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• Medicare Advantage/SNP
• Community HealthEssentials Plus
• Health Homes
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Introduction

Welcome to Community Health Plan of Washington

We are pleased that you have chosen to participate in our network of dedicated providers and share in our organization’s mission to deliver accessible managed care services which meet the needs and improve the health of our communities, and make managed care participation beneficial for community responsive providers.

This Community Health Plan of Washington (CHPW) Provider Manual serves as a provider resource, and is inclusive of this document and all other applicable CHPW manuals, policies and procedures, and documents referred to within the Provider Manual. The Provider Manual is reviewed and updated annually and as applicable, and includes: information and guidance related to Compliance Program requirements, the Credentialing and Re-credentialing process, Utilization Management (including Prior Authorization requirements), Claims and Encounter data submissions, Reimbursement policies, CHPW Drug Formulary, and CHPW Provider Directories. The 2017 CHPW Provider Manual includes relevant revisions, as well as any new information. CHPW’s policies and procedures, and other information and resources are available at www.chpw.org. If you have questions regarding the Community Health Plan of Washington Provider Manual or any of the information explained within, please contact our Customer Service Department:

CHPW Washington Apple Health Customer Service: 1 (800) 440-1561 (Toll Free)
CHPW Washington Apple Health, FIMC and BHSO Only in Clark and Skamania Counties: 1 (866) 418-1009
Medicare Customer Service: 1(800) 942-0247 (Toll Free)
Fax: (206) 521-8834

Your Role as a CHPW Provider
As a CHPW provider, you have agreed to provide care to our enrolled members. We look forward to supporting you in providing accessible, quality health care that meets the needs of your patients—our members. A description of benefits and compensation extended to you are detailed in your Provider Agreement, in this Provider Manual, and in the policies and procedures referenced throughout this document. As part of your role, you are obligated to cooperate and participate in utilization review, quality improvement, quality assurance programs, necessity of care evaluations, coordination of benefit activities, health care coding reviews, care coordination and cost containment activities as described in this Provider Manual, CHPW Policies and Procedures, and in your Provider Agreement.
# Directory of Services and Contacts

Community Health Plan of Washington  
1111 Third Avenue, Suite 400  
Seattle, WA 98101  
Phone: (206) 521-8830 (Local), 1 (800) 440-1561 (Toll Free), or  
Only in Clark and Skamania Counties: FIMC and BHSO  
1 (866) 418-1009 (Toll Free)  
Fax: (206) 521-8834  
www.chpw.org

## CHPW Contacts

<table>
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<tr>
<td><strong>CHPW Washington Apple Health</strong></td>
<td>1 (800) 440-1561 (Toll Free)</td>
</tr>
<tr>
<td>Customer Service Monday-Friday,</td>
<td>FIMC and BHSO Only in Clark and Skamania Counties 1 (866) 418-1009</td>
</tr>
<tr>
<td>8 a.m. to 5 p.m.</td>
<td>TTY: Relay Dial 7-1-1</td>
</tr>
<tr>
<td></td>
<td>Customer Service Fax: (206)652-7040</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.chpw.org">www.chpw.org</a></td>
</tr>
<tr>
<td></td>
<td>General information about policies and procedures, benefits and eligibility verification, member lists, provider complaints, provider contracts, updates to clinic and PCP information, credentialing, compliance, and any other provider concerns.</td>
</tr>
<tr>
<td><strong>Medicare Advantage Customer Service</strong></td>
<td>1 (800) 942-0247 (Toll Free)</td>
</tr>
<tr>
<td></td>
<td>TTY Relay: Dial 7-1-1</td>
</tr>
<tr>
<td></td>
<td>Fax: (206) 652-7050</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.healthfirst.chpw.org">www.healthfirst.chpw.org</a></td>
</tr>
<tr>
<td>Service</td>
<td>Contact</td>
</tr>
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<td>----------------------------------------------</td>
</tr>
<tr>
<td><strong>Medical Management</strong></td>
<td>1 (800) 440-1561 (Toll Free)</td>
</tr>
<tr>
<td>Monday-Friday, 8 a.m. to 5 p.m. Prior authorizations, hospital notifications, case management, disease management, care management, pharmacy management, quality improvement, and utilization management. Customer Service toll-free number is available to accept collect calls regarding utilization management (UM) issues. UM staff is accessible to callers who have questions about the UM process. --Apple Health prior authorizations requests. --Apple Health Inpatient Admission notifications. --Medicare Advantage prior authorization requests and Medicare Advantage Inpatient Admission notifications. --Fully Integrated Managed Care (FIMC) prior authorizations requests for behavioral health services</td>
<td>Fax: (206) 613-8873 Fax: (206) 613-7078 Fax: (206) 652-7065 Fax: (206) 652-7067</td>
</tr>
<tr>
<td><strong>Record Retrieval</strong></td>
<td>Email: <a href="mailto:Record.Retrieval@chpw.org">Record.Retrieval@chpw.org</a></td>
</tr>
<tr>
<td>Questions and requests around record retrieval projects underway or coming from CHPW, including HEDIS and Risk Adjustment.</td>
<td></td>
</tr>
<tr>
<td><strong>Appeals and Grievances Disputes</strong></td>
<td>(206) 521-8830 1 (800) 440-1561 (Toll Free) 1 (866) 418-1009 (Toll Free) for FIMC and BHSO Only in Clark and Skamania Counties Fax: (206) 613-8984 (routine) Fax: (206) 613-8983 (urgent) Email: <a href="mailto:Appealsgrievances@chpw.org">Appealsgrievances@chpw.org</a></td>
</tr>
<tr>
<td><strong>Provider Training &amp; Education</strong></td>
<td>Email: <a href="mailto:Provider.Relations@chpw.org">Provider.Relations@chpw.org</a></td>
</tr>
<tr>
<td><strong>Provider Updates</strong></td>
<td>Email: <a href="mailto:Provider.Changes@chpw.org">Provider.Changes@chpw.org</a></td>
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<tr>
<td>Please submit the following through the Provider Changes mailbox:</td>
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<tr>
<td>--All provider updates, including demographic updates</td>
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<tr>
<td>--All group updates, including pay-to changes and clinic changes</td>
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<tr>
<td>--Inquiries about submitted updates</td>
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<th><strong>New Provider Contract Requests</strong></th>
<th>Email: <a href="mailto:NewContractRequest@chpw.org">NewContractRequest@chpw.org</a></th>
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<tr>
<th><strong>Provider Relations and Contracting</strong></th>
<th>Email: <a href="mailto:Provider.Relations@chpw.org">Provider.Relations@chpw.org</a></th>
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<tr>
<th><strong>Credentialing</strong></th>
<th>Email: <a href="mailto:Provider.Credentialing@chpw.org">Provider.Credentialing@chpw.org</a></th>
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<th><strong>Electronic Data Interface (EDI) Support</strong></th>
<th>Email: <a href="mailto:edi.support@chpw.org">edi.support@chpw.org</a></th>
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<td>--Signing up for electronic funds transfer (EFT) and 835 (Health Care Claim Payment and Remittance Advice)</td>
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<td>--Other questions about Remittance Advice/835</td>
<td></td>
</tr>
<tr>
<td>--Other questions about EFT</td>
<td></td>
</tr>
<tr>
<td>--Questions about 270/271 (Health Care Eligibility/Benefit Inquiry and Response)</td>
<td></td>
</tr>
<tr>
<td>--See also Electronic Claims (under Additional Contacts Outside of CHPW and Electronic Data Interface (EDI)/Electronic Transactions /Electronic Claims Submission in this manual for more information</td>
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**Claims Investigation Unit (CIU)**
The below items are the types of inquiries you can submit to the CIU through the CS Claims Distribution email distribution:

- Fee Schedule Issues
- Anesthesia Pricing Issues
- Negative Balance Issues
- Re-occurring Benefit Configuration Issues
- Interim Billing Issues
- Endoscopic Pricing Issues
- Multiple Surgery Pricing Issues
- Ambulance Pricing Issues
- DRG Pricing Issues
- Re-admission Issues
- Health Home Claims Questions
- Overpayments and Underpayments
- Applied Behavioral Analysis (ABA) Claims
- ICD-10 Billing Issues

Email: [cs.claimsdistribution@chpw.org](mailto:cs.claimsdistribution@chpw.org)

We request that all providers continue to call Customer Service for all other inquiries not listed as CIU inquiry types:

Washington Apple Health Customer Service: 1 (800) 440-1561
FIMC and BHSO Only in Clark and Skamania Counties 1 (866) 418-1009

Medicare Customer Service: 1 (800) 942-0247

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**Federally Qualified Health Center (FQHC)/Rural Health Center (RHC)**
Enhancement Questions or Issues

If you have questions about these enhancements, please email: [enhancement.questions@chpw.org](mailto:enhancement.questions@chpw.org)

---

**Additional Contacts Outside of CHPW**

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<th>Service</th>
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<td><strong>Pharmacy Benefits Manager – Express Scripts, Inc.</strong></td>
<td></td>
</tr>
<tr>
<td>For Washington Apple Health</td>
<td>To Request Coverage Determination: 1 (844) 605-8168 (Toll Free)</td>
</tr>
<tr>
<td>For Medicare Advantage</td>
<td>To Request Coverage Determination: 1 (844) 605-8168 (Toll Free)</td>
</tr>
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</table>
Eligibility and Claims

| All Claims | http://www.onehealthport.com/ |
| Electronic Claims | Mail all paper claims to: |
| | CHP Claims |
| | PO Box 269002 |
| | Plano, Texas 75026-9002 |
| Washington Apple Health Claims Questions | CHPW accept electronic claims via the Availity clearinghouse. Please use CHPW’s Payer Identifier: CHPWA. |
| Monday-Friday, 8 a.m. to 5 p.m. | 1 (800) 440-1561 (Toll Free) |
| Medicare Claims | FIMC and BHSO Only in Clark and Skamania Counties 1 (866) 418-1009 (Toll Free) |
| Questions Every day, 8 a.m. to 8 p.m. | 1 (800) 942-0247 (Toll Free) |
| Health Care Authority website | http://www.hca.wa.gov/Pages/index.aspx |
| First Choice Health Network/Health Benefit Exchange | 1-800-930-0132 (Toll Free) |
| https://www.fchn.com/ |
| The Centers for Medicaid & Medicare Services website | https://www.cms.gov/ |

Coordination of Care Contacts
CHPW is providing Telephonic Interpreter Assistance for our providers to use with Community HealthFirst Medicare Advantage members. The telephonic interpreter service is offered through Voiance. Please see directions for this service on page 66.

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<td>CHPW Care Managers</td>
<td>(206) 521-8833 (Local)</td>
</tr>
<tr>
<td></td>
<td>1 (800) 440-1561 (Toll Free)</td>
</tr>
<tr>
<td></td>
<td>1 (866) 418-1009 (Toll Free) for FIMC and BHSO Only in Clark and Skamania Counties</td>
</tr>
<tr>
<td>Children Services</td>
<td><a href="http://www.childcarenet.org/">http://www.childcarenet.org/</a></td>
</tr>
<tr>
<td>Service</td>
<td>Link</td>
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<td>Foster Care–Fostering Well-Being</td>
<td><a href="http://www.dshs.wa.gov/search/site/fostering%20well-being">http://www.dshs.wa.gov/search/site/fostering%20well-being</a></td>
</tr>
<tr>
<td>Health Homes</td>
<td><a href="https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html">https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html</a></td>
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<tr>
<td>Behavioral Health Organizations (formerly Regional Support Networks) for mental health services</td>
<td><a href="https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/mental-health-services-and-information">https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/mental-health-services-and-information</a></td>
</tr>
<tr>
<td>Substance Use Disorder services</td>
<td><a href="https://www.dshs.wa.gov/bha/substance-use-treatment-services">https://www.dshs.wa.gov/bha/substance-use-treatment-services</a></td>
</tr>
<tr>
<td>Aging and Disability Services, including home and community based</td>
<td><a href="http://www.aasa.dshs.wa.gov/default.htm">http://www.aasa.dshs.wa.gov/default.htm</a></td>
</tr>
<tr>
<td>Deaf/Hard of Hearing Services</td>
<td>Telecommunication Access Services 1 (800) 422-7941 (TTY) 1 (800) 422-7930 (Voice)</td>
</tr>
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### Skilled nursing facilities and community based residential programs

[https://www.dshs.wa.gov/ALTSA/resources](https://www.dshs.wa.gov/ALTSA/resources)

### Early Support for Infants and Toddlers (ESIT)

[https://del.wa.gov/providers-educators/early-support-infants-and-toddlers-esit](https://del.wa.gov/providers-educators/early-support-infants-and-toddlers-esit)

### Department of Health and Local Health Jurisdiction services, including Title V services for Children with special health care needs

[http://www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions](http://www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions)

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### 2017 Changes

**Washington Apple Health**

CHPW continues to be committed to serving the members of Washington Apple Health and the providers who take care of this diverse population. Together we aim to streamline and improve the health of these members and achieve better outcomes.

Income eligibility requirements: Important note for Healthy Options contracted providers:

Any reference to “Healthy Options” in your current contract will continue to refer to the State’s Medicaid Managed Care program and will apply to Washington Apple Health. As a result, the changes described above do not require any amendments or modifications to our current contract with you.

We will continue to serve Washington Apple Health members statewide with the **exception** of Clallam and Garfield counties.

Beginning April 1, 2016 Clark and Skamania Counties, also known as SW WA region, created the first region in Washington State to initiate Apple Health Fully Integrated Managed Care (AH-FIMC). Physical health, mental health, and drug and alcohol treatment are coordinated through one managed care plan.

Behavioral Health Services (BHSO) are also available in the SW WA region to clients who are Medicaid eligible but not eligible for managed care. Behavioral Health Services are covered by a managed care plan.
Please visit http://chpw.org/for-providers/care-and-case-management/member-benefits for complete benefits information.

If you have any questions about CHPW Washington Apple Health members, please do not hesitate to call our Customer Service team at 1 (800) 440-1561 (TTY Relay: Dial 7-1-1) or for Monday – Friday, 8 a.m. to 5 p.m., or email CustomerCare@chpw.org. For questions specific to FIMC and BHSO Only in Clark and Skamania Counties, call 1 (866) 418-1009.

Community HealthFirst™ Medicare Advantage Plans are changing
Community Health Plan of Washington has made changes to the benefits for our Community HealthFirst™ Medicare Advantage Plans effective January 1, 2017. Please visit http://chpw.org/for-providers/care-and-case-management/member-benefits for complete benefits information. Below is an overview of these changes by plan.

In addition, our vision benefit continues to be administered through Vision Service Plan (VSP), offering our members a number of options to receive frames and basic lenses within the benefit amount allowed per plan.

MA Special Needs Plan (014)
Benefit Changes:
- Part A Deductible $1316.00
- Part B Deductible $183.00
- Inpatient coinsurance per day
  - Days 61-90: $329.00
  - Days 91 and beyond: $658.00
- Skilled Nursing Facility days 21-100: $164.50 per day
- $1200 per year for supplemental dental services
- $130 per year for supplemental eyewear benefit

Note: All copays, deductibles, and coinsurance are applied before Medicaid reimbursement. The member has no patient responsibility for Medicare covered services on the Special Needs Plan.

MA Plan (006)
Benefit Changes:
- Inpatient Acute Care days 1-4: $360 per day
- Urgent Care $0 per visit
MA Pharmacy Plan (008)
Benefit Changes:
- Inpatient Acute Care days 1-4: $360 per day
- Urgent Care $0 per visit
- Decrease Preferred Generic Drug copay to $2 per prescription

MA Pharmacy Plan (009)
Benefit Changes:
- Inpatient Acute Care days 1-4: $360 per day
- Urgent Care $0 per visit
- Decrease Preferred Generic Drug copay to $2 per prescription

MA Extra Plan (010)
Benefit Changes:
- Inpatient Acute Care days 1-4: $360 per day
- Urgent Care $10 per visit
- Decrease Preferred Generic Drug copay to $2 per prescription
- Supplemental dental benefits no longer available

Community HealthEssentials™ Plus
CHPW will continue to offer individual commercial Gold and Silver plans on the Washington State Health Benefit Exchange in 2017.

There are no changes to the Community HealthEssentials Plus plan benefits or service area in 2017. However, there are changes to the Annual Deductible and/or Out-of-Pocket Maximums in most of the plans.

Members have a $0 office visit copay when they receive primary care services from a Community Health Network of Washington Community Health Center provider.

CHPW continues to partner with First Choice Health Network (FCHN) to serve as the PPO network and Third Party Administrator (TPA) for Community HealthEssentials Plus plans. First Choice Health Customer Service representatives are available to assist both members and providers. They can be reached toll free by calling 1-800-930-0132. Providers can also access the provider portal at www.fchn.com.

Washington Apple Health and Exchange Marketplace: Member Options
Medicaid coverage has expanded to include adults up to 138% of the Federal Poverty Level (FPL). This program is called Washington Apple Health.
New private insurance coverage options are available through the Washington State Health Benefit Exchange marketplace, Washington Healthplanfinder. Individuals and families with annual household incomes between 138% and 400% of FPL may be eligible for premium subsidies to help cover the cost of their insurance.

Provider Responsibilities
This section outlines a few of the roles and responsibilities of CHPW providers. Specific Terms and conditions of your obligations as a CHPW provider can be found in your Provider Agreement.

Access to Care Standards and Responsibilities
CHPW members shall have timely access to adequate and appropriate care based on CHPW’s approved accessibility standards. CHPW providers will meet the following access to care standards and other responsibilities.

All providers (Primary Care, Specialty Care, Facility and Ancillary) must:
- Provide members with telephone access to a licensed health care professional 24 hours per day, 7 days per week for the purpose of rendering medical advice concerning emergent or urgent medical conditions.
- Maintain an appointment system for members’ prompt access to health care.
- Maintain continuity of care.
- Provide, to the extent applicable, transitional health care by a home care nurse or home care registered counselor within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the member’s primary care provider or as part of the discharge plan.
- Inform members of their right to self-refer for certain services.
- Provide or arrange for interpretive services for members who are hearing impaired or whose primary language is not English.
- Obtain informed consent from the member, or from a person authorized to consent on behalf of the member, prior to treatment.
- Provide adult members with written information about advance directives and the right to make anatomical gifts.
- Assist members in receiving health care services not covered by CHPW.
- Providers must not be sanctioned by the Office of Inspector General (OIG) and the General Services Agency (GSA).
- Medicare Advantage providers must not be opted out of Medicare. Providers that have opted out of Medicare may be admitted to the network for the other lines of business.
- Accept payment in full and shall not request payment for covered services from HCA or the enrollee. To access CHPW’s Balance Billing Training Program, go to http://chpw.org/for-providers/training/.
PCPs (including OB/GYN providers and midwives) must, in addition, provide:

- Telephone response time to an after-hours urgent phone call no greater than 30 minutes.
- Routine or preventive care appointment accessibility no greater than 30 calendar days.
- Non-urgent, symptomatic office visits are available from the PCP or another provider within 10 calendar days.
- Access to an urgent care appointment within 24 hours.
- Emergency care accessibility 24 hours a day, 7 days a week.
- Coordinate appropriate services and programs that are available to members within the community, through regulatory agencies, and/or from local health jurisdictions.
- If applicable, transitional health care by a PCP available for clinical assessment and care planning within 7 calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.

Behavioral health providers must, in addition, provide:

- Care for a life threatening emergency immediately.
- Care for a non-life threatening emergency within 6 hours.
- Urgent care within 24 hours.
- An appointment for a routine office visit within 10 business days.
- Schedule transitional care visit within 7 calendar days after discharge from inpatient/institutional care facility.

Specialists must, in addition, provide the member's PCP with a written report within 14 days of the date of service regarding the proposed plan of treatment, including any proposed hospitalization or surgery and information regarding self-referred services such as women's health care services. Failure to provide the PCP with this report will result in denial of claim for services and the specialist may not bill the member.

Facilities must, in addition:

- Notify CHPW of all inpatient admissions in a timely fashion as described in the "Care Management" section of this manual, as a condition of payment.
- Have inpatient and emergency services available 24 hours a day, 7 days a week.

The provider shall utilize research-based practices for individuals, including those with co-occurring mental health and chemical dependency diagnoses.
The provider must ensure that all individuals have a voice in developing individualized service plans, advance directives and crisis plans. This shall include children and their families (e.g. caregivers and significant others, parents, foster parents, assigned/appointed guardians, siblings), and adults. At a minimum, treatment goals shall include the words of the individual and documentation must be included in the clinical record describing how the individual sees his/her progress. An individual peer support plan may be incorporated into or appended to the Individual Service Plan.

The Contractor will demonstrate efforts to coordinate care with crisis services and other allied systems. Contractor must have a process to convey all necessary information to ensure continued delivery of medically-necessary services.

Program Standards and Responsibilities

Wraparound with Intensive Services (WISe)- All Contracted WISe providers will follow the guidelines in the Washington State WISe Program, Policy and Procedure manual for program standards and CHPW Policies and Procedures related to program.

Program of Assertive Community Treatment (PACT) - All Contracted PACT providers will follow the guidelines in the Washington state PACT Program Standards CHPW Policies and Procedures related to the program.

Transitional Age Youth (TAY)- All contracted providers serving enrollee’s between the ages of sixteen (16) and twenty-five (25) years will address in the treatment/care plan any noted challenges for the enrollee as identified in their assessment(s). The elements addressed in the treatment and/or care plan will include:

- A comprehensive transition plan linked across systems that identify goals, objectives, strategies, supports, and outcomes. Developed in partnership with other child serving agencies, as appropriate.
- Individual behavioral health and physical health needs in the context of a Transition Age Youth, which include supported transition to meaningful employment, post-secondary education, technical training, housing, community supports, natural supports, and cross-system coordination with other system providers.
- For youth who require continued services in the adult behavioral or physical health system must identify transitional services that allow for consistent and coordinated services and supports for young people and their parents.
- Developmentally and culturally appropriate adult services that are relevant to the individual or population.

If appropriate, CHPW notifies members, either by mail or phone, about alternatives and resources for continuing care and assists them in understanding how to access those services or can facilitate helping them to obtain the services.
Screenings and Assessments
Early Periodic Screening Diagnosis and Treatment (EPSDT) services must be structured in ways that are culturally and age appropriate, involve the family and are available to all individuals under the age of twenty-one (21). Intake evaluations provided under an EPSDT referral must include an assessment of the family’s needs. Mental health and substance use providers will ensure all consumers age 13 and above at admission are asked to complete the statewide approved screening and assessment tool, GAIN-SS (Global Appraisal of Individual Needs-Short Screener).

Medical treatment and referral for services
Contractor shall provide medically-necessary services to Medicaid recipients upon request: Medically-necessary services shall not be contingent upon full completion of intake evaluations. An intake completed in the previous twelve (12) months that establishes medical necessity may be used as the basis for requesting authorization along with a current intake addendum, as long as a copy is available in the individual’s clinical record. The Contractor shall request authorization (for those services requiring authorization) in accordance with the CHPW Authorization Policy and Procedure. The Contractor shall ensure that: a) An intake evaluation is first offered within ten (10) business days of a request for service and that authorization requests occur within three (3) calendar days of the intake; b) Emergent care occurs within two (2) hours; c) Urgent care occurs within twenty-four (24) hours from the request for services.

Where health care needs are identified, individuals of all ages shall be referred by the provider for diagnostic services and/or primary care within the 30-day period following the intake. Referrals and all other efforts made by the provider to assist the individual will be clearly documented in the individual’s file.

Compliance with these standards and responsibilities is monitored during, but not limited to, office site visits. CHPW will report necessary corrective action plans or follow-up to the Credentialing Committee and the Quality Council on a regular basis.

Care Standards Documents
- Site Tools http://chpw.org/for-providers/documents-and-tools
- Policies and Procedures http://chpw.org/for-providers/other-resources/policies

Credentialing and Recredentialing
The CHPW mission is to arrange for delivery of accessible, managed care services that meet the needs and improve the health status of our communities, and make managed health care participation beneficial for underserved populations and community-responsive providers.
In furtherance of that mission, the CHPW Board of Directors has developed a Credentialing Program that meets the criteria set forth in this statement, and that meets the standards for accreditation by the National Committee for Quality Assurance (NCQA).

The Credentialing Program governs the credentialing function and sets forth the criteria, standards, and processes to select and retain qualified health care providers to promote quality care to members.

The Credentialing Program also includes the structure and oversight responsibilities of CHPW for any credentialing activities that may be delegated to another provider group or health care organization.

The Credentialing Program includes annual evaluation and periodic revision to the policies and procedures adopted by the Credentialing Committee.

This program lists the credentialing criteria and standards that determine compliance for CHPW network participation.

**Provider Rights**

**Right to review information to support application**

Providers who have been or are in the process of being credentialed by CHPW have the right to review credentialing information collected during credentialing, recredentialing, and ongoing review processes.

Providers are notified of this right to access in the cover letter that accompanies CHPW’s credentialing and recredentialing applications. The cover letter describes the intent of the process and the steps a provider must take to review the information collected. This notification is also made available to the provider as part of this Provider Manual, which is available at www.chpw.org.

**Right to correct erroneous information**

If information provided on the application is inconsistent with information obtained via primary source verification, the CHPW Credentialing Specialist will send the provider written notification of the discrepancy and request formal written clarification. The notification will include a summary of the inconsistent information and a request to have the provider’s response returned within 14 business days. Notification will be sent electronically or return receipt requested and the correspondence will be marked “Confidential” as applicable.
The provider may not correct an application already submitted and attested to be correct and complete. However, the provider has a right to submit an addendum to correct erroneous information submitted by another party. If preferred, the provider may add an explanation for the erroneous information on his or her application, include a signed and dated statement attesting to the accuracy of the information provided, and then return the information to the CHPW Credentialing Specialist who initiated the query.

**Right to be informed of application status**

Providers may request a review of their credentials file by calling the Credentialing Assistant and scheduling an appointment with the Credentialing Staff.

All reviews must be done in person at CHPW offices. A member of the credentialing staff will accompany the provider during the file review.

Items that may be reviewed include:

- Items submitted by the applicant
- Malpractice insurance information
- Licensing boards’ information
- American Medical Association (AMA) or American Osteopathic Association (AOA) query response

Peer review documents and references or other information that is peer review protected will not be shared with the applicant. CHPW is not required to reveal the source of information that is not obtained to meet the primary source verification requirements or, when law prohibits, disclosure.

Upon request, CHPW will provide the provider with the status of his or her application. The provider is notified of this right when he or she receives the cover letter that accompanies CHPW’s credentialing and recredentialing application. The provider may call the credentialing specialist for information about the status of the credentialing application and the credentialing specialist will explain where the application is in the process. The credentialing specialist may share other permitted information with the provider regarding his or her application.

**Access to Records and Member Health Information**

Provider shall permit reasonable access to financial records, medical records, and any other records that relate to their Provider Agreement to authorized representatives of CHPW, Payers, and state/federal agencies with applicable authority.
Access to such records shall be to the extent permitted by law and as necessary to fulfill the terms of the Provider Agreement, CHPW’s state and federal contracts, and legal and accreditation requirements.

Provider shall permit audits by CHPW of member's medical records for covered services rendered under their Provider Agreement. Such inspection, audit, and duplication of records shall be allowed upon reasonable notice during regular business hours.

Providers have the right to reasonable access to CHPW claim payment records for the purpose of auditing their claim payment history and claim denials pursuant to WAC 284-43-324.

Provider shall maintain all member information in compliance with their Provider Agreement and with applicable state and federal laws and regulations. Member information includes, but is not limited to, medical records, claims, benefits, and other medical or administrative data that is personally identifiable to the member.

**Security of Health Information**
CHPW and the provider must each develop, implement, maintain, and use administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of every member’s private health information. This applies to all formats that CHPW or the provider creates, receives, maintains, or transmits in performing duties under the Provider Agreement in order to protect member safety, and the privacy and security of member protected health information. Further, CHPW and the provider must safeguard all member medical information including the paper and/or electronic health record against loss, defacement, theft, and tampering, and from use by unauthorized individuals.

**Medical Record Documentation Standards**
A provider must construct and maintain a medical record for each CHPW member while the member is an active patient. If the member becomes an inactive patient, the medical record may be moved to storage. The provider must keep the medical record for 10 years after the last visit if the member is 18 years old or older, and for 10 years past the age of majority if the member was a child at the time of the last visit.

All medical records, x-ray films, tissue specimens, slides, and photographs are the property of the provider.
The provider’s office may determine the method of filing the medical records; that is, alphabetical order, terminal digit order, or other numbering system. The record itself must be organized to allow easy access to information. For example, the record may be organized with dividers to separate notes and laboratory reports.

All paper-based notes, reports, etc. in the medical record must be secured in the member’s folder or electronically attached to the member’s file/record.

An active member’s medical record should be kept at each provider’s office. If the member becomes an inactive patient, the medical record may be kept off site. Records must be easily retrievable. All medical records, active and inactive, must be supplied within 30 days of a request by CHPW. Urgent requests should be met according to the clinical situation.

The provider must comply with all federal, state, and local laws and regulations pertaining to medical records and medical record requests.

All medical record information must be released only by properly trained personnel and only with a HIPAA compliant patient authorization form for release of information.

**Reporting Changes in Provider Information**

All CHPW providers must give notice to CHPW at least 60 days in advance of any provider changes such as:

- Tax identification
- NPI number (individual and/or group)
- Billing (vendor) address, office, and fax phone numbers
- Clinic Contact Information (name, phone number, fax, and email)—i.e., Credentialing Coordinator, Billing Manager, Clinic Manager
- Provider additions (include Provider effective date)
- Provider terminations (include Provider termination date)
- Clinic/facility location additions/changes (if applicable, include effective and termination dates for your clinics and/or facility)

This ensures ample time for CHPW to update all systems, notify members, and prevent claims payment delays. Provider changes should be reported to CHPW by completing a Provider Add Change Term Form located at [http://chpw.org/providers/documents-and-tools](http://chpw.org/providers/documents-and-tools) and send via email to Provider.Changes@chpw.org.

For Delegated Credentialing provider groups, please refer to and follow your delegated credentialing agreement. Delegated Credentialing provider groups should submit provider updates via email to DelegatedCredentialing@chpw.org.
**Practice Capacity**
Primary care providers must notify CHPW if their practice reaches capacity and they can no longer accept new patients. This notice must be in writing and will be effective the first day of the month following 45 days from receipt of the written notice. You should submit your notice to Provider.Changes@chpw.org.

**Provider Termination**
All CHPW providers must give notice of intended termination at least 120 days prior to the termination date. This ensures compliance with the Patient Bill of Rights and provides time for CHPW to notify members. If a member is not notified at least 30 days prior to the provider’s termination date, the provider and CHPW are required to continue care with the terminated provider for 60 days from the date of actual notice to the member. You should submit your notice to Provider.Changes@chpw.org.

**Note:** Contract Terminations are governed by the individual contract terms.

**Ownership and Control Disclosure Form**
Contracted providers are required to submit a Disclosure of Ownership and Control (“O&C form”) form with their contract application. The only time an updated O&C form would need to be submitted to CHPW within 35 day of the change, is if changes such as the following were to occur: new business owners, new tax ID, management, and/or board of director updates. If such changes or updates occur, a new O&C form must be completed and submitted to CHPW immediately.

The O&C form may be found here: http://chpw.org/for-providers/documents-and-tools under the Compliance header.

**Checking Eligibility/Benefits**
Each CHPW product has a specific set of rules governing who is eligible for coverage, the enrollment process, and the termination process. These rules are not established by CHPW, but by Health Care Authority (HCA) for Washington Apple Health and by the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage.

For details about Washington Apple Health membership and eligibility, please see the Provider One section of the HCA website (http://www.hca.wa.gov/billers-providers/providerone-resources) Providers should check Washington Apple Health Provider One enrollment status prior to providing services. For details about Medicare Advantage membership and eligibility, please see the Medicare section of the CMS website https://www.cms.gov/.
CHPW will not refuse enrollment or re-enrollment, terminate a member’s enrollment, or discriminate against a member in any way because of his or her health status, the expectation of the need for frequent high-cost care, or the existence of a pre-existing physical or mental condition, including pregnancy or hospitalization.

**Medicare Advantage Providers in the Health Care Setting**

CHPW understands that Medicare beneficiaries look to their health care professionals to provide them with complete information regarding their health care choices.

To the extent of their ability, providers may assist a beneficiary in an objective assessment of the beneficiary's needs and potential plan options that may meet those needs. Providers are permitted to make available and/or distribute marketing materials for all plans with which the provider participates and to display posters or other marketing materials announcing plan contractual relationships.

Our CMS contractual obligations prohibit providers from distributing or accepting enrollment applications or offering inducements to persuade beneficiaries to join Medicare Advantage plans. Providers cannot direct, urge, or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests. In addition, providers cannot offer anything of value to induce a CHPW member to select them as the member’s provider.

CMS is concerned with provider marketing activities for the following reasons:

- Providers may not be fully aware of all plan benefits and costs; and
- Providers may confuse the beneficiary if the provider is perceived as acting as an agent of CHPW versus acting as the beneficiary’s provider.

Because providers are usually unaware of the full range of Medicare plan options, they should refer their patients to other sources of information:

- CHPW representatives at 1 (800) 944-1247
- State Health Insurance Assistance Programs (SHIP) at 1 (800) 432-4040
- State Medicaid Office [www.medicaid.gov](http://www.medicaid.gov)
- Social Security Administration Office: [www.medicare.gov](http://www.medicare.gov), or 1 (800) MEDICARE
- Providers may distribute Medicare and You or Medicare Compare Information from the CMS website at [www.medicare.gov](http://www.medicare.gov).

**Provider Directory**

Our provider directory is available on the CHPW website, [www.chpw.org](http://www.chpw.org). Click the Find a Doctor tab to search for a provider by region. The “Show Advanced Filters” allow you to search for specialties, doctor, accepting new patients, language, gender, clinic, group, hospital, CHPW plan, and board cert/accreditation.
This list is subject to change and may not be a complete representation of CHPW’s network. If a provider that you utilize is not contracted with CHPW or if you have any questions, please contact your Provider Relations Department via email at Provider Relations@chpw.org or Customer Service at 1 (800) 440-1561 or for FIMC and BHSO Only in Clark and Skamania Counties questions call 1 (866) 418-1009. For termination of a Contract with CHPW, please refer to your contractual terms within your agreement with CHPW.

**CHPW Washington Apple Health and Medicare Advantage Service Area**

CHPW participates in Washington Apple Health in most counties with the exception of Clallam and Garfield.

CHPW offers Medicare coverage through its Community HealthFirst™ Medicare Advantage Plan as follows:

<table>
<thead>
<tr>
<th>HPMS Plan ID</th>
<th>Plan Name</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>014</td>
<td>Community HealthFirst™ MA Special Needs Plan</td>
<td>6 counties: Adams, Clark, King, Spokane,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Whatcom and Yakima</td>
</tr>
<tr>
<td>006</td>
<td>Community HealthFirst™ MA Plan</td>
<td>3 counties: Clark, King, and Spokane</td>
</tr>
<tr>
<td>008</td>
<td>Community HealthFirst™ MA Pharmacy Plan</td>
<td>3 counties: Clark, King, and Spokane</td>
</tr>
<tr>
<td>009</td>
<td>Community HealthFirst™ MA Pharmacy Plan</td>
<td>3 counties: Adams, Whatcom, and Yakima</td>
</tr>
<tr>
<td>010</td>
<td>Community HealthFirst™ MA Extra Plan</td>
<td>4 counties: Clark, King, Spokane, and Yakima</td>
</tr>
</tbody>
</table>

CHPW participates in the Washington Health Benefit Exchange Community HealthEssentials Plus through First Choice Health in 14 counties.

<table>
<thead>
<tr>
<th>Adams</th>
<th>Douglas</th>
<th>Ferry</th>
<th>Walla Walla</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin</td>
<td>Grant</td>
<td>Lewis</td>
<td>Yakima</td>
</tr>
<tr>
<td>Pacific</td>
<td>Pend Oreille</td>
<td>Spokane</td>
<td></td>
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<tr>
<td>Stevens</td>
<td>Thurston</td>
<td>Wahkiakum</td>
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</table>
CHPW Eligibility Department

Eligibility Documents
- [http://chpw.org/for-providers/other-resources/policies](http://chpw.org/for-providers/other-resources/policies)
  - Clinic/PCP Selection Form
  - PCP Assignment for State Programs Members Procedure

PCP Assignment Procedure
PCP changes need to be made by the member or, if requested by the provider, verified with the member prior to making the change. Members will be assigned only to open providers or clinics unless a closed practice is willing to accept the member. For more details regarding PCP changes for state programs, please refer to the PCP Assignment policy and Process Eligibility PCP Enrollment Request procedure available online at [http://chpw.org/for-providers/documents-and-tools](http://chpw.org/for-providers/documents-and-tools). For information regarding PCP changes for Medicare Advantage, please refer to the Evidence of Coverage on the [http://healthfirst.chpw.org/](http://healthfirst.chpw.org/) website.

PCP changes may be faxed via the PCP Selection Form to (206) 652-7085 or completed online at [https://secure.chpw.org/for-members/member-center/member/pcp](https://secure.chpw.org/for-members/member-center/member/pcp).

Involuntary Disenrollment from Washington Apple Health
A client may be involuntarily disenrolled from Washington Apple Health products under the following condition:
- The client loses eligibility for a medical eligibility category that allows or requires enrollment.

Member Reassignment Policy
The Member Reassignment Policy addresses instances where CHPW members may, due to inappropriate behavior, be reassigned involuntarily to another provider or clinic or disenrolled from CHPW. In the majority of cases of member misconduct, it is the intent of CHPW either to educate the member or, if necessary, to reassign the member to a different site or center. Whenever possible, members will be given an opportunity to change or improve inappropriate behavior. However, if a member’s behavior is such that CHPW determines it is no longer safe or prudent to offer medical care to the member at any CHPW network facility, CHPW may, at its discretion, seek member disenrollment from the appropriate state agency.
This policy applies to members who:

- Exhibit behavior that is grossly inconsistent with clinic rules and standards;
- Refuse to follow a recommended diagnostic treatment plan;
- Are intentionally and continually noncompliant or abusive; or
- Consistently engage in drug-seeking behavior.

Each case will be reviewed independently according to the procedures below.

CHPW will not at any time request from the State of Washington disenrollment of a client solely due to an adverse change in the client’s health or due to the cost of meeting the client’s health care needs.

In the event that any contracted provider is no longer able or willing to continue to provide care for a member, CHPW will arrange for and secure alternative care until such time as another permanent provider can be located by member reassignment, or until the state approves the disenrollment of the member. This care will be covered by CHPW under the member’s benefits as outlined in the applicable program contracts (such as Washington Apple Health and Medicare Advantage) at the time of service.

Members who are to be reassigned involuntarily to another CHPW provider will be notified in writing 30 days in advance. This written notice will inform the member of the right to appeal this reassignment, except in cases when the member’s conduct presents a threat of immediate harm to others.

Members who appeal any decision to reassign or disenroll will be provided all necessary covered healthcare arranged through their current PCP with the assistance of the appropriate CHPW staff until a decision is rendered by CHPW or the applicable state agency.

**Disenrollment Procedure**

Requests to reassign or disenroll a member must be processed by using the following CHPW procedure.

Providers will, in accordance with their internal policies and procedures, document and address instances of member noncompliance or misbehavior. This documentation may include reports of misbehavior from specialty providers. Providers may request that CHPW reassign or disenroll a member if the member’s behavior repeatedly falls under one or all of the following descriptions:

- Member exhibits repeated abusive behaviors toward staff or visitors. This behavior
may include yelling; the use of profanity or name-calling; any inappropriate or unwelcome touching; or any threatening words or actions.

- Member refuses to follow the outlined diagnostic treatment plan or continually engages in drug-seeking behavior.
- Member repeatedly refuses to follow the procedures of the clinic or member handbook by continually missing appointments, by inappropriately using the emergency room, or by self-referring to specialists without consulting with the primary care physician.

To initiate a reassignment or disenrollment, a provider must follow these steps:

1. When a primary care physician or clinic manager wishes to reassign a member, the appropriate staff member will send a warning letter to the member. This letter will clearly document instances of misbehavior and outline steps of a written plan that the member must follow if he or she wishes to continue to receive health care at the clinic site. Warning letters will be copied to the clinic’s Managed Care Coordinator and the CHPW Provider Relations Department. The member will be provided written copies of a center’s or clinics written procedures relating to patient behavior.

2. If the member repeats the behavior in question or chooses not to follow the steps outlined, clinic staff, with the approval of the clinic Medical Director, will consult with the assigned Provider Relations Department at CHPW to request that the member be reassigned or, in the most serious cases, disenrolled from CHPW. Plan staff and clinic or center representatives will determine the feasibility of reassigning the member within the CHPW network.

3. If reassignment is not an option due to the member’s location or circumstance, the clinic staff involved will establish a plan for resolution and follow-up that includes member education.

4. If, after reviewing the case, it is decided that the member should be reassigned to another site or center, the Provider Relations Department will inform the member in writing of the decision. This letter will provide thirty (30) days’ notice and will inform the member of his or her right to appeal the decision and the right to a fair hearing under Washington Administrative Code (WAC). Also, the letter will outline the member's options for receiving future health care through CHPW. The Provider Relations Department will work with clinic staff and/or a CHPW case manager and/or program manager to arrange for the member's future care. At no time will a member be transferred to another clinic or site without the prior agreement of that clinic. If, after reviewing the case, the clinic provider or staff member and CHPW case manager determine that the member's behavior is serious enough to warrant disenrollment:
   a. The case manager will notify the member in writing of CHPW’s intent to request an involuntary disenrollment from CHPW, including the right to appeal.
b. The case manager will work with the Provider Relations Department to gather all necessary documentation from the primary care clinic.
c. All information provided by the primary care clinic will be forwarded to the CHPW Medical Director for review.
d. If the Medical Director determines that the involuntary disenrollment request meets WAC requirements and the necessary documentation has been provided, he or she will submit the documentation along with a letter requesting the disenrollment to the HCA Exception Case Management (ECM) Section.
e. HCA will make a determination within 30 days of receiving CHPW’s request. If approved, HCA will notify CHPW and the member with at least 10 days’ notice of termination.
f. The member will stay enrolled with CHPW until a decision is made by ECM.

Clinic staff is responsible for:
- Documenting member misbehavior
- Creating a written action plan for improvement of behavior if applicable
- Providing members with written notice about action the clinic plans to take
- Providing members with written policies and procedures relating to member responsibility
- Reporting to law enforcement agencies any criminal behavior

The CHPW staff is responsible for reviewing documentation and consulting with clinic staff to determine alternatives for providing health care for the member. If this is not possible, the CHPW case manager serves as liaison to the state when requesting disenrollment.

**Involuntary Disenrollment Medicare Advantage Plan**
A member may be involuntarily disenrolled from a Medicare Advantage plan under the following conditions (which are described in the following sections):
- Change in residence outside CHPW’s service area or temporary absence for more than six consecutive months.
- Loss of entitlement to Washington State Medicaid (applicable only to Plan 014).
- Loss of entitlement to Medicare Part A or loss of enrollment in Part B.
- Death
- Disruptive behavior
- If the member becomes incarcerated (goes to prison)
- Failure to Pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA).
- Fraud and abuse
- Contract termination
- If the member lies about or withholds information about other insurance that
provides prescription drug coverage. The CHPW Eligibility Coordinator (EC) will document receipt of a verbal request for disenrollment and will document and stamp the date of receipt on written requests.

When a member or legal representative contacts CHPW with an address change that is outside the service area, the EC will determine the effective date of disenrollment and then mail to the member a Disenrollment Due to Permanent Move letter. The EC will transmit a Disenrollment Transaction to CMS.

When CHPW receives a member’s address change from a source other than the member or the member's representative, the EC cannot disenroll until the member or member's representative has confirmed that this out-of-area move is permanent or that six months have passed. The EC will call the member to verify the address change. If the EC cannot contact the member by a telephone call, the EC will mail the member a Verification of Change in Address letter. If the EC does not receive a response to written attempts from the EC to confirm a permanent out-of-area move by the beginning of the sixth month after sending the letter, the EC will mail to the member an Upcoming Disenrollment Due to Out of Area Over 6 Months letter. The EC will determine the disenrollment effective date and send a Disenrollment Transaction to CMS. When the reply is received from CMS, a Final Confirmation of Disenrollment Due to Out of Area for 6 Months letter will be sent to the member.

**Loss of Entitlement to Washington State Medicaid**

If a member is in a Special Needs Plan and is no longer eligible with Medicaid, the CHPW EC will mail the member a Disenrollment from the Special Needs Plan Due to Loss of Medicaid letter. However, the member will be eligible for a Special Election Period (SEP), which lasts through the two months following their disenrollment from the Special Needs Plan. During this SEP the member can apply for another Medicare Advantage plan in their area.

**Loss of Entitlement to Medicare Part A or Loss of Enrollment in Medicare Part B**

When the CHPW EC receives a CMS Reply Listing that indicates a member has lost Medicare Part A or Part B benefits, the EC will mail to the member a Disenrollment Due to Loss of Part A or Part B Coverage letter. If a member then contacts CHPW regarding an erroneous disenrollment, the EC will use the Enrollment Reinstatement procedure.

**Member is Deceased**

When the CHPW EC receives a CMS Reply Listing that indicates a member is deceased, the EC will mail a Disenrollment Due to Death letter to the estate of the member. If a member then contacts us regarding an erroneous disenrollment, the EC will use the Enrollment
Reinstatement procedure.

**Disruptive Behavior**

When the CHPW EC determines that a member exhibits behavior that substantially impairs CHPW’s ability to arrange or provide care to the disruptive individual or other plan members, the EC will assess the situation.

The EC will determine if the member's behavior may be related to the use of medical services or diminished mental capacity. If it is not, the EC will try to resolve the issue with the member and document his or her efforts. The EC will call the Regional Office to discuss the issue with the CMS Plan Manager.

If the CMS Plan Manager advises CHPW to proceed with disenrolling the member, the EC will mail to the member a Warning of Potential Disenrollment Due to Disruptive Behavior letter and will work to resolve the issues and document all efforts to do so.

If the disruptive behavior does not end after the EC sends the letter, the EC will mail the member Intent to Disenroll letter. Then, the EC will send a disenrollment request to CMS with all of the required documentation about the disruptive behavior. Within 20 business days of receiving the documentation, CMS will decide to approve or deny the disenrollment request and CMS will notify CHPW of the decision to approve or deny the disenrollment request.

If the disenrollment request was denied by CMS, we will send a letter to the member and enrollment will continue.

If the disenrollment request was approved by CMS, the EC will determine the effective date of disenrollment and mail to the member a Disenrollment for Disruptive Behavior letter. EC will then transmit a Disenrollment Transaction to CMS.

**Failure to pay a Part D Income Related Monthly Adjustment Amount (Part D IRMAA)**

Members with Part D-IRMAA must pay this additional premium directly to the government, not to CHPW. CMS has established a 3-month initial grace period before members who fail to pay their assessed Part D-IRMAA will be disenrolled from CHPW. CMS will report the disenrollments to CHPW via normal reporting, with the effective date of the disenrollment being the first of the month following the end of the initial grace period.

**Fraud and Abuse**

Examples of fraud and abuse are when a member:

- Submits fraudulent information on an enrollment form;
• Allows another person to use his or her enrollment card to obtain services or a prescription drug; or
• Is untruthful about or withholds information about other insurance that provides prescription drug coverage to the member.

When CHPW receives information that a member has committed fraud and abuse, the CHPW EC will call the Regional Office to discuss the issue with the CMS Plan Manager. If the CMS Plan Manager advises CHPW should disenroll the member, the EC will determine the effective date of disenrollment and send a Disenrollment for Fraud and Abuse letter to the member. The EC will then send a Disenrollment Transaction to CMS. At this time the EC will send all supporting documentation to the Inspector General in the CMS Regional Office, and to CHPW’s Compliance Officer.

**CHPW/CMS Contract Termination**
If CHPW decides not to renew its contract with CMS, the CHPW Eligibility Coordinator (EC) will mail to the member a Contract Non-Renewal letter at least 90 calendar days before the effective date of the nonrenewal.

If CHPW receives a contract termination from CMS, the EC will mail to the member a Contract Termination by CMS letter at least 30 calendar days before the effective date of termination.

If we receive a contract termination from CMS for immediate termination, the EC will mail a notice of termination to the affected members. CMS establishes the Special Election Period (SEP) that will be used in the notice of termination.

If CHPW terminates the contract with CMS due to CMS substantially not carrying out the terms of its contract, members will be sent the Contract Termination by CHPW letter 60 days prior to the effective date of termination.

**Member ID Cards**
Below are samples of the member ID cards. Please note that CHPW did not send updated replacement cards to Healthy Options, Healthy Options BD, Healthy Options FC, or CHIP members when the group names changed in January 2014. Members who have lost their ID card can call 1 (800) 440-1561 to order a replacement or for FIMC and BHSO service please call 1 (866)418-1009.
Washington Apple Health ID Cards
Apple Health – Family:

LIFE-THREATENING EMERGENCY. Call 911 or go to the nearest emergency room. Member must call clinic (PCP) within 24 hours of emergency.

URGENT CARE. Call your clinic (PCP).

After hours, call the NURSE ADVICE LINE, 1-866-418-1002 voice or (TTY Relay: Dial 7-1-1).

HOSPITAL ADMISSIONS. Hospitals must notify customer service within one business day of hospital admissions.

SUBMIT CLAIMS. Community Health Plan of Washington Claims Processing, PO Box 269002, Plano, TX 75026-9002.

FOR PHARMACY COVERAGE DETERMINATIONS. Call 1-800-753-2851.

CUSTOMER SERVICE. 1-800-440-1561 (TTY Relay: Dial 7-1-1)
Direct (206) 521-8830
CRISIS LINE. 1-800-626-8137 Voice or (TTY Relay: Dial 7-1-1)
Community Health Plan of Washington AH www.chpw.org

Apple Health – Premium

LIFE-THREATENING EMERGENCY. Call 911 or go to the nearest emergency room. Member must call clinic (PCP) within 24 hours of emergency.

URGENT CARE. Call your clinic (PCP).

After hours, call the NURSE ADVICE LINE, 1-866-418-1002 voice or (TTY Relay: Dial 7-1-1).

HOSPITAL ADMISSIONS. Hospitals must notify customer service within one business day of hospital admissions.

SUBMIT CLAIMS. Community Health Plan of Washington Claims Processing, PO Box 269002, Plano, TX 75026-9002.

FOR PHARMACY COVERAGE DETERMINATIONS. Call 1-800-753-2851.

CUSTOMER SERVICE. 1-800-440-1561 (TTY Relay: Dial 7-1-1)
Direct (206) 521-8830
CRISIS LINE, 1-800-626-8137 Voice or (TTY Relay: Dial 7-1-1)
Community Health Plan of Washington AH www.chpw.org

Apple Health – Blind & Disabled

LIFE-THREATENING EMERGENCY. Call 911 or go to the nearest emergency room. Member must call clinic (PCP) within 24 hours of emergency.

URGENT CARE. Call your clinic (PCP).

After hours, call the NURSE ADVICE LINE, 1-866-418-1002 voice or (TTY Relay: Dial 7-1-1).

HOSPITAL ADMISSIONS. Hospitals must notify customer service within one business day of hospital admissions.

SUBMIT CLAIMS. Community Health Plan of Washington Claims Processing, PO Box 269002, Plano, TX 75026-9002.

FOR PHARMACY COVERAGE DETERMINATIONS. Call 1-800-753-2851.

CUSTOMER SERVICE. 1-800-440-1561 (TTY Relay: Dial 7-1-1)
Direct (206) 521-8830
CRISIS LINE, 1-800-626-8137 Voice or (TTY Relay: Dial 7-1-1)
Community Health Plan of Washington AH www.chpw.org
Apple Health – Adult

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LIFE-THREATENING EMERGENCY. Call 911 or go to the nearest emergency room. Member must call clinic (PCP) within 24 hours of emergency.
URGENT CARE. Call your clinic (PCP).
After hours, call the NURSE ADVICE LINE, 1-866-4-8-1002 voice or (TTY Relay Dial 7-1-1).
HOSPITAL ADMISSIONS. Hospitals must notify customer service within one business day of hospital admissions.
SUBMIT CLAIMS. Community Health Plan of Washington Claims Processing, PO Box 269902, Plano, TX 75026-9002.
FOR PHARMACY COVERAGE DETERMINATIONS. Call 1-800-755-2851.
CUSTOMER SERVICE. 1-800-4-0-1561 (TTY Relay Dial 7-1-1) Direct (206) 21-9830
CRISIS LINE. 1-800-626-8137 Voice or (TTY Relay Dial 7-1-1).
Community Health Plan of Washington AH  www.chpw.org

Apple Health – Fully Integrated Managed Care

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LIFE-THREATENING EMERGENCY. Call 911 or go to the nearest emergency room. Member must call clinic (PCP) within 24 hours of emergency.
URGENT CARE. Call your clinic (PCP).
After hours, call the NURSE ADVICE LINE, 1-866-4-18-1002 voice or TTY Relay Dial 7-1-1.
HOSPITAL ADMISSIONS. Hospitals must notify customer service within one business day of hospital admissions.
SUBMIT CLAIMS. Community Health Plan of Washington Claims Processing, PO Box 269902, Plano, TX 75026-9002
FOR PHARMACY COVERAGE DETERMINATIONS. Call 1-800-755-2851.
CUSTOMER SERVICE. 1-866-4-18-1009 TTY Relay Dial 7-1-1
CRISIS LINE. 1-800-626-8137 Voice or TTY Relay Dial 7-1-1
Community Health Plan of Washington FIMC  www.chpw.org

Apple Health – Behavioral Health Services Only (No Medical Services)

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LIFE-THREATENING EMERGENCY. Call 911 or go to the nearest emergency room. Member must call clinic (PCP) within 24 hours of emergency.
URGENT CARE. Call your clinic (PCP).
After hours, call the NURSE ADVICE LINE, 1-866-4-18-1002 voice or TTY Relay Dial 7-1-1.
HOSPITAL ADMISSIONS. Hospitals must notify customer service within one business day of hospital admissions.
SUBMIT CLAIMS. Community Health Plan of Washington Claims Processing, PO Box 269902, Plano, TX 75026-9002
CUSTOMER SERVICE. 1-866-4-18-1009 TTY Relay Dial 7-1-1
CRISIS LINE. 1-800-626-8137 Voice or TTY Relay Dial 7-1-1
Community Health Plan of Washington BHSO  www.chpw.org
Medicare Advantage ID Cards
Medicare – Dental

Medicare – 014 Special Needs Plan

Medicare 006 – MA plan
Medicare 008 – MA Pharmacy Plan

Medicare 009 – MA Pharmacy Plan

Medicare 010 – MA Extra Plan
**Language Card**
This mock-up is a folded business sized card that members may carry with them when they have an appointment.

**Outside**

(translated into desired language)

Important things to know about your appointment:
- Ask the interpreting service what day and time your appointment is scheduled
- Write down your questions before your appointment.
- Ask your questions at your appointment.
- Ask about instructions for care after your appointment.

**Inside**

I need a <INSERT LANGUAGE> interpreter for my appointment.
Please write my preferred language and interpreting needs in my chart. Thank you.
Practitioner: If you have any questions, please call 1-800-440-1561.

(in translated language)
I need a <INSERT LANGUAGE> interpreter for my appointment.
Please write my preferred language and interpreting needs in my chart. Thank you.
Practitioner: If you have any questions, please call 1-800-440-1561.

Languages available:
Amharic, Cambodian, Chinese, Hmong, Korean, Laotian, Russian, Samoan, Spanish, Tigrigna, Ukrainian, Vietnamese.

**Member Benefits**

**Benefit Information**
To learn more about benefits and copays for Washington Apple Health and Medicare Advantage programs, see the benefit grids online at [http://chpw.org/for-providers/care-and-case-management/member-benefits](http://chpw.org/for-providers/care-and-case-management/member-benefits).

For more detailed information about benefits, please call the Customer Service team at 1 (800) 440-1561 or for FIMC or BHSO benefit questions call 1 (800) 440-1561. For more detailed information about the Exchange, contact First Choice Health at [www.fchn.com](http://www.fchn.com) or 1(800)930-0132.
**Member Materials**

For State programs (Washington Apple Health) CHPW makes available member benefit materials and posts information on the website describing plan services and features. The handbooks, other printed materials, and web content contain helpful information about how to use the plan, its benefits, member rights and responsibilities, and more.

In the new member packet, Washington Apple Health members get:

- A listing of information members can find on the CHPW website, including member privacy and other rights; how to file grievances and appeals; and utilization management practices and policies. Printed versions of these materials can also be obtained from CHPW Customer Service
- A multi-language translation sheet explaining how to get materials and information in various languages
- Information about the Children First™ program
- A Nurse Advice Line contact card

**State Enrollment Materials and Publications**

Please refer to the Health Care Authority website for enrollment materials, publications, order forms and directions.

For information about Washington Apple Health enrollment and eligibility, see the Washington Apple Health website [http://www.hca.wa.gov/medicaid/Pages/index.aspx](http://www.hca.wa.gov/medicaid/Pages/index.aspx).

**Children First™**

CHPW rewards members who get regular checkups and preventive care. Children First™ is our reward program for children and pregnant women who get scheduled care.

In our **Prenatal Program** (administered by Alere), members receive a $65 certificate toward the purchase of a car seat by completing two required prenatal checkups.

In our **Well Child Program**, children who are up-to-date on checkups and immunizations are eligible to receive rewards according to their age.

Children between birth and 13 years of age, who get Well Child checkups on time, can get FREE rewards such as: children’s books; school backpacks; school clothes; school supplies; booster seats; baby welcome kits; car seats; thermometers; diapers; bike helmets; dental kits; and safety locks.

For more information about Children First, patients or providers can contact CHPW at 1 (800) 461-5832.
Use these Children First™ forms located at http://chpw.org/for-providers/documents-and-tools to enroll your patients online in the Children First™ rewards program which is the preferred method:

- Children First™ Prenatal Form (English)  
  http://chpw.org/resources/CF1742_PrenatalProgramForm_pro.pdf
- Children First™ Prenatal Form (Spanish)  
  http://chpw.org/resources/CF1742_PrenatalProgramForm_SPA.pdf
- Children First™ Well Child/Immunization Form (English)  
  http://chpw.org/resources/CF1742_WellChild-ImmunizationForm_pro.pdf
- Children First™ Well Child/Immunization Form (Spanish)  
  http://chpw.org/resources/CF1742_WellChild-ImmunizationForm_SPA.pdf

**Compliance Program Guide**

CHPW maintains a comprehensive, mandatory compliance program tailored to promote an organizational culture of ethical behavior and the prevention, detection and correction of conduct that does not conform to federal and state law, contract requirements, or sound and ethical business practices. The Compliance Program strives to articulate and practically applies standards, processes, and programs that support and drive CHPW’s commitment to integrity and adherence to the spirit and letter of the law.

Designed around the seven elements of an effective compliance program expressed in chapter 8 of the US Federal Sentencing Guidelines, section 1902(a)(68) of the Social Security Act, 42 CFR 422.503(b)(4)(vi)(A), 423.504(b)(4)(vi)(A), and 438.608(a), the Compliance Program creates a framework for compliance through:

1. Oversight
2. Standards and Procedures
3. Effective Education and Training
4. Reporting and Effective Lines of Communication
5. Routine Monitoring, Auditing, and Identification of Compliance Risks
6. Response and Prevention
7. Well-Publicized Disciplinary Standards and Consistent Enforcement and Discipline

CHPW’s Compliance Program consists of four core programs maintained by CHPW’s Compliance department, detailing objectives to help ensure overall compliance program effectiveness:

- Compliance Education Program
- Fraud, Waste, and Abuse (FWA) Program
- Privacy and Security Program
- Delegated Vendor Oversight Program
CHPW’s Compliance Program applies to all CHPW lines of business, workforce members, first tier, downstream, and related entities² (FDRs).

**Note:** The term “workforce member” is defined as an employee (including the CEO, senior administrator, manager, and governing body), and may be referred to as staff, temporary staff, volunteer, agent, employee. A **First Tier Entity** is any party that enters into a written arrangement with CHPW to provide administrative services or healthcare services to our members. The term "subcontractors" is the equivalent of a first tier entity. A **Downstream Entity** is any party that enters into a written arrangement, below the level of the arrangement between CHPW and a first tier entity. The term **Related Entity** means any entity that is related to CHPW by common ownership or control and performs some of CHPW's management functions under contract or delegation. The term “contractor,” “subcontractor,” or “vendor” is defined as an FDR and must comply with CHPW policies and procedures, state and federal laws and regulations, contractual obligations, accreditation standards, and the Health Insurance Portability and Accountability Act (HIPAA).

**Standards of Conduct**

CHPW’s standards of conduct apply to CHPW workforce members and contractors (FDRs). The standards of conduct state the overarching principles and values by which CHPW operates, and define the underlying framework for compliance policies and procedures. Contractors are encouraged to adopt their own standards of conduct to demonstrate a commitment to operate in an ethical manner; emphasize that issues of noncompliance and potential fraud, waste, and abuse are reported through appropriate channels; and to commit to detect, prevent, and correct issues of noncompliance.

**CHPWs Standards of Conduct are:**

1.0 **Responsibility**

Community Health Plan of Washington serves an important role in the community delivering accessible managed health care to those enrolled in government-sponsored health insurance programs. We work hard to maintain the public’s trust and to keep the privilege of serving our members. In order to keep this privilege, we act responsibly and are accountable for our actions.

1.1 **Stewardship of Tax-Payer Dollars.** We responsibly use financial resources and other company assets to achieve long-term company goals and increase our members’ access to appropriate medical care. We make sure every expense is reasonable, relates to company business, and is documented accurately.
1.2 **Legal and Procedural Compliance.** Complying with the law is a fundamental element of our daily operations. Each of us actively evaluates our understanding of and compliance with the company policies and legal obligations that apply to our work. If in doubt, we seek guidance from our manager or Compliance Officer.

1.3 **Take Action.** Ensuring compliance with these principles and standards of professional conduct is everyone’s job. If any of us become aware of a potentially unethical or illegal situation, we report the situation to our manager, HR department, Compliance Officer, or the anonymous Hotline.

2.0 **Confidentiality**

   Proper management of confidential information and the protection of privacy as it relates to our members, workforce members, and business interests are critical to Community Health Plan of Washington’s success.

2.1 **Preserve the Confidentiality of Business Information.** Whether verbal or written we protect pricing, marketing, and sales strategies; product design, materials, and information; payor contract terms and rates; and financial statements, budgets, and other financial analyses.

2.2 **Protect Member Privacy.** We value our members, their rights to privacy, and the trust they have in us. We are dedicated to complying with all laws, regulations, and internal policies to protect the privacy of member information from unlawful disclosure and misuse.

2.3 **Workforce Member Confidentiality.** We are committed to promoting an environment that retains the full trust and confidence of all workforce members. To that end, the confidentiality of sensitive information communicated by a workforce member to his or her manager, the Hotline, the Compliance Officer, or the HR department is vigilantly protected.

3.0 **Dignity**

   We conduct ourselves in a dignified and professional manner in every human interaction, relationship, and business transaction. We take pride in respecting our own dignity and the dignity of others.

3.1 **Foster a Safe and Supportive Workplace.** Our conditions of employment and management practices earn and promote exceptional performance by our workforce members. Individual contributions are respected, acknowledged, and fairly rewarded.
3.2 **Practice Equal Employment Opportunity.** We recruit, hire, promote, and evaluate all personnel without regard to race, color, religion, sex, age, national origin, disability, veteran status, sexual orientation, genetic information, or any other basis prohibited by law.

3.3 **Avoid and Disclose Conflicts of Interest.** We make decisions based on what is best for Community Health Plan of Washington. When we are in a position to influence a decision or circumstance that may result in personal gain at the expense of Community Health Plan of Washington, we avoid and disclose those situations to our Compliance Officer or the HR department.

3.4 **Engage in Mutually Beneficial Business Relationships.** Our business associates are our partners in serving the interests of our members. We treat them with fairness, respect, and integrity and expect the same in return.

4.0 **Member-Centered**

Members are our most important stakeholders. We are committed to providing services that are accessible, coordinated, and responsive to the needs of our members.

4.1 **Respectful.** We treat our members with courtesy, politeness, and kindness at all times.

4.2 **Responsive.** We respond to all member concerns in a timely and accurate manner. We provide them with the information and support they need to effectively use their health insurance.

4.3 **Empathy.** We put ourselves in our members’ shoes. The member experience is a key driver of how we organize and conduct our business.

**Reporting Concerns**

CHPW provides avenues for reporting suspected ethical, criminal, or illegal activities, privacy or security risks and issues, and fraud, waste or abuse. All suspected or known criminal, ethical or legal violations must be reported. Depending on the nature and severity of the issue, failure to report may result in termination of contract. A contractor’s staff may report concerns by any means available including:

- Completing the appropriate form and emailing, mailing or faxing it to CHPW’s Compliance Officer; or
- Contacting the Compliance Officer by phone or email.

Compliance Officer Contact Information
Community Health Plan of Washington
Attention: Compliance Officer
1111 Third Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 652-7017
Email: compliance.officer@chpw.org

Contractors may report anonymously by:
• Contacting CHPW’s Customer Service Department at 1 (800) 440-1561 (State Programs), 1(866) 418-1009 (FIMC and BHSO) or 1 (800) 942-0247 (Medicare) and completing a form over the phone.
• Emailing a completed form to the Compliance Officer (compliance.officer@chpw.org) from a proxy email address.
• Faxing the form to the Compliance Officer at (206) 652-7017.

CHPW has zero tolerance against retaliation on individuals or entities making good faith reports of noncompliance. Workforce members and First Tier, Downstream, and Related entities (FDRs) are advised annually, through Compliance Program Training, of the protections afforded them under the Qui Tam Whistleblower Provision of the False Claims Act. CHPW’s policy on False Claims Prevention and Whistleblower Protections (CO310) is made available at http://chpw.org/for-providers/other-resources/integrity-program
Contractors (FDRs) are contractually obligated to comply with CHPW’s policies and procedures relating to fraud, waste, and abuse. CHPW’s policies and procedures reinforce the Plan’s commitment to open communications and reporting and describe how reporting channels are administered and utilized.

Reports may also be made to the Office of the Inspector General (OIG):
• Website: http://oig.hhs.gov/fraud/hotline/
• Phone: 1 (800) HHS-TIPS (1-800-447-8477)
• TTY: 1 (800) 377-4950
• Email: HHSTips@oig.hhs.gov

Callers are encouraged to provide information on how they can be contacted for additional information, but may remain anonymous if they choose.

Compliance Education Program
Contractors (FDRs) are required to complete General Compliance Training and Fraud, Waste, and Abuse training, within 90 days of contract and annually thereafter. Failure to complete annual training will result in contract termination.
Contractors and their staff must complete CMS’s General Compliance training and FWA training within 90 days of contract, and annually thereafter. Contractors (FDRs) who have met the FWA certification requirements through enrollment into the traditional Medicare Program or accreditation as Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provider, are not required to complete FWA training.

The link to the Medicare Learning Network (MLN) is provided for contractors on the www.chpw.org website, as well as CHPW attestation forms. Refer to: http://chpw.org/resources/GCFWA_Attestation_Form_041514.pdf.

In addition to the General Compliance and FWA training provided on the MLN website, CHPW Provider Relations department provides workshops and orientations for contracted health care providers. Contractors may request additional training on compliance-related topics, including how to detect and prevent fraud, waste, and abuse, by contacting their CHPW Provider Relations Department.

**Privacy and Security Protections**
A core component of CHPW’s Compliance Program is the Privacy and Security Program, which creates a framework for honoring member rights under the Health Insurance Portability and Accountability Act (HIPAA) and maintaining the privacy and security of member protected health information (PHI) along with CHPW’s confidential and proprietary business information.

The Privacy and Security Program is targeted at preventing the impermissible use and disclosure of PHI and, thereby, any resultant fraud or identity theft. This member-focused program centers on administrative, technological and physical safeguards, and the monitoring and auditing of workforce activities and operations to ensure the privacy and security of sensitive information.

CHPW has safeguards in place to ensure the privacy and security of its members’ protected health information (PHI). PHI is information that: 1) identifies an individual (or his/her relatives, employer, or household members) or which reasonably can be used to identify the same; and 2) relates to the past, present or future health of the individual. Examples of PHI identifiers include, but are not limited to, names, addresses, dates, phone numbers, medical record numbers, and account numbers.

Only the minimum necessary amount of PHI required to complete a given task should be used at all times. PHI can only be shared without a member’s written authorization for
specific, limited purposes. For more information, please visit the U.S. Department of Health and Human Services (HHS) Health Information Privacy site at http://www.hhs.gov/ocr/privacy/.

CHPW maintains a Notice of Privacy Practices, policies, and procedures which describes an individual’s rights under HIPAA and CHPW’s privacy and security safeguards. These documents are made available on CHPW’s website:

- Privacy/Security Policies and Procedures: http://chpw.org/for-providers/other-resources/integrity-program

Contractors are required to be familiar with HIPAA requirements and have in place protections for CHPW members as required of covered entities under the law. If a contractor determines that a privacy or security incident affecting a CHPW member has occurred or identifies a potential risk in a system or process that may impact the privacy or security of member PHI, the contractor must report it to the CHPW Compliance Officer and the appropriate agencies required by law.

**Physical and Electronic Safeguards**

CHPW’s facility is secure with controlled badge entry. All CHPW workforce members are required to visibly wear badges at all times. Following another person through a secured entryway without using an assigned badge (tailgating) is prohibited. Visitors to CHPW must be escorted at all times, by the business owner.

CHPW uses anti-virus software to maintain PHI security and systems integrity. CHPW’s IS&T department examines activity in information systems that contain or use PHI and reports concerns to the Compliance department. Workstations are set to lock after a period of inactivity. CHPW staff are trained to manually lock workstations when temporarily away from their workstation. CHPW uses National Institute of Standards and Technology (NIST) approved email encryption software to ensure that PHI sent outside of the organization is encrypted. In addition, connecting to CHPW’s systems from public or shared computers is not permitted.

In keeping with best business practice, passwords to CHPW’s network require a minimum of eight characters; a combination of letters, numbers, and symbols; and are involuntarily reset on a routine basis. Access to systems containing PHI is managed through role-based assignment to ensure that the minimum necessary standard is met.
The IS&T department records the movements of hardware and electronic media and devices. Prior to disposal, all data on equipment and media devices is securely overwritten or physically destroyed. Lost or stolen equipment that may contain PHI must be reported immediately to the Compliance Officer, Security and Privacy Officer, or the Compliance department.

Workforce members are required to dispose of printed PHI and digital media (i.e., CD, DVD, and thumb drive) in secure shred bins for destruction and secure such materials after hours when not in use.

**Fraud, Waste, and Abuse Program**

CHPW’s Compliance department maintains a Fraud, Waste, and Abuse (FWA) program to prevent, detect, and correct Fraud, Waste, and Abuse to ensure compliance with applicable laws, including but not limited to, those provisions outlined in 42 CFR §§ 422.503, 423.504, and 438.608, the Federal False Claims Act (31 USC §§3279-3733), §6032 of the Federal Deficit Reduction Act of 2005 (42 USC§1396(a)(68)), and the Washington State Health Care False Claims Act (RCW 48.80). This integrative program is designed to address issues across divisions and departments discovered through monitoring and auditing activities and reports from workforce members, FDRs (referred to as provider, contractor, subcontractor, and vendor), other health plans, and state or federal agencies.

In the interest of ensuring quality, integrity, and sound business practices, CHPW’s Compliance department investigates and seeks resolution of irregular billing practices, suspected cases of identity theft, and reports of suspected fraud, waste, and abuse. CHPW is committed to collaborating with state and federal agencies, other health plans, and providers to identify and correct Fraud, Waste, and Abuse. CHPW utilizes multiple avenues to prevent, detect, and correct Fraud, Waste, and Abuse, including:

- Oversight
- Standards, policies and procedures
- Education and training
- Systems and processes to detect and prevent fraud, waste, abuse, and medical identity theft
- Mechanisms for reporting suspected fraud, waste or abuse
- Processes for addressing and correcting at-risk business practices or noncompliant behaviors related to fraud, waste or abuse
- Processes for referring and reporting credible allegations of fraud to state and federal agencies
Additional information for members and contractors on “How To Prevent Health Care Fraud” and a form for making reports is available on www.chpw.org.

“What is Fraud, Waste, and Abuse?”
For the purposes of the FWA Program, CHPW defines Fraud, Waste, and Abuse as:

**Fraud:** Intentional deception or misrepresentation made by an individual who knows that the false information reported could result in an unauthorized benefit to him/herself or another person. Fraud is determined by intent and action. Examples of fraud may include:
- Misrepresenting the diagnosis to justify higher payments;
- Falsifying certificates of medical necessity, plans of care, or other records;
- Knowingly submitting duplicate claims for reimbursement;
- Soliciting, offering, or receiving kickbacks; and
- Unbundling of services to increase reimbursement.

**Waste:** Overutilization of services or improper billing practices that result in unnecessary costs. Waste is generally caused by the misuse of resources. Examples of waste may include:
- An organization’s culture fails to identify waste vulnerabilities and protect company resources;
- Submitting inaccurate claims that cause unnecessary rebilling or claims reprocessing;
- Inaccurate claims payment causing unnecessary member appeals, or provider disputes;
- Employees attending conferences that are unrelated to their work or unnecessary to perform their job function; and
- Overuse, underuse, and ineffective use of health care services.

**Abuse:** Gross negligence or reckless disregard for the truth in a manner that could result in an unauthorized benefit and unnecessary costs either directly or indirectly. Examples of abuse may include:
- Providing excessive or unnecessary services;
- Routinely waiving coinsurance and deductibles; and
- Billing Medicaid/Medicare patients at a higher rate than non-Medicaid/Medicare patients.

Contractors must understand how to detect fraud, waste, and abuse, be aware and on the lookout for the types of activities described here, and report suspected misconduct to the Plan.
“Where Does Fraud, Waste, and Abuse occur?”
Although most people and organizations are honest, Fraud, Waste, and Abuse may be committed by anyone, including:

- Patients
- Claims processing subcontractors
- Pharmacies and pharmacists
- Home health agencies
- Primary care providers
  - Hospitals
  - Subcontractors
  - Dentists
  - Specialist providers
  - Billing agencies
  - Ancillary providers
  - Coworkers
  - Suppliers

Examples of Fraud, Waste, and Abuse
The following types of activities are examples of Fraud, Waste, and Abuse. An identified occurrence of these or similar activities must be reported to CHPW’s Compliance Officer, FWA Program Manager or designee.

Provider Fraud, Waste, and Abuse
- Routinely waiving coinsurance and deductibles
- Failing to authorize the provision of medically necessary services or falsifying certificates of medical necessity
- Selecting or denying coverage to patients based on their illness profile or other discriminating factors
- Providing excessive/unnecessary services or treatment not warranted by type/severity of illness
- Billing Medicare patients at a higher rate than non-Medicare patients
- Double billing or knowingly submitting duplicate claims for reimbursement
- Billing non-covered services as covered items
- Billing for services not rendered and/or supplies not provided
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Offering inducements to patients for overutilization of services
- Unbundling of services to increase reimbursement
- Misrepresenting dates of service
Provider Prescription Fraud, Waste, and Abuse
- Illegal remuneration schemes where a prescriber is offered, paid, solicits, receives unlawful remuneration to induce or reward the prescriber to write prescriptions for drugs or products.
- Prescription mills where a prescriber writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients that are not theirs.
- Prescription drug switching involves offers of cash payments or other benefits to a prescriber to induce the prescriber to prescribe certain medications rather than others.

Pharmacy Prescription Fraud, Waste, and Abuse
- Inappropriate billing practices such as:
  - Billing for brand when generics are dispensed
  - Billing for non-covered prescriptions as covered items
  - Billing for prescriptions that are never picked up
- Dispensing expired or adulterated prescription drugs
- Pill splitting or prescription drug shorting
- Bait and switch pricing
- Prescription forging or altering to increase quantity or number of refills, especially narcotics.
- Theft of prescriber’s DEA number, prescription pad, or e-prescribing information to illegally write prescriptions for controlled substances or other medications often sold on the black market. In the context of e-prescribing, this includes the theft of the provider’s authentication (log in) information.
- Coding medical services at a level that isn’t supported by medical record documentation.
- Falsifying a diagnosis or the identity of the individual who received the services, a diagnosis to justify higher payments.

Patient/Member Fraud, Waste, and Abuse
- Misrepresentation of status/personal information, such as identity, eligibility, or medical condition in order to illegally receive care or a drug benefit.
- Medicare member manipulates true out of pocket (TrOOP) to push through the coverage gap, so the patient can reach catastrophic coverage before they are eligible.
- Improper coordination of benefits where a patient fails to disclose multiple coverage policies, or leverages various coverage policies to game the system.
- Identity theft involving the use of another person’s card to obtain care or prescriptions.
• Prescription diversion, inappropriate use, or stockpiling where a patient obtains prescription drugs from a provider to avoid out-of-pocket costs, protect against non-coverage (i.e., by purchasing a large amount of prescription drugs and then dis-enrolling), or for purposes of resale on the black market.
• Doctor shopping where a patient consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs.
• Falsely reporting loss/theft or feigning illness to obtain drugs for resale on the black market.

Consequences of Fraud, Waste, and Abuse
In terms of patient safety and quality of care, Fraud, Waste, and Abuse can cause serious personal harm:
• Unnecessary procedures may cause injury or death.
• Falsely billed procedures and medical identity theft can create an erroneous record of the patient’s medical history.
• Diluted or substituted drugs may render treatment ineffective or expose the patient to harmful side effects or drug interactions.
• Prescription narcotics on the black market contribute to drug abuse and addiction, and perpetuate criminal activity.

Perpetrators of Fraud, Waste, and Abuse face serious repercussions:
• Termination of contract or disenrollment of patient from state/federal health care programs.
• Exclusion from participating in or benefiting from a state or federally funded health care program.
• Assessment of damages, reimbursement, restitution, compensation, including civil monetary penalties.
• Denial/revocation of Medicare/Medicaid provider application.
• License revocation or suspension.
• Suspension of payments.

Provider Payment Suspension for Fraud (Washington Apple Health)
If the Compliance Officer, Fraud, Waste, and Abuse Program Manager or a designee determines after conducting a reasonable inquiry that credible fraud or misconduct has occurred in relation to CHPW’s Washington state lines of business, the conduct is referred in writing to Health Care Authority (HCA).

As appropriate or at the direction of state or federal agencies, CHPW will notify state or federal law enforcement.
Framework for Detecting and Preventing Fraud, Waste, and Abuse
Contractors should consider implementing standards, processes, and systems to help find, fix, and prevent Fraud, Waste, and Abuse, including the following elements:

- Knowing what constitutes Fraud, Waste, and Abuse
- Understanding where Fraud, Waste, and Abuse can occur
- Knowing how to identify Fraud, Waste, and Abuse
- Knowing how to report suspected or potential Fraud, Waste, and Abuse
- Reporting concerns and taking action when problems are identified
- Maintaining an organizational culture that promotes identifying waste vulnerabilities and protecting company resources
- Developing and maintaining a compliance program
- Cooperation and coordination between providers, vendors, contractors, government agencies, and law enforcement officials
- Fraud, Waste, and Abuse training and/or resources for providers, contractors, and patients
- Maintaining written policies and procedures
- Well-publicized, consistently applied enforcement policies
- Performing regular internal audits
- Monitoring claims to ensure coding reflects services provided
- Monitoring medical records to ensure documentation supports services rendered
- Avoiding unnecessary spending that can be eliminated without reducing the quality of care
- Avoiding redundancy, delays, and unnecessary process complexity in providing treatment
- Maintaining open lines of communication with colleagues and staff
- Asking about potential compliance issues in exit interviews

Monitoring OIG and GSA Exclusion/Sanction Lists
Contractors must screen all employees and health care-related subcontractors monthly, and prior to hiring or executing a contractual agreement by using the Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists (links are noted below). The screening is conducted to ensure that employees, independent contractors and/or entities that assist in the administration or delivery of services are not excluded from participating in a federally funded program.

- OIG List of Excluded Individuals/Entities (LEIE): http://oig.hhs.gov/fraud/exclusions.asp
- GSA System for Award Management (SAM): https://www.sam.gov/portal/SAM/##11
If individuals or entities are found to be on either list, they must immediately be removed from any work that relates to CHPW members. Individuals/entities who are or will become debarred, excluded or otherwise ineligible to participate in a federally funded program must report it immediately to the CHPW Compliance Officer.

CHPW is required to screen each person with 5% direct or indirect ownership and control interest monthly, and prior to executing a contract by using the Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists. The screening is conducted to ensure that employees, independent contractors, and/or entities that assist in the administration or delivery of services are not excluded from participating in a federally funded program.

Conflicts of Interest
A conflict of interest can arise when a person or a member of a person’s family has an existing or potential interest or relationship which impairs or might appear to impair the person’s independent judgment. Family members include spouses, parents, siblings, children, and others living in the same household.

Contractors should require managers, officers, and directors involved in work that relates to CHPW members to report potential conflicts that may arise and sign a Conflict of Interest Statement at the time of hiring and annually thereafter.

Understanding Relevant Laws
The following federal laws prohibit specific activities related to health care fraud, waste, and abuse:
- The False Claims Act or “Lincoln Law” (31 U.S.C §3729-3733)
- The Anti-Kickback Law (42 U.S.C. §1320a-7b(b))
- The Stark Law (42 U.S.C. §1395nn)

Find a brief summary of these laws below. Additional information is available on the OIG’s website at https://oig.hhs.gov/. The Civil Monetary Penalties Law (42 U.S.C. § 1320au 7a) outlines penalties related to violations of the above laws.

Federal False Claims Act
The False Claims Act allows people who are not affiliated with the government to file actions claiming fraud against a government contractor on the government’s behalf for:
- Presenting to the government a false claim for payment
- Causing someone else to submit a false claim for payment
• Making or using a false record or statement to get a claim paid by the government
• Conspiring to get a false claim paid by the government
• Making or using a false record to avoid or decrease an obligation to pay or reimburse the government

The False Claims Act provides protections for “whistleblowers.” A whistleblower is a person who raises a concern about wrongdoing occurring in an organization or body of people, usually from that same organization. Whistleblower protections:
• Allow individuals to report fraud anonymously, sue an entity on behalf of the government, and collect a portion of any resulting settlement.
• Prohibit employers from threatening, intimidating, or retaliating against employees, who in good faith report misconduct or wrong doing.

Violations of the False Claims Act result in social and business consequences, causing irreparable damage to one’s reputation, and loss of business. In addition, violations may result in civil and monetary penalties, including:
• Fines up to $11,000 for each false claim
• Exclusion from participation in Medicare & Medicaid programs
• Plus treble damages suffered by the government
• Possible criminal prosecution and imprisonment
• Trial costs

Federal Anti-Kickback Law
The Anti-Kickback Law states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health care program business, including Medicare and Medicaid, can be held accountable for a felony.

Violations of the law are punishable by up to five years in prison, criminal fines up to $25,000, administrative civil money penalties up to $50,000, and exclusion from participation in federal health care programs.

Please refer to the Office of the Inspector General website for additional info and a list of safe harbor protections at http://oig.hhs.gov

Stark Law
The Stark Law is a broad statute in the Social Security Act that prohibits:
• The referral of Medicare and Medicaid patients to entities with which the referring physician or members of his or her immediate family have a financial relationship for services identified in the statute as “designated health services.”
• An entity from billing or filing a claim for a designated health service as a result of a prohibited referral.

Compliance Program Policies and Procedures
CHPW maintains Compliance Program policies and procedures which further detail the information provided in this manual. CHPW makes the following policies and procedures available at www.chpw.org.

Fraud, Waste, and Abuse Policy (CO289)
This policy defines how CHPW works to prevent, detect, investigate, and report potential fraud, waste, and/or abuse through its Fraud, Waste, and Abuse Program. The policy outlines the manner in which potential fraud, waste, and/or abuse are identified. The following are examples of CHPW’s efforts to prevent, detect, and investigate fraud, waste, and abuse:

• Post payment review of claims and other claims analysis activities to identify patterns of potential inappropriate billing practices, including high dollar claim review;
• Medical claims review to determine appropriateness of services and level of care, reasonable charges, and potential over-utilization;
• Pre-payment medical record review of claims submitted by specific providers that have been identified as having suspicious billing patterns and thus the potential for fraud, waste or abuse;
• Claims trend reviews prompted by a recurrent pattern in claims (may be suggested by either CHPW or its third-party administrator);
• Medical Management staff or other employees asking for an ad hoc review;
• Reports of suspected fraud, waste and abuse;
• Reports of suspected identity theft; and,
• Discrepancies indicated by a member that a provider billed for services not received.

Fraud and Provider Payment Suspension Procedure (CO339)
This procedure documents the requirements and processes employed by CHPW to address credible allegations of provider fraud. “Credible allegation” is defined to mean the following: An allegation is generally defined as an assertion of wrongdoing, the truth or falsity of which has yet to be proved. An allegation is credible when it retains a semblance of truth following examination. The credibility increases as a function of the number and the reliability of the indicators. Through this procedure, allegations of fraud by a provider are reviewed for credibility. Credible allegations are referred to appropriate agencies and law enforcement and may lead to provider payment suspension and notification.
False Claims and Whistleblower Protections Policy (CO310)
This policy defines how CHPW ensures compliance with applicable laws including, but not limited to, those provisions outlined in the Federal False Claims Act (31 USC §3279-3733), §6032 of the Federal Deficit Reduction Act of 2005 (42 USC §1396(a)(68)), and the Washington State Health Care False Claims Act (RCW 48.80). This policy communicates the standards CHPW uses to help prevent fraudulent claims to the government and provides an avenue for employees, agents, contractors, and Board members to raise potential and actual concerns of any and all conduct that may not comply with federal, state, and/or local law.

CHPW protects individuals or organizations that, in good faith and belief, raise potential and/or actual concerns of any and all conduct that may not comply with federal and state law from reprisal or victimization.

Identity Theft Prevention (Red Flags of Identity Theft) Policy (CO303)
The Identity Theft Prevention policy and procedure define processes to 1) identify the red flags of identity theft encountered in CHPW’s day-to-day operations; 2) detect the identified red flags as they occur; 3) take the appropriate actions to mitigate harm to members when red flags are discovered; and 4) ensure training materials include information relevant to the Federal Trade Commission’s Red Flags Rule.

Exclusion Screening (CO318)
The Exclusion Screening policy outlines how CHPW prevents the employment of, or contracting with, any employee, vendor, provider, or provider entity that is ineligible to participate in federal health care programs in compliance with 42 USC §1320c-5, 42 USC §1320a-7, Social Security Act §1903(i)(2), 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 1001.1901(b).

HIPAA Security Policy (CO330)
The HIPAA Security Policy designates a Security Officer and describes the technical, physical, and administrative security requirements for employees, consultants, contractors, business associates, and vendors who create, access, transmit, receive, or store protected health information (PHI) at or for CHPW as required to address the HIPAA Security Rule.

HIPAA Privacy Policy and Procedures (CO298, CO315, CO316, CO317)
These policies designate a Privacy Officer and define how to honor HIPAA member rights, rules around the use and disclosure of PHI, and the day-to-day employee responsibilities that help ensure administrative, technical, and physical safeguards of PHI.
Privacy Incidents and Breach Notifications Policy (CO311)
This policy defines how CHPW helps ensure that impermissible uses and disclosures of member PHI by CHPW workforce, contractor, subcontractor, vendor (FDR), including those incidents determined to be breaches, are reported and processed in accordance with federal and state law.

HIPAA Violations Policy (CO325)
This policy defines violations of the HIPAA Privacy and Security Rules and CHPW’s corporate privacy and security policies and explains how CHPW responds to such violations by an employee and business associate.

Advance Directive
CHPW is required to educate and inform workforce members, providers, and members about a patient’s rights to an Advance Directive.

An advance directive provides written instructions about a member’s future medical care in the event that the member is unable to express his or her medical wishes. For the state of Washington, this written instruction is in the form of two documents: a Health Care Directive (also known as a Living Will) and a Durable Power of Attorney for Health Care. A mental health advance directive provides instructions and/or appoints an agent to make decisions on behalf of the member regarding the member’s mental health treatment.

Primary care providers are encouraged to discuss advance directives with adult patients and are required to document the discussion in the members’ medical record. Providers of medical or behavioral health services for CHPW members must:

1. Review each member’s medical record prior to admittance or enrollment to determine if the member has an advance directive;
2. Clearly document on the member’s medical record whether or not the member has executed an advance directive;
3. Honor the advance directive or follow the process explained under the section “Conflicts and Conscientious Objections” below; and
4. Not refuse, put conditions on care, or otherwise discriminate against a member based on whether or not the member has completed an advance directive.

Providers must document in a prominent place in an adult member’s medical record whether an Advance Directive exists. If an Advance Directive does exist, a copy of it should be filed in the medical record.
At the time of enrollment, CHPW notifies its members in writing that they or their authorized representative have a right to make decisions concerning their care, including decisions to withhold resuscitative services, to decline or withdraw form life-sustaining treatment, to accept or refuse surgical or medical treatment, to implement an Advance Directive, and to cancel an Advance Directive at any time.

Information about Advance Directives should be given to patients by providers at the time of admission during stays at hospitals and nursing facilities; for in-home care services before the member comes under the care of the provider or at the time of the first home visit so long as it is provided prior to care being rendered; and for hospice programs at the time the member comes under the care of the provider. This information must include the following:

- That a provider cannot refuse care or otherwise discriminate against a member based on whether or not the member has executed an Advance Directive;
- That members have the right to file a complaint about the provider’s noncompliance with Advance Directive requirements, and where to file the complaint;
- That the provider must document in a prominent part of the member’s current medical record whether or not the member has executed an advance directive;
- Describe how the provider is required to comply with WAC 182-501-0125; and
- That the provider must educate its staff about its policies and procedures for Advance Directives.

If a provider cannot implement an advance directive as a matter of conscience, the provider must issue a clear and precise written statement of this limitation to CHPW. The statement must include information that:

- Clarifies the differences between institution-wide objections based on conscience and those that may be raised by individual physicians;
- Identifies the State legal authority permitting such objection; and
- Explains the range of medical conditions or procedures affected.

Providers who have a policy or practice that would keep it from honoring an Advance Director should also:

- Advise the enrollee in advance, or when admitted of existing conscientious objections.
- Prepare and keep a written plan of intended actions if the enrollee chooses to stay.
- Make a good faith effort to transfer the enrollee to another provider who will honor the directive.

Providers should review their obligations concerning Advance Directives in WAC 182-501-0125. For more information, access CHPW’s policy (CO291) and procedure (CO292)
on Advance Directives at http://chpw.org/for-providers/other-resources/integrity-program.

Auditing and Monitoring
Auditing and monitoring activities aid CHPW in detecting and preventing fraud, waste, and abuse. Focused audit and monitoring activities are determined annually for the Compliance Program Work Plan through any of the following:

- Findings in the annual US Department of State Office of Inspector General (OIG) Work Plan;
- Findings in the annual CMS Recovery Audit Contractors (RAC) Audit Work Plan;
- Monitoring and tracking email alerts from the OIG and CMS;
- As the result of a report(s) made to the Compliance department in the past;
- Findings from previous auditing or monitoring activities;
- By organizational need or requirement;
- At the request of the CEO and/or internal individuals or departments; and,
- Customer service calls or inquiries from members, vendors and/ or providers.

Ad hoc auditing and monitoring activities may be added to the Work Plan at any time to address identified risks. Auditing and monitoring may include, but is not limited to, the activities outlined below.

CHPW’s Compliance department may proactively initiate review of claims and CHPW member explanation of benefits (EOB) to ensure that diagnosis, evaluation and management or procedure codes submitted for payment are supported by the medical record documentation for a member. An investigation may be triggered as a result of the targeted review of any of the following:

- Post payment review of claims and other claims analysis activities to identify patterns of potential inappropriate billing practices, including high dollar claim review;
- Medical claims review to determine appropriateness of services and level of care, reasonable charges, and potential over-utilization;
- Pre-payment medical record review of claims submitted by specific providers that have been identified as having suspicious billing patterns and thus the potential for fraud, waste or abuse;
- Claims trend reviews prompted by a recurrent pattern in claims (may be suggested by either CHPW or its third-party administrator);
- Medical Management staff or other employees asking for an ad hoc review;
- Reports of suspected fraud, waste and abuse;
- Reports of suspected identity theft; and/or
- Discrepancies indicated by a member that a provider billed for services not received.

CHPW may proactively review claims for any of the following red flags of fraud:
- **Up-coding:** Up-coding occurs when a health care provider submits a claim for health care services, treatments, diagnostic tests or items which represent a more serious and more expensive procedure than that which was performed. Up-coding can be a violation of the Federal False Claims Act.
- **Unbundling:** When individual components of a procedure are coded separately and a single code describes the service provided.

CHPW may perform a post payment review of claims for any of the following red flags of fraud:
- **Services Not Rendered:** The submission of a claim for health care services, treatments, diagnostic tests, medical devices or pharmaceuticals that were never rendered.
- **Kickback Referrals:** The Federal Anti-Kickback Statute prohibits any offer, payment, solicitation or receipt of money, property or remuneration to induce or reward the referral of patients or health care services. These improper payments can come in many different forms, including, but not limited to: referral fees; finder’s fees; productivity bonuses; discounted leases; discounted equipment rentals; research grants; speaker’s fees; excessive compensation; and free or discounted travel or entertainment. The offer, payment, solicitation or receipt of any such monies or remuneration can be a violation of the Federal Anti-Kickback statute, 42 U.S.C. §1328-7b(b), the Federal False Claims Act, as well as various other federal and state laws and regulations.
- **Lack of Medical Necessity:** Health care providers are required by law to document the medical necessity of the treatment or services for which they are seeking reimbursement. One common type of fraud has been to submit claims for services, treatments, diagnostic tests, and medical devices that are not medically necessary.

CHPW may monitor member EOBs with cost sharing for one or more of the following red flags of fraud:
- **Phantom Billing/Ghost Billing:** The submission of a claim for health care services, treatments, diagnostic tests, medical devices or pharmaceuticals provided to a patient who either does not exist or who never received the service or item billed for in the claim.
- **Falsifying Diagnosis:** When a member's diagnosis is falsified to justify the performance of tests, treatments, procedures and even surgery that is not medically necessary. For
example, medical insurance companies generally do not offer coverage for cosmetic surgery, but a cosmetic surgeon might falsify the claim submitted to an insurance company in order to receive payment.

**Investigation**

Once an allegation of fraud is deemed credible, the Compliance Officer, the Fraud, Waste, and Abuse Program Manager or a designee may initiate, as applicable, the following activities:

- Review the case with all appropriate internal resources;
- Gather and review pertinent documents;
- Run data query/sampling;
- Request records for review;
- Provider payment suspension; and
- Interview involved parties (e.g., members, providers)

CHPW requires by contract that each of its FDRs, subcontractors, including providers, provide CHPW access to records for the purposes of investigating fraud, waste, and abuse. In the event that a subcontractor fails to cooperate with an investigation, CHPW will recoup funds for the services billed and terminate the contract. Records requested and reviewed may include any of the following:

- Medical records
- Claims processing records
- Appeal files
- Adjustment reports

CHPW’s investigation of a CHPW member or provider may include, but is not limited to, the following procedures and practices:

- Immediate flagging of provider for post-payment review of services for medical and billing appropriateness;
- Review of provider information (provider ID, tax ID number, contract status, and specialty);
- Review of provider contract terms;
- Review of provider claims history or reconciliation report for services billed and adjudicated prior to the date of service for the claim(s) cited in the request for investigation;
- Collection of any necessary information from and/or discussion with other CHPW departments or subcontractors relevant to the investigation (Claims Specialists, Care Management, Customer Service, Provider Relations, Provider Operations, Quality
Management, CHPW’s third-party administrator, etc.);
• Collection of other information from outside sources as circumstances warrant; and
• Investigation of encounters, billing, medical procedure coding, medical necessity, or other information as circumstances warrant to develop data for analysis to inform the decision. Where applicable and appropriate, the relevant internal or external Credentialing organization may be a part of the investigation.

Any material used in the investigation of a complaint of Fraud, Waste or Abuse remains confidential during the investigation and is only shared with limited, appropriate staff and only for purposes of the investigation and reporting.

Once an investigation is complete, case findings and supporting documentation are compiled in a case file, an action plan is established, and the Compliance Officer or the Fraud, Waste, and Abuse Program Manager provides feedback to the originator of the request.

Enforcement and Discipline
Upon completion of an investigation, the Compliance Officer, the Fraud, Waste, and Abuse Program Manager or a designee reviews the assembled case file and makes a determination regarding further action by CHPW. Depending on the findings, CHPW may do any of the following:

• Recover overpayments or reverse a claim charge;
• Institute a manual review of claims;
• Determine and implement case-specific corrective actions;
• Provide education and training to staff or providers;
• Employ mitigations and/or process improvements;
• Terminate a provider contract;
• Move a member into Member Review and Intervention Program (MRIP) and,
• Refer a member to the MFCU or law enforcement for prosecution and continue surveillance of all activities of that member;
• Expand a single case to review/scrutinize the manner in which a provider bills other services.

CHPW may choose to monitor activities in certain cases to ensure process improvements/mitigations have been appropriately employed.

For staff, grossly negligent or intentional conduct that is demonstrably and materially injurious to CHPW, monetarily or otherwise, including but not limited to fraud, theft,
forgery, embezzlement, misappropriation, identity theft or other unethical activity is grounds for disciplinary action up to and including termination.

**Member Rights and Responsibilities**
CHPW has contractual and regulatory obligations to ensure that all members eligible for state and federal programs receive a copy of their health care Member Rights and Responsibilities, which:

- Inform patients of their rights under the law for treatment, drug prescription, and care management decisions;
- Guarantee that members will be treated with respect; and
- Outline what members, in return, are responsible for to their providers physicians
- Inform all individuals on the availability of language assistance services clearly and in their preferred language, verbally and in writing.

Members Rights and Responsibilities should not be confused with Member Rights under HIPPA. Member Rights and Responsibilities may vary by CHPW line of business:

- For programs administered by Washington State, Member Rights and Responsibilities can be found for each product on CHPW’s website at [http://chpw.org/for-members/your-privacy-and-rights/](http://chpw.org/for-members/your-privacy-and-rights/).
- For Community HealthFirst™ Medicare Advantage, Member Rights and Responsibilities can be found on the Community HealthFirst™ website at [http://healthfirst.chpw.org/for-members/your-rights-and-privacy/](http://healthfirst.chpw.org/for-members/your-rights-and-privacy/).

**Second Opinion**
An enrollee or the PCP may request a second opinion where there is a question concerning a diagnosis, options for surgery, or other health care treatment. If the enrollee desires a second opinion, he or she must request that the PCP arrange one. The enrollee may request a referral directly from CHPW, if necessary.

If the enrollee requests a second opinion, the PCP or CHPW shall promptly refer the enrollee to an appropriate participating provider of a similar specialty and authorize the referral. If there is not a participating provider with the expertise required for the condition, an authorization from CHPW must be obtained prior to a second opinion from a non-participating provider. The PCP or CHPW is not obligated to refer to and/or authorize a second opinion from a non-participating provider.

The requirement for a second opinion has been satisfied when the PCP recommends treatment by a specialist and that specialist agrees with the treatment plan. This is
considered a first and second opinion. If the specialist presents a treatment plan and the PCP agrees with that plan, this is also considered to be a first and second opinion.

**Women’s Health Care**

CHPW provides all female members with direct access to network women’s health care specialists for covered services necessary to provide women’s routine and preventive health care services in accordance with the provisions of WAC 284-43-250 and 42 CFR 438.206(b)(2).

Female members can self-refer to any women’s health care providers in our network for the following services without needing a referral from their PCP:

- Maternity care, including prenatal, delivery, and postnatal care
- Routine gynecological exams
- Examination and treatment of disorders of the female reproductive system, except as specifically excluded
- Family planning (infertility is not covered)
- Advice on birth control methods
- Other health problems discovered and treated during the course of the member’s office visit, as long as the treatment is within the provider’s scope of practice, and the service provided is not excluded.

In addition, CHPW allows coverage for medically necessary ancillary services such as laboratory services, imaging services, diagnostic services, or prescriptions for pharmaceutical or medical supplies, which are ordered by a self-referred women's health care provider in our network, and which are within the provider's scope of practice, if such services would be covered when provided by a primary care provider without authorization.

To find a women’s health care provider within our network, please visit Find a Doctor at [http://chpw.org/provider-search/](http://chpw.org/provider-search/).

**Balance Billing**

For Washington Apple Health members, providers must accept payment by CHPW as payment in full. Providers are prohibited from “balance billing” a client, i.e., charging the difference between usual, customary rates and the CHPW’s payment. A provider must not bill a member, or anyone on the members behalf, for any services until the provider has completed all requirements, including the conditions of payment (i.e. Prior Authorization, Plan Authorized Referral), and until the provider has then fully informed the member of his or her covered options.
A provider must not bill a member for:

- Any services for which the provider failed to satisfy the conditions of payment described by the HCA, and the requirements by CHPW.
- A covered service even if the provider has not received payment from CHPW.
- A covered service when CHPW denies an authorization request for the service because the required information was not received from the provider.

The Agreement to Pay for Healthcare Services covered in WAC 182-502-0160 ("Billing a Client") is an agreement between a “client” and a “provider,” and where an HCA 13-879 form must be completed, signed and dated before the service(s) are rendered. The member agrees to pay the provider for healthcare service(s) that the HCA will not pay. For the purposes of this Agreement, “services” include, but are not limited to healthcare treatment, equipment, supplies, and medications. For a complete understanding relevant to HCA policies on “Billing a Client”, please go to: http://app.leg.wa.gov/wac/default.aspx?cite=182-502-0160.

All Medicare physicians, providers, and suppliers who offer services and supplies to Qualified Medicare Beneficiaries must be aware that they may not bill Qualified Medicare Beneficiaries for Medicare cost-sharing. This includes deductible, coinsurance, and copayments, known as “balance billing.” Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing Qualified Medicare Beneficiaries for Medicare cost sharing. Qualified Medical Beneficiaries have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing.

Providers who inappropriately bill Qualified Medicare Beneficiaries for Medicare cost-sharing are subject to sanctions. Please access CHPW Balance Billing Program at http://chpw.org/for-providers/training/.

**Interpreter Services**

All members who are eligible for medical assistance through HCA are eligible for interpreter services, including those who are deaf, deaf-blind, or hard of speaking. A complete guide on HCA interpreter services may be found on the HCA website. CHPW is providing Telephonic Interpreter Assistance for our providers to use with Community HealthFirst™ Medicare Advantage members. This is free of charge. Clinic staff is responsible for verifying a member is a Community HealthFirst™ Medicare Advantage member. The telephonic interpreter service is offered through Voiance.
To access Voiance Interpreter Services:
1. Dial 1-866-998-0338
2. Enter account number: 14767
3. Enter the pin: 0044
4. Enter the Cost Center Code: 44
5. Say the language you need
6. Hold as you connect to an interpreter
7. If you need assistance say "customer service" or call 1-800-481-3289

If you have questions about CHPW, please contact CHPW's Customer Service team at 1-800-440-1561.

Medical Provider Responsibilities
When Health Care Authority clients need interpreter services to receive medical or health care services, the medical provider is responsible for:

- Verifying that the patient is an eligible Health Care Authority client.
- Checking to see whether the medical service to be provided is covered by the client’s medical program.
- Notifying the Health Care Authority client that interpreter services are available to the client at no charge.
- Coordinating the interpreter services.
- Following Health Care Authority medical service authorization procedures, whenever applicable.
- Notifying the independent interpreter or interpreter agency when interpreter services are required.
- Notifying the interpreter of any changes to scheduled appointments.
- Verifying the interpreter’s picture identification with the interpreter.
- Documenting in the client’s record that the person is deaf, deaf-blind, hard of hearing, or limited-English speaking (LEP), and that interpreter services were provided. Include the name of the interpreter and what form of identification was presented.

Other Provider Responsibilities
When necessary, the provider may also be responsible for:

- Contacting the Health Care Authority’s CTS LanguageLink service at 1 (800) 535-7358 when a limited-English-speaking client requires urgent care that cannot be rescheduled and the medical provider has no other resource for an interpreter.
- Contacting the Washington State Relay Service for TDD connection (7-1-1) to communicate with a person who is deaf, deaf-blind, or hard of hearing.
- Contacting the Health Care Authority at 1 (800) 535-7358 for help with obtaining an interpreter.
Medicare: CHPW provides this service at 1 (866) 998-0338 with the following log in
Enter Account Number: 14767
Enter PIN Number: 0044
Enter Cost Center: 44

Billing and Claims Payment Governance
CHPW pays claims in accordance with health insurance industry standard practice, with rules defined and published by government agencies that conduct business with or regulate CHPW (that is, the Centers for Medicare & Medicaid Services, Washington Department of Social and Health Services, and Washington Health Care Authority), with nationally recognized coding standards, and/or with CHPW established policies.

Billing Requirements
CHPW would like to remind providers to follow appropriate billing guidelines. This includes ensuring that claims have the rendering service location address.

Per CMS guidelines under the Medicare Claims Processing Manual Chapter 26: “Effective January 1, 2011, for claims processed on or after January 1, 2011, submission of the location where the service was rendered will be required for all POS codes.”

CMS also has a crosswalk for the CMS 1500 to 5010EDI transaction sets; please see [http://www.palmettogba.com/Palmetto/Providers.Nsf/files/CMS1500_ANSI837v5010_Crosswalk.pdf/$File/CMS1500_ANSI837v5010_Crosswalk.pdf](http://www.palmettogba.com/Palmetto/Providers.Nsf/files/CMS1500_ANSI837v5010_Crosswalk.pdf). For a side-by-side version between 4010 and 5010 EDI billing, see [https://www.cms.gov/medicare/billing/electronicbillingeditrans/downloads/professionalclaimm4010a1to5010.pdf](https://www.cms.gov/medicare/billing/electronicbillingeditrans/downloads/professionalclaimm4010a1to5010.pdf). The “Service Facility Location” is loop 2310C and can be found on page 45 in the document. The “Billing Provider” is loop 2010AA and can be found on page 4. The “Pay to Provider” is loop 2010AB and can be found on page 6.

Provider Status
To ensure timely adjudication and payment of claims, CHPW recommends that providers verify their participation or contracting status prior to submitting claims.

Submission of credentialing application does not guarantee claims payments. The provider must verify credentialing/recredentialing status prior to treating CHPW members and submitting claims. See the Credentialing and Recredentialing section of this manual for more information.
Providers need to send demographic provider/clinic changes to CHPW in advance of billing a claim. If the service location is different than the Billing Provider 2010AA, the 2310C loop must be populated. Provider changes may be reported to CHPW by completing a Provider Add Change Term Form located at http://chpw.org/for-providers/documents-and-tools emailing it directly to Provider.Changes@CHPW.org.

Core Provider Agreement (CPA) – Washington Apple Health
The Code of Federal Regulations (federal law) mandates that the Washington State Health Care Authority (HCA) require a CPA so the HCA can enroll eligible providers in its Apple Health Medicaid program to pay those providers for covered services, supplies, and equipment rendered to eligible Apple Health clients. In addition, Washington Administrative Code (WAC) allows the option for providers who do not bill Medicaid but write orders and prescriptions for services Medicaid pays for to have “an approved agreement with the agency [HCA] as a nonbilling provider.” Providers and Community Health Plan of Washington (CHPW) must comply with the federal mandate. Please see http://chpw.org/for-providers/bulletin-board/core-provider-agreement for more information.

Consent Forms
Completed consent forms and a 30-day wait period after signature are required for payment of Washington Apple Health claims for sterilization services. Please refer to the following for more information:


Note: Signature stamps are not accepted on consent forms. Completed and signed consent forms must be submitted with the claim.
Newborn Claims
Providers should bill for newborn care using the mother's CHPW ID number until the end of the month in which the newborn’s 21st day of life falls. After the end of that month, the newborn should have his or her own Plan ID number. Newborns whose mothers are enrolled on the date of birth shall be deemed enrollees and enrolled in the same plan as the mother as follows:

- Retrospectively for the month(s) in which the first twenty-one (21) days of life occur and prospectively, beginning the first of the month after the newborn is reported to the Health Care Authority.
- If the newborn does not receive a separate client identifier from the Health Care Authority the newborn enrollment will be only available through the end of the month in which the first twenty-one (21) days of life occur.

Claim Documents
- 1500 Claim Form and Instructions (02-12)
- UB04 Form and Instructions
  http://chpw.org/resources/Forms_and_Tools/UB04_Claim_Form.pdf
- Sample Remittance Advice http://chpw.org/resources/New_RA_Sample.pdf
- Supporting Documentation Cover Sheet
  http://chpw.org/resources/Forms_and_Tools/SupportingDocumentationCoverSheet.pdf
- Corrected Claim – Standard Cover Sheet
  http://chpw.org/resources/Forms_and_Tools/CorrectedClaimsCoverSheet.pdf

Please refer to http://chpw.org/for-providers/documents-and-tools on our website for a complete list of forms.

Corrected Claims
A corrected claim is one that was previously billed and processed but needs to be reprocessed with corrected information (such as date of service, patient information, procedure codes, etc.).

CHPW encourages our providers to submit corrected claims electronically, rather than on paper; paper is needed only when the corrected claim requires an attachment. At this time, we are not able to accept attachments with electronic claims.

How to Submit Electronic Corrected Claims
Please complete the following steps when electronically submitting a corrected claim to CHPW in the ANSI-837 professional or institutional format:
837P (Professional) and 837I (Institutional) Claims: In Loop 2300 (Claim Information), segment CLM05-3, use Claim Frequency Type Code “7” for “Replacement.” The corrected claim will process as a replacement claim and reverse the original claim on file.

**How to Submit Paper Corrected Claims**

For paper claims, please:

- Complete a Corrected Claim – Standard Cover Sheet, available from our website at [http://chpw.org/resources/Forms_and_Tools/CorrectedClaimsCoverSheet.pdf](http://chpw.org/resources/Forms_and_Tools/CorrectedClaimsCoverSheet.pdf). Make sure to include the original claim number as indicated on the cover sheet.
- Attach any necessary supporting documentation.
- Mail the cover sheet, corrected claim, and any supporting documentation to:
  
  CHP Claims
  
  PO Box 269002
  
  Plano, TX 75026-9002

Please do not send corrected claims to our Customer Service department as that may delay receipt and claim reprocessing.

**Electronic Data Interchange (EDI) / Electronic Transactions / Electronic Claims Submission**

Providers may contact edi.support@chpw.org with questions relating to any of the electronic transactions that CHPW supports.

Using electronic transactions has the following benefits:

- More environmentally and financially friendly by reducing paper and related costs such as envelopes, postage, and other processing costs
- 24 hour availability
- Access to timely benefit, eligibility, and claims status information
- Claims are submitted faster
- Eliminating time spent waiting for mail delivery of remittance advices (RAs) and checks
- Automatic crediting and availability of funds without making a manual check deposit; elimination of lost or misplaced checks and associated fees

**Electronic Transactions**

We currently support these electronic transactions:

- 270: Eligibility, coverage, or benefit inquiry
- 271: Eligibility, coverage, or benefit information
- 276: Health care claim status report
• 277: Health care information status notification
• 834: Benefit enrollment and maintenance
• 835: Health care claim payment advice
• 837: Health care claim
• ACH payments: Automated clearing house (ACH) payments are electronic payments often referred to as direct deposit or electronic funds transfer (EFT).

**Member Eligibility**

**Electronic Claims Submission**
To start submitting electronic claims, contact your software vendor to learn about options for installing electronic claims systems and choosing a clearinghouse.

CHPW uses Availity for our 837 transactions. Our Availity Payer ID is CHPWA. Once you are ready to send electronic claims, please register with Availity online (go to [http://www.availity.com/](http://www.availity.com/) and click Get Started) or contact Availity Client Services at 1-800-AVAILITY (282-4548).

**Check Claim Status**

**Claim Message Codes**
Please contact CHPW’s EDI Support department at edi.support@chpw.org if you have questions about CHPW’s reason codes, or about CARCs and RARCs.

**Claim Issues**
• We request that all providers call Customer Service first.
The Claims Investigation Unit (CIU) gives you direct contact with CHPW Claims Analysts, only after attempts to resolve issues through Customer Service have been exhausted. Please see the “Claims Investigation Unit (CIU)” section of this manual (below) for more information.

835 files (Electronic Remittance Advices, or ERA)
CHPW uses Availity for our 835 transactions. To receive 835 files, you must enroll with Availity. Access the Availity 835/ERA Enrollment Form, a 4-page PDF, from our website at http://chpw.org/resources/multipayer_era_835_enrollment.pdf.

Pages 1 through 3 of the Availity enrollment form give an overview of the ERA process, instructions for completing the form and where to send it, and detailed descriptions of the information you need to provide to sign up for ERA.

Page 4 of the form has all of the fields that you need to fill in before you send the completed, signed form to Availity.

When you’re ready to fill out the form:
- To complete a text field, click in a blue area and type your response.
- To place a checkmark in a checkbox, click once in the appropriate checkbox to mark it with an “X”.
- Make sure to fill out the Receiver Information section. If you use another clearinghouse (such as Office Ally), please complete the Receiver Information section for your clearinghouse. Have the provider or the provider’s representative sign the form and submit it to Availity. Please note that Availity will not accept the form without a signature. You may email, fax, or mail the form to Availity. Instructions are included at the bottom of the last page of the form.
- If you have been receiving paper RAs and then sign up for 835s, we will automatically turn off your paper RAs within 90 days unless you contact EDI.Support@chpw.org and ask us not to.
- If you have questions about enrolling for 835 files or if you previously enrolled for 835s and would like to stop receiving paper RAs right away, please contact EDI.Support@chpw.org.
- If your 835 or RA is missing, please contact CHPW’s Customer Service department.
Electronic Banking
You have two ways to sign up to receive payments electronically via automated clearing house (ACH) transactions, often referred to as electronic funds transfer (EFT) or direct deposit:


2. Or, you can complete a 1-page PDF form manually (by writing or typing your answers): [http://chpw.org/resources/Providers/EFT_form_electronic_signature.pdf](http://chpw.org/resources/Providers/EFT_form_electronic_signature.pdf). Mail a paper copy or scan and email an electronic copy as instructed on the form.

To change bank information for ACH/EFT payments, please complete a new ACH enrollment form.

Once we receive your enrollment, we will send a test file to your bank during our regularly scheduled check run; this is called a pre-note. If that file transfer is successful you will start receiving ACH/EFT payments the next time you have a paid claim (during our regularly scheduled check run).

Our claims processing starts on Friday night. ACH/EFT payments will be sent to your bank account as early as Monday evening.

When you sign up for electronic payments, we will continue to send paper remits to the billing address we have on file unless you have signed up for electronic remittance advices (ERA). We strongly encourage you to sign up for ERA in addition to EFT.

Please note that CHPW is required to notify you, the provider, when we make a deposit to your account. We must provide the amount of the deposit, the date, and an EFT number as a way for you (and us) to trace the deposit. If you have a question about your deposit, email edi.support@chpw.org with your tax identification number and the EFT number so we can find the 835 file and trace the payment.

Please contact edi.support@chpw.org to change the email address for the weekly EFT notification email.
**Claims Investigation Unit (CIU)**

We are pleased to provide our valued providers a way to submit complicated or escalated inquiries electronically to our Customer Service Department.

This email distribution has been developed as a way to supplement our Customer Service team on more complex or difficult topics. The below items are the types of inquiries you can submit through the email distribution to cs.claimsdistribution@chpw.org.

- Fee schedule issues
- Anesthesia pricing issues
- Negative balance issues
- Re-occurring benefit configuration issues
- Interim billing issues
- Endoscopic pricing issues
- Multiple surgery pricing issues
- Ambulance pricing issues
- DRG pricing issues
- Re-admission issues
- Health homes claims questions
- Applied behavioral analysis (ABA) claims
- ICD-10 billing issues

We request that all providers continue to call Customer Service for all other inquiries not listed above:

- FIMC and BHSO Only in Clark and Skamania Counties Customer Service: 1 (866) 418-1009
- Medicare Customer Service: 1 (800) 942-0247
- Or email customercare@chpw.org

You can save time by checking the status of your claims by visiting the Health Information Portal (HIP) [http://chpw.org/for-members/health-information-portal/](http://chpw.org/for-members/health-information-portal/).

**DRG, Fee Schedule, and Refund Request Disputes**

Please submit disputes related to DRG pricing, fee schedule determinations, and CHPW refund requests directly to:

Community Health Plan of Washington  
Attention: Claims Investigation Unit (CIU)  
1111 Third Avenue, Suite 400  
Seattle, WA 98101  
Fax: (206) 521-8834
This helps ensure more efficient processing and faster response times for these issues. You may also wish to see the Overpayment and Underpayment Recoveries section of your Provider Agreement or the Dispute Resolution section of your facility agreement for more information.

**Timely Filing Requirements**

CHPW maintains the following timely filing requirements for claim submissions:

- CHPW must receive the *original* Medicare Advantage or Washington Apple Health claim within 365 days from date of service (DOS).
- CHPW must receive *Medicare Advantage* corrected claims within one year of the initial process date.
- CHPW must receive *Washington Apple Health* corrected claims within 24 months of DOS.
- **CHPW is secondary** to other insurance. We must receive the claim with the primary payer’s explanation of benefits (EOB) within 24 months from the DOS. CHPW cannot process the claim if the primary payer denied for timely filing.

**Claims Processing Standards for Participating Providers**

CHPW processes claims on a first in, first out basis and shall pay or deny claims according to these standards:

| State | • 95% of clean claims within 30 calendar days of receipt  
|       | • 95% of all claims within 60 calendar days of receipt  
|       | • 99% of clean claims within 90 calendar days of receipt  
| Medicare | • 95% of clean claims within 30 calendar days of receipt  
|        | • 100% of unclean claims within 60 days |

In addition to the above standards, CHPW’s goal is to process 85% of clean claims in 14 days.

**Fee Schedules/Rate Updates**

Throughout any given year, numerous government payer rate changes occur, sometimes with retroactive effective dates. In order to improve CHPW claim payment turnaround times in cases where federal and state rate changes do not provide 60 days’ advance notice, starting January 1, 2013, CHPW implemented rate changes on the later of:

- The date that CHPW completed the reconfiguration of its claim system; or
The published effective date of the new rates provided by the governmental entity.

We see this policy as beneficial to you, when compared to the extended claims holds and payment delays required for short notice governmental rate changes. This policy will result in payment of claims at the non-current rate for only the minimal timeframe necessary to successfully configure the short notice rate change, if any. If such action results in a substantial negative impact to either party, the impacted party may request that the parties negotiate a settlement payment in lieu of retroactive adjustment of individual claims. Please contact your contract administrator if you have questions about this policy.

**Encounter Data**

CMS and HCA require encounter data reporting (EDR) from contracted managed care organizations (MCOs). Data reporting must include all health care and behavioral health (mental health and substance abuse) services delivered to eligible clients. Complete, accurate, and timely encounter reporting is the responsibility of each MCO and is critical to the success of the managed care health care delivery system.

Encounter data is conceptually equivalent to paid claims records. They are records of the health care services for which MCOs pay and the amounts MCOs pay to providers of those services. Federal law requires this data to be submitted electronically in specific formats, the ANSI ASC X12N Version 5010.

Please refer to the resources below for more information about encounter data.


The following section gives information on how to prevent some of the most common errors we’ve identified based on your billed encounter data:

- **Revenue Code/Procedure Code Grid** (use the grid to help determine which revenue codes require you to include procedure codes): [http://www.hca.wa.gov/medicaid/hospitalpymt/pages/outpatient.aspx](http://www.hca.wa.gov/medicaid/hospitalpymt/pages/outpatient.aspx)
  scroll down to “revenue code grids” and choose the one that applies for the date of service.

- **Quarterly NDC-HCPCS Crosswalk:** [https://www.cms.gov/Medicare/Medicare‐Fee‐for‐Service‐Part‐B‐Drugs/McrPartBDrugAvgSalesPrice/2016ASPFiles.html](https://www.cms.gov/Medicare/Medicare‐Fee‐for‐Service‐Part‐B‐Drugs/McrPartBDrugAvgSalesPrice/2016ASPFiles.html)

- **NPI provider directory:** [https://npiregistry.cms.hhs.gov/](https://npiregistry.cms.hhs.gov/)

Billing providers should submit all information required for payment of the claim.

- **837P**—Includes any professional or medical healthcare service that could be billed on the standard “1500 Health Insurance Claim” form. Professional services usually include:
  - Ambulatory surgery centers
  - Anesthesia services
  - Durable medical equipment (DME) and medical supplies
  - Laboratory and radiology interpretation
  - Physician visits
  - Physician-based surgical services
  - Therapy (i.e., Speech, P.T., O.T.)
  - Transportation services


- **837I**—Includes any institutional services and facility charges that would be billed on the standard “UB‐04 Claim” form. These services usually include:
  - Inpatient hospital stays and all services given during the stay
  - Outpatient hospital services
  - Evaluation & Treatment Centers
  - Home Health and Hospice services
  - Kidney Centers
  - Skilled Nursing Facility stays


**National Drug Codes (NDC)**
HCA requires all MCOs to report the NDC of drugs provided in outpatient settings. The
ProviderOne system rejects encounters with a missing or invalid NDC. Please see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html?redirect=/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp.

Enhanced Ambulatory Patient Group (EAPG) Claims
Enhanced Ambulatory Patient Groups (EAPGs) are patient classification systems designed to explain the amount and type of resources used in an ambulatory care visit. EAPGs represent ambulatory care across all Medicaid patients.

Patients in each EAPG have similar clinical characteristics, resource use, and cost. These groups were developed to encompass the full range of ambulatory settings including same day surgery units, hospital emergency rooms, and outpatient clinics. EAPGs cannot address nursing home services, inpatient services, or miscellaneous services such as transportation. Community Health Plan of Washington began using the EAPG pricing methodology in November 2014 as required by the Washington State Health Care Authority (HCA). Original fee schedules provided by the HCA for EAPG conversion contained incorrect pricing data. Data was not corrected until April 2015. This resulted in incorrect claim denials, mostly for claims received between November 2014 and May 2015.

We have created a process to address any questions providers may have about the transition to EAPG pricing, and to reprocess any claims that denied in error. Please contact our Customer Service department if you have questions about EAPG pricing on claims:
- Phone: 1-800-440-1561 (TTY Relay: Dial 7-1-1)
- Email: CustomerCare@chpw.org
- Fax: (206) 521-8834

You can also review Washington State Medicaid Outpatient Hospital Rates Fee-For-Service at http://www.hca.wa.gov/medicaid/hospitalpymt/pages/outpatient.aspx.

Taxonomy Codes
As a reminder, the Department of Social and Health Services requires all providers to submit both the National Provider Identifier (NPI) number and Taxonomy Code on all claims. Please see http://www.hca.wa.gov/billers-providers/providerone/fact-sheets for more information.

Applied Behavioral Analysis (ABA) Taxonomy
Applied Behavioral Analysis (ABA) providers must use taxonomy number 103K00000X for billing ABA therapy services to ensure claims are paid appropriately. Providers must enter this taxonomy code in both the billing and the servicing taxonomy fields on the CMS-1500 (HCFA).
Please refer to the following for more information:
- Washington State Health Care Authority’s ABA services Provider Guide: 
  http://www.hca.wa.gov/assets/billers-and-providers/aba_services_20160701.pdf

**Telehealth Services (Telemedicine)**
CHPW follows the Apple Health provider guidance and related WAC 182-531-1730 (http://apps.leg.wa.gov/wac/default.aspx?cite=182-531-1730) and CMS guidelines (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf). The limitations are the same for any provider providing telemedicine services. The provider must be operating within the scope of their license; they must be at an approved originating site, and using HIPAA compliant, interactive, real-time audio and video telecommunications (including web-based applications) or store and forward technology. The services must be covered services that are within the scope of the provider’s license. Additional limitations apply for drug monitoring. Please see the HCA’s Physician-Related Services/Health Care Professional Services Billing Guide (physical health services; https://www.hca.wa.gov/assets/billers-and-providers/physician-related-services-bi-20170401.pdf) or Mental Health Services Billing Guide (includes drug monitoring; https://www.hca.wa.gov/assets/billers-and-providers/mental-health-svc-bi-20170401.pdf) for more information.

Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS code Q3014.

Eligible originating sites:
- Clinics
- Community mental health/chemical dependency settings
- Dental offices
- Federally qualified health center (FQHC)
- Home or any location determined appropriate by the individual receiving service
- Hospitals (inpatient and outpatient)
- Neurodevelopmental centers
- Physician or other health professional’s office
- Rural health clinics (RHC)
- Schools
- Skilled nursing facilities

If a provider from the originating site performs a separately identifiable service for the client
on the same day as telemedicine, documentation for both services must be clearly and separately identified in the client’s medical record.

Distant site:
The payment amount for the professional service provided through telemedicine by the provider at the distant site is equal to the current fee schedule amount for the service provided.

Use the appropriate CPT codes with modifier GT or modifier 95 (via interactive audio and video telecommunications system) when submitting claims to the agency for payment. Both of these modifiers are acceptable to indicate synchronized telecommunication.

Effective January 1, 2017, a new point of service (POS) code 02 has been created for physicians or practitioners providing Telehealth services from a distant site. The POS 02 code is the location where health services are provided through telecommunication technology. *The POS 02 code does not apply to the originating site.*

 Modifiers GT, GQ, and 95 are required when billing POS 02. Please make sure to bill Telehealth services correctly, using POS code 02 and the GT, GQ, or 95 modifiers, to avoid claim payment delays.

If you have questions, you can:
- Call Apple Health Customer Service, (800) 440-1561
- Call Medicare Customer Service, (800) 942-0247
- Email cs.claimsdistribution@chpw.org (for Apple Health or Medicare)

**Federally Qualified Health Center (FQHC) / Rural Health Center (RHC) Enhancement Reporting**

Health plans are responsible for reporting members that are assigned to an FQHC/RHC (collectively known as “Health Centers”) in a monthly per member per month (PMPM) report. Once a month, CHPW sends a report of members assigned to Health Centers to Washington State Health Care Authority (HCA, or the Agency). HCA sends the Health Plan the enhancement payment monthly, and the Health Plan passes the payment to the FQHC/RHC no later than 30 days after receipt of payment from HCA.

CHPW submits PMPM enhancements in an Excel file based on the State’s required format. These files represent all active Medicaid members (including newborns) whose assigned clinic or primary care provider (PCP) is eligible for the FQHC/RHC enhancement dollars. CHPW sends files to HCA no later than the second business day of the reporting month.
If you have questions about these enhancements, please email enhancement.questions@chpw.org.

To enroll as a medical assistance provider and receive payment for services, an FQHC must do all of the following:

• Receive FQHC certification for participation in the Title XVIII (Medicare) program according to 42 CFR 491. Go to https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html for information on Medicare provider enrollment;
• Sign a Core Provider Agreement (CPA). To obtain medical assistance certification as an FQHC, the center must contact the FQHC Program Manager directly to obtain the paperwork necessary to enroll with the Agency; and
• Operate in accordance with applicable federal, state, and local laws.

**Note:** A center must receive federal designation as a Medicare-certified FQHC before the Agency can enroll the center as a medical assistance-certified FQHC. Go to https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html for information on Medicare provider enrollment. When adding a new site or service, indicate on the CPA that you are an FQHC.

To obtain medical assistance certification as an RHC, the clinic must contact the RHC Program Manager directly to obtain the paperwork necessary to enroll with the Health Care Authority.

To be eligible to offer medical assistance, RHCs must have federal and medical assistance certifications.

• Federal Certification: RHCs must be federally certified for participation as an RHC by the Department of Health and Human Services (DHHS). DHHS or its representative notifies the State Medicaid agency that it has certified or denied certification to a prospective RHC.
• Medical Assistance Certification: A clinic certified under Medicare is considered to meet the standards for medical assistance certification.

**Note:** A clinic must receive federal designation as a Medicare-certified RHC before the Agency can enroll the clinic as a medical assistance-certified RHC. Go to https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html for information on Medicare provider enrollment.

If you have questions about enrolling as a medical-assistance-certified FQHC or RHC, overall management of the program, or specific payment rates, please contact:
Coordination of Benefits
Coordination of benefits (COB) becomes necessary when there is more than one source of payment for health services. The payment for such services is coordinated to assure that the insurer who has primary responsibility for coverage pays for the services.

At the time of registration, providers should ask patients if they have other insurance coverage. If there is another possible source of insurance identified, the provider should include this information on the claim form.

CHPW will coordinate benefit payments with any other group plan, Medicaid plan, or Medicare plan that covers the member.

To assure proper coordination of benefits, claims must be submitted to CHPW with an Explanation of Benefits statement from the other carrier.

If CHPW is not the primary insurance (payer), and the primary payer does not cover a specific service (for example, maternity), you must bill the primary payer first. When you receive the primary payer’s denial, you may then send the claim to CHPW along with the primary payer’s explanation of benefits (EOB). CHPW will then evaluate the claim for processing as the secondary payer.

When Medicare or another governmental program of health care coverage is one of the plans, federal law determines which plan provides benefits first. Washington Apple Health is always the secondary payer.

For Medicare Advantage Plans, CHPW follows Medicare as Secondary Payer rules. Otherwise, the following rules determine which plan provides benefits first:

1. When both plans coordinate benefits, the plan covering the person as a subscriber provides benefits first.
2. Dependent children are covered first under the plan of the parent whose birthday is earlier in the calendar year. If the parents are divorced or separated, the following
rules determine which plan pays first:
   a. Plan of the parent with custody.
   b. Plan of the spouse of the parent with custody.
   c. Plan of the parent without custody.
   d. Plan of the spouse of the parent without custody.
   e. If there is a court decree that establishes responsibility for the child’s health care, the plan of the parent with that responsibility provides benefits first.

3. If none of these rules establishes which plan provides benefits first:
   a. The plan that has covered the member the longest time provides benefits first.
   b. All other plans provide benefits first if the person is a retiree, a laid-off employee, or a dependent of a person who is retired or laid off, if the other plans include this rule.

4. When none of the above rules establishes the order of benefits, then the plan that has covered a subscriber for the longer period of time will provide benefits first.

Under no circumstances shall CHPW reimburse a provider for any amount greater than the amount provided for at the time of service. If a provider has received payment from another carrier or resource that has primary payment responsibility under coordination of benefits rules, and that payment is equal to or greater than the rates for services rendered, the provider may not seek additional reimbursement from CHPW. In addition, the provider shall promptly refund to CHPW any amount CHPW has already paid to the provider that, when added to amounts paid by another coverage plan or third party resource for the same services, are in excess of the rates for the services per the provider’s Agreement with CHPW.

**Post Payment Review (PPR)**

CHPW recognizes that we are stewards of state and federal funding and as part of our due diligence to ensure that claims are paid appropriately, we conduct post payment reviews.

Our goal in conducting post payment review is to:
- Educate our provider community on appropriate billing and guidelines
- Ensure we are paying according to our contracts
- Monitor for fraud, waste, and abuse

Our post payment review includes, but is not limited to:
- Medical necessity of the admission and/or procedure(s) performed
- Appropriateness of the treatment setting or length of treatment
- Patient’s status upon discharge
• All patient diagnosis-related group (AP-DRG) validation
• General quality of care delivered
• Validation of the procedure(s) and diagnosis codes submitted

In order to conduct a thorough review we will request copies of medical records. We ask that providers and facilities provide complete records timely in order to prevent any financial implications.

Medical Records for Post Payment Review
If we ask you to send medical records to us for post payment review, please note that we would prefer to receive medical records electronically. You can send medical records to us via fax, CD, thumb drive, or you can use an online medical records solution like IOD or HealthPort.

Sending records electronically means we’ll receive them faster, reducing your risk of having claims deny for non-receipt of records. CHPW will eventually stop allowing paper records. We haven’t set a date yet but when we do, we’ll let you know through our Provider Bulletin Board (http://chpw.org/for-providers/bulletin-board/) and other means.

Third Party Liability (Subrogation/Reimbursement)
CHPW benefits are available to a member who is injured or becomes ill because of a third party’s action or omission. CHPW has subrogation rights and other rights to recovery against any third party liable for the illness or injury. This means CHPW:

1. Is entitled to reimbursement from recoveries by the member from the liable third party after the member is fully compensated for his or her loss; and
2. Has the right to pursue claims for damages from the party liable for the injury or illness. CHPW’s rights extend to the value of benefits paid by the plan for such an injury or illness.

As a condition of receiving benefits for such an illness or injury, the member and his or her representatives are responsible for cooperating fully with CHPW in recovering the amounts it has paid, including but not limited to:

• Providing information to CHPW concerning the facts of the illness or injury and the identity and address of the third party or parties who may be liable for the illness or injury, their liability insurers, and their attorneys.
• Providing reasonable advance notice to CHPW of any trial or other hearing, or any intended settlement, of a claim against any such third party.
• Repaying CHPW from the proceeds of any recovery from or on behalf of any such third party.
Provider Obligations in Third Party Liability
A provider is responsible for notifying CHPW when he or she becomes aware that a member has a right to reimbursement from a third party and to assist in arranging for assignment of such right to CHPW for collection.

The following information, to the extent that the provider is aware, should be reported to CHPW:
- Facts of the member's condition or injury.
- Any changes in the member's condition or injury.
- Name of any person responsible for the member's condition or injury and that person’s insurance carrier.

Appeals/Disputes
Member Appeals
For a description of the grievance and appeal process, please see the information for the member's specific plan:
- Grievances and Appeals for Washington Apple Health can be found under the specific plan on the website: http://chpw.org/for-members/grievances-and-appeals/.
- For Medicare Advantage Grievances and Appeals, on the Community HealthFirst™ website: http://healthfirst.chpw.org/for-members/grievances-appeals/.

Consent Documents
- Consent form for appeals: http://chpw.org/resources/Forms_and_Tools/Consent_Form_approved_12-13-05_-_updated_logo_3-6-06.pdf
- Appeals Request Form: http://chpw.org/resources/Appeal_Request_Cover.pdf

A member appeal may be submitted by the member, a representative acting on behalf of and with permission from the member, or a provider acting on behalf of and with written authorization from the member within the timeframe outlined in the Grievances and Appeals guide or the Evidence of Coverage for the member's specific plan.

When assisting a member with an appeal, provider should:
1. Review their appeal processes and rights in the Grievances and Appeals guide or the Evidence of Coverage for the member's specific plan.

2. For state program members, obtain a signed authorization form
   [http://chpw.org/resources/Forms_and_Tools/Consent_Form_approved_12-13-05_-updated_logo_3-6-06.pdf](http://chpw.org/resources/Forms_and_Tools/Consent_Form_approved_12-13-05_-updated_logo_3-6-06.pdf)

3. For Medicare program members, obtain a signed appointment of representative form

**Definitions**

- **Action:** A decision by CHPW to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a facility.

- **Appeal:** A request for review of an action, as defined above. A member may file an appeal due to an adverse benefit determination or action by CHPW.

- **Behavioral Health Services Only (BHSO):** “Behavioral Health Services Only” refers to those enrollees who receive only behavioral health benefits through this Contract and the companion non-Medicaid Contract.

- **Fully Integrated Managed Care (AH-FIMC):** “Washington Apple Health – Fully Integrated Managed Care (AH-FIMC)” refers to the program covered by this Contract, under which behavioral health services are added to the Apple Health Managed Care (AHMC) contract.

**Provider Appeals**

With the exception of CHPW decisions related to DRG pricing, Fee Schedules, and member financial responsibility, a provider may appeal a CHPW decision that s/he believes is incorrect. Non-Par provider appeals must be in writing and submitted within 90 days from the date of the notice of the denial or initial payment of clean claim for Apple Health members, or within 60 days for Medicare members.

Providers’ appeals must be in writing and submitted within 24 months from the date of the notice of denial or initial payment of a clean claim. The second level appeals will be reviewed if new information is provided within 60 days of the first level decision.

An appeal must include:

- Member name and member ID number
• Claim number (if applicable)
• Date of service
• All pertinent supporting documentation
• Reason for requesting the appeal
• Signed authorization (if filing on behalf of a member)
• To access CHPW's appeal cover sheet go to: http://chpw.org/for-providers/documents-and-tools

Submit appeals to:
Community Health Plan of Washington
Attention: Appeals Department
1111 Third Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 613-8984
Email: appealsgrievances@chpw.org

DRG and Fee Schedule Disputes
For disputes related to DRG pricing or Fee Schedule determinations, see the Overpayment and Underpayment Recoveries section of your Provider Agreement or the Dispute Resolution section of your facility agreement. Submit DRG and fee schedule disputes to:
Community Health Plan of Washington
Provider Customer Service
Attention: Claims Investigative Unit (CIU)
1111 Third Avenue, Suite 400
Seattle, WA 98101
Email: cs.claimsdistribution@chpw.org

Refund Request Disputes
To contest a Refund Request from CHPW, see the Overpayment and Underpayment Recoveries section of your Provider Agreement or the Dispute Resolution section of your facility agreement. Submit Refund Request disputes to:
Community Health Plan of Washington
Provider Customer Service
Attention: Claims Investigative Unit (CIU)
1111 Third Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 521-8834
Email: cs.claimsdistribution@chpw.org
Care Management
Care Management at CHPW is a comprehensive method of member assessment and support. The goal is to provide a systematic approach to managing the member’s health care needs, which may include member advocacy, coordination of care, and support of the member-provider relationship.

The Care Management Team consists of clinical and nonclinical staff in the following areas:
- Utilization Management
- Case Management
- Disease Management
- Patient Review and Coordination (PRC)
- Medicare Opioid Overutilization Program (MOOP)

Providers contracted with CHPW are expected to cooperate and communicate freely with CHPW regarding quality issues and notify us of any member’s medical, behavioral health condition or special health care needs that may benefit from case management in accordance with the conditions of the member’s benefit plans and this Provider Manual.

Utilization Management
CHPW uses referral management, prior authorization, and concurrent review to ensure appropriateness, medical need, and efficiency of health care services and procedures being provided.

Referral Management
A referral is a primary care provider’s written statement of intent to refer a member to specialty care or ancillary services. A primary care physician (PCP) does not require approval by CHPW to refer a member to a participating provider. However, for any referral to a non-participating provider, CHPW must review and provide a Plan Authorized Referral prior to the services being rendered.

Nonparticipating provider referrals are reviewed for the following:
- The proposed services are not available within our network of participating providers;
- The proposed number of visits does not exceed the approved guidelines;
- The proposed services are medically necessary;
- The proposed services are a covered benefit;
- The provider rendering the proposed services is not sanctioned by the Office of Inspector General (OIG), nor has opted out of Medicare.

No referrals or authorizations are required for treatment in an Emergency Room. Please see
also the “Emergency Room Care/Emergency Medical Condition” section on page 93.

Prior Authorization
Prior authorization review is the process of reviewing certain medical, surgical, and behavioral health services according to established criteria or guidelines to ensure medical necessity and appropriateness of care are met prior to services being rendered.

Prior Authorization is required for all referrals to non-participating providers, all scheduled (planned) inpatient admissions, and certain predetermined services, medical pharmaceuticals, surgical, diagnostic, and imaging procedures. A list of procedures and services requiring prior authorization is maintained separately and may change from time to time based on utilization performance, changes in standards of medical care, new technology, or denial rate.

The most current Prior Authorization list may be found on our website at: http://chpw.org/for-providers/prior-authorization-and-medical-review/

Prior Authorization Documents

• Prior Authorization Request Form:
  http://chpw.org/resources/2017_PA_Form.pdf
• Prior Authorization List and Utilization Guidelines:
• FIMC Provider Services Reference Guide:

Prior Authorization requests for Apple Health members may be faxed to (206) 613-8873. Prior Authorization requests for Medicare Advantage members may be faxed to (206) 652-7065.

Authorization Determination Timelines
CHPW strives to process authorization requests within Washington State and Federal (CMS) guidelines for timeliness, and in accordance with our member’s healthcare needs. Periodic increases in request volume may affect turnaround times. CHPW makes best effort to adhere to the following processing timelines:

• Routine prior authorization requests are processed within 5-14 business days of receiving the request from the provider.
• Clinically urgent requests are processed within 24-72 hours of receiving the request from the provider.
Requests are processed in the order received using clinical information submitted by the provider. Processing times for both routine and urgent request may be delayed if sufficient information is not provided.

Determination letters are faxed directly to the requesting and servicing provider and are mailed to the member.

**Required Clinical Information**
Documentation to support medical necessity must be submitted with Prior Authorization requests. This information supports the need for the treatment and submitting detailed information on initial submission helps to ensure the request can be processed in a timely manner. Examples of appropriate documents include:

- Current history and/or physician examination notes that address the problem and need for services requested
- Relevant lab and/or radiology results
- Relevant specialty consultation notes
- Other pertinent information to aid in decision making process

**Clinical Decision Making**
Utilization Management decisions to approve or deny are based on appropriateness of the care and service and whether the care or service is a covered benefit. CHPW does not offer financial incentives to encourage Utilization Management decision makers to make decisions that result in under-using care or services.

CHPW does not reward anyone, providers or others, for denying coverage or care. CHPW staff is available to discuss the clinical decision making process. An appropriate peer reviewer (Medical Director, Pharmacist, or Associate Clinical Director) is available to discuss any authorization or denial by contacting the CHPW Washington Apple Health Customer Service Department at 1 (800) 440-1561, or the Medicare Customer Service Department at 1 (800) 942-0247.

**Exception to Rule**
A Washington Apple Health member and/or the member’s provider may request CHPW pay for a non-covered health care service; this is called an exception to rule ETR). The provider must document that the service would benefit the member’s clinical condition through cost-effective treatment, and that there is no equally effective, less costly covered service or equipment that meets the member’s needs (WAC 182-501-0160).
ETR Documents

- Exception to Rule Request Form http://chpw.org/for-providers/documents-and-tools

Medicare Outpatient Observation Notice (MOON)
Under the Notice Act, Hospitals and Critical Access Hospitals (CAH) must deliver a Medicare Outpatient Observation Notice (MOON) to Medicare beneficiaries (including a Medicare Advantage (MA) enrollee) who receives observation services as an outpatient for more than 24 hours: https://www.federalregister.gov/articles/2016/08/22/2016-18476/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-etc.

Inpatient Admission Notification
Facilities must provide notification of inpatient admissions within 24 hours or the next business day. This allows CHPW the opportunity to assist with management and coordination of care, including appropriateness of services and discharge planning.

Member eligibility for inpatient services may be verified through One Health Port at www.onehealthport.com or through the CHPW Medical Management Portal at www.chpw.org/submitcare. For those organizations that do not have internet access please contact Customer Service at 1 (800) 440-1561 or for FIMC and BHSO Only in Clark and Skamania Counties services call Customer Service at 1 (866) 418-1009. Benefit information may be viewed on our website for state programs, or at www.healthfirst.chpw.org for Medicare.

Inpatient Admission Documents

- Inpatient Admission Notification Form http://chpw.org/for-providers/documents-and-tools

Inpatient Admission notifications for Apple Health members may be faxed to (206) 652-7078. Inpatient Admission notifications for Medicare Advantage members may be faxed to: (206) 652-7065.

Concurrent Review
During the inpatient hospitalization, the member's clinical progress is reviewed by the CHPW clinical team using clinical criteria approved by CHPW. The frequency of reviews varies according to the member's clinical course. Reviews are accomplished using records submitted to CHPW via the Medical Management Portal, fax, and/or telephonic review.

Discharge Planning Coordination
Discharge planning needs are identified through the concurrent review process or by
referral from someone on the member’s care team. The extent of the concurrent review coordinator’s direct role in planning and arranging post discharge care varies with the member’s needs and includes a collaborative approach with the hospital staff, care team, member and family, and community resources, as appropriate.

**Emergency Room Care/Emergency Medical Condition**

No referrals or authorizations are required for treatment in an Emergency Room. An emergency medical condition is a condition that manifests itself by acute symptoms of sufficient severity (for example, severe pain) 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 any of the following:

- Placing the health of the patient, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part

CHPW uses several resources to determine whether a specific intervention is medically necessary.

Each case is assessed using appropriate criteria, also taking into account individual case information.

For Washington Apple Health members, CHPW looks first to clinical criteria established by the Health Technology Assessment Program of the Health Care Authority (WAC 182 55 055). To assure that coverage determinations meet HCA clinical criteria for coverage, reviewers next consult CHPW’s Clinical Coverage Criteria (CCCs). Where HCA specific guidance is not available, reviewers then rely on the nationally recognized MCG Guidelines as the primary source for evidence-based recommendation for clinical coverage.

For Medicare members, CHPW utilizes the Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), if available. NCDs and LCDs are available through Noridian, Washington’s Medicare Fee-for-Service Contractor, or they are accessible on the CMS website. If CMS criteria are not available, then MCG Guidelines and/or CHPW’s CCCs are used.

Cases that cannot be approved using the designated criteria are sent to CHPW Medical Directors for determination of medical necessity. Our Medical Directors assure that requests for care are consistent with accepted current evidence-based community medical practice. When appropriate, cases may be sent for pertinent specialty or sub-specialty medical review prior to a clinical coverage decision being made.
Clinical Criteria are available upon request by contacting the Medicaid Customer Service team at 1 (800) 440-1561, or the Medicare Customer Service Team at 1 (800) 942-0247.

**Individuals with Special Health Care Needs (ISHCN)**

CHPW provides outreach to members new to the plan. A screening tool is utilized to identify members who self-identify as having special health care needs. ISHCN members who agree to participate in Care Management are supported by our clinical team, which develops care coordination goals and interventions in the form of a care plan. The care plan and results from the screen are developed and shared with the member’s PCP in order to facilitate care coordination. These documents are intended to support the member’s coordination and become a part of their medical record with the PCP.

**Continuity and Transition of Care**

From time to time, member benefits may be transferred from one plan or PCP to another or expire during a course of treatment through termination of the contract, disenrollment, or exhaustion of available benefits. At these times, CHPW promotes smooth and seamless continuity and transition of medically necessary care and integration of services with no interruption to the member’s care or prescription medications, while striving to preserve the relationship between members and providers throughout the process. If appropriate, CHPW notifies members, either by mail or phone, about alternatives and resources for continuing care and assists them in understanding how to access those services or can facilitate helping them to obtain the services.

The Care Management staff will work with both members directly, or by facilitating coordination efforts by providers to assist the continuity and transition to other care when necessary. They will contact community agencies or make referrals to public assistance as appropriate and authorized by the member. They are also available to assist providers to coordinate appropriate services and programs available to members from such resources as:

- Care Managers
- First Steps Maternity Support Services/Infant Case Management
- Transportation and Interpreter Services
- Patient Review and Coordination (PRC) program, for members who meet the criteria identified in WAC 182-501-0135
- Dental services
- Foster Care – Fostering Well-Being
- Health Homes
• Behavioral Health Organizations (formerly Regional Support Networks) for mental health services
• Substance Use Disorder services
• Aging and Disability Services, including home and community based services
• Skilled nursing facilities and community based residential programs
• Early Support for Infants and Toddlers (ESIT)
• Department of Health and Local Health Jurisdiction services, including Title V services for Children with special health care needs

Case Management
Case Management is a collaborative process that addresses individual health care needs. It is a free of charge program for those members who both meet criteria and choose to participate. CHPW provides case management services to members in collaboration with the member’s health care delivery team in order to coordinate the highest quality and efficient health care.

Case Management involves the coordination of services to identify alternative options and educate members about resources available to them. A case manager’s role is advocacy, assessment, and coordination of care between multiple providers and the member.

A Case Manager works with the members and providers to optimize the member’s ability to access care and ensures services are used efficiently. Case Managers empower the member to improve self-management of their health, provide education, and serve as a member advocate.

For members meeting criteria for complex case management, the case managers will develop and implement individualized care plans working in collaboration with the member’s providers.

Case Management may be an appropriate service for:
• Members with complex or chronic care needs
• Members with complex discharge planning needs
• Members with needs that are beyond the available clinic resources
• Members with multiple conditions that require coordination with several specialty providers

For more information, call the CHPW Washington Apple Health Customer Service team at 1
(800) 440-1561, or the Medicare Customer Service Team at 1 (800) 942-0247.

**Case Management Documents**

**Medicaid Health Home Program**
The Health Home program offers additional care coordination services to eligible Medicaid members with chronic conditions. The goal is to make things easier for members with complex needs by increasing coordination between health and social service providers.

Health Home services include:
- Comprehensive care management
- Care coordination
- Health promotion
- Transitional care
- Individual and family supports
- Referrals to community and social support services

If you have questions regarding specific Health Home claims payment status or remittance advice, contact CHPW’s Claims Investigation Unit at [cs.claimsdistribution@chpw.org](mailto:cs.claimsdistribution@chpw.org).

**How it Works**
Members enrolled in the Health Home program work with a care coordinator who is specially trained to assess the needs and goals of those they are working with. The care coordinator can help members with follow-up care and increase communication between the different medical and social service providers to create comprehensive care around the member.

Care coordinators are affiliated with CHPW but based in your community. Many work in our Community Health Clinics (CHCs). Others work for local community-based organizations, including the Area Agencies on Aging, behavioral health providers in the Behavioral Health Northwest statewide network, and the Washington Care Coordination Services Group (WAcare).

Health Home care coordination services do not replace or change any of the benefits currently received as a Medicaid member. They do not cost extra. These services are there to support members in managing their health goals. This should result in fewer hospital stays, fewer emergency room visits, and a greater number of primary and specialty care visits.
Eligibility
Health Home services are available for eligible individuals with Medicaid or fee-for-service dual coverage with Medicaid and Medicare. Eligible individuals have high service needs and complex chronic conditions like asthma, diabetes, cancer, and depression.

The state determines eligibility and identifies those individuals for CHPW. Those members are then assigned to local Care Coordination Organizations (CCOs) to provide direct services according to the members’ needs. When members become eligible, they will receive a letter and will be contacted by a local care coordinator. Once eligible, members may opt out of the program at any time; they can also change their mind and opt back in at any time.

If you believe a CHPW member could benefit from the Health Home program, checking eligibility with the CHPW Customer Service Department is the best place to start.

Clinical Eligibility Tool
If your patient is not already eligible, there is a Clinical Eligibility Tool that can be used to refer individuals to the State for Health Home consideration. For CHPW members, you can submit this form via secure email to healthhomes@chpw.org.

The Clinical Eligibility Tool can be found on the HCA Health Home website at: http://www.hca.wa.gov/assets/billers-and-providers/Clinical_Eligibility_Tool.xls.

King and Snohomish Counties
The Health Home program will be coming to King and Snohomish Counties in 2017. If you provided services in one of these counties in 2016, CHPW may have other care management services.

Questions
If you have questions about eligibility, call CHPW Customer Service at 1 (800) 440-1561 (Toll Free) or for FIMC and BHSO Only in Clark and Skamania Counties related questions call 1 (866) 418-1009 (Toll Free), Monday – Friday, 8 a.m. to 5 p.m.

For other questions about the program, you can also email CHPW’s Health Home mailbox at healthhomes@chpw.org.

If you have questions regarding specific Health Home claims payment status or remittance advice, contact CHPW’s Claims Investigation Unit at cs.claimsdistribution@chpw.org.

Partnership with WSHA for Transitional Care Training Care coordination and follow-up after
hospitalization is one of the key Health Home services in reducing costs and assuring a safe and effective hospital discharge. Current research shows that around 20 percent of patients in the U.S. are re-hospitalized within 30 days of discharge, and many researchers believe that this percentage is even higher for Medicaid patients.

to reduce readmissions through effective transitional care. WSHA offers tools for both hospitals and primary care providers, many of which are being used in Washington State’s health homes strategies.

**The Mental Health Integration Program (MHIP)**
The Mental Health Integration Program (MHIP) is a state-wide, patient-centered, integrated program serving CHPW Medicaid enrollees with medical, mental health, and substance abuse needs. The program delivers high quality mental health screening and treatment in an evidence-and outcome-based model of collaborative care to treat common mental health disorders. Primary care clinic-based mental health professionals called ‘care coordinators’ provide brief interventions and care coordination to members in consultation with a psychiatrist. Care coordinators and consulting psychiatrists partner with members and the members’ primary care providers to achieve improvements in whole-person health and well-being. A list of participating MHIP clinics can be found at [http://chpw.org/for-members/mental-health-resources/](http://chpw.org/for-members/mental-health-resources/).

**Disease Management**
The Disease Management (DM) program identifies members with chronic disease and engages the members in a dialogue that stresses a self-management approach to the member’s chronic condition and encourages the patient/provider therapeutic relationship. Disease Management provides program enrollees with current best practice and evidence based educational materials and ongoing assessment and support of the member’s needs by DM Case managers.

CHPW identifies chronic care programs that are relevant to and address the needs of its member population, such as diabetes, asthma, and hypertension. The objectives of the DM program are to:

- Improve member reported adherence to self-monitoring activities,
medications, and provider visits;

• Reduce hospitalization rate and ER visits for members with DM Program diagnosis-related admissions;

• Provide education and information to members that will increase awareness and knowledge of their illness and help them better manage symptoms;

• Ensure that members and providers are satisfied with program elements; and

• Improve HEDIS scores, demonstrating use of appropriate chronic disease medication measures.

**Patient Review and Coordination Program**

The Patient Review and Coordination Program (PRC) is for Washington Apple Health members only. It is a CHPW program designed to control overutilization and inappropriate use of medical services by members. This program allows restriction of members to certain providers, including primary care providers (PCPs), pharmacies, and hospitals.

PRC focuses on the health and safety of these members, who are often seen by several different prescribers, have a high number of duplicate medications, use several different pharmacies, and have high emergency room usage. Based on clinical and utilization findings, members are placed in PRC for at least two years.

**The Role of the Primary Care Provider in PRC**

The PCP plays a key role in managing the member’s health care. When a member is restricted, the member's PCP must approve any care that member receives from other providers or specialists, which may include prescriptions for scheduled drugs (CII–CV). A major focus of PRC is to educate the member about:

• Appropriate use of services

• Relevance of office visits

• Accessing resources in the community and within HCA

• The importance of maintaining one provider to manage and monitor one’s health care

**PRC Documents**

PRC policy and procedure documents can be found here: [http://chpw.org/for-providers/other-resources/policies](http://chpw.org/for-providers/other-resources/policies)

**The Role of the Pharmacy in PRC**

The primary pharmacy is a key player in managing the member’s prescriptions. The pharmacist will be able to alert the member’s PCP, the CHPW PRC staff, or the HCA PRC staff of misuse or potential problems with the member’s prescriptions. All pharmacy policies remain in effect. However, if the member goes to a non-assigned pharmacy for scheduled drugs (CII–CV), the claim will be rejected.
The Role of the Hospital in PRC
The hospital, particularly the emergency room staff, is a key player in assisting the member’s PCP to more effectively manage the member’s care to avoid unnecessary and costly services, especially emergency room services. By being aware of the member’s restriction, the hospital can assist in the coordination of care by referring the member back to their PCP and/or pharmacy, whether treatment is provided or not. We welcome referrals of members who may benefit from the PRC program. Please contact us at: Patient Review and Coordination Program (PRC).

Community Health Plan of Washington
1111 Third Avenue, Suite 400
Seattle, WA 98101
Phone: (206) 521-8833

Members may self-refer to the PRC by calling our Washington Apple Health Customer Service Department: 1 (800) 440-1561, for State programs Monday – Friday, 8 a.m. to 5 p.m. Voicemail may be left after hours.

Medicare Opioid Overutilization Program (MOOP)
The Medicare Opioid Overutilization Program (MOOP) is for Medicare members only. It is a CHPW program designed to monitor members for opioid or acetaminophen overutilization in the Medicare Part D program. If necessary, the program allows restriction of a specific drug or class of drug.

The Role of the Primary Care Provider in MOOP
The PCP plays a key role in managing the member’s health care. When a member is restricted, the PCP must provide alternative treatments, case management, or pain management.

MOOP Documents
MOOP Documents located at http://chpw.org/for-providers/other-resources/policies
• MOOP for providers information
• MOOP for providers procedure

We welcome referrals of members who may benefit from this program. Please contact us at:
Medicare Opioid Overutilization Program
Community Health Plan of Washington
1111 Third Avenue, Suite 400
Seattle, WA 98101
Phone: (206) 521-8833
Medicare members may self-refer by calling the Medicare Customer Service Department at 1 (800) 942-0247, Monday – Friday, 8 a.m. to 8 p.m. Voicemail may be left after hours.

**Pharmacy Management**

*Drug Formulary and Medication Utilization Washington Apple Health*

The CHPW drug formulary is developed by the CHPW Pharmacy and Therapeutics Committee. The formulary is searchable on the website at [http://chpw.org/](http://chpw.org/).

For all CHPW members, submit prior authorization, step therapy, and non-formulary medication requests as well as requests for quantity overrides for review to CHPW’s pharmacy benefit manager, Express Scripts Inc. (ESI). All requests will be resolved within 1 business day unless additional information is required.

**Community HealthFirst™ Medicare Advantage Drug Formulary**

The Community HealthFirst™ Medicare Advantage drug formulary is developed by the ESI Pharmacy and Therapeutics Committee. The formulary is available on the Community HealthFirst™ Medicare Advantage website: [http://healthfirst.chpw.org/](http://healthfirst.chpw.org/).

For all Community HealthFirst™ Medicare Advantage Part D beneficiaries, submit prior authorization, step therapy, and non-formulary medication requests, as well as requests for quantity overrides for review to ESI. All standard requests will be resolved by ESI within 72 hours if all required information is provided.

Note: ESI requires a Community HealthFirst™ Medicare Advantage beneficiary number to process requests. You may obtain a member number from Community HealthFirst™ Medicare Advantage Customer Service Department at 1 (800) 942-0247 (Toll Free).

**Notification Regarding Formulary Changes:** For updates regarding periodic changes to the formulary and other pharmaceutical management programs, please see the member pharmacy web page at [http://chpw.org/](http://chpw.org/).

**Washington Apple Health Prior Authorization**

To request a prior authorization, step therapy, non-formulary, or quantity limit override, please call ESI at 1 (844) 605-8168 (Toll Free), 24 hours a day, 7 days a week, and speak to a prior authorization service specialist. This specialist will review medical information and criteria with the provider or designee regarding the need for the requested drug.
If the drug is denied by ESI, providers may appeal the decision by sending a letter and clinical documentation, including the date and reason for the denial given by ESI, to:

Community Health Plan of Washington
Attn: Appeals Department
1111 Third Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 613-8983

Expedited appeals are reserved for emergency situations only; call 1 (800) 440-1561 (Toll Free) or for FIMC and BHSO Only in Clark and Skamania Counties expedited appeals call 1 (866) 418-1009.

Community HealthFirst™ Medicare Advantage Prior Authorization
To request a prior authorization, step therapy, non-formulary, or quantity limit override, please call ESI at 1-800-605-8168 (Toll Free), 24 hours a day, 7 days a week, and speak to a prior authorization service specialist. The specialist will review medical information and criteria with the provider or designee regarding the need for the requested drug.

If the drug is denied by ESI, providers may appeal the decision by sending a letter and clinical documentation, including the date and reason for the denial given by ESI, to:

Community Health Plan of Washington
Attn: Community HealthFirst™ Medicare Advantage Appeals
1111 Third Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 613-8983

Expedited appeals are reserved for emergency situations only; call 1 (800) 942-0247 (Toll Free).

Pharmacy Benefit Exclusion Washington Apple Health
Certain medications are benefit exclusions and are not covered under any circumstances.

These include:
- Non-FDA approved drug products
- Experimental and investigational (E & I) drugs
- Compounded drugs with non-FDA approved ingredients
- Drugs for weight loss or appetite suppression
- Drugs for impotence or sexual dysfunction
• Drugs to treat cosmetic conditions
• Infertility drugs

**Community HealthFirst™ Medicare Advantage Benefit Exclusion**
Certain medications are not covered by Part D. These include:

• Drugs for anorexia, weight loss, or weight gain
• Drugs used to promote fertility
• Drugs used for cosmetic purposes or for hair growth
• Drugs used for symptomatic relief of cough and colds
• Drugs for erectile dysfunction
• Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparation products
• Non-prescription or over-the-counter (OTC) drugs
• Drugs for which the manufacturer seeks to require, as a condition of purchase, that associated test and monitoring services be purchased exclusively from the manufacturer or its designee.

**Quality Improvement Program**
**Program Overview**
The Quality Improvement Program (QIP), hereafter referred to as “the Program”, is designed to objectively monitor, systematically evaluate, and effectively improve the health and care of those being served while lowering cost. This section is defined by three distinct areas of Better Health, Better Care, at a Lower Cost consistent with the Institute for Healthcare Improvement (IHI)’s Triple Aim. Better Health focuses on activities to improve and promote the health status of those served across care settings and stages of life. Concurrently, the efforts for care improvement target processes that enhance the service provided, honing in key domains of improvement for care. Finally, lowering the cost of care is essential to ensuring both network and plan sustainability. This program describes activities undertaken by both CHNW and CHPW for objective achievement to successfully address the three larger, over-arching goals.

The achievement of goals and objectives is primarily accomplished through the Program structure’s work and quality improvement activities and projects described.

**Program Scope**
The annual delegation of authority from the Board of Directors allows the Program to fulfill its goals and objectives while effectively using resources. Through this annual declaration,
the Program is authorized to make decisions that impact quality and safety. Special attention is given to high volume, high risk areas for each population. Health promotion, health management and patient safety activities are also an integral part of the Program and are specialized according to regulatory requirement, population needs and delivery models. The Program is integrated into the activities of both CHNW and CHPW. This includes, but is not limited to, interactions with CHNW and affiliated providers, as well as departments within CHPW delivering on projects essential to the Program’s success.

The scope of the Program includes all CHPW lines of business including the Health Benefit Exchange (HBE), Medicaid (Washington Apple Health), and Medicare (including Special Needs Plan (SNP)) products. The Program’s oversight extends to both delegated and non-delegated activities and functions assumed by sub-contractors or vendors. Quality Improvement oversight is not a function that is delegated to any other organization. In instances where functions in this program are delegated, such as Case Management, Disease Management, or Utilization Management, the delegated entity must meet the requirements set forth in this program description and underlying accreditation or regulatory standard.

Program Structure
CHPW supports the Program by providing governance over plan activities that impact better health and care at a lower cost. The Plan Quality Council has delegated authority from the CHPW Board of Directors annually to effectuate the Program. The CHPW committees provide review of key plan activities, such as service use by members, prescription formulary, provider credentialing and peer review, complaint review, as well as network adequacy. The CHPW structures pertaining to this Program are shown in the diagram on the next page.
For more information about the Program, including an outline, achievements and current status of our performance measures, please visit [http://chpw.org/for-members/qip/](http://chpw.org/for-members/qip/).