorizations</th>
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<tbody>
<tr>
<td>Please see the Prior Authorization list on our website for the most up-to-date listing of services that require a prior authorization.</td>
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<tr>
<td>Phone: 1-844-450-1926</td>
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<tr>
<td>Fax: (414) 266-4726</td>
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<tr>
<th>Credentialing</th>
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<tr>
<td>Email: <a href="mailto:cchp-credentialing@chw.org">cchp-credentialing@chw.org</a></td>
<td></td>
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<tr>
<td>Phone: 1-844-229-2776</td>
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<tr>
<td>Fax: (414) 266-5797</td>
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<tr>
<th>Customer Service for members</th>
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<tr>
<td>Monday through Friday, 8:00 a.m. to 5:00 p.m.</td>
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<tr>
<td>Saturdays, 8:00 a.m. to 2:00 p.m.</td>
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<tr>
<td>Phone: 1-844-201-4672</td>
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<tr>
<td>Fax: 1-844-201-4673</td>
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<tr>
<th>Pharmacy Questions</th>
<th>1-844-201-4677</th>
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<tr>
<td>Please see the Pharmacy Benefit Guide for the latest listing of prescriptions drugs that are covered or not covered.</td>
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<tr>
<td>Fax 1-844-201-4675</td>
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<thead>
<tr>
<th>Provider Appeals Address</th>
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<tr>
<td>Please see Provider Appeals Process page in this manual for more information on the appeals processes.</td>
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<tr>
<td>Provider Appeals</td>
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<tr>
<td>Attn: Appeals Department</td>
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<tr>
<td>P.O. Box 1997, MS 6280 z</td>
<td></td>
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<tr>
<td>Milwaukee, WI 53201</td>
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<tr>
<th>Claims Address</th>
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<tbody>
<tr>
<td>Please see the Provider Appeals Process page in this manual for more information on the claims process. Mail check or money order to the claims address.</td>
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<tr>
<td>Together with CCHP</td>
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<tr>
<td>P.O. Box 106013</td>
<td></td>
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<tr>
<td>Pittsburgh, Pennsylvania 15230-6013</td>
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<td>EDI#: 251CC</td>
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<tr>
<th>Provider Manual</th>
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<tr>
<th>Fraud, Waste, and Abuse</th>
<th>1-877-659-5200</th>
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<tr>
<th>Provider Relations Manager</th>
<th>Dawn Rady</th>
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<tr>
<td>Senior Provider Relations Representative</td>
<td>Diana Schneider</td>
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<tr>
<td>Provider Relations Representative</td>
<td>Tina Powell</td>
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<tr>
<td>Provider Relations Representative</td>
<td>Stacey Martinez</td>
</tr>
<tr>
<td>Provider Contracting Specialist Provider</td>
<td>Sue Gorecki</td>
</tr>
<tr>
<td>Network Specialist</td>
<td>Blia Lor</td>
</tr>
<tr>
<td>Provider Network Specialist</td>
<td>Kamesha Hall</td>
</tr>
<tr>
<td>Provider Communications Specialist</td>
<td>Christie Green</td>
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<tr>
<td><a href="mailto:drady@chw.org">drady@chw.org</a></td>
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<td><a href="mailto:cgreen@chw.org">cgreen@chw.org</a></td>
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INTERPRETER SERVICES
CCHP provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and who have language services needs and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

If a member you’re helping has questions about Together with CCHP, they have the right to get help and information in their language at no cost.
   Interpreter services, call 1-844-201-4672
   TTY users, call 1-844-531-4856

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

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

TOGETHER WITH CCHP’S PROVIDER TOOL
The Together with CCHP Provider Tool is used to check member eligibility, search and submit claims and chat with Customer Service. Registration instructions and instructions on how to use the tool can be found inside CCHP’s Provider Portal. If have additional questions you can call 844-202-0117.

ACCESSING PROVIDER DIRECTORY INFORMATION
Together with CCHP offers a Provider Directory to ensure our members are receiving the most current information about their providers. You can access the Provider Directory at togetherCCHP.org. You can search by provider’s name, location, and specialty.

THE PROVIDER UPDATE/CHANGE FORM
To ensure we meet the Centers for Medicare & Medicaid Services (CMS) online provider directory requirements, CCHP updates its Provider Directory regularly. To make sure the provider information we have in our Provider Directory is accurate, review your information often. If any of your information has changed, or is not listed accurately or at all, please make the appropriate changes quickly and easily by downloading the Provider Update/Change Form, which is available on the Provider Forms page at togetherCCHP.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 their Provider Directory:
- Name
- Gender
- Specialty
- Hospital affiliation
- Medical group affiliation
- Board certification
- Accepting new patients (PCP only)
- Languages spoken (by provider and staff)
- Office location and phone number
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

Together with 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 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

Together with 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
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:
Together with CCHP
Attn.: Manager of Utilization Management
P.O. Box 1997, MS6280
Milwaukee, WI 53201-1997

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

PROCESSES USED TO MAKE DETERMINATIONS
Utilization Management staff members review concurrent inpatient admissions with the exception of obstetrical delivery admissions for medical necessity. Specifically identified services as outlined on the prior authorization list of services are also reviewed. 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.
PRIOR AUTHORIZATIONS
Together with 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 the Utilization Management (UM) Program.

Our contracted providers are responsible for obtaining prior authorization before they provide services to covered members.

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

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

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

If the provider chooses to provide a service that has been determined not to be medically necessary, and is not a covered service, or has not been prior authorized though prior authorization is required, the covered member will be responsible for paying all charges and no benefits will be paid.

PROCESS FOR OBTAINING PRIOR AUTHORIZATIONS
Providers should start the prior authorization process as soon as possible, before the beginning of treatment. The provider must submit a prior authorization request online through the Provider Portal at togetherCCHP.org. If you have questions about the prior authorization process, please contact Together with CCHP Customer Service at 1-844-201-4672.

URGENT PRE-SERVICE REQUESTS
If the member or a health care professional with knowledge of the member’s medical condition has an urgent request for prior authorization, the provider must submit the request via the Provider Portal. Together with 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:
- Together with 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 Together with 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
Together with 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
Together with 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
Together with 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
Together with 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:

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

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

- All in-network providers must use the provider portal for reporting of inpatient admissions and submission of clinical documentation supporting those admissions.
- All inpatient admissions are reviewed for medical necessity.
EMERGENCY CARE SERVICES
Together with 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:
- Knee arthroplasty, total
- Elbow arthroplasty
- Shoulder arthroplasty
- Shoulder hemiarthroplasty
- Hip arthroplasty
- Hysterectomy
• Wrist arthroplasty
• Cervical and lumbar laminectomy, disectomy / micro discectomy
• Sympathectomy by thoracoscopy or laparoscopy
• Urethral suspension procedures
• Electrophysiologic study and implantable cardioverter-defibrillator (ICD) insertion, transvenous
• Genetic testing, including BRCA genetic testing
• Home Health care
• Hospice care
• Inpatient hospital stays require notification within 24 hours of admission
• Inpatient rehabilitation

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

Substance use disorder services, including the following levels of care:
• Inpatient
• Partial hospitalization / day treatment
• Intensive outpatient

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

TOGETHER WITH CCHP PRIOR AUTHORIZATION LIST
Before submitting your prior authorization request, go to our website at togetherCCHP.org 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 CareWebQI Auto Authorization tool allows providers to submit notifications, prior authorizations, and check authorization status. Network providers must submit their notifications and requests using this tool through our Provider Portal. Documentation supporting the medical necessity of an inpatient admission or a prior authorization request should be uploaded into the authorization request when it’s created. There are Portal user’s guides available on the Provider Resources page at togetherCCHP.org.

Preregistration instructions
If you’re registered for the Provider Portal with the CCHP Medicaid plan, the same login and password can be used. If you’re a new network provider or haven’t registered for the Together with 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 Together with 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 at togetherCCHP.org to complete our registration form. Site administrators will need their facility’s tax ID number and registration code.
2. Confirm the online registration form was submitted. Within a few minutes of submitting the registration form, site administrators should receive a confirmation email.
3. Verify the email address. Within 30 minutes of submitting the online registration form, site administrators should receive an email to verify the email address they provided — they should click on the link in that email.
4. Next, site administrators will receive an “Email Verification Completed” email from Together with CCHP.
5. In approximately three business days, site administrators will receive another email from Together with CCHP with their user login information and password.

REGISTERING ADDITIONAL USERS
Once the site administrator has registered for the Together with CCHP Provider Portal, there are two options for registering additional users.
1. For site administrators registering individual users:
   • Go to the online registration form at togetherCCHP.org
   • Complete the fields with individual user’s information
   • Enter the organization’s tax ID number
• Enter the registration code provided in the portal welcome letter
• Go to the drop-down menu “What type of user are you registering?” and select “A general user”

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

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