Provider & Practitioner Manual

YOUR GUIDE TO THE POLICIES, PROGRAMS AND PROCEDURES OF TOGETHER WITH CCHP

Together with Children’s Community Health Plan (CCHP) is a Qualified Health Plan issuer in the Health Insurance Marketplace. Together with CCHP does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

(Rev 2017.0515)
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Welcome
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
We are a Wisconsin-based health plan that has offered health insurance to individuals and families in our community for more than 10 years. We have more than 135,000 members with our Medicaid (BadgerCare) plan, and are pleased to expand with Together with CCHP health insurance coverage in southeast Wisconsin.

We are proud to be affiliated with Children's Hospital of Wisconsin and to offer our members access to high-quality health care 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 Together with CCHP 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 Together Provider Services at 1-844-202-0117 to request a paper copy.

Updates to this Manual
Updates will also be communicated periodically through the “Provider News Brief” e-newsletter and on the Provider News page located at togetherCCHP.org.

Providers can also receive newsletters and updates from CCHP by signing up to receive emails from Provider Relations online at togetherCCHP.org.

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

For hospitals
Together with 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, Together may begin utilizing these measures to select practitioners and/or hospitals.

The use of the term “Provider” in this manual
Children’s Community Health Plan 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.
Our six-county service area not only includes some of the area’s top providers, but also in-network specialists, pharmacists, and chiropractors.
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
- Interpretation 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 system.

Members may also seek care after hours at an in-network urgent care facility or through our CCHP on Call 24/7 nurseline at 1-877-257-5861. Please see the Urgent Care section of this manual for details.

### Our definition of a Primary Care Provider
Together with Children’s Community Health Plan 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 is the time limits with the providers in Together with CCHP’s network for scheduling medical and behavioral health care appointments.

<table>
<thead>
<tr>
<th>Standards</th>
<th>Scheduled Appointment Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td>For a life-threatening situation, members are instructed to go to the nearest emergency room or call 911 for immediate medical attention</td>
</tr>
<tr>
<td>Urgent Care Clinic or Urgent Care Walk-in Clinic</td>
<td>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 Routine Well-baby Visits</td>
<td>Visit within 30 calendar days of member’s request</td>
</tr>
<tr>
<td>Preventive Care – Immunizations, Routine Physical Exam</td>
<td>Visit within 30 calendar days of member’s request</td>
</tr>
<tr>
<td>High-risk Prenatal Visit Appointment</td>
<td>Visit within two weeks of member’s request or within three weeks if the member’s request is with a certain doctor</td>
</tr>
<tr>
<td>After-hours Access Standards — 24-hour Accessibility</td>
<td>All network providers must be available, either directly or through coverage arrangements 24 hours a day, 7 days a week, 365 days a year</td>
</tr>
<tr>
<td>Primary Care Office Wait Time</td>
<td>Members with scheduled appointments should be seen within 30 minutes of their check-in time</td>
</tr>
<tr>
<td>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 24 hours 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 noncovered 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 my 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**

Children’s Community Health Plan 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 Children’s Community Health Plan, along with the denial for consideration. Members are required to follow all CCHP’s referral and/or prior authorization guidelines. Claims must be submitted within the timely filing guidelines along with a copy of the denial.

**Timely filing deadlines**

Please reference your Provider Network Agreement for the submission of new claims timely filing limits. Claims submitted after the time frame outline in your Provider Network Agreement, will be denied for untimely filing. Members cannot be billed for 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 CCHP for processing. CCHP will pursue recovery of those expenses from the at-fault party and/or their liability insurer. Members are required to follow CCHP’s referral and prior authorization guidelines. Claims must be submitted within the timely filing guidelines along with the denial.

**CCHP Medical Records Policy**

Children’s Community Health Plan requires that all service 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 CCHP.

**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:

- Please submit their claim to the primary carrier first.
- 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:

1. **Electronic Data Interchange (EDI)**
   
   Children’s Community Health Plan 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.

2. **Paper claims**
   
   - **CMS-1500 Form**
     
     These forms are used for billing professional services performed in a provider’s office, hospital, or ancillary facility. (CCHP doesn’t 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 CCHP to route the claims to the appropriate processing area. Late charges are subject to the timely filing limit.

   **Submit claim forms to:**
   
   Together with Children’s Community Health Plan
   
   P.O. Box 106013
   
   Pittsburgh, PA 15230-6013

   **Clean claims**
   
   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.

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

<table>
<thead>
<tr>
<th>REQUIRED INFORMATION</th>
<th>CMS-1500 CLAIM FORM</th>
<th>UB-04 CLAIM FORM</th>
<th>NOTE</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</td>
<td>Box 29</td>
<td>Box 54</td>
<td></td>
</tr>
<tr>
<td>(if applicable)</td>
<td></td>
<td></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>
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>CODES</th>
<th>DESCRIPTION</th>
</tr>
</thead>
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<td>11</td>
<td>Office</td>
</tr>
<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/Mentally Retarded</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>

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 codes 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 specially 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.
**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. Children’s Community Health Plan 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>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**: Children’s Community Health Plan does 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**: Children’s Community Health Plan processes all clean claims within 30 days from the date they are received. Please reference your Provider Network Agreement for reimbursement information.

- **Multiple payee addresses**: Children’s Community Health Plan requires providers to submit a single payee address per tax ID number. Children’s Community Health Plan does not honor multiple payee addresses.

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.

Process for refunds or returned checks

Children's Community Health Plan accepts overpayments in two ways – provider may refund additional money directly to CCHP or CCHP will take deductions from future claims.

**Refunds**

If 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 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 a.m. to 5 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.

Children’s Community Health Plan 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 Together with CCHP, 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 CCHP by the due date is in default. However, there is a grace period beginning with the first day of the payment period during which the member fails to pay the premium.

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, 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 pended 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, 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.
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, CCHP has a set of standards that help safeguard the confidentiality of member information. The following is a brief summary of how Together with CCHP uses, discloses and safeguards 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.

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 accounting of such information and to place limitations on the disclosure of such information.

Official Notice of Privacy Practices
Providers can find more information in our official Notice of Privacy Practices on our website at togetherCCHP.org.

Children’s Community Health Plan 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.
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’ PCPs to play an integral part in meeting their comprehensive health care needs. Together with CCHP does 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.

Outpatient follow-up care
Together with CCHP strongly encourages 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 Together with CCHP member does not require or would not benefit from specific behavioral health care services, your staff needs to document this conclusion in writing to Together with CCHP, with a notification to the member. Together with CCHP will stand by your recommendation or in special circumstances, seek a second opinion. In all cases such as these, Together with CCHP assumes that you will communicate your recommendations directly to the member.

Noncovered 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 EOC for a complete list. Please contact Provider Services at 1-844-202-0117 with questions about coverage.

Noncovered 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
- 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 is available from Together with CCHP to assist members with care coordination. Please complete the Together with CCHP 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. Together with CCHP will determine whether the item will be purchased or rented.

Multiple items may appear on an authorization, 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 CCHP’s internal medical policies. The Together with CCHP Prior Authorization List has more information, codes requiring authorization, a link to noncovered 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 diseases 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 tracheo-esophageal 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
Coverage

**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 limits:
- 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.

**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.
- 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.

**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 the Together with CCHP 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 Together with CCHP 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
Coverage

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 EOC.

Transplant criteria
Together with CCHP contracts with a transplant coordinator. The covered member’s condition must meet the following criteria of and be approved by CCHP’s designated transplant provider and CCHP:
- 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, CCHP will rely only on scientifically designed and controlled research studies. Children’s Community Health Plan 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 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 will be available from Together with CCHP to assist the member with care coordination/case management. Please complete the Together with CCHP Case / Disease Management Referral Form for the member, which is available on the Provider Forms page at togetherCCHP.org.

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About the CCHP Credentialing program

Children’s Community Health Plan credentials both individual practitioners and organizational providers. The CCHP Credentialing program determines if a practitioner or organizational provider is qualified to provide quality care to CCHP 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, providers 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 with Children’s Community Health Plan:

- 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
- Include a start date (month and year) and an affiliation status for hospital privileges
  - If in process, you’ll need to explain your admitting arrangements. If through a covering practitioner, you will need to state hospital affiliation and status
  - 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:

Children’s Community Health Plan
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:

1. Applicant has current valid and unrestricted license without limitations or sanctions from the state(s) in which they practice.
2. Applicant is not excluded from participating in Medicare and/or Medicaid programs (lack of sanctions or debarment).
3. No prior denials or terminations. The Applicant must not have been denied participation (for reasons other than network need) by CCHP within the preceding 24 months.
Credentialing

Recredentialing
Children’s Community Health Plan 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 Together with CCHP’s 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 CCHP.

Credentialing confidentiality
Children’s Community Health Plan 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 CCHP subcommittee of the Board of Directors that is responsible for the oversight and direction of the CCHP Credentialing Committee. The QOC reviews and approves changes to the Credentialing program description 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 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 CCHP within 30 days of CCHP’s notification of the discrepancy or the processing of his/her application will be terminated. A CCHP Medical Director notifies 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 / site visits
In order to ensure its members can easily access quality health care, Children’s Community Health Plan may conduct site visits of practitioner offices when:

- Children’s Community Health Plan receives more than two complaints related to any of CCHP’s site assessment and medical record keeping assessment standards regarding the same practitioner or organizational provider within any three-month period. If CCHP receives more than three complaints during a calendar year regarding the same practitioner or organizational provider, CCHP conducts a practice site visit.
- There is potential that the practitioner and/or organizational provider is not in compliance with CCHP’s Network Agreement, state or federal regulations, or applicable laws
- There is potential for harm or inadequate safety for CCHP members

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

Children’s Community Health Plan conducts 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 Together with CCHP’s network.
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.

Urgent care facility
A facility that 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 Together with CCHP service area.

Urgent care limitations:
- Children’s Community Health Plan 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, the CCHP on Call 24-hour nurseline at 1-877-257-5861, or may seek services from an urgent care facility. You can locate an urgent care facilities on our website at togethercchp.org.
Together with CCHP offers local, personalized health management programs that focus on members with chronic health problems or members who need extra help with their specific health care needs. Our specially trained health management teams work with members and providers to create a plan that fits their needs.

Children’s Community Health Plan’s Health Management programs encompasses case management (CM), disease management, and Healthy Mom, Healthy Baby programs.

Case Management program
Children’s Community Health Plan’s case management program uses a proactive and collaborative approach to coordinating care, which includes a set of processes that integrate:

- Utilization management
- Discharge planning
- Disease state management
- Advocacy
- Education

Case Management definition
The Case Management Society of America defines case management as “a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and a family’s comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.”

Children’s Community Health Plan’s CM programs utilize this formal definition as a framework for responding to members’ comprehensive health needs along a continuum of qualitative care, which:

- Focuses on early identification and intervention
- Provides alternate care, when appropriate
- Minimizes preventable hospitalizations and emergency department care
- Monitors the progression of disease states
- Promotes health, recovery and quality of life
- Prevents complications
- Promotes communication with practitioner, member and caregiver/family

Together with CCHP case management programs include the following:

- Complex case management services
- High-risk pregnancy case management services
- High-risk family case management services
- Case management services

Children’s Community Health Plan fosters members self-management of their conditions by offering them the tools, resources and support they need to manage their condition. To help achieve this goal, some of the resources and services Together with CCHP members may receive are:

- The CCHP on Call 24/7 nurseline at 1-877-257-5861
- Educational mailings with helpful condition-related health information
- Provider frequency visit reminders, along with screening and exam reminders
- Annual flu shot reminders
Disease Management programs
The CCHP Disease Management programs are intended to address some of the most chronic and prevalent conditions of its members, considering general criteria such as:
- Prevalence of chronic disease states
- High utilization of prescription drug use
- Potential for wide variation in treatment approach
- Potential for lifestyle modification to improve outcomes
- Therapies with many treatment options
- Diseases with high risk of negative outcomes

Currently, CCHP offers the following disease management programs:
- Pediatric and adolescent asthma
- Major depression or major depressive disorder in adults
- Adult diabetes

Children’s Community Health Plan 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. The goal is to enhance and support the member’s knowledge of his/her respective condition(s) in attempt to improve overall health outcomes.

Case and Disease Management referrals
To make a referral for case management or disease management, please complete the CCHP Case or Disease Management Referral Form, which is on our website at togetherCCHP.org, or call our Case and Disease Management referral line at 1-844-450-1926.

Healthy Mom, Healthy Baby program
This program is for pregnant women to receive the support and services they need to have a healthy pregnancy and baby. Pregnant women receive services in her home or over the phone from social workers or nurses who are specially trained in maternal/infant health.

Other services include high-risk pregnancy services and breastfeeding support by Certified Lactation Consultants.

We would also be happy to come to your office to discuss our various programs. To download the Notification of Pregnancy form, go to our Provider Forms page at togetherCCHP.org.

Call us at 1-877-227-1142, option 3, or more information about the Healthy Mom, Healthy Baby program.

Preventive services
Together with Children’s Community Health Plan (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).

Together with CCHP has 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.

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 percent.

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.
Providers’ rights
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 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 CCHP on behalf of a member, with the member’s consent.
  - See Provider Claims Appeals in this manual.
- Have access to information about 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.

Providers’ responsibilities
Children’s Community Health Plan (CCHP) offers the support, resources, and education providers need to ensure they are in compliance with our policies as well as the state’s policies.

Title III of the Americans with Disabilities Act (ADA) prohibits discrimination against individuals with disabilities by places of public accommodation. 42 U.S.C. §§ 12181 - 12189. Private health care providers are considered places of public accommodation. The U.S. Department of Justice issued regulations under Title III of the ADA at 28 C.F.R. Part 36. The Department’s Analysis to this regulation is at 56 Fed. Reg. 35544 (July 26, 1991).

The provider is responsible to follow these policies. For questions about these policies, please contact your Provider Relations Representative at 1-844-229-2775.

Notify CCHP in writing of the following events:
- Any changes in practice ownership, name, address, phone or federal tax ID numbers
- 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 Together with CCHP members
- Send written notification of any of the above events to:
  Together 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
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.

Arranging substitute coverage
When a physician is out of the office and another provider covers his/her practice, CCHP requests:

- Notification to include the duration of coverage, name, and location of the covering provider
- The covering practitioner must be a Together with CCHP provider and have completed the Together with CCHP credentialing process

Providers not accepting new patients
Providers closing their panel to new patients must submit a written notice to the Together with CCHP 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 (from our website), to the Together with CCHP Member Advocate prior to notifying the member.
- Mail termination of patient care letter and Missed Appointment Notification form to:
  
  Together with Children’s Community Health Plan
  Atttn.: 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 Together with CCHP as outlined in the Together with CCHP Provider Network Agreement
- At least 30 days prior to the effective date of termination, Together with CCHP will send members a letter notifying them of the change, provided CCHP was notified timely of the change

Transition of patient care following termination of provider participation:

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

Advance Directives
The federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make decisions about their medical care in advance of an incapacitating illness or injury through an advance directive.

- Physicians and providers, including home health agencies, skilled nursing facilities and hospices, must provide patients with written information on state laws about a patient’s right to accept or refuse treatment, and the provider’s own policies regarding advance directives

**As a provider, you must:**

- Inform patients about their right to have an advance directive
- Document in the patient’s medical record any results of a discussion on advance directives. If a patient has or completes an advance directive, their patient file should include a copy of the advance directive
- If you are unable to implement the member’s advance directive due to an objection of conscience, you must inform the member
- The member should contact Together with CCHP Customer Service to select a new primary care provider
- As a primary care provider, you should contact the Together with CCHP Customer Service if you’re not able to be the member’s primary care provider because of a conscionable objection to an advance directive
Medical records
As a contracted provider with CCHP, we expect that you have policies to address the following:
- Maintain a single, permanent medical record for each patient that is available at each visit
- Protect patient records from destruction, tampering, loss or unauthorized use
- Maintain medical records in accordance with state and federal regulations
- Maintain patient signature of consent for treatment/screening

General Documentation Guidelines
Children’s Community Health Plan expects you to follow these commonly accepted guidelines for medical record information and documentation:
- Date all entries, and identify the author
- Make entries legible
- On a problem list, site significant illnesses and medical condition, include dates of onset and resolution
- Make notes on medication allergies and adverse reactions. Also note if the patient has no known allergies or adverse reactions.
- Make it easy to identify the medical history, and include serious illnesses, injuries and operations for patients seen three or more times

Document these items:
- Alcohol use, tobacco habits and substance abuse for patients ages 11 and older, including cessation counseling
- Immunization record
- Family and social history
- Preventive screenings and services
- Blood pressure, height, and weight

To document demographic information, the patient medical record should include:
- Patient name and/or member ID number on every page
- Gender
- Age or date of birth
- Address
- Marital status
- Occupational history
- Home and work phone numbers
- Name and phone number of emergency contact
- Name of spouse or relative
- Health insurance information

To document patient hospitalization, the patient medical record should include:
- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information

To document patient encounters, the patient medical record should include:
- Patient's complaint or reason for the visit
- Physical assessment
- Unresolved problems from previous visit(s)
- Diagnosis and treatment plans consistent with your findings
- Growth chart for pediatric patients
- Development assessment for pediatric patients
- Patient education, counseling or coordination of care with other providers
- Date of return visit or other follow-up care
- Review by the primary care provider (initialed) on consultation, lab, imaging, special studies, outpatient and inpatient records
- Consultation and abnormal studies including follow-up plans
- Discharge note for any procedure performed in the provider’s office
- Reasons for referrals documented
Together with CCHP Members have the right to:

- Ask 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 CCHP, our services, practitioners and providers and member rights and responsibilities.
- Voice complaints or appeals with CCHP or the care 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

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. The Pharmacy Benefit Guide is current as of October 31, 2016.

Locate a participating pharmacy

Together with CCHP 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 CCHP covers. 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. Together with CCHP requires members to use a generic version of the drug if one is available.
- **Tier 2** is for preferred-brand medications. Together with CCHP classifies 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 Guide.

For the latest information on the complete Together with CCHP formulary and other pharmacy benefits, visit our website at togetherCCHP.org/formulary. (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 may also call our 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, Together with CCHP recommends 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 our Customer Service, or by requesting the form through togetherCCHP.org.
Specialty medications

Most 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 Together with CCHP member ID card.

To find a participating pharmacy, members can call Together with CCHP Customer Service at 1-844-201-4672.

To fill a prescription at a participating out-of-area pharmacy, members should show their Together with CCHP 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 our Customer Service at 1-844-201-4672, or by requesting the form through the CCHP Connect Member Portal at togetherCCHP.org.
Non-formulary exceptions

If the drug a 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 the CCHP Connect Member Portal. When members make this request, we may contact the prescriber or physician for information to support the request. After CCHP receives 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 Together with 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 Together with CCHP Customer Service at 1-844-201-4672.

Medication prior authorization

If a drug requires prior authorization, the 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 Together with CCHP wants to track usage.
- Drugs not used as a standard first-line option in treating a medical condition.
- Drugs with potential side effects that Together with CCHP wants 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 CCHP Pharmacy Services Department before it will be covered.

- Newer drugs for which Together with CCHP wants to track usage.
- Drugs not used as a standard first-line option in treating a medical condition.
- Drugs with potential side effects that Together with CCHP wants 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 CCHP Pharmacy Services Department. Prescriptions for controlled substances and specialty medications are limited to a 30-day supply.

Please see the Together with CCHP 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 Together with CCHP 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:
  Children’s Community Health Plan
  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.

Appealing a decision
You may try to resolve your problem by taking the steps outlined above in the complaint and appeal process.

You may also contact the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin’s insurance laws, and file a complaint. You can contact the Office of the Commissioner of Insurance by writing to:
- Office of the Commissioner of Insurance
  Complaints Department
  P.O. Box 7873
  Madison, WI 53707-7873

You can 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 Together with CCHP 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), Together with CCHP will indicate if medical records are required and need to be submitted with the appeal.
3. Submit the written request or the Together with CCHP 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

If we are unable to resolve the appeal within 30 calendar days, you will be notified and receive an explanation that the appeal is not resolved and the time period will be extended another 14 calendar days.

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 Together with CCHP Provider Services at 1-844-202-0117. Provider Services representatives are available to take your call during regular business hours, Monday through Friday. After we receive your complaint, we will notify you of our decision within 30 days.
**Plan Descriptions**

**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 bronze, silver, standard silver, and gold plans, which can be purchased on or off the Marketplace. Together with CCHP also offers 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>Individual Plans</th>
<th>Together Bronze</th>
<th>Together Silver</th>
<th>Together Standard Silver</th>
<th>Together Gold</th>
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<tbody>
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<td>Individual Medical Deductible</td>
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<td>Individual Medical and Prescription Out-of-pocket Maximum</td>
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**Family Plan**

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<th>Family Plan</th>
<th>Together Bronze</th>
<th>Together Silver</th>
<th>Together Standard Silver</th>
<th>Together Gold</th>
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<td>Family Medical Deductible</td>
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**Prescription Deductible**

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<td>$75 copay then deductible</td>
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<td>Mental Health/Substance Use Office Visit</td>
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<td>Inpatient and Outpatient Services</td>
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<td>Laboratory Services</td>
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<td>$50 copay</td>
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<tr>
<td>X-Rays and Diagnostic Imaging (CT/PET Scans, MRIs)</td>
<td>Deductible then 30% coinsurance</td>
<td>Deductible then 40% coinsurance</td>
<td>Deductible then 20% coinsurance</td>
<td>Deductible then 20% coinsurance</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Deductible then 30% coinsurance</td>
<td>Deductible then 40% coinsurance</td>
<td>Deductible then 20% coinsurance</td>
<td>Deductible then 20% coinsurance</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$75 copay then deductible</td>
<td>$80 copay</td>
<td>$75 copay</td>
<td>$35 copay</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$250 copay then deductible</td>
<td>$500 copay</td>
<td>$400 copay</td>
<td>$250 copay</td>
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**Pharmacy**

<table>
<thead>
<tr>
<th>Generic</th>
<th>$15 copay then deductible</th>
<th>$15 copay</th>
<th>$15 copay</th>
<th>$5 copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Brand</td>
<td>$50 copay then deductible</td>
<td>$60 copay</td>
<td>$50 copay</td>
<td>$55 copay</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>Deductible then 30% coinsurance</td>
<td>Deductible then 40% coinsurance</td>
<td>Deductible then 20% coinsurance</td>
<td>Deductible then 20% coinsurance</td>
</tr>
<tr>
<td>Specialty Prescription Drugs</td>
<td>Deductible then 30% coinsurance</td>
<td>Deductible then 40% coinsurance</td>
<td>Deductible then 40% coinsurance</td>
<td>Deductible then 20% coinsurance</td>
</tr>
<tr>
<td>Preventive Prescription Drugs</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

1 The out-of-pocket maximum is the sum of the deductible amount, prescription drug deductible amount (if applicable), copayment amount and coinsurance percentage of covered expenses, as shown in the Evidence of Coverage.
2 Many specialty medications are paid according to medical plan benefits, not prescription drug benefits.
3 Visit our website for a list of covered preventive prescriptions in the Together with CCHP Pharmacy Benefit Guide.
**Member Identification Cards**

**Together with CCHP member ID cards**

All Together with CCHP members receive one individualized identification card. Together with CCHP requires 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 Together with CCHP 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 Together with CCHP member identification (ID) card includes the following enrollment related information:

- Together with CCHP 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
## Provider Resources

### Together with CCHP Provider Relations Representatives: 1-844-229-2775

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations Manager</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>Senior Provider Relations</td>
<td>Diana Schneider</td>
<td><a href="mailto:dschneider2@chw.org">dschneider2@chw.org</a></td>
</tr>
<tr>
<td>Representative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Relations Representative A-L</td>
<td>Christina Sandoval</td>
<td><a href="mailto:csandoval@chw.org">csandoval@chw.org</a></td>
</tr>
<tr>
<td>Representative M-Z</td>
<td>Tina Thomas</td>
<td><a href="mailto:tthomas@chw.org">tthomas@chw.org</a></td>
</tr>
<tr>
<td>Provider Network Specialist</td>
<td>Mary Swanson</td>
<td><a href="mailto:mlswanson@chw.org">mlswanson@chw.org</a></td>
</tr>
<tr>
<td>Provider Network Specialist</td>
<td>Blia Lor</td>
<td><a href="mailto:blor@chw.org">blor@chw.org</a></td>
</tr>
<tr>
<td>Provider Communications Specialist</td>
<td>Laura Bagg-Rosenthal</td>
<td><a href="mailto:lbagg-rosenthal@chw.org">lbagg-rosenthal@chw.org</a></td>
</tr>
</tbody>
</table>

### Together with CCHP Contacts

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Together with CCHP Provider Services</td>
<td>We have a team dedicated to serve your specific needs. Call us, we’re happy to help. 1-844-202-0117</td>
</tr>
<tr>
<td>Prior Authorizations</td>
<td>Phone: 1-844-450-1926</td>
</tr>
<tr>
<td></td>
<td>Fax: (414) 266-4726</td>
</tr>
<tr>
<td>Credentialing</td>
<td>Email: <a href="mailto:cchp-credentialing@chw.org">cchp-credentialing@chw.org</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 1-844-229-2776</td>
</tr>
<tr>
<td></td>
<td>Fax: (414) 266-5797</td>
</tr>
<tr>
<td>Customer Service for members</td>
<td>Phone: 1-844-201-4672</td>
</tr>
<tr>
<td>Hours: Monday through Friday, 8 a.m. to 6 p.m., Saturdays, 8 a.m. to 2 p.m.</td>
<td>Fax: 1-844-201-4673</td>
</tr>
<tr>
<td>Pharmacy Benefit questions</td>
<td>1-844-201-4677</td>
</tr>
<tr>
<td>Please see the Together with CCHP Pharmacy Benefit Guide for the latest listing of prescriptions drugs that are covered or not covered.</td>
<td>Provider Appeals P.O. Box 1997, MS 6280 Milwaukee, WI 53201</td>
</tr>
<tr>
<td>Provider Appeals Address</td>
<td></td>
</tr>
<tr>
<td>Please see Provider Appeals Process page in this Manual for more information on the appeals processes.</td>
<td>Together with Children’s Community Health Plan P.O. Box 106013 Pittsburgh, Pennsylvania 15230-6013 EDI#: 251CC</td>
</tr>
<tr>
<td>Claims Address</td>
<td></td>
</tr>
<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>Together with Children’s Community Health Plan Provider Manual togetherCCHP.org</td>
</tr>
<tr>
<td>Fraud, Waste, and Abuse</td>
<td>1-877-659-5200</td>
</tr>
</tbody>
</table>
Interpreter services

Children’s Community Health Plan 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

Here at Together with CCHP, 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 the Together with CCHP’s programs and services available, call our Customer Service at 1-844-201-4672.

Accessing Provider Directory information

Children’s Community Health Plan offers a Provider Directory to ensure our members are receiving the most current information about their providers. You can access the Provider Directory on our Provider Resources page 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 Together with CCHP 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

For questions or if you need assistance completing the online Together with CCHP Provider Update/Change form, please contact your Provider Relations Representative by phone at 1-844-229-2775 or by email at cchp-providerupdates@chw.org.
Utilization Management Program

The goal of the Utilization Management (UM) Program is to ensure that services provided are a covered benefit, medically necessary, appropriate to the patient’s condition, rendered in the appropriate setting, and meet professionally recognized standards of care. In addition, UM seeks to facilitate the use of alternative settings when the above circumstances are not met, or when a quality of care concern arises.

Utilization Management Program goals:

- Ensure that the enrollee is accessing medical care in the most appropriate setting. Actively monitor utilization to guard against over or under utilization of services.
- Provide feedback to the providers who demonstrate inappropriate utilization patterns using approved standards and practice guidelines.

Affirmative statement

Together with CCHP wants its members to get the best possible care when they need it most. To ensure this, we use a prior authorization process, which is part of our UM program.

Utilization Management decision-making is based only on appropriateness of care and service, and existence of coverage. CCHP does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Annual evaluation of the UM Program

Children’s Community Health Plan 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 4:30 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 CCHP must be medically necessary and a covered benefit.

What is medical necessity?

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 Management

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 Children’s Community Health Plan
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 CCHP Board of Directors is ultimately responsible for UM activities, and delegates the responsibility for the UM program (including the review and appropriate approval of the UM policies and procedures) to the Quality Oversight Committee (QOC) and the Medical Advisory Committee (MAC).

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

Together with Children’s Community Health Plan (CCHP) wants its members to get the best possible care when they need it most. To ensure this, Together with CCHP uses a prior authorization process, which is part of the Together with CCHP Utilization Management (UM) Program.

Together with CCHP contracted providers are responsible for obtaining prior authorization before they provide services to covered members. However, if a provider is not contracted with Together with CCHP and provides services, or if Together with CCHP is 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 the Together with CCHP 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, Together with CCHP 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 Together with CCHP Provider Portal at togetherCCHP.org.

If you have questions about the prior authorization process, please contact Together with CCHP Customer Service at 1-844-450-1926.

Urgent preservice 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 Together with CCHP Provider Portal. Together with CCHP will make a decision on the request and notify the provider via the portal within 72 hours of Together with CCHP’s 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 Together with CCHP receives the urgent request.
- If the submitting provider fails to provide the information requested, Together with CCHP will provide the submitting provider with our decision based on the current information that Together with CCHP has 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 14 days of Together with CCHP’s receipt of a correctly submitted request. If the request does not contain sufficient clinical information to make a medical necessity decision, CCHP will request the required information, which must be submitted within the initial 14 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 preservice 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 Together with CCHP’s procedure for prior authorization requests:
- Together with CCHP will notify the submitting provider within 24 hours of Together with CCHP’s 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 nonemergent conditions should be directed to CCHP 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-Auth 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 Together with CCHP members without prior approval — where a prudent layperson, acting responsibly, would believe that an emergency medical condition exists.

Approval will also be granted if an authorized representative, acting for the organization, authorized the provision of emergency services.

All out-of-network providers, including outside the state of Wisconsin, will receive approval for these emergency services based on the same criteria.
- Emergency inpatient admissions must be reported to Together with CCHP within 24 hours of admission or the next business day.
Utilization Management

Covered services that require prior authorization

The list below has some of the covered services that require a 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): CCHP 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
- Wrist arthroplasty
- Cervical and lumbar laminectomy, disectomy / microdisectomy
- Sympathectomy by thoracoscopic or laparoscopic
- 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 Together with CCHP 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 Together with CCHP 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 CCHP 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 Together with CCHP 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, Together with CCHP mails a letter with the registration code and instructions on how to complete portal registration. You should receive this letter within seven business days.
- If you’re an existing network provider, you’ll receive your registration code by phone or email.

To complete online registration
Once the site administrator gets the registration code, they will need to complete their Provider Portal registration using the following steps:

1. Go to our Provider Portal Registration page at togetherCCHP.org to complete our registration form. Site administrators will need their facility’s tax ID number and registration code.
2. Confirm the online registration form was submitted. Within a few minutes of submitting the registration form, site administrators should receive a confirmation email.
3. Verify the email address. Within 30 minutes of submitting the online registration form, site administrators should receive an email to verify the email address they provided — they should click on the link in that email.
4. Next, site administrators will receive an “Email Verification Completed” email from Together with CCHP.
5. In approximately three business days, site administrators will receive another email from Together with CCHP with their user login information and password.

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

1. For site administrators registering individual users:
   - Go to the online registration form at togetherCCHP.org
   - Complete the fields with individual user’s information
   - Enter the organization’s tax ID number
   - Enter the registration code provided in the portal welcome letter
   - Go to the drop-down menu “What type of user are you registering?” and select “A general user”

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

Note: Each facility may have two site administrators. To register additional users, site administrators will need to complete their registration first, and then individual users can follow the administrator’s steps for email verification and login.
The Quality Improvement program

The Quality Improvement (QI) program of Children’s Community Health Plan provides a framework for continuous performance improvement of the health care provided to its members, ensuring the provision of appropriate, affordable, and accessible care. This is accomplished by identifying, evaluating, and monitoring the quality of health care services provided to or proposed for plan members.

Goals and objectives

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

The CCHP 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/recredentialing, peer review, etc.).

For more information about our QI program, including details about our activities and progress toward goals, please call CCHP’s Quality Improvement department at 1-844-229-2776.