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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 11 years.

In 2016, 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.
CHILDREN’S COMMUNITY HEALTH PLAN POLICY CHANGES:

POLICY CHANGES AND NEW POLICIES CAN BE FOUND IN THE PROVIDER SECTION OF CCHP’S WEBSITE.

HERE ARE THE MOST UPDATED POLICIES:

1. DRUG TESTING FOR SUBSTANCE USE DISORDERS AND CHRONIC PAIN TREATMENT
2. PROVIDER SUSPENSION TERMINATION APPEAL RIGHTS
3. QUALITATIVE DRUG SCREENING REIMBURSEMENT
4. SCOLIOSIS
5. SAPHENOUS VEIN ABLATION
6. REPLACEMENT AND REPAIR OF DME
7. PCW
8. NEW TECHNOLOGIES
9. MEDICAL NECESSITY
10. LUMBOSacRAL ORTHOTICS (BACK BRACES)
11. KNEE BRACE
12. HIGH FREQUENCY CHEST WALL COMPRESSION DEVICES
13. GENETIC TESTING
14. GENDER REASSIGNMENT SURGERY
15. FACET NEUROTOMY BY RADIOFREQUENCY ABLATION FOR SPINAL PAIN
16. FACET JOINT INJECTIONS
17. EPIDURAL CORTICOSTEROID INJECTIONS FOR SPINAL PAIN
18. CUSTOM FOOT ORTHOTICS
19. CRANIAL ORTHOTIC MOLDING HELMETS FOR BRACHYCEPHALY
20. CONTINOUS PASSIVE MOTION DEVICES
21. CPAP APAP USE IN OBSTRUCTIVE SLEEP
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.

<table>
<thead>
<tr>
<th>Standards</th>
<th>Scheduled Appointed Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td>For a life-threatening situation, members are instructed to go to the nearest emergency room or call 911 for immediate medical attention</td>
</tr>
<tr>
<td>Urgent Care Clinic / 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>
</tbody>
</table>
## ACCESS STANDARDS

<table>
<thead>
<tr>
<th>Standards</th>
<th>Scheduled Appointed Time Frame</th>
</tr>
</thead>
<tbody>
<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 a claim is submitted with an error, the provider must submit a new claim. Claims must be submitted within the timely filing requirements or the claim will be denied.
• 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.

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 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.

Claims for Qualified Treatment Trainees
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 QTTs 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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<thead>
<tr>
<th>Required Information</th>
<th>CMS-1500 Claim Forms</th>
<th>UB04 Claim Form</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Name</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>
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>Code</th>
<th>Place of Service</th>
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</thead>
<tbody>
<tr>
<td>11</td>
<td>Office</td>
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<tr>
<td>12</td>
<td>Home</td>
</tr>
<tr>
<td>15</td>
<td>Mobile</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Facility</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
</tr>
<tr>
<td>49</td>
<td>Independent Clinic</td>
</tr>
<tr>
<td>50</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric Facility Partial Hospitalization</td>
</tr>
<tr>
<td>53</td>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>54</td>
<td>Intermediate Care Facility / Individuals with Intellectual Disabilities</td>
</tr>
<tr>
<td>55</td>
<td>Residential Chemical Dependency Treatment Facility</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric Residential Treatment Facility</td>
</tr>
<tr>
<td>60</td>
<td>Mass Immunization Center</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
</tr>
<tr>
<td>65</td>
<td>End-Stage Renal Disease Treatment Facility</td>
</tr>
<tr>
<td>71</td>
<td>State or Local Public Health Clinic</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td>81</td>
<td>Independent Laboratory</td>
</tr>
</tbody>
</table>
CODES AND MODIFIERS

• **Unlisted codes**
  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.

• **Modifiers**
  Listed below are physician modifiers that are billed frequently.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<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>
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.
CODING POLICIES AND PROCEDURES

• 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 QTTs with a graduate degree working towards full clinical licensure.

CLAIMS EDITING SOFTWARE
Children’s Community Health Plan 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. See Claims Filing Methods on page 5 for more details.

**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 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 ember.

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

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 ear 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

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.
CREDENTIALING PROGRAM
Together with CCHP credentials both individual practitioners and organizational providers. Our Credentialing Program determines if a practitioner or organizational provider is qualified to provide quality care to members by verifying adequate training, experience, licensure, and by evaluating data and information collected. More information on our Credentialing Program is available on our website at togetherCCHP.org.

CREDENTIALING APPLICATION PROCESS
To begin the credentialing process, practitioners can use the Council for Affordable Healthcare’s (CAQH) ProView™ database for their registration, which is available at proview.caqh.org.

To apply using the CAQH ProView™ database for registration:
- Already registered? Simply email your CAQH number to cchp-credentialing@chw.org.
- Not registered? Register with CAQH and complete the CAQH credentialing application. Notify CCHP when you have registered by emailing us your CAQH number at cchp-credentialing@chw.org.

Completing the credentialing application
While completing the CAQH application, you will need to include the following required information to begin the credentialing process:
- All sections of the application must have a response (“N/A” if not applicable)
- All dates (work/employment/education) must be documented in month/year format
- Employment history (include month and year) from the last five years
- Gaps in employment greater than 90 days must be explained in writing
- For hospital privileges include hospital name, affiliation status, start date (month and year)
  - If in process, must include covering physician’s name, hospital affiliation, status, start date (month and year)
  - If no hospital privileges, need to explain admitting arrangements, if thru a covering physician, include hospital name, affiliation status and start date (month/year)
- A copy of professional liability insurance face sheet (must include dates and incident/aggregate dollar amounts)

CREDENTIALING DEPARTMENT CONTACT INFORMATION
All credentialing information can either be emailed to cchp-credentialing@chw.org or faxed to the attention of Credentialing at (414) 266-5797.

If you prefer to send via U.S. Mail, please address to:
Together with CCHP
Attn: Credentialing
P.O. Box 1997, MS6280
Milwaukee, WI 53201-1997

Application acceptance criteria
For an application to be accepted, a provider must meet the following three criteria:
- Applicant has current valid and unrestricted license without limitations or sanctions from the state(s) in which they practice.
- Applicant is not excluded from participating in Medicare and/or Medicaid programs (lack of sanctions or debarment).
- No prior denials or terminations. The Applicant must not have been denied participation (for reasons other than network need) by us within the preceding 24 months.
RECREDENTIALING

CCHP recredentials licensed individual practitioners (LIPs) at least every 36 months from the month of the previous credentialing decision.

If the LIP is on active military duty, maternity leave or sabbatical, the Recredentialing cycle is extended by the Credentialing Committee and documentation is placed in the practitioner’s credentialing file. Upon return to practice, the LIP is recredentialed within 60 calendar days.

If an LIP has been terminated for administrative reasons and not for quality reasons, and the LIP is reinstated within 30 days, initial credentialing is not required. If reinstatement is more than 30 calendar days after termination, initial credentialing is performed.

Credentialing of organizational providers
- Continued participation of network organizational providers is periodically assessed by verifying:
  - Copies of current licenses (if applicable)
  - Copy of current accreditations
  - Compliance with Provider Network Agreement. An applicant for Recredentialing must have demonstrated compliance with all terms of the Provider Network Agreement, specifically including successful participation in quality improvement initiatives or completion of individual improvement plans requested by us.

CREDENTIALING CONFIDENTIALITY

CCHP monitors access to information obtained during the credentialing process and does not disclose to outside parties without permission of the practitioner involved, or as permitted by law, including the Health Care Quality Improvement Act of 1986.

CREDENTIALING DEFINITIONS

- **Licensed independent practitioner or LIP**
  Any health care professional who is permitted by law to practice independently within the scope of the individual’s license or certification, which includes but is not limited to: audiologists (AUDs); certified nurse midwives (CNMs); certified registered nurse anesthetist (CRNAs); medical doctors (MDs); doctors of osteopathy (DOs); oral surgeons (DDS or DMD); chiropractors (DCs); doctors of podiatric medicine (DPMs); psychiatrists (MDs); psychologists (PsyD or PhD); nurse practitioners (NP or APNP); allied behavioral health practitioners (CSAC, LPC, LCSW, LMFT); and all other non-physician practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision), have an independent relationship with CCHP, and provide care under a benefit plan.

- **Organizational provider**
  Includes but is not limited to: hospitals; home health agencies; skilled nursing; behavioral health centers providing mental health and substance abuse services (inpatient, residential, and ambulatory); and freestanding surgical centers.

- **Quality Oversight Committee (QOC)**
  The QOC is the Together with CCHP subcommittee of the Board of Directors that is responsible for the oversight and direction of the Together with CCHP Credentialing Committee. The QOC reviews and approves changes to the Credentialing program description which are required to meet regulatory requirements or other organizational and business needs.

The Credentialing Committee evaluates and investigates Covered Persons Quality of Care complaints, and determines or recommends to the QOC whether and what type of disciplinary action should be taken in relation to those complaints between the credentialing and recredentialing cycle.
Complaints requiring investigation may involve a physician, health care professional, or Organizational Provider that delivers health care to Covered Persons. The QOC complies with applicable state peer review requirements and is composed of medical directors, participating physicians and CCHP clinical staff.

**PRACTITIONER AND PROVIDER RIGHTS**

**Right to review information**
To evaluate the credentialing application, including information from outside sources (e.g., malpractice insurance carriers, state licensing boards), with the exception of references, recommendations, or other peer-review protected information.

**Right to correct erroneous information**
The Together with CCHP credentialing department notifies practitioners within 15 days when credentialing information obtained from other sources varies substantially from what was provided by the practitioner. Practitioners must submit any corrections in writing to us within 15 days of notification of the discrepancy or the processing of his/her application will be terminated. A CCHP Medical Director will notify applicants by mail or email of the credentialing decision within 30 calendar days of the Credentialing Committee’s decision and notification will not exceed timelines required by the credentialing authority.

**Right to be informed of application status**
All applicants have the right to be informed of their application status. Please email us at cchp-credentialing@chw.org for application status inquiries.

**Right to an appeal**
Participating practitioners and providers have the right to request an appeal of an adverse decision. To request an appeal, the practitioner and/or organizational provider has 30 days from the receipt of notice of a restricted participation or denial of participation to submit a written request for appeal. The request:
- Outlines why the practitioner and/or organizational provider disagrees with the decision.
- Includes new information and/or highlights specific points for reconsideration.
- Provides notification if the practitioner and/or organizational provider will be represented by an attorney or another person.

The CCHP Quality Oversight Committee (QOC) meets and reviews the appeal during the next regularly scheduled meeting. Upon review, the QOC provides written notice upholding, reversing, or revising the earlier decision within 10 business days of the QOC’s decision.

**PROVIDER OFFICE AND SITE VISITS**
In order to ensure its members can easily access quality health care, CCHP may conduct site visits of practitioner offices when:
- Children’s Community Health Plan receives more than two complaints related to any site assessment and medical record keeping assessment standards regarding the same practitioner or organizational provider within any three-month period. If we receive more than three complaints during a calendar year regarding the same practitioner or organizational provider, we will conduct a practice site visit.
- There is potential that the practitioner and/or organizational provider is not in compliance with the Network Agreement, state or federal regulations, or applicable laws.
- There is potential for harm or inadequate safety for members.

Within 60 days from the date the established complaint threshold was met, we will conduct the site visit utilizing the site visit tool to document the results of the site review.
Within 30 days of the site visit, we will notify the practitioner and/or organizational provider of any deficiencies that must be corrected. Any provider who receives site assessment scores below the minimal threshold for passing (85%), is required to submit an Improvement Action Plan within 60 days of the date of the site visit. The Credentialing Committee reviews it for acceptability.

We will conduct a follow-up site visit for re-assessments within six months from the receipt of the Improvement Action Plan to ensure all deficiencies have been corrected. Practitioners and providers must receive a passing score of 85 percent or greater on the follow-up site visit to continue participation in our network.
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 an 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.
Together with CCHP offers a variety programs available at no extra costs.

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. Case management 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

This collaborative case management process involves integrating with the services of others into member care, including utilization and disease management. Together with CCHP offers a Complex Case Management program for those at highest risk.

Case Managers work closely with the member, their caregivers and practitioners to ensure the member's complex needs are met.

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. Together with CCHP considers an integrated system of intervention, measurement, and refinement of health care delivery designed to optimize clinical and economic outcomes within these specifically defined populations.

Members with Major Depression over the age of 18 and/or members with Asthma and/or diabetes between the ages of 6-17 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.

Together with CCHP also offers support for general health management. For members would like help managing any concerns related to their health, please call 414-266-3173 to reach the Health Management team. For more information or online resources and tools that support your healthy lifestyle, visit our website at togetherCCHP.org

HEALTHY MOM, HEALTHY BABY

Healthy Mom, Healthy Baby is a free program that helps pregnant women get the support and services needed to have a healthy baby. Services are provided by social workers or nurses who have a special background for providing services for pregnant moms and families.

Our team will provide this service at your home, a place that you prefer or by phone. Other services include breast feeding support and high-risk family case management. We will be happy to provide more information and set members up with an appointment with one of the case managers. Please call [1-844-450-1926] for more information.
HEALTH MANAGEMENT PROGRAMS

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

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.

Note: Under some plans that are “grandfathered” under the Affordable Care Act, the member may have to pay all or part of the cost of routine preventive services. They will need to refer to their specific Schedule of Benefits.
PROVIDER RIGHTS AND RESPONSIBILITIES

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
GENERAL DOCUMENTATION GUIDELINES (CONTINUED)

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 (initialled) 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
MEMBER RIGHTS AND RESPONSIBILITIES

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 select generic medications – Select generic medications are offered at no additional cost share to members.
• Tier 6 is for zero cost-share preventive drugs.

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, Accredo. 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.
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.

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.

APPELLING 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 COMPLIANT

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 include two 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.

<table>
<thead>
<tr>
<th>PLAN DESCRIPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SILVER</strong></td>
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<tr>
<td>Individual Prescription Deductible</td>
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<tr>
<td>Individual Medical and Prescription Out-of-pocket Maximum</td>
</tr>
<tr>
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<tr>
<td>Family Prescription Deductible</td>
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<tr>
<td>Family Medical and Prescription Out-of-pocket Maximum</td>
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<tr>
<td>Specialist Office Visit</td>
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<td>Ambulance</td>
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<td>Urgent Care</td>
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<td>Emergency Room</td>
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Prescription Drugs

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<tr>
<th>Type</th>
<th>Generic</th>
<th>Preferred Brand</th>
<th>Non-Preferred Brand</th>
<th>Specialty Prescription Drugs2</th>
<th>Preventive Prescriptions3</th>
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</thead>
<tbody>
<tr>
<td>0%</td>
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Preventive Prescriptions3

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<tr>
<th>Type</th>
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<th>No Charge</th>
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Award-winning Customer Service

- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔

CCHP on Call

- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔
- Yes ✔
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

![Member ID Card Example](image-url)
**PROVIDER RESOURCES**

**TOGETHER WITH CCHP PROVIDER RELATIONS REPRESENTATIVES – 1-844-229-2775**

<table>
<thead>
<tr>
<th>Senior Provider Relations</th>
<th>Diana Schneider</th>
<th><a href="mailto:dschneider2@chw.org">dschneider2@chw.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Representative Provider Relations</td>
<td>Christina</td>
<td><a href="mailto:csandoval@chw.org">csandoval@chw.org</a></td>
</tr>
<tr>
<td>Representative (A-L) Provider Relations</td>
<td>Sandoval Tina</td>
<td><a href="mailto:tthomas@chw.org">tthomas@chw.org</a></td>
</tr>
<tr>
<td>Representative (M-Z) Provider Network</td>
<td>Thomas</td>
<td><a href="mailto:blor@chw.org">blor@chw.org</a></td>
</tr>
<tr>
<td>Specialist</td>
<td>Blia Lor</td>
<td><a href="mailto:cgreen@chw.org">cgreen@chw.org</a></td>
</tr>
<tr>
<td>Provider Communications Specialist</td>
<td>Christie Green</td>
<td></td>
</tr>
</tbody>
</table>

**TOGETHER WITH CCHP CONTACTS:**

<table>
<thead>
<tr>
<th><strong>Provider Services</strong></th>
<th>1-844-202-0117</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have a team dedicated to serve your specific needs. Call us, we’re happy to help.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th><strong>Prior Authorizations</strong></th>
<th>Phone: 1-844-450-1926</th>
</tr>
</thead>
<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>
<td>Fax: (414) 266-4726</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Credentialing</strong></th>
<th>Email: <a href="mailto:cchp-credentialing@chw.org">cchp-credentialing@chw.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 1-844-229-2776</td>
<td>Phone: 1-844-201-4672</td>
</tr>
<tr>
<td>Fax: (414) 266-5797</td>
<td>Fax: 1-844-201-4673</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Customer Service for members</strong></th>
<th>Phone: 1-844-201-4672</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday through Friday, 8:00 a.m. to 5:00 p.m.</td>
<td>Fax: 1-844-201-4673</td>
</tr>
<tr>
<td>Saturdays, 8:00 a.m. to 2:00 p.m.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Pharmacy Questions</strong></th>
<th>1-844-201-4677</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please see the Pharmacy Benefit Guide for the latest listing of prescriptions drugs that are covered or not covered.</td>
<td>Fax 1-844-201-4675</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Provider Appeals Address</strong></th>
<th>Provider Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please see Provider Appeals Process page in this manual for more information on the appeals processes.</td>
<td>Attn: Appeals Department</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 1997, MS 6280 z</td>
</tr>
<tr>
<td></td>
<td>Milwaukee, WI 53201</td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>Claims Address</strong></th>
<th>Together with CCHP</th>
</tr>
</thead>
<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>
<td>P.O. Box 106013</td>
</tr>
<tr>
<td></td>
<td>Pittsburgh, Pennsylvania 15230-6013</td>
</tr>
<tr>
<td></td>
<td>EDI#: 251CC</td>
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<table>
<thead>
<tr>
<th><strong>Provider Manual</strong></th>
<th>togetherCCHP.org</th>
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</table>

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<thead>
<tr>
<th><strong>Fraud, Waste, and Abuse</strong></th>
<th>1-877-659-5200</th>
</tr>
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</table>

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 our 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
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

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. However, if a provider is not contracted with us and provides services, or if we are not contacted by the provider, it is ultimately the responsibility of the covered member to ensure prior authorization was obtained.

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 CareWebQI 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
• Any procedure that could be considered cosmetic, including: breast reduction and mastectomy for gynecomastia
• Autism Spectrum Disorder services
• Bone-anchored hearing device
• 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
• Prosthetic devices
• Proton beam therapy (PBT)
• Pain management procedures (including but not limited to: epidural steroid injections and radio frequency ablation and spinal cord stimulators)
• Radiation oncology
• Reconstructive procedures, excluding breast reconstruction surgery following mastectomy skilled nursing facility
• Specialty medications

Elective surgeries, including but not limited to:
• Knee arthroplasty, total
• Elbow arthroplasty
• Shoulder arthroplasty
• Shoulder hemiarthroplasty
• Hip arthroplasty
• Hysterectomy
PRIOR AUTHORIZATIONS

- Wrist arthroplasty
- Cervical and lumbar laminectomy, discectomy / micro discectomy
- Sympathectomy by thoracoscopy or laparoscopy
- Urethral suspension procedures
- Electrophysiologic study and implantable cardioverter-defibrillator (ICD) insertion, transvenous
- Genetic testing, including BRCA genetic testing
- Home Health care
- Hospice care
- Inpatient hospital stays require notification within 24 hours of admission
- Inpatient rehabilitation

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

Substance use disorder services, including the following levels of care:
- 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
AUTO AUTHORIZATIONS

• 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.