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CHPW’s HealthMAPS online provider portal for patient lets you enter and view member claims, check eligibility, see other health insurance, view roster reports, and more.

Create a HealthMAPS Account

Your HealthMAPS Provider Account

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The Mental Health Integration Program (MHIP)

Washington Partnership Access Line (PAL):

Patient Review and Coordination Program

The Role of the PCP in PRC

PRC Documents

The Role of the Pharmacy in PRC

The Role of the Hospital in PRC

PHARMACY

Medicare Opioid Overutilization Program (MOOP)

The Role of the PCP in MOOP

MOOP Documents

Second Opinion Network

Pharmacy Management

Drug Formulary and Medication Utilization IMC

Community Health Plan of Washington Medicare Advantage Drug Formulary
Introduction

Welcome to Community Health Plan of Washington (CHPW)

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 that meet the needs and improve the health of our communities and make managed care participation beneficial for community responsive providers.

This 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 at least annually (or as necessary) 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 Formularies, and the CHPW Network Provider Directories. The 2020 CHPW Provider Manual includes relevant revisions, as well as any new information. CHPW’s policies and other information and resources are available at http://www.chpw.org/for-providers/documents-and-tools. If you have questions regarding the CHPW Provider Manual or any of the information explained within, please contact our Customer Service Department at:

- CHPW Washington Apple Health Integrated Managed Care (IMC) Customer Service: 1 (800) 440-1561 (Toll Free) Monday through Friday, 8am to 5pm
- CHPW Medicare Advantage Customer Service: 1 (800) 942-0247 (Toll Free) 7 days/week, 8am to 8pm
- 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 is detailed in your Provider Agreement, in this Provider Manual, and in the policies referenced throughout this document. As part of your role, you are obligated to cooperate and participate in utilization review, quality improvement (including collection of performance data), quality assurance programs, necessity of care evaluations, clinical and service evaluations, coordination of benefit activities, health care coding reviews, care coordination, participation in provider training
including clinical, operational, IMC specific and other training topics 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) or 1 (800) 440-1561 (Toll Free)
Fax: (206) 521-8834
www.chpw.org

Please note that most contact numbers are triaged through Customer Service.

**CHPW Contacts**

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHPW Washington Apple Health</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Integrated Managed Care (IMC) and</strong></td>
<td>Monday – Friday, 8am – 8pm</td>
</tr>
<tr>
<td><strong>Behavioral Health Services Only (BHSO)</strong></td>
<td>1 (800) 440-1561 (Toll Free)</td>
</tr>
<tr>
<td><strong>Customer Service</strong></td>
<td>TTY: Relay Dial 711</td>
</tr>
<tr>
<td>General information about policies and</td>
<td>Customer Service Fax: (206) 652-7040</td>
</tr>
<tr>
<td>procedures, benefits and eligibility</td>
<td><a href="http://www.chpw.org">www.chpw.org</a></td>
</tr>
<tr>
<td>verification, member lists, provider</td>
<td></td>
</tr>
<tr>
<td>complaints, provider contracts, updates to</td>
<td></td>
</tr>
<tr>
<td>clinic and PCP information, credentialing,</td>
<td></td>
</tr>
<tr>
<td>compliance, and any other provider concerns.</td>
<td></td>
</tr>
<tr>
<td><strong>CHPW Medicare Advantage Customer Service</strong></td>
<td>1 (800) 942-0247 (Toll Free)</td>
</tr>
<tr>
<td>• 7 days a week, 8am – 8pm</td>
<td>TTY Relay: Dial 711</td>
</tr>
<tr>
<td>Benefits and eligibility verification, member</td>
<td>Fax: (206) 652-7050</td>
</tr>
<tr>
<td>lists, PCP changes, provider participation</td>
<td><a href="https://medicare.chpw.org/">https://medicare.chpw.org/</a></td>
</tr>
<tr>
<td>status, member and provider complaints.</td>
<td></td>
</tr>
<tr>
<td><strong>Health Services</strong></td>
<td>1 (800) 440-1561 (Toll Free)</td>
</tr>
<tr>
<td>Monday-Friday, 8 a.m. to 5 p.m.</td>
<td></td>
</tr>
<tr>
<td>Prior authorizations, hospital notifications,</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Contact Information</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>-- IMC prior authorizations requests.</td>
<td>Fax: (206) 613-8873</td>
</tr>
<tr>
<td>-- IMC Inpatient Admission notifications.</td>
<td>Fax: (206) 613-7078</td>
</tr>
<tr>
<td>-- Medicare Advantage prior authorization requests and Medicare Advantage Inpatient Admission notifications.</td>
<td>Fax: (206) 652-7065</td>
</tr>
<tr>
<td>-- IMC prior authorizations requests for behavioral health services</td>
<td>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>Appeal and Grievance Disputes</strong></td>
<td>(206) 521-8830</td>
</tr>
<tr>
<td></td>
<td>1 (800) 440-1561 (Toll Free)</td>
</tr>
<tr>
<td></td>
<td>1 (800) 942-0247 (Toll Free) for Medicare</td>
</tr>
<tr>
<td></td>
<td>Fax: (206) 613-8984 (routine)</td>
</tr>
<tr>
<td></td>
<td>Fax: (206) 613-8983 (urgent)</td>
</tr>
<tr>
<td></td>
<td>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>Electronic Data Interchange (EDI Support)</strong></td>
<td>Email: <a href="mailto:edi.support@chpw.org">edi.support@chpw.org</a></td>
</tr>
<tr>
<td>-- Signing up for Electronic Funds Transfer (EFT) and 835 (Health Care Claim Payment and Remittance Advice)</td>
<td></td>
</tr>
<tr>
<td>-- Other questions about Remittance</td>
<td></td>
</tr>
</tbody>
</table>
### Advice/835
--Other questions about EFT
--Questions about 270/271 (Health Care Eligibility/Benefit Inquiry and Response)
--Questions about 276/277 (Health Care Claim Status Inquiry and Response)
--See also Electronic Claims (under Additional Contacts Outside of CHPW) and Electronic Data Interchange (EDI)/Electronic Transactions/Electronic Claims Submission in this manual for more information

### Claims Investigation Unit (CIU)
You can email inquiries related to the following topics to the CIU:
--Fee schedule
--Anesthesia pricing
--Negative balance
--Re-occurring benefit configuration
--Interim billing
--Endoscopic pricing
--Multiple Surgery pricing
--Ambulance pricing
--DRG pricing
--Re-admission
--Health Homes claims
--Overpayments and underpayments
--Applied Behavioral Analysis (ABA) claims
--IMC and BHSO claims
--RHC encounter payments

Email: cs.claimsdistribution@chpw.org

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

**IMC Customer Service:**
1 (800) 440-1561 (Toll Free)

**Medicare Advantage Customer Service:**
1 (800) 942-0247 (Toll Free)

---

### New Provider Contract Requests
Email: NewContractRequest@chpw.org

### Provider Relations and Contracting
Email: Provider.Relations@chpw.org

### Credentialing
Email: Provider.Credentialing@chpw.org

### Provider Updates
Please submit the following through the Provider Changes mailbox:
--All provider updates, including demographic
--All group updates, including pay-to changes

Email: Provider.Changes@chpw.org
and clinic changes
--Inquiries about previously submitted updates
--Inquiries about the online Provider Directory

| 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 |

**Additional Contacts Outside of CHPW**

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Benefits Manager – Express Scripts, Inc.</td>
<td>To Request Coverage Determination: 1 (844) 605-8168 (Toll Free) 24 hours a day, 7 days a week</td>
</tr>
<tr>
<td>For IMC or Medicare Advantage</td>
<td></td>
</tr>
<tr>
<td>Health Care Eligibility Benefit Inquiry and Response (HIPAA 270/271 Batch and Real Time Transactions) and claim processing status (276/277 transactions)</td>
<td>To setup service for connectivity, email <a href="mailto:DL_Consumerism_Services@nttdata.com">DL_Consumerism_Services@nttdata.com</a></td>
</tr>
<tr>
<td>All Claims</td>
<td>Mail all paper claims to:</td>
</tr>
<tr>
<td></td>
<td>CHP Claims</td>
</tr>
<tr>
<td></td>
<td>PO Box 269002</td>
</tr>
<tr>
<td></td>
<td>Plano, Texas 75026-9002</td>
</tr>
<tr>
<td>Electronic Claims</td>
<td>CHPW accepts electronic claims via the Availity Clearinghouse. Please use CHPW’s Payer Identifier: CHPWA. (800) 282-4548</td>
</tr>
<tr>
<td>The Centers for Medicaid &amp; Medicare Services (CMS) website</td>
<td><a href="https://www.cms.gov/">https://www.cms.gov/</a></td>
</tr>
</tbody>
</table>
**Coordination of Care Contacts**

CHPW is providing Telephonic Interpreter Assistance for our providers to use with CHPW Medicare Advantage members. The telephonic interpreter service is offered through LanguageLine Solutions. For more information and directions on how to use this service, please see the Interpreter Services section of this manual.

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHPW Care Managers</td>
<td><a href="mailto:CareMgmtReferrals@chpw.org">CareMgmtReferrals@chpw.org</a> (all LOB)</td>
</tr>
<tr>
<td></td>
<td>IMC 1 (866) 418-7004 (Toll Free)</td>
</tr>
<tr>
<td></td>
<td>Medicare / SNP 1 (800) 418-7005 (Toll Free)</td>
</tr>
<tr>
<td>Children Services</td>
<td><a href="https://childcareawarewa.org/">https://childcareawarewa.org/</a></td>
</tr>
<tr>
<td>Transportation Services</td>
<td><a href="https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/transportation-services-non-emergency">https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/transportation-services-non-emergency</a></td>
</tr>
<tr>
<td>Interpreter Services</td>
<td><a href="https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/interpreter-services">https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/interpreter-services</a></td>
</tr>
<tr>
<td>Patient Review and Coordination (PRC) program, for members who meet the criteria identified in WAC 182-501-0135</td>
<td><a href="https://www.hca.wa.gov/billers-providers-partners/programs-and-services/patient-review-and-coordination-prc">https://www.hca.wa.gov/billers-providers-partners/programs-and-services/patient-review-and-coordination-prc</a></td>
</tr>
<tr>
<td>Dental services</td>
<td><a href="https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/dental-services">https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/dental-services</a></td>
</tr>
<tr>
<td>Foster Care–Fostering Well-Being</td>
<td><a href="https://www.dcyf.wa.gov/services/foster-parenting">https://www.dcyf.wa.gov/services/foster-parenting</a></td>
</tr>
<tr>
<td>Health Homes</td>
<td><a href="https://www.hca.wa.gov/billers-providers/programs-and-services/health-homes">https://www.hca.wa.gov/billers-providers/programs-and-services/health-homes</a></td>
</tr>
<tr>
<td>Health Care Authority (HCA) website, behavioral health covered services and primary care integration information</td>
<td><a href="https://www.hca.wa.gov/billers-providers-partners/programs-and-services/behavioral-health-and-recovery">https://www.hca.wa.gov/billers-providers-partners/programs-and-services/behavioral-health-and-recovery</a></td>
</tr>
<tr>
<td>Health Care Authority (HCA) website, substance use disorder treatment information</td>
<td><a href="https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/substance-use-treatment">https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/substance-use-treatment</a></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Aging and Disability Services, including home and community-based services</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>
<tr>
<td>Skilled nursing facilities (SNF) and community based residential programs</td>
<td><a href="https://www.dshs.wa.gov/ALTSA/resources">https://www.dshs.wa.gov/ALTSA/resources</a></td>
</tr>
<tr>
<td>Early Support for Infants and Toddlers (ESIT)</td>
<td><a href="https://www.dcyf.wa.gov/services/child-dev-support-providers/esit">https://www.dcyf.wa.gov/services/child-dev-support-providers/esit</a></td>
</tr>
<tr>
<td>Department of Health and Local Health Jurisdiction services, including Title V services for Children with special health care needs</td>
<td><a href="https://www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions">https://www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions</a></td>
</tr>
</tbody>
</table>

**Changes**

**Washington Apple Health Integrated Managed Care (IMC)**

Effective January 1, 2020, Washington Apple Health will be known as Washington Apple Health Integrated Managed Care (IMC). In IMC, physical health, mental health, and substance use disorder treatment are coordinated through one managed care plan. Behavioral Health Services Only (BHSO) are also available to clients who are Medicaid eligible but not eligible for managed care. These services are covered by an IMC plan.

Please refer to the Billing Requirements section of this manual for additional information about the IMC and BHSO plans.

If you have any questions about CHPW IMC members, please do not hesitate to call our Customer Service team at 1 (800) 440-1561 (TTY Relay: Dial 7-1-1), Monday – Friday, 8 a.m. to 5 p.m., or email CustomerCare@chpw.org.

**CHPW Medicare Advantage (MA) and Special Needs (SNP) Plans**

CHPW makes annual changes to the benefits for CHPW Medicare Advantage Plans. To see the changes effective January 1, 2020, please visit [https://medicare.chpw.org/provider-center/provider-resources/](https://medicare.chpw.org/provider-center/provider-resources/) for a brief summary of benefit information or for the Evidence of Coverage (EOC), go to [https://medicare.chpw.org/chpw-washington-state-medicare-advantage-plans/all-medicare-plans-2020/](https://medicare.chpw.org/chpw-washington-state-medicare-advantage-plans/all-medicare-plans-2020/) and click “See More” for the appropriate plan to see or download the EOC. *Note: The 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 utilizing the VSP Advantage Network of providers.*

**Provider Rights and Responsibilities**

**CHPW Provider Rights**

- To be treated with dignity and respect by our members.
- To receive accurate and complete information and medical history for members’ care.
- To expect members to follow treatment plans and protocols.
- To file a complaint or file an appeal against CHPW and/or a member.
- To file a grievance on behalf of a member, with the member’s consent.
- To have access to CHPW’s quality improvement programs, including goals, processes, and outcomes that relate to member care and services.
- To collaborate with other healthcare professionals who are involved in the care of members.
- To have access to Provider Relations and/or Customer Care for questions, issues and/or concerns.

**CHPW Provider Responsibilities**

- Inform members of their right to self-refer for certain services.
- Provide or arrange 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.
- Inform members of their right to file a grievance and how to do so. In the case of a member grievance regarding behavioral health services, offer the assistance of the Behavioral Health Ombuds in the region where the member resides.
- Utilize research-based practices for individuals, including those with a co-occurring mental health and chemical dependency diagnosis.
• 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.
• Must not be excluded or sanctioned by the Office of Inspector General (OIG) and the General Services Agency (GSA).
• Ensure that members 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, for members receiving behavioral health services.
• Demonstrate efforts to coordinate care with crisis services and other allied systems and have a process to convey all necessary information to ensure continued delivery of medically-necessary services.
• 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.
• Facilities must notify CHPW of all inpatient admissions in a timely manner as described in the “Care Management” section of this manual, as a condition of payment. Inpatient and emergency services must be available 24 hours a day, 7 days a week.
• Accept payment in full and not request payment for covered services from the member.

To access CHPW’s Member/Balance Billing Training Program, go to [https://www.chpw.org/resources/Providers/Balance_Billing_Training_042415.pdf](https://www.chpw.org/resources/Providers/Balance_Billing_Training_042415.pdf).
Appointment Availability and Wait Times

CHPW is committed to providing timely access to care for all members in a safe and healthy environment. CHPW will ensure providers offer their members the same hours of operations as they do for commercial members. CHPW follows the accessibility and appointment wait time requirements set forth by the HCA and applicable regulatory and accrediting agencies. Access standards have been developed to ensure that all health care services are provided in a timely manner. The tables below outline the appointment availability standards for CHPW members:

PCPs, OB/GYN and Midwife Providers

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Appointment Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Appointment</td>
<td>Within 30 calendar days of request</td>
</tr>
<tr>
<td>Routine Primary Care</td>
<td>Within 10 calendar days of request</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Available by phone 24/7, 365 days/year</td>
</tr>
<tr>
<td>Second Opinion Appointments</td>
<td>Within 30 calendar days of request</td>
</tr>
<tr>
<td>Care Transition – PCP Visit</td>
<td>Transitional health care services by a PCP shall be available for clinical assessment and care planning within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a SUD treatment program.</td>
</tr>
<tr>
<td>Care Transition – Home Care</td>
<td>Transitional health care services by a home care nurse, a home care Mental Health Professional or other behavioral health professional within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health care, if ordered by the enrollee’s PCP or as part of the discharge plan.</td>
</tr>
</tbody>
</table>

Behavioral Health Providers

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Appointment Wait Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Threatening Emergency</td>
<td>Immediately</td>
</tr>
<tr>
<td>Non-Life-Threatening Emergency</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine Office Visit</td>
<td>Within 10 calendar days of request</td>
</tr>
<tr>
<td>Transitional Care Visit</td>
<td>Within 7 calendar days after discharge</td>
</tr>
</tbody>
</table>
Specialist Providers

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Appointment Wait Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent, symptomatic care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Non-Urgent</td>
<td>Within 1 month of referral or as clinically indicated</td>
</tr>
</tbody>
</table>

Specialist Provider Responsibilities

Specialists can refer members for additional care such as radiology, therapies or other specialist care. The PCP should be apprised of additional care the member may need, which allows for better member care coordination.

To ensure continuity of care for the member, every participating Specialist provider must:

- Maintain contact and open communication with the member’s PCP.
- Obtain authorization from CHPW for services that require a prior authorization.
- Coordinate the member’s care with the PCP.
- Provide the member’s PCP with consultation reports and other appropriate patient records within five (5) business days of receipt of such reports or test results.
- Be available for or provide on-call coverage through another source, 24/7 for management of member care.
- Actively participate and cooperate with CHPW quality initiatives and programs.

IMC and BHSO Special Program Standards and Responsibilities

Wraparound with Intensive Services (WISe):-All contracted WISe providers will follow the guidelines in:

- The SERI guide (Service Encounter Reporting Instructions) ([https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri](https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri)); and
- CHPW internal policies and procedures related to this program.
Program of Assertive Community Treatment (PACT): All contracted PACT providers will follow the guidelines in the:

- Washington state PACT Program Standards (https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/program-assertive-community-treatment-pact);
- SERI Guide (https://www.hca.wa.gov/assets/billers-and-providers/SERI_v2019-1EffectiveJuly1_2019.pdf); and
- CHPW internal policies and procedures related to the program.

**NOTE:** The WISe and PACT programs are for IMC and BHSO plans.

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

When necessary, CHPW notifies members, either by mail or phone, about alternatives and resources for continuing care. CHPW may assist members to gain access to those services.
Access to Providers 24 Hours a Day, Seven Days a Week (24/7)

CHPW providers are required to maintain access to health care services on an ongoing basis and shall ensure that services are accessible to members as needed 24/7, 365 days/year as follows:

- Provider offices must answer the phone during normal business hours
- After normal business hours and on weekends, a provider must have:
  - A covering provider;
  - An answering service;
  - A triage service or voicemail message that provides a second phone number that is answered. For example, behavioral and mental health providers should include a crisis center phone number on their answering machine.
  - Any recorded message must be provided in English. If the provider’s practice includes a high population of Spanish speaking members, the message should also be recorded in Spanish.

Unacceptable After-Hours Coverage

Unacceptable after-hours coverage includes, but is not limited to:

- Calls received after hours are answered by a recording advising callers to leave a message;
- Calls received after hours are answered by a recording directing members to go to an Emergency Room; and
- Calls received by behavioral and mental health providers after hours are answered by a recording that does not include a crisis number in the answering machine message.
- Not returning calls or responding to messages within thirty (30) minutes.

After hours coverage requires providers to connect the member to someone who can render a clinical decision or reach a PCP/Specialist for a clinical decision. The PCP, Specialists, or covering medical professional must respond to the initial contact within thirty (30) minutes. After hours coverage must be accessible using the medical office’s daytime telephone number. CHPW will monitor compliance through audits.

Screenings and Assessments

Early Periodic Screening Diagnosis and Treatment (EPSDT) services must be structured in a way that is culturally and age appropriate, involve the family and are available to individuals under the age of 21. The intake evaluations provided under an EPSDT referral must include an assessment of the family’s needs.
Following are Washington’s State schedules for health screening visits:

- Five (5) total screenings during the first year of the child’s life

<table>
<thead>
<tr>
<th>Screening Visits</th>
<th>Age of Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Screening</td>
<td>Birth to six weeks</td>
</tr>
<tr>
<td>2nd Screening</td>
<td>Two to three months</td>
</tr>
<tr>
<td>3rd Screening</td>
<td>Four to five months</td>
</tr>
<tr>
<td>4th Screening</td>
<td>Six to seven months</td>
</tr>
<tr>
<td>5th Screening</td>
<td>Nine to Eleven Months</td>
</tr>
</tbody>
</table>

- Three (3) screening examinations are recommended for children between the ages of One (1) and Two (2) years, with one screening recommended before the child is fifteen (15) months of age.
- One (1) screening examination is recommended annually for children between the ages of three (3) and six (6)
- One (1) screening examination is recommended annually for children between the ages of seven (7) and eighteen (18)
- One (1) screening examination is recommended biennially for adults between the ages of nineteen (19) and twenty (20)

Mental health and substance use disorder treatment providers will ensure all consumers ages thirteen (13) and older are asked to complete the GAIN-SS (Global Appraisal of Individual Needs-Short Screener) upon admission. The GAIN-SS is a statewide approved screening and assessment tool. For more information, go to: https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/gain-ss

**Care Standards Documents**

Policies and Procedures [http://chpw.org/for-providers/other-resources/policies](http://chpw.org/for-providers/other-resources/policies)
**Critical Incident Reporting**

A Critical Incident is an event involving a member or provider in a harmful situation with impact to health and safety. CHPW is required to identify, investigate and track Critical Incidents and report the incident to the Washington State HCA.

The HCA identifies a set of Critical Incidents that must be reported to the state for all Washington Apple Health IMC contracted plan members. Examples are:

- Suicide or attempted suicide by the member.
- Death, abuse, neglect or sexual/financial exploitation to a member, occurring within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), FQHC, or by independent behavioral health provider.
- Violent acts allegedly committed by a Member with a behavioral health diagnosis; or history of behavioral health treatment within the previous 365 days. Acts to include:
  - Arson;
  - Assault or action resulting in serious bodily harm;
  - Homicide or attempted homicide by abuse;
  - Extortion;
  - Kidnapping;
  - Sexual assault
- Unauthorized leave from a behavioral health facility during an involuntary detention
- A credible threat to member’s safety
- Poisonings/overdoses unintentional or intention unknown
- Event that is likely to attract media attention

The provider shall report Critical Incidents within **one (1) business day** in which the Contractor becomes aware of the event by submitting the *Critical Incident Report Form* at the following link: [https://www.chpw.org/resources/Forms_and_Tools/Critical-Incident-Form_Providers-12132019.pdf](https://www.chpw.org/resources/Forms_and_Tools/Critical-Incident-Form_Providers-12132019.pdf)

Providers can contact CHPW at Critical.Incidents@chpw.org.

CHPW enters the required incident into the **HCA Incident Reporting System** within **one (1) business day** of reporter’s awareness of the incident. CHPW tracks the incident within the semi-annually population-based reporting template. CHPW completes the investigation with follow-up actions within **45 days** to close the incident in the **HCA Incident Reporting System**.
**Community Behavioral Health Reporting and Data**

Effective January 1, 2020, all licensed and certified Behavioral Health Agencies (BHAs) contracted with CHPW will be required to collect and submit Behavioral Health (BH) supplemental transactions. BHAs will be required to comply with the data collection and reporting requirements provided in the Behavioral Health Supplemental Transaction Guide.

If you have questions regarding Behavioral Health Supplemental Data requirements, please contact Provider.Relations@CHPW.org.

**Credentialing and Re-credentialing**

CHPW developed a Credentialing Program to meet the criteria set forth in the CHPW mission statement and 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 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 an annual evaluation and periodic revision to the supporting policies and procedures adopted by the Credentialing Committee.

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

For credentialing status inquiries, please contact provider.credentialing@chpw.org.

**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, re-credentialing, and ongoing review processes.
Providers are notified of this right in the cover letter that accompanies CHPW’s credentialing and re-credentialing 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 https://www.chpw.org/for-providers/provider-manual1/.

**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 ten (10) business days. Notification will be sent electronically, or certified return receipt requested, and the correspondence will be marked “Confidential” as applicable.

The provider may not make any corrections to an application that has already been 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.

**Right to be informed of application status**

Providers may request a review of their credentials file by calling the Credentialing Coordinator at (206) 515-7942 to schedule an appointment.

All reviews must be performed onsite at the CHPW office. The Medical Director or a member of the Credentialing Team will accompany the provider during the file review.

Documents available for review are:

- 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, references or other information that is peer reviewed/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 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 Re-credentialing Application. The provider may contact the Credentialing Specialist for information about the status of their credentialing application. The Credentialing Specialist will explain where the application is at in the process. The Credentialing Specialist may share other permitted information with the provider regarding his or her application.

Note: As a reminder while a provider is in the credentialing process, the provider cannot provide health care services to CHPW members. Claims will be denied if the provider has not completed the credentialing process at the time services were rendered.

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 contractual obligations, NCQA, and legal and accreditation requirements.

Provider shall permit CHPW to conduct audits of member 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 protected health information. This applies to all formats that CHPW or the provider creates, receives, maintains, or transmits in performing
duties under the Provider Agreement 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, 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, however the provider must retain and maintain medical records for ten (10) years. This includes all medical records, x-ray films, tissue specimens, slides, and photographs which are the property of the provider.

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 offsite. 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 trained personnel and only with a completed and signed HIPAA compliant *Patient Authorization Form for Release of Information*.

**Provider Data Quality Assurance**

**Reporting Changes in Provider Information**

All CHPW providers must give notice to CHPW at least sixty (60) days in advance of any provider changes including, but not limited to:

- Tax identification
- NPI (National Provider Identifier) number (individual and/or group)
- Billing (vendor) address, office, phone, and fax numbers
- Clinic contact information (name, phone number, fax, and email)—i.e., Credentialing Coordinator, Billing Manager, Clinic Manager
- Provider additions (include provider effective date)
• Changes to providers locations within a group
• Provider terminations (include provider termination date)
• Clinic/facility location additions/changes (if applicable, include effective and termination dates for your clinics and/or facility)

A 60-day advance notice for changes will provide CHPW ample time to update all systems, notify members, and prevent claims payment delays. Provider and group changes should be reported to CHPW by completing a Provider Add Change Term Form and/or Clinic and Group Add Change Term Form. Excel, PDF, and online forms are available on the Provider Forms and Tools page of our website, https://www.chpw.org/for-providers/documents-and-tools/, under the Provider Updates heading. Email completed Excel or PDF forms to Provider.Changes@chpw.org or click the “submit form” button of the online form.

For new providers requiring credentialing, please send a request to Provider.Credentialing@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.

Provider Rosters
CHPW appreciates the valued services that your clinic/facility provides to our members.

In accordance with 42 C.F.R. §422.111, CHPW is committed to providing clear and accurate information to members regarding our provider network. We will send you a letter with a standard roster with the provider details we have on file. The roster request letter will include a Provider Roster FAQ and description of the columns on the roster. That information is also available on our Provider Bulletin Board, https://www.chpw.org/for-providers/bulletin-board/ or https://medicare.chpw.org/provider-center/bulletin-board/, Provider Roster FAQ topic. The roster includes practice details such as Tax ID, NPI, Licensure, Specialty, office location addresses, phone numbers, office hours, whether you are accepting new patients, etc. We also need to verify demographic information such as ADA access; any additional languages spoken by staff other than English; gender or age restrictions. All practice locations where your providers render services under your agreement should be included in the roster.
When you receive your roster, please review for accuracy, highlight any changes, and return the roster to provider.changes@chpw.org. Going forward, please submit any additions, changes, or terminations immediately to CHPW via our Provider Add Change Term Form or Clinic and Group Change Term Form. Both forms are available on the Provider Forms and Tool page of our website: https://www.chpw.org/for-providers/documents-and-tools/.

CHPW appreciates your time in partnering with us to ensure our directory is up to date and accurate. Feel free to reach out to our Provider Data Specialists at provider.changes@chpw.org for questions.

**Practice Capacity**
PCPs must notify CHPW if their practice reaches capacity and can no longer accept new patients. This notice must be in writing and will be effective the first day of the month following forty-five (45) days from receipt of the written notice. Providers may submit their notice to Provider.Changes@chpw.org.

**Provider Termination**
If you find it necessary to terminate your agreement with CHPW, refer to your contract for notice requirements. Giving notice ensures compliance with the Patient Bill of Rights and provides time for CHPW to notify members. Providers may submit their termination notice to Provider.Changes@chpw.org.

Note: Contract terminations are governed and specified under provider contract terms.

**Ownership and Control Disclosure Form**
The Centers for Medicare and Medicaid Services (CMS) and Washington State Health Care Authority (HCA) require hospitals, clinics and other health care organizations to submit a completed Disclosure of Ownership and Control (O&C) form to CHPW prior to contract execution. Providers are required to submit an updated O&C within thirty-five (35) days, if the following changes occur:
- New business owner(s)
- Tax ID change
- Management (CEO) change, and/or Board of Director changes
- Other pertinent changes

The O&C form may be found on the CHPW website at http://chpw.org/for-providers/documents-and-tools.
Checking Eligibility/Benefits
Each CHPW product has a specific set of rules governing who is eligible for coverage, and the enrollment and termination processes. These rules are established by the HCA for IMC and by CMS for Medicare Advantage.

For details about IMC enrollment and eligibility, please refer to the ProviderOne section of the HCA website at http://www.hca.wa.gov/billers-providers/providerone-resources. Providers should verify member eligibility through ProviderOne prior to providing services by accessing this link: https://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage.


Providers can verify eligibility and benefits by submitting Health Care Eligibility Benefit Inquiry and Response (HIPAA 270/271 Batch and Real Time Transactions). To set up service for connectivity, email DL_Consumerism_Services@nttdata.com.

CHPW will not refuse or terminate a member’s enrollment, nor will CHPW discriminate against a member in any way due to his or her health status, the need for frequent high-cost care, or because of a pre-existing physical or mental condition- including pregnancy or hospitalization.

Medicare Advantage Providers in the Health Care Setting
CHPW understands that Medicare members look to their health care providers to provide them with complete information regarding their health care choices.

To the extent of their ability, providers may assist a member in an objective assessment of the member’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.
CHPW’s contractual obligations with Medicare prohibit providers from distributing or accepting enrollment applications or offering inducements to persuade members to join Medicare Advantage plans. Providers cannot direct, urge, or attempt to persuade members 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.

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

- Providers may not be fully informed of all plan benefits and costs; and
- Providers may be perceived as agents of CHPW and cause confusion to beneficiaries.

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

- CHPW Customer Service Representatives at 1 (800) 944-1247 (Toll Free)
- State Health Insurance Assistance Programs (SHIP) at 1 (800) 432-4040 (Toll Free)
- 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 (Toll Free)

**Provider Directory**

CHPW launched a new and improved Provider Directory (provider search tool) in July 2019.

You have a few options to access the Provider Directory:

1. Go to the CHPW IMC website, [www.chpw.org](http://www.chpw.org), or the CHPW Medicare Advantage website, [https://medicare.chpw.org/](https://medicare.chpw.org/). Click the “Find a Doctor” tab on the home page to search for a provider.
2. Go directly to [https://www.chpw.org/provider-search/](https://www.chpw.org/provider-search/) or [https://medicare.chpw.org/find-a-doctor/](https://medicare.chpw.org/find-a-doctor/).
3. **New!** Access the directory from within the HealthMAPS online provider portal. Once you’re logged in, click the Provider Search link on your dashboard.

The new directory has a more organized look and feel with many new features. Here are just a few:

- You can quickly search by location (zip code, city, or county) and benefit plan; and by provider type (doctor/medical professionals, facility, hospital, behavioral health, durable medical equipment, pharmacy).
- Advanced filters accessible from the home page.
• Additional filters on the left side of your search results let you quickly and easily see more information about the provider.
• You can select more than one filter; for example, you can select **Accepting New Patients** and **ADA Accessibility** and **Extended Hours**.


The Provider Directory is subject to change and may not be a complete representation of CHPW’s network. If a specialist you utilize/refer to is not contracted with CHPW, please email our Provider Relations department at Provider.Relations@chpw.org or call IMC Customer Service at 1 (800) 440-1561 (Toll Free) or Medicare Advantage Customer Service at 1 (800) 942-0247 (Toll Free). For termination of a contract with CHPW, please refer to your contract terms within your Provider Agreement.

CHPW needs your help to ensure we have the correct provider information for you. You can send updates to us for the Provider Directory at any time via the **Provider Directory Intake Form**. The form is available on the on the Provider Forms and Tools page of our website, [https://www.chpw.org/for-providers/documents-and-tools/](https://www.chpw.org/for-providers/documents-and-tools/), under the Provider Updates heading. To report inaccurate data in our provider directory you can notify us via our Report an Error page on our website, [https://www.chpw.org/about-us/contact-us/report-an-error](https://www.chpw.org/about-us/contact-us/report-an-error).

**CHPW IMC and Medicare Advantage Service Area**

CHPW participates in IMC in the following Regions and counties:

<table>
<thead>
<tr>
<th>Region</th>
<th>County(ies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater Columbia Region</td>
<td>Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, and Yakima</td>
</tr>
<tr>
<td>King Region</td>
<td>King</td>
</tr>
<tr>
<td>North Sound Region</td>
<td>Island, San Juan, Skagit, Snohomish, and Whatcom</td>
</tr>
<tr>
<td>Spokane Region</td>
<td>Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens</td>
</tr>
<tr>
<td>Southwest Washington Region</td>
<td>Clark, Klickitat, and Skamania</td>
</tr>
</tbody>
</table>
CHPW offers Medicare Advantage coverage through its CHPW Medicare Advantage Plan(s) as follows:

<table>
<thead>
<tr>
<th>Health Plan Management System - Plan Benefit Package (PBP)</th>
<th>Marketing Name</th>
<th>Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>006 Community Health Plan of Washington MA Plan</td>
<td></td>
<td>Clark, Cowlitz, King, Kitsap, Pierce, Snohomish, Spokane, and Thurston</td>
</tr>
<tr>
<td>008 Community Health Plan of Washington MA Pharmacy Plan</td>
<td></td>
<td>Clark, Cowlitz, King, Kitsap, Pierce, Snohomish, Spokane, and Thurston</td>
</tr>
<tr>
<td>009 Community Health Plan of Washington MA Pharmacy Plan</td>
<td>Adams, Chelan, Douglas, Grant, Lewis, Okanogan, Skagit, Walla Walla, Whatcom, and Yakima</td>
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<tr>
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<td>Clark, Cowlitz, King, Kitsap, Pierce, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, and Yakima</td>
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CHPW Eligibility Department

Eligibility Documents

Refer to the following resources for more information on PCP assignment and Roster Corrections:

- [http://chpw.org/for-providers/other-resources/policies](http://chpw.org/for-providers/other-resources/policies)
- Clinic/PCP Selection Form
- Member Roster Correction Template
- PCP Assignment for State Programs Members Procedure [http://www.chpw.org/for-providers/other-resources/policies/](http://www.chpw.org/for-providers/other-resources/policies/)

PCP Assignment Procedure

PCP changes must be initiated by the member or, at the request of the provider (confirmed by the member). Members will be assigned to providers or clinics not accepting new patients only if the Provider has agreed.


Members can complete their own PCP changes by logging into their account at [https://www.chpw.org/for-members/health-information-portal/](https://www.chpw.org/for-members/health-information-portal/). The PCP Selection Form may also be completed and faxed to (206) 652-7085.

Providers may request corrections to their rosters if they have evidence that the member is being seen or wants to be seen at another clinic location. The Roster Correction Template can be completed and emailed to EligibilityDept@chpw.org.

Involuntary Disenrollment from IMC

A member may be involuntarily disenrolled from IMC products under the following condition:

- The member 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 be reassigned involuntarily to another provider or clinic or disenrolled from CHPW, due to inappropriate
behavior if CHPW’s attempts to address this behavior with reasonable accommodations of any disability of the Enrollee have not been successful; and continued enrollment would impair CHPW’s ability to furnish services to the Enrollee or any other Enrollees.

In the majority of member misconduct cases, CHPW either educated or reassigned the member to a different site or center. Whenever possible, members are given an opportunity to change or improve inappropriate behavior. In the event a member’s behavior 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 disenrollment of a member from the State of Washington solely due to an adverse change in the member’s health or due to the cost of meeting the member’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 and secure alternative care until another permanent provider is assigned to the member, 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 IMC and Medicare Advantage) at the time of service.

Members who are to be reassigned involuntarily to another CHPW provider will be notified in writing thirty (30) days in advance. This written notice will inform the member of their 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 for reassignment or dis-enrollment will receive necessary covered health care arranged by their current PCP, with the assistance of appropriate CHPW staff until a decision is rendered by CHPW or the applicable state agency.
Disenrollment Procedure – IMC

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 non-compliance 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 utilizing the emergency room, or by self-referring to specialists without consulting with their PCP.

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

1. When a PCP 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 clinic’s written procedures relating to patient behavior.

2. If the member repeats the misbehavior or chooses not to follow the steps outlined, clinic staff, with the approval of the clinic Medical Director, will consult with the assigned CHPW Provider Relations department to request that the member be reassigned or disenrolled from CHPW. CHPW 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 which includes member education.
4. If it is determined that the member should be reassigned to another clinic or center, the Provider Relations department will inform the member in writing. This letter will provide thirty (30) days notice and will inform the member of his or her appeal rights and the right to a fair hearing under Washington Administrative Code (WAC). The letter also outlines the member's options for receiving future health care through CHPW. The Provider Relations department will coordinate 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 the clinic provider or staff member and CHPW Case Manager determines that the member's behavior is serious enough to warrant disenrollment:
   a) The CHPW Case Manager will notify the member in writing of CHPW's intent to request an involuntary disenrollment from CHPW, which includes the member's appeal rights.
   b) The Case Manager will work with the Provider Relations department to gather all necessary documentation from the PCP.
   c) All information provided by the PCP will be forwarded to the CHPW Medical Director for review.
   d) If the necessary documentation has been provided and the Medical Director determines the involuntary disenrollment request meets WAC requirements the Medical Director will submit the documentation along with a letter requesting the disenrollment to the HCA Exception Case Management (ECM) Section.
   e) HCA ECM will make a determination within thirty (30) days of receiving CHPW’s request. If approved, HCA ECM will notify CHPW and the member with at least ten (10) days notice of termination.
   f) The member will stay enrolled with CHPW until a decision is made by the HCA 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 any criminal behavior to law enforcement agencies
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 a 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 (6) 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 premium
- Failure to Pay a Part D- Income Related Monthly Adjustment Amount (Part D-IRMAA).
- Fraud and abuse
- Contract termination
- If the member lies 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 send 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 the out-of-area move is permanent or that six (6) months have passed. The EC will contact the member to verify the address change.

If the EC cannot contact the member by phone, the EC will mail the member a Verification of Change in Address letter. If the EC does not receive a response back 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 (2) 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 the member a Disenrollment Due to Loss of Part A or Part B Coverage letter. If a member 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 contacts CHPW regarding an erroneous disenrollment, the EC will use the Enrollment Reinstatement procedure.

**Disruptive Behavior – Medicare Advantage Process**

When the CHPW EC determines that a member exhibits behavior that substantially impairs CHPW’s ability to arrange or provide care to the member 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 dis-enrolling the member, the EC will mail the member a Warning of Potential Disenrollment Due to Disruptive Behavior letter and will work to resolve the issues and document all efforts.
If the disruptive behavior does not end after the EC sends the letter, the EC will mail the member an Intent to Dis-enroll letter. The EC will then send a disenrollment request to CMS, with all of the required documentation. CMS will decide to approve or deny the disenrollment request within twenty (20) business days of receiving the documentation. CMS will notify CHPW of the decision to approve or deny the disenrollment request.

If the disenrollment request is denied by CMS, CHPW will notify the member and enrollment will continue.

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

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

Members with Part D-IRMAA must pay an 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 individual to use his or her enrollment card to obtain services or a prescription drug; or
- Is untruthful and/or withholds information about other insurance that provides them with additional prescription drug coverage.

**CHPW/CMS Contract Termination**

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

If CHPW receives a contract termination from CMS, the EC will mail the member a Contract Termination by CMS letter at least thirty (30) calendar days before the effective date of termination.
If CHPW receives a contract termination from CMS indicating 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 failing to meet contractual obligations, members will be sent the Contract Termination by CHPW letter sixty (60) days prior to the effective date of termination.

**Member ID Cards**
Below are samples of the member ID cards. Members who have lost their ID card may contact 1 (800) 440-1561 to order a replacement. Medicare Advantage Members may call 1 (800) 942-0247.

**Washington Apple Health Integrated Managed Care (IMC) ID Cards**
By Region:

**Southwest**

**Greater Columbia**
King County

Name: John Sample  
Member ID: 12345678  
Group: IMC Apple Health – Family  
Region: King County  
Clinic (PCP): Clinic XYZ  
Clinic Phone: 555-555-5555  
Copay: OV $0 / ER $0 / RX $0  
RXBin: 003858 / RXGroup: CHWA  
State ID: 2000000000WA

North Sound

Name: John Sample  
Member ID: 12345678  
Group: IMC Apple Health – Family  
Region: North Sound  
Clinic (PCP): Clinic XYZ  
Clinic Phone: 555-555-5555  
Copay: OV $0 / ER $0 / RX $0  
RXBin: 003858 / RXGroup: CHWA  
State ID: 2000000000WA

Spokane

Name: John Sample  
Member ID: 12345678  
Group: IMC Apple Health – Family  
Region: Spokane  
Clinic (PCP): Clinic XYZ  
Clinic Phone: 555-555-5555  
Copay: OV $0 / ER $0 / RX $0  
RXBin: 003858 / RXGroup: CHWA  
State ID: 2000000000WA
Behavioral Health Services Only (No Medical Services)
By Region:

Southwest

Greater Columbia

King County

CUSTOMER SERVICE 1-800-440-1561 TTY Relay: 711.
Member chpw.org
LIFE-THREATENING EMERGENCY Call 911 or go to the nearest emergency care facility. Contact your PCP or call CHPW customer service at 1-800-440-1561 within 24 hours.
NURSE ADVICE LINE (NAL) 1-866-418-2920 or TTY Relay:711.
URGENT CARE Call your clinic (PCP). After hours, call the NAL CRISIS LINE 1-800-626-8137
Provider mychpw.chpw.org/en/provider
HOSPITAL ADMISSIONS Hospitals must notify customer service within one business day of hospital admissions.
SUBMIT CLAIMS Community Health Plan of Washington Claims, PO Box 269002 Plano, Texas 75026-9002.
Medicare Advantage ID Cards

Medicare 006 – MA plan

Medicare 008 – MA Pharmacy Plan

Medicare 009 – MA Pharmacy Plan
Medicare – Supplemental ID Card
This card will be made available to members with certain chronic diagnoses including diabetes, chronic obstructive pulmonary disease, and congestive heart failure. These members should not be charged copays or coinsurance when presenting with this supplemental ID card.

**Member Benefits**

**Benefit Information**
To learn more about benefits and copays for IMC 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) (Medicaid) or [https://medicare.chpw.org/provider-center/provider-resources/](https://medicare.chpw.org/provider-center/provider-resources/) (Medicare Advantage and Special Needs Plan).

For more detailed information about IMC and BHSO, benefits, please call the Customer Service team at 1 (800) 440-1561 (Toll Free).

For more detailed information about Medicare Advantage benefits, please call the Customer Service team at 1 (800) 942-0247 (TTY: Dial 711) 7 days a week, 8am to 8pm.

**Member Materials**
For State programs (IMC), 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, IMC members get:

- Getting started information including overall summary of benefits and programs such as Maternity Support Services, Care Management and Well Child Rewards.
- 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 ChildrenFirst™ program.
- Customer Service and Nurse Advice Line phone number.

**State Enrollment Materials and Publications**

Please refer to the HCA website for enrollment materials, publications, order forms and directions.

For information about IMC enrollment and eligibility, visit the IMC website at http://www.hca.wa.gov/medicaid/Pages/index.aspx.

**ChildrenFirst™**

CHPW rewards members who obtain regular checkups and preventive care through their scheduled well child and prenatal visits. ChildrenFirst™ is our reward program for children and pregnant women who receive scheduled care.

In our **Prenatal Program**, members who complete at least two prenatal checkups while they are CHPW members receive a $65 Amazon gift card toward the purchase of a car seat.

In our **Well Child Program**, parents are eligible to receive a $20 Amazon gift card for every Well Child checkup between the ages of one week (7 days) thru the end of their 17th year (until 18 years old). If parents did not receive a reward from the Prenatal Program, then they are also eligible for a one-time $65 gift card for a car seat during their child’s first year in place of the first of the $20 rewards. The child must be current and up to date with their immunizations for parents to receive the reward.

For more information about ChildrenFirst, patients or providers can contact CHPW at 1 (800) 440-1561 (Toll Free), or visit http://www.chpw.org/for-members/children-first-rewards-program/.
Providers are responsible for submitting complete patient information to CHPW so the patient can receive their reward through use of the ChildrenFirst™ online form. Information for the Well Child program must be submitted after every eligible well child visit within three months of the visit. Information for the Prenatal Program must be submitted through use of the ChildrenFirst™ online form after the patient completes two prenatal visits as a CHPW member. Please allow 2-3 weeks from submission for patients to receive their reward from the time of the form submission.

To submit patient information for a ChildrenFirst™ reward, please use the online submission forms located at [http://www.chpw.org/for-providers/documents-and-tools/](http://www.chpw.org/for-providers/documents-and-tools/)

- **ChildrenFirst™ Prenatal Form**: [https://portal.chpw.org/childrenfirst/clinic/prenatal#/login](https://portal.chpw.org/childrenfirst/clinic/prenatal#/login)
- **ChildrenFirst™ Well Child/Immunization Form**: [https://portal.chpw.org/childrenfirst/clinic/wellchild#/login](https://portal.chpw.org/childrenfirst/clinic/wellchild#/login)

For more guidance regarding ChildrenFirst and reward submission status, patients or providers can contact CHPW at 1 (800) 440-1561 (Toll Free).

**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 sub-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\(^1\), first tier, downstream, and related entities (FDRs).

**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. Providers 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.

**1.0 RESPONSIBILITY**

CHPW 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 Vice President, Compliance Officer.

\(^{1}\) 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.
1.3 **Take Action.** Ensuring compliance with these 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, Vice President, 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 CHPW’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 Vice President, 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 CHPW. When we are in a position to influence a decision or circumstance that may result in personal gain at the expense of CHPW, we avoid and disclose those situations to our Vice President, 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 multiple mechanisms 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 submitting it by emailing, mailing or faxing it to CHPW’s Vice President, Compliance Officer; or
- Contacting the Vice President, Compliance Officer directly by phone or email.


Vice President, Compliance Officer Contact Information
Community Health Plan of Washington
Attention: Vice President, Compliance Officer
1111 Third Avenue, Suite 400
Seattle, WA 98101
Phone: (206) 613-5091
Fax: (206) 652-7017
Email: compliance.officer@chpw.org
Providers may report **anonymously** by:
- Contacting CHPW’s Customer Service Department at 1 (800) 440-1561 (State Programs), or 1 (800) 942-0247 (Medicare) and completing a form over the phone.
- Emailing a completed form to the Vice President, Compliance Officer at compliance.officer@chpw.org from a proxy email address.
- Faxing the form to the Vice President, 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.

Contractors 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: [https://oig.hhs.gov/fraud/report-fraud/](https://oig.hhs.gov/fraud/report-fraud/)
- 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**
First Tier, Downstream and Related Entities (FDRs)\(^2\) 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.

\(^2\) A First Tier Entity is any party that enters into a written agreement with CHPW to provide administrative services or healthcare services to our members. The term subcontractor 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.
Providers and their staff must complete CMS’s General Compliance training and FWA training within 90 days of contract, and annually thereafter. Providers 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 the FWA portion of the training.

Providers will find the link to the Medicare Learning Network (MLN) at https://medicare.chpw.org/provider-center/provider-resources/. The provider Compliance/FWA completion of training attestation is located at https://forms.chpw.org/#/gcfwa.

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. Providers 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 Notice of Privacy Practice(s) (NPP), which describe an individual’s rights under HIPAA. The NPPs are available on CHPW’s website:

- IMC: https://www.chpw.org/for-members/your-privacy-and-rights/
- Medicare Advantage: https://medicare.chpw.org/member-center/member-rights/

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 Vice President, 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 is 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 Vice President, 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 FWA 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 FWA. CHPW is committed to collaborating with state and federal agencies, other health plans, and providers to identify and correct FWA. CHPW utilizes multiple avenues to prevent, detect, and correct FWA, including:

- Oversight
- Standards of Conduct, policies and procedures
- Education and training
- Systems and processes to detect and prevent FWA, as well as, identity theft
- Mechanisms for reporting suspected FWA
- Processes for addressing and correcting at-risk business practices or noncompliant behaviors related to FWA
- Processes for referring and reporting credible allegations of fraud to state and federal agencies
Additional information for contractors and members on how to prevent health care fraud and a form for making reports is available at https://www.chpw.org/fraud-and-identity-theft.

“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 FWA, 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, FWA may be committed by anyone, including:

- Patients
- Claims processing subcontractors
- Pharmacies and pharmacists
- Home health agencies
- PCPs
- 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 FWA. An identified occurrence of these or similar activities must be reported to CHPW’s Vice President, Compliance Officer, FWA Program Manager or designee.

Provider FWA

- 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 FWA
- 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 FWA
- 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.

Patient/Member FWA
- 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, FWA 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 FWA 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 (IMC, BHSO)
If the Vice President, Compliance Officer 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 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 FWA, including the following elements:

- Knowing what constitutes FWA
- Understanding where FWA can occur
- Knowing how to identify FWA
- Knowing how to report suspected or potential FWA
- 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
- FWA 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

Providers 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): https://exclusions.oig.hhs.gov/
- GSA System for Award Management (SAM): To register for an account to view SAM, visit https://www.sam.gov/SAM/
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 Vice President, 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 FWA:
- 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/fraud/enforcement/cmp/background.asp](https://oig.hhs.gov/fraud/enforcement/cmp/background.asp). 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 wrongdoing.

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:

- Civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410)
- Exclusion from participation in the Medicare and Medicaid program(s)
- 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 (5) years in prison and/or additional criminal fines up to $25,000 if found guilty of a felony; and up to one (1) year in prison and/or additional fines up to $10,000 if found guilty of a misdemeanor; and exclusion from participation in federal health care programs upon conviction.


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
CHPW maintains Compliance Program policies and procedures which further detail the information provided in this manual. Copies of CHPW’s Compliance Program Policies are available upon request.
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 FWA 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 FWA:
  - 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.

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 Policy (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 (CO298)
This policy designates a Privacy Officer and defines 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.
Substance Use Disorder Records Use and Disclosure Policy and Procedure (CO367)
This policy and procedure establishes confidentiality restrictions and safeguards for the release of confidential information specific to substance use disorder treatment records as outlined at 42 CFR Part 2.

42 CFR Part 2 are federal regulations prohibiting the disclosure of patient information (without patient consent) that could reasonably be used to identify an individual with a substance use disorder receiving treatment by a federally assisted substance use disorder program.

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.

PCPs are encouraged to discuss advance directives with adult patients and are required to document the discussion in the member’s 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 of 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 from 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 Directive should also:

- Advise the member in advance, or when admitted of existing conscientious objections.
- Prepare and keep a written plan of intended actions if the member chooses to stay.
- Make a good faith effort to transfer the member 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) on Advance Directives at https://www.chpw.org/for-providers/other-resources/policies.

Auditing and Monitoring

Auditing and monitoring activities aid CHPW in detecting and preventing FWA and non-compliance. 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 FWA;
- 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 FWA;
• 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 potential 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 potential 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 potential 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 Vice President, Compliance Officer, the FWA 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 FWA. In the event that a subcontractor fails to cooperate with an investigation, CHPW will recoup funds for the services billed and potentially 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 FWA 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 Vice President, Compliance Officer or the FWA Program Manager provides feedback to the originator of the request.

**Enforcement and Discipline**

Upon completion of an investigation, the Compliance Officer, the FWA 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 Patient Review and Coordination Program (PRC) and,
Refer a member to the HCA Office of Medicaid Eligibility and Policy 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 and 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 members 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
- Inform all members 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 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 CHPW Medicare Advantage, Member Rights can be found on the CHPW website at [https://medicare.chpw.org/member-center/member-rights/](https://medicare.chpw.org/member-center/member-rights/).
**Second Opinion**

Members or the PCP may request a second opinion where there is a question concerning a diagnosis, options for surgery, or other health care treatment, including behavioral health. If the member desires a second opinion, he or she must request that the PCP or their behavioral health provider arrange one. The member may request a referral directly from CHPW, if necessary.

If the member requests a second opinion, the PCP, behavioral health provider, or CHPW shall promptly refer the member 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 the member shall be referred to an appropriate non-networked specialist. The PCP, behavioral health provider, 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. In the case of a second opinion regarding a behavioral health diagnosis or treatment plan, the treating behavioral health provider must consider the recommendations of the provider of equal or higher credentials rendering a second opinion but is not obligated to follow them.

**Women’s Health Care**

CHPW provides 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 284-170-350 and 42 CFR 438.206(b)(2).

Female members can self-refer to any women’s health care provider 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 PCP without authorization.

To find a women’s health care provider within our network, please visit Find a Doctor at http://chpw.org/provider-search/ or https://medicare.chpw.org/find-a-doctor/.

**Member and Balance Billing**
For IMC 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 Member and Balance Billing Program at http://chpw.org/for-providers/training/.

CHPW members will not be held liable for payment of any fees that are the legal obligation of CHPW. For any member eligible for both Medicare and Medicaid, the member will not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts (42 CFR 422.504 (i)(3)(i) and 422.504 (g)(1)(i).

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 CHPW Medicare Advantage members. This is free of charge. Clinic staff is responsible for verifying a member is a CHPW Medicare Advantage member. The telephonic interpreter service is offered through LanguageLine Solutions.

To access LanguageLine Solutions Interpreter Services:
   1. Dial: 1 (866) 874-3972 (Toll Free)
   2. Provide Client ID: 509696
   3. Indicate: Language you need
   4. When agent or system asks: Enter the Cost Center Code 60
   5. When agent or system asks: Enter 4-digit phone extension
Document the interpreter name and ID number for reference.
Brief the interpreter and give any special instructions.

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

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

- Verifying that the patient is an eligible HCA client.
- Checking to see whether the medical service to be provided is covered by the client’s medical program.
- Notifying the HCA client that interpreter services are available to the client at no charge.
- Coordinating the interpreter services.
- Following HCA 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 HCA’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 (711) to communicate with a person who is deaf, deaf-blind, or hard of hearing.
- Contacting the HCA at 1 (800) 535-7358 for help with obtaining an interpreter.
- Medicare Advantage: CHPW provides this service through LanguageLine at 1 (855) 380-9244 with the following log in
  - Provide Client ID: 509696
  - Indicate the Language needed
  - Enter Cost Center: 60
HealthMAPS Provider Portal
CHPW’s HealthMAPS online provider portal for patient lets you enter and view member claims, check eligibility, see other health insurance, view roster reports, and more.

Create a HealthMAPS Account
You can go online to https://mychpw.chpw.org/en/provider and register to create a HealthMAPS account. You will need to know your Billing Tax ID number(s) in order to do so. Once you have an account, you can view CHPW members’ eligibility, benefits coverage, claim information, and more.
You can also access the HealthMAPS portal with your existing OneHealthPort credentials. Please visit CHPW’s page at OneHealthPort here: https://www.onehealthport.com/payer/community-health-plan-washington.

Training guides are available from the Provider Orientation, Training, and Education page on our website, https://www.chpw.org/for-providers/training/, under Training Workbooks and then under HealthMAPS Portal. The HealthMAPS Provider User Guide has details about how to create your HealthMAPS account, customize your HealthMAPS dashboard, view and send secure messages, and more. You will also find instructions for entering claims in HealthMAPS. The HealthMAPS Provider Portal FAQ addresses questions and feedback we have received from providers via email to customercare@chpw.org. We will continue to update the FAQ based on provider input.

Your HealthMAPS Provider Account
Please note, it may take up to five (5) calendar days to process your HealthMAPS registration. You will receive an email when your registration is complete.
Once you have an account, these features are available right away with HealthMAPS Phase 1:

- Your dashboard, which has news and notifications, claims and membership information, and more.
- The Provider News area has general information that all CHPW providers can view.
- Provider Notifications are specific to you; no other CHPW providers can see your notifications.
- Customize your dashboard based on your preferred tax ID(s) so you can see the information that you are most interested in each time you log in.
- Access authorization requests via a link to the Jiva Portal, https://jiva.chpw.org/; you will need a Jiva Portal account login. Please continue to use the Jiva Portal to submit and view prior authorization requests and inpatient notifications.
• Enhanced ability to send and receive benefit/eligibility (270/271) and claim status (276/277) transactions.
• Search for and view claim details.
• Request claim reviews.
• View a member’s other health insurance.
  
  Note: Other health insurance (OHI) information in the state’s ProviderOne system may be inaccurate or out of date. CHPW collects, verifies, and then reports other health insurance for our members back to the Health Care Authority via a monthly update file. There may be a window of time where member third party liability (TPL)/OHI information has changed in HealthMAPS but has not yet been reported to the HCA. Please always consider HealthMAPS as the system of truth concerning our members’ other health insurance information.
• Report a member’s other health insurance.
• View capitation and member roster reports.
• Enter a new claim.
• Enter a corrected claim.
• In some screens, you can export information, such as authorizations, to Microsoft Excel or Adobe Acrobat PDF.
• Send an inquiry or other secure message to a CHPW Customer Service Representative. In some screens, you can attach a file to your message.
• Get quick access to different forms and tools housed on the CHPW website via the Provider Resources Quick Link menu option.

These features will be available at a later date:
• View provider remittance advices (RA) and member Explanations of Benefits (EOB).

Questions?
If you have general provider relations and contracting questions, please email provider.relations@chpw.org.

If you have questions or problems registering for HealthMAPS or if you have general questions about other topics, please email Customer Service at customercare@chpw.org.
Billing and Claims Payment

Governance

CHPW shall process and adjust all claims in accordance with the following, in order:

1. All federal and state laws;
2. CHPW provider contracts;
3. Rules defined and published by the Centers for Medicare & Medicaid Services (CMS) and the Washington State HCA;
4. Nationally recognized coding standards and National Correct Coding Initiative (NCCI) payment system edits;
5. CHPW established policies; and

Billing Requirements

CHPW would like to remind providers to follow appropriate billing guidelines. This includes ensuring that claims have the rendering service location address. Visit our Provider Bulletin Board (https://www.chpw.org/for-providers/bulletin-board/ or https://medicare.chpw.org/provider-center/bulletin-board/) or our Provider Orientation, Training, and Education page (https://www.chpw.org/for-providers/training/) for additional information related to billing.

Complex Behavioral Health Services

CHPW uses the SERI guide (Service Encounter Reporting Instructions) for complex behavioral health services billing requirements. The HCA will adopt additional rules for HIPAA compliance and update the SERI Guide accordingly. The guide includes CPT and HCPCS codes, modifiers, and other billing requirements, such as servicing/rendering NPI. The SERI guidelines are located at: https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri.

Provider Status

To ensure timely adjudication and payment of claims, CHPW recommends that providers verify their participation or contracting status with us 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. For credentialing status inquiries, please contact Provider.Credentialing@chpw.org.
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 and emailing it directly to Provider.Changes@CHPW.org.

Core Provider Agreement (CPA) IMC and BHSO
The Code of Federal Regulations (federal law) mandates that eligible providers who see Medicaid clients obtain a CPA with the HCA. The HCA must enroll eligible providers in its IMC program to pay those providers for covered services, supplies, and equipment rendered to eligible IMC and BHSO 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 CHPW must comply with the federal mandate. Please see https://www.chpw.org/resources/Providers/Core_Provider_Agreement_FAQ_-_Final_2019-02-05.pdf, Core Provider Agreement bulletin, for more information.

Consent Forms

Sterilization
Completed consent forms and a 30-day wait period after signature are required for payment of IMC claims for sterilization services. The Sterilization Consent forms (English and Spanish) are available on the Provider Forms and Tools page of our website, https://www.chpw.org/for-providers/documents-and-tools/, under the Care Management/Claims/Quality heading.

Hysterectomy
Completed consent forms (no wait period) with signatures are required for payment of IMC claims for hysterectomy services. Signature stamps are not accepted on consent forms. Completed and signed consent forms must be submitted with the claim. The Hysterectomy Consent and Patient Information Form is available on the Provider Forms and Tools page of our website, https://www.chpw.org/for-providers/documents-and-tools/, under the Care Management/Claims/Quality heading.
Please note:

- CHPW must have a consent form on file for a member who has a hysterectomy performed (the form can come with the surgeon’s claim, anesthesiologist, facility, etc.). Claims that do not have a consent form on file shall be denied.
- A Sterilization Consent form is not the correct form for hysterectomies. The Hysterectomy Consent and Patient Information Form is the correct form for hysterectomies.

**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 a member 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 HCA.
- If the newborn does not receive a separate client identifier from the HCA 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**

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

- 1500 Claim Form and Instructions (02-12), [https://www.chpw.org/resources/Forms_and_Tools/1500_claim_form_2012_02_508.pdf](https://www.chpw.org/resources/Forms_and_Tools/1500_claim_form_2012_02_508.pdf)
- Sample Remittance Advice, [https://www.chpw.org/resources/Forms_and_Tools/Sample_Remittance_Advice_2017_508.pdf](https://www.chpw.org/resources/Forms_and_Tools/Sample_Remittance_Advice_2017_508.pdf)
- Claims Supporting Documentation Cover Sheet, [https://www.chpw.org/resources/Forms_and_Tools/Supporting_Documentation_Cover_Sheet_508.pdf](https://www.chpw.org/resources/Forms_and_Tools/Supporting_Documentation_Cover_Sheet_508.pdf)
- Corrected Claim – Standard Cover Sheet, [https://www.chpw.org/resources/Forms_and_Tools/Corrected_Claims_Cover_Sheet_508.pdf](https://www.chpw.org/resources/Forms_and_Tools/Corrected_Claims_Cover_Sheet_508.pdf)
Corrected Claims
A corrected claim is one that was previously billed and processed (paid or denied) but needs to be reprocessed with corrected information (such as date of service, patient information, procedure codes, etc.). If a claim was previously processed and is not submitted as a corrected claim, it will be denied as a duplicate claim.

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 CLM05-03, 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:
2. Make sure to include the original claim number as indicated on the cover sheet.
3. Attach any necessary supporting documentation.
4. 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 claim(s) to our Customer Service department as that may delay receipt and claim(s) reprocessing.
Electronic Data Interchange (EDI) / Electronic Transactions / Electronic Claims Submission

Using electronic transactions has many benefits, including:

- More environmentally and financially friendly by reducing paper usage 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 the electronic transactions listed below. Providers may contact edi.support@chpw.org with questions relating to any of these transactions.

- 270: Eligibility, coverage, or benefit inquiry
- 271: Eligibility, coverage, or benefit response
- 276: Health care claim status inquiry
- 277: Health care information status response
- 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 and Benefits
To check member eligibility and benefit inquiry (270/271 transaction), you need to have a signed trading partner agreement with NTT Data. Please contact NTT Data at DL-Consumerism_Services@nttdata.com to set up connectivity. You can also check eligibility through the new CHPW HealthMAPS online provider portal at https://mychpw.chpw.org/en/provider. Please see the “HealthMAPS Provider Portal” section of this manual for more information.
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 utilizes Availity for our 837 transactions. Our Availity Payer ID is CHPWA. Once you are ready to send electronic claims, please register with Availity online at http://www.availity.com/ and click Get Started. You may also contact Availity Client Services by phone at 1-800-AVAILITY (282-4548).

Check Claim Processing Status
You can check claim processing status (276/277 transaction) if you are signed up with NTT Data. Please contact NTT Data at DL-Consumerism_Services@nttdata.com to enroll. You can also check claim processing status on a claim-by-claim basis through the CHPW HealthMAPS online provider portal at https://mychpw.chpw.org/en/provider. Please see the “HealthMAPS Provider Portal” section of this manual for more information.

When you check the processing status of a claim, please note that it may not have the final payment status (i.e. allowed, adjusted, denied, etc.) because claim adjudication may not have been completed.

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 Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARC).

Claim Issues
For claims issues, CHPW requests that all providers contact Customer Service first.

- IMC Customer Service, (800) 440-1561
- CHPW Medicare Advantage Customer Service, (800) 942-0247

The Claims Investigation Unit (CIU) gives you direct contact with CHPW Claims Analysts, once 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 transactions (Electronic Remittance Advices, or ERA)

CHPW uses Availity for our Electronic Remittance Advice (ERA), or 835, transactions. Availity discontinued its paper 835/ERA Enrollment Form in 2019. The new enrollment process is all electronic and does not require a fee to register or enroll.

You or your clearinghouse will need to enroll in ERA directly with Availity. Please contact Availity at Availity.com or call 1-800-AVAILITY (282-4548) to enroll in ERA.

If you have been receiving paper RAs and then sign up for 835s, be advised that CHPW will automatically discontinue your paper RAs once CHPW receives confirmation that you have been enrolled in ERA. Please contact EDI.Support@chpw.org if you prefer to continue receiving your paper RAs.

If you have questions about enrolling for 835 files or if you previously enrolled for 835s and would like to immediately stop receiving paper RAs, please contact EDI.Support@chpw.org.

If your 835 or RA is missing, please contact CHPW’s Customer Service department.

- IMC (Medicaid) Customer Service: (800) 440-1561
- Community Health Plan of Washington Medicare Advantage Customer Service: (800) 942-0247

Electronic Banking

You have two (2) ways to sign up for electronic payments via automated clearing house (ACH) transactions, often referred to as electronic funds transfer (EFT) or direct deposit:

1. Complete an ACH/EFT (Electronic Funds Transfer) Form online securely at: https://www.chpw.org/for-providers/documents-and-tools/; under EDI Support, use the ACH/EFT (Electronic Funds Transfer) Form (online) form.

2. Complete a form manually at https://www.chpw.org/for-providers/documents-and-tools/; under EDI Support, use the ACH/EFT (Electronic Funds Transfer) Form (PDF). The form can be submitted via email or regular mail.

To change bank information for ACH/EFT payments, please complete the ACH Enrollment Form and check the Change Enrollment box on the 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 when CHPW makes a deposit to your account. We will always 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 any questions about your deposit, email edi.support@chpw.org with your tax identification number and the EFT number so we can trace the payment.

Please contact edi.support@chpw.org to change the email address for the weekly EFT notification email.

**Claims Investigation Unit (CIU)**

CHPW offers providers a way to submit inquiries that may be complex or pertain to difficult topics via email to our Claims Investigation department at cs.claimsdistribution@chpw.org.

You may email inquiries related to the following topics:

- Fee schedule
- Anesthesia pricing
- Negative balance
- Re-occurring benefit configuration
- Interim billing
- Endoscopic pricing
- Multiple surgery pricing
- Ambulance pricing
- DRG pricing
- Re-admission
- Health Homes claims
• Overpayments and underpayments
• Applied Behavioral Analysis (ABA) claims
• IMC and BHSO claims
• RHC encounter payments

We request that all providers continue to call Customer Service for all other inquiries not listed above.
- CHPW IMC and BHSO Customer Service: 1 (800) 440-1561
- Medicare Customer Service: 1 (800) 942-0247
- Email customercare@chpw.org

You also have the option to check the status of your claims by visiting the CHPW HealthMAPS online provider portal at https://mychpw.chpw.org/en/provider. Please see the “HealthMAPS Provider Portal” section of this manual for more information.

**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
Email: cs.claimsdistribution@chpw.org

This helps ensure more efficient processing and faster response times for these issues. You may also view the Overpayment and Underpayment Recoveries section of your Provider Agreement or the Dispute Resolution section of your facility agreement for more information.
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
   Attention: Claims Investigative Unit (CIU)
   1111 Third Avenue, Suite 400
   Seattle, WA 98101
   Fax: (206) 521-8834
   Email: cs.claimsdistribution@chpw.org

Submit Refunds
Please submit checks for overpayment refunds to:
   CHPW
   PO Box 94751
   Seattle, WA 98124-4751

Timely Filing Requirements
CHPW maintains the following timely filing requirements for claim submissions:
   • CHPW must receive the original Medicare Advantage or IMC claim within one (1) year from date of service (DOS).
   • CHPW must receive Medicare Advantage corrected claims within one (1) year of the initial process date.
   • CHPW must receive IMC corrected claims within twenty-four (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.

Please consult your CHPW provider contract for information on timely filing of encounters.
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 regulatory standards:

<table>
<thead>
<tr>
<th>State</th>
<th>95% of clean claims within thirty (30) calendar days of receipt</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>95% of all claims within sixty (60) calendar days of receipt</td>
</tr>
<tr>
<td>Medicare</td>
<td>95% of clean claims within thirty (30) calendar days of receipt</td>
</tr>
<tr>
<td></td>
<td>100% of unclean claims within sixty (60) days</td>
</tr>
</tbody>
</table>

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 sixty (60) days advance notice, CHPW will implement 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 for Medicaid and paid and denied claims records for Medicare. 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 following resources 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/2019ASPFiles.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2019ASPFiles.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
  - SNF stays


**National Drug Codes (NDC)**

All MCOs are required to report in their encounter data the NDC of drugs provided in outpatient settings. Encounters with a missing or invalid NDC will be rejected. Please see the following CMS webpage for more information:

Billing for Administration of Drugs
When billing for the administration (injection) of a drug that you did not supply (dispense), please make sure to follow these guidelines to ensure appropriate billing.

- Bill the administration through the medical benefit (the provider who supplies the drug should bill the drug through the pharmacy benefit).
- Use the appropriate CPT code for the physical administration.
- Include the name of the drug in a claim line note of the administration line billed; do not include the HCPCS drug code or the NDC number.
- Do not bill for one cent (we previously had providers bill for one cent, $0.01, for informational purposes).

Including the NDC number when you are only administering the drug may cause a delay or error in processing the claim. In addition, submitting a HCPCS/NDC combination on any claim type (pharmacy and/or medical) results in calculated “drug units” on the encounter. This makes the encounter, or the line on the encounter, subject to federal rebates, which would constitute “double dipping” (double billing) for the cost of the drug.

Please see the Billing for Administration of Drugs bulletin on our website for more information at http://www.chpw.org/for-providers/bulletin-board/billing-for-administration-of-drugs.

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.
Please contact our Customer Service department if you have questions about EAPG pricing on claims:

- Phone: 1-800-440-1561 (TTY Relay: Dial 711)
- 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, all providers are required to submit both the National Provider Identifier (NPI) number and Taxonomy Code on all claims. Please visit 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) claim form.

Please see the NUCC’s Taxonomy Code Set Updates, http://www.nucc.org/, for more information.

**Telehealth Services (Telemedicine)**
CHPW reimburses providers for all billable services delivered via telemedicine. These services must meet the site and services criteria approved by the state for Medicaid services, which include physical and behavioral health services. In addition, these services must meet Original Medicare requirements for Medicare Advantage and SNP members. Please see these CMS resources for more information: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf or https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

Please see the SERI guide for information about Medicaid behavioral health services: https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri. Limitations apply 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.

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
- Renal dialysis centers, except an independent renal dialysis center
- Rural health clinics (RHC)
- Schools
- Skilled Nursing Facilities (SNF)

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 for payment. Both of these modifiers are acceptable to indicate synchronized telecommunication.

Effective January 1, 2017, a new point of service (POS) code 02 was 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 for IMC when billing POS 02. Please make certain to bill Telehealth services correctly in order to avoid claim payment delays. (For Medicare only, the GT modifier is no longer required effective January 1, 2018.)

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

Effective 01/01/2018 CHPW RHC’s have the option to opt in. The RHC is locked in for one year (per HCA). RHC’s that opt in will be paid their full encounter rate on encounter eligible claims. **Beginning January 1, 2020 HCA will reimburse MCOs for the T1015 via service-based enhancement (SBE) through ProviderOne**, thus eliminating the need to perform an annual reconciliation. The service-based enhancement will provide MCOs with reimbursement for T1015 paid amounts on RHC encounter eligible claims. SBEs will be generated after the paid claim with a T1015 is submitted to ProviderOne.

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](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 HCA.

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 HCA 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:

FQHC/RHC Program Manager Office of Rates Development
PO Box 45510
Olympia, WA 98504-5510
Phone: (360) 725-1961
Fax: (360) 586-7498
Email: FQHCRHC@hca.wa.gov

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. In some circumstances, the member could have dual CHPW coverage with the Medicare Advantage Special Needs Plan, 014, as primary and IMC plan as secondary. In such cases, CHPW pays as primary and IMC is the secondary payer.

To assure proper COB, claims must be submitted to CHPW with an Explanation of Benefits (EOB) 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 EOB. CHPW will then evaluate the claim for processing as the secondary payer. An EOB is not required for behavioral health services that are not covered by Medicare.

When Medicare or another governmental program of health care coverage is one of the plans, federal law determines which plan provides benefits first. IMC 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 COB 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 strives to be stewards of state and federal funding. As part of our due diligence to ensure
that claims are paid appropriately, we conduct post payment reviews.

Our goal in conducting PPR is to:
- Educate our provider community on appropriate billing and guidelines;
- Ensure we are paying according to our contracts; and
- Monitor for potential fraud, waste, and abuse (FWA)

Our PPR 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 request
that providers and facilities provide complete records timely in order to prevent any financial
implications.
Medical Records for Post Payment Review
CHPW prefers that medical record documentation be sent electronically via fax, CD, or thumb drive.

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 (https://www.chpw.org/for-providers/bulletin-board/ or https://medicare.chpw.org/provider-center/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:

- For Medicare Advantage Grievances and Appeals, on the Community Health Plan of Washington Medicare Advantage website: [https://medicare.chpw.org/member-center/member-rights/grievances-appeals/](https://medicare.chpw.org/member-center/member-rights/grievances-appeals/).

**Consent Documents**

Consent form for appeals:

- [https://www.chpw.org/resources/Forms_and_Tools/Member_Appeal_Consent_Form.pdf](https://www.chpw.org/resources/Forms_and_Tools/Member_Appeal_Consent_Form.pdf)
- Appeals Request Form: [http://chpw.org/resources/Appeal_Request_Cover.pdf](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, providers 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 Medicaid members, obtain a signed authorization form [https://www.chpw.org/resources/Forms_and_Tools/Member_Appeal_Consent_Form.pdf](https://www.chpw.org/resources/Forms_and_Tools/Member_Appeal_Consent_Form.pdf)
3. For Medicare members, obtain a signed *Appointment of Representative* form [https://medicare.chpw.org/wp-content/uploads/content/member_documents/Appointment_of_Representative_1.pdf](https://medicare.chpw.org/wp-content/uploads/content/member_documents/Appointment_of_Representative_1.pdf)
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 Members who receive only behavioral health benefits through this Contract and the companion non-Medicaid Contract.

Integrated Managed Care (AH-IMC): “Washington Apple Health – Integrated Managed Care (AH-IMC)” 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 they believes is incorrect. Non-participating provider appeals must be in writing and submitted within ninety (90) days from the date of the notice of the denial; or initial payment of clean claim for IMC members; or within sixty (60) days for Medicare members. Par provider appeals must be in writing and submitted within twenty-four (24) months from the date of the notice of denial or initial payment of a clean claim. Second level appeal requests will be reviewed if new information is provided to CHPW within sixty (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 supporting documentation pertinent to the reason for denial
- 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

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Providers may 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

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 PCP’s written statement of intent to refer a member to specialty care or ancillary services. A PCP is not required to obtain approval for referring a member to a participating provider or non-networked specialist. CHPW must review and provide a Plan Authorized Referral when a member needs to see a PCP outside of their assigned PCP or group. In addition, members in the Patient Review and Coordination (PRC) program require Plan Authorized Referrals from their PCP approving the care that member receives from other providers and specialists.

Prior Authorization
Prior Authorization 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 scheduled (planned) inpatient admissions, and certain predetermined services, medical pharmaceuticals, surgical, diagnostic, therapy 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. The list is updated at least annually at a minimum based on changes in standards of medical care, new technologies, or denial rates. No authorizations are required for treatment in an emergency room. Please see also the “Emergency Room Care/Emergency Medical Condition” section of this manual.
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 authorizations can be submitted online via the Jiva Portal: https://jiva.chpw.org

Additionally, requests for Medicare and IMC members can be faxed to (206) 652-7077.

Prior Authorization Request Forms:
Medical Prior Authorization Form:
- https://www.chpw.org/resources/Providers/Prior_Authorization/PA_Form.pdf

Mental Health Prior Authorization Form:
- https://www.chpw.org/resources/Providers/Prior_Authorization/Mental_Health_Service_Request_Form.pdf

Substance Use Disorder Prior Authorization Form:
- https://www.chpw.org/resources/Providers/Prior_Authorization/IMC_SUD_Service_Request_Form_1.pdf

Prior Authorization List and Utilization Guidelines
- http://www.chpw.org/for-providers/prior-authorization-and-medical-review/

In accordance with HCA guidelines, Neurodevelopmental Centers of Excellence (NDCOEs), as defined by the HCA and designated by the Washington State Department of Health (DOH), are exempt from prior authorization requirements for outreach, evaluation, diagnosis, treatment planning, and specialized therapy services provided to IMC Members under the age of twenty (20). CHPW will conduct regular PPR of NDCEO claims to ensure that services rendered by NDCOEs are medically necessary, and otherwise consistent with applicable state and federal guidelines.

Authorization Determination Timelines
CHPW strives to process authorization requests within Washington State and Federal contractual requirements for timeliness, and in accordance with our member’s health care needs. Periodic increases in request volume may affect turnaround times. CHPW strives to adhere to the following processing timelines:
- Medicaid: Standard prior authorization requests are processed within 5-14 calendar days. Clinically urgent requests are processed within 2-5 calendar days.
- Medicare: Standard prior authorization requests are processed within 14 calendar days. Clinically urgent requests are processed within 72 hours.
Requests are processed in the order received using clinical information submitted by the provider. Processing times for both standard and expedited requests 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
- Relevant medication history
- Other pertinent information to aid in decision making process

CHPW Utilization Management staff may request specific additional clinical information via fax or telephonically to complete the authorization 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 involved in the UM process, for denying coverage or care. UM decision making is based on appropriateness of care and service and existence of coverage. Any financial incentives for UM decision makers do not encourage decisions that result in underutilization.

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 IMC Customer Service Department at 1 (800) 440-1561, or the Medicare Customer Service Department at 1 (800) 942-0247.
Non-covered Services and Benefits for IMC Members

An IMC member and/or the member’s provider may request CHPW to pay for a non-covered health care service by submitting an exception to rule (ETR) request with supporting medical records. 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). Members and/or providers do not have a right to a fair hearing or appeal on ETR determinations. ETR is not applicable for EPSDT members.

An ETR request can be made after a service has been denied and must be made within ninety (90) days of the denial notification.

- ETR Request Forms are available online at http://chpw.org/for-providers/documents-and-tools

Early and Periodic Screening, Diagnostics, and Treatment Services (EPSDT)

EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for IMC members under the age of twenty-one (21). EPSDT rules require coverage for members under age twenty-one (21) when they are medically necessary, safe and effective, generally recognized as accepted medical practice, and not experimental or investigational. Services which are not-covered for adult IMC members are reviewed for medical necessity under EPSDT requirements for members under age twenty-one (21). If the service is medically necessary then it is approved, if not then it is denied for medical necessity and appeal rights are provided. ETR does not apply to EPSDT members.

Limitation Extension

An IMC member and/or the member’s provider may request CHPW extend coverage for additional services when available benefits are exhausted due to Medicaid benefit limits; this is called a limitation extension (LE). An LE request must be made when there is sufficient clinical evidence that continued treatment or services will result in continued improvement or that the member’s condition will worsen if the requested health care service is not extended. (WAC 182-501-0169)
CHPW will accept LE requests when the benefit limit will be exhausted within one (1) week.

- Limitation Extension Request Form:
  http://www.chpw.org/resources/Providers/Prior_Authorization/Limited_Extension_Request_Form_508.pdf

In accordance with HCA guidelines, NDCOEs, as defined by the HCA and designated by DOH, are exempt from annual limitations for outreach, evaluation, diagnosis, treatment planning, and specialized therapy services provided to IMC Members under the age of twenty (20). CHPW will conduct regular PPR of NDCEO claims to ensure that services rendered by NDCOEs are medically necessary, and otherwise consistent with applicable state and federal guidelines.

**Medicare Outpatient Observation Notice (MOON)**
Under the Notice Act, Hospitals and Critical Access Hospitals (CAH) must deliver a MOON to Medicare beneficiaries (including a Medicare Advantage (MA) Member) who receives observation services as an outpatient for more than twenty-four (24) hours:

**Inpatient Admission Notification**
Facilities must provide notification of inpatient admissions within twenty-four (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, as well as to facilitate discharges to an appropriate setting.

Member eligibility for inpatient services may be verified through One Health Port at www.onehealthport.com or through the CHPW Medical Management Portal at https://jiva.chpw.org/cms/ProviderPortal/Controller/providerLogin. For those organizations that do not have internet access, please contact Customer Service at 1 (800) 440-1561 (Toll Free). Benefit information may be viewed on our website for State Programs, or at https://medicare.chpw.org/ for Medicare Advantage Plans.
Inpatient Admission Documents
The *Inpatient Admission Notification Form* is available online at [http://chpw.org/providers/documents-and-tools](http://chpw.org/providers/documents-and-tools).

Inpatient Admission notifications for IMC 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 an 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 completed 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 inpatient admission and concurrent review process or by referral from someone on the member’s care team. The extent of the UM reviewer’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 (i.e. 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

Clinical Care Management Criteria
CHPW uses several resources to determine whether a specific intervention is medically necessary.
Criteria Used in Determining Authorization for Service

For IMC members, CHPW first reviews clinical criteria established by the Health Technology Assessment Program of the HCA (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 and/or CHPW's Clinical Coverage Criteria (CCC) are used.

Behavioral Health, for Substance Use Disorder or Mental Health determinations CHPW utilizes American Society of Addiction Medicine (ASAM), Level of Care Utilization System (LOCUS), and Child and Adolescent Level of Care Utilization System (CALOCUS) criteria to determine medical necessity.

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.

All Clinical Criteria are available online for review on our Prior Authorization webpage under the section “How CHPW Determines Prior Authorization”:

https://www.chpw.org/for-providers/prior-authorization-and-medical-review/

In addition, all criteria can be requested by contacting the Medicaid Customer Service team at 1 (800) 440-1561, or the Medicare Customer Service Team at 1 (800) 942-0247.
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 non-clinical staff in the following areas:

- Case Management
- Transitions of Care
- Community Linkages
- Health Home
- Population Health / Disease Management
- Patient Review and Coordination (PRC)

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.

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 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 is personalized to meet the needs of the member. Case Management involves the coordination of services to identify alternative options and to educate members about resources available to them. A Case Manager’s role can include, but is not limited to:

- Locating providers,
- Being a health advocate,
- A support in understanding benefits, identifying community resources, coordination of information and services with medical team and provided education materials and information.
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 and the member’s providers. Case Management may be an appropriate service for members with:

- Complex or chronic care needs
- Needs that are beyond the available clinic resources
- Multiple conditions that require coordination with several specialty providers

Members can be referred to Case Management by:

- Medical Management program referral
- Discharge Planner referral
- Member or caregiver referral
- Practitioner referral

For more information, or to make a referral to Case Management, call the CHPW IMC Customer Service team at 1 (800) 440-1561 (Toll Free), or the Medicare Customer Service Team at 1 (800) 942-0247 (Toll Free). You may also refer online by using the Case Management Referral Form at https://www.chpw.org/for-providers/documents-and-tools/.

For more information on Care Management, please see the Care Management section of the CHPW webpage at www.chpw.org.

**IMC 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 and Utilization Management staff will work with members directly, and/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 providers for mental health services
- Substance Use Disorder services
- Aging and Disability Services, including home and community-based services
- Skilled Nursing Facilities (SNFs) 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
Special Needs Plan (SNP)
Medicare and Medicaid/Dual eligible

Under the Medicare Modernization Act of 2003 (MMA), Congress created a new type of Medicare Advantage coordinated Care Plan focused on individuals with special needs. Special needs plans (SNPs) were allowed to target enrollment to one or more types of special needs individuals identified by Congress as: 1) institutionalized; 2) dually eligible (DE); and/or 3) individuals with severe or disabling chronic conditions. CHPW’s SNP plan is a Dually Eligible plan.

- SNPs must have a Model of Care. This is CHPW’s document delineating how it will deliver the specialized services and benefits to our SNP members.
- An initial and yearly comprehensive Health Risk Assessment (HRA) of the member is also required.
- The Case Manager must gather information, as available, from the member, the member’s caregivers and the member’s physical and behavioral health care team(s).
- The information is to be reviewed by an Interdisciplinary Care Team (ICT) that develops a Care Plan specifically tailored to each SNP member.
- Coordinated Care must be provided through transitions from Hospital to SNF to Home.
- To monitor the effectiveness and improve the Care Plan and outcomes to SNP members.

For more information, call the CHPW Washington Medicare Customer Service Team at 1 (800) 942-0247 or the Special Needs Plan Case Management Department 1-866-418-7005, Fax: 206-652-7088.

Transitions of Care (TOC) Programs
Transition of Care (TOC) coordination services is integral part of CHPW’s Care Management Program. The TOC program coordinates care and services as members transition between care settings. TOC services, when successful, reduce the fragmentation in the delivery of medical, behavioral, and social services. It can also enhance coordination among providers and community-based services to improve access and improve overall health care services to members. The ultimate goal is to reduce the utilization of unnecessary, emergency services and increase the utilization of preventative services.

CHPW’s TOC program promotes the safe and timely transition between care settings for our members with complex health and social service needs who are particularly vulnerable to breakdowns in care and thus most likely to readmit or seek emergency services. Care settings may include hospitals, mental health facilities, substance use treatment, SNFs, long-term care facilities, rehabilitation facilities, and correctional facilities. TOC services ensure that necessary
care, services, and supports are in place for the member once discharged or transitioning from one care setting to the next. Services offered by the TOC team include discharge planning, coordination of post-discharge care and services, medication consultations, and follow-up calls. CHPW’s TOC team engages members, families, and caregivers in the discharge process to ensure goals are realistic and attainable.

The TOC program will focus on four (4) initial categories of transition of care that are especially vulnerable to gaps in care:

- Post-facility discharge
- Correctional facility incarceration and/or release
- Difficult hospital discharge
- Behavioral Health Post-Facility discharges
- Difficult Behavioral Health discharges

The TOC program works in coordination with other CHPW departments including the Utilization Management, Case Management, and Community Linkages to ensure a team-based approach that coordinates care for members without duplication of effort.

**Community Linkages**

Social determinants of health (SDoH) are conditions in the environments in which people were born, live, learn, work, play, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The Community Linkages team addresses SDoH by creating and/or supporting sustainable, effective linkages between clinical and community setting for the benefit of our members.

Community Linkages coordinates care and links members to community-based resources and health care services, including behavioral health, oral health, and other specialty care. Community Linkages staff ensure that health care providers are connected, work together on an integrated service plan, and coordinate with involved community resource organizations engaged with the member to ensure the delivery of quality health care and social support services. Community Linkages staff include Housing Specialists, Wellness & Recovery Coordinator (certified peer), and regionally-based Community Health Workers.

Community Linkages may be an appropriate service for:

- Members with housing or transportation needs
- Members with food or caregiving needs
- Members with employment or education needs
- Members requiring short term care coordination

For more information, call the CHPW Community Linkages team at 1 (866) 418-7006 (Toll Free).
Population Health (Disease Management)

The Population Health (PH) Program (formerly Disease Management) identifies members with chronic conditions and engages the members in a dialogue that encourages a self-management approach to the member’s condition and strengthens the patient/provider therapeutic relationship. The PH Program provides members with current best practices and evidence-based educational materials; and utilizes Clinical Health Coaches to work with the members on achieving healthy, holistic goals.

CHPW identifies chronic care conditions that are relevant to and address the needs of its member population, such as diabetes, CHF, asthma, and COPD. The objectives of the PH Program are to:

- Improve member reported adherence to self-monitoring activities, medications, and provider visits;
- Reduce hospitalization rate and ER visits for members with PH 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 condition medication measures.

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

As of April 1, 2017, the Health Home program is available statewide for eligible individuals.

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.
How it Works
Members enrolled in the Health Home program work with a Care Coordinator who is specifically 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), while others work for local community-based organizations, including Area Agencies on Aging, behavioral health, and general social service providers.

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 ultimately 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 member’s needs. When members become eligible, they will receive a letter and will be contacted by a local Care Coordinator. Once eligible, members may opt in and out of the program at any time.

If you believe a CHPW member could benefit from the Health Home program, check for eligibility with the CHPW Customer Service Department.

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.
Questions
If you have questions about eligibility, call CHPW Customer Service at 1 (800) 440-1561 (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 Washington State Hospital Association (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 twenty (20) percent of patients in the U.S. are re-hospitalized within thirty (30) days of discharge, and many researchers believe that this percentage is even higher for Medicaid patients.

CHPW partners with WSHA and other organizations to support implementation of WSHA’s Care Transitions toolkit: http://wsha.wpengine.com/wp-content/uploads/WSHACareTransToolkit.pdf to reduce readmissions through effective transitional care. WSHA offers tools for both hospitals and PCPs, 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 and Medicare Members with medical, mental health, and substance abuse needs. The program focuses on treating common, mild to moderate mental health disorders in a primary care setting with the Collaborative Care Model (CoCM) of care, a model endorsed by the Healthcare Authority and Bree Collaborative. This model is evidence- and outcome-based and incorporates the use of a clinical registry and regular psychiatric case consultation to support high quality mental health screening and treatment to target. Primary care clinic-based mental health professionals called ‘behavioral health care managers’ support the PCP in care of the member by providing brief interventions and care coordination to members in consultation with a psychiatric provider. This team-based approach to behavioral health care helps to achieve improvements in whole-person health and well-being.
**Washington Partnership Access Line (PAL):**
The Partnership Access Line (PAL) supports primary care providers (doctors, nurse practitioners and physician assistants) with questions about mental health care such as diagnostic clarification, medication adjustment or treatment planning. Our child and adolescent psychiatrists are available to consult during business hours.

PAL has a master’s-level social worker available to assist with finding mental health resources for your patients. PAL is also partnered with [Washington’s Mental Health Referral Service for Children and Teens](https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/wa-pal/), where families can speak directly with a referral specialist.

The PAL consultation program is funded by Washington’s HCA and is available to providers caring for any patient in Washington, regardless of insurance type. Washington providers may call (866) 599-7257 (Toll Free), Monday–Friday, 8 a.m. to 5 p.m. Pacific Time, to be directly connected to a PAL child and adolescent psychiatrist. For more information, please visit the PAL website https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/wa-pal/.

**Patient Review and Coordination Program**
The Patient Review and Coordination Program (PRC) is for IMC members only. It is a HCA mandated CHPW program designed to control overutilization and inappropriate use of medical services by members. This program allows restriction of members to certain providers, including 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 (2) years.

**The Role of the PCP 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–CIV).

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 can be found online at 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. If the member goes to a non-assigned pharmacy for scheduled drugs (CII–CIV), 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: 1 (866) 901-1902 (Toll Free)

Members may self-refer to the PRC by calling the CHPW PRC staff: 1 (866) 907-1902 (Toll Free), Monday – Friday, 8 a.m. to 5 p.m. Voicemail may be left after hours.
PHARMACY

Medicare Opioid Overutilization Program (MOOP)
The Medicare Opioid Overutilization Program (MOOP) is for Medicare members only. It is a CMS mandated CHPW program designed to monitor members for opioid, benzodiazepine, or acetaminophen overutilization in the Medicare Part D program. If necessary, the program allows restriction of a specific drug, class of drug, and/or lock-in to certain providers, including PCPs and pharmacies.

The Role of the PCP 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
The MOOP Policy can be found online at http://chpw.org/for-providers/other-resources/policies
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 MOOP Staff at 1 (866) 907-1902 (Toll Free), Monday – Friday, 8 a.m. to 5 p.m. Voicemail may be left after hours.

Second Opinion Network
“Second Opinion Network (SON)” refers to an organization consisting of an agency recognized as experts in the field of child psychiatry (Seattle Children’s Hospital) contracted with the HCA to perform peer-to-peer medication reviews with health care providers when psychotropic medications or medication regimens for children under eighteen (18) years of age exceed the medications review thresholds established for the HCA Medicaid mental health benefit.
Medication Review Thresholds

- Medication age/dose limits
  - Alpha-agonists
  - ADHD medications
  - Antipsychotic medications
  - Other (i.e., duloxetine, citalopram, hypnotics, etc.)
- Duplication of ADHD medication
  - Products from different classes are duplicative with each other
- Duplication of antipsychotic medications
  - All products are duplicative with each other
- Duplication of antidepressant (second generation) medications
  - Products within the same class, or closely related classes, are duplicative with each other
- Polypharmacy
  - Five or more psychotropic products

SON Review Process

CHPW conducts reviews of pharmacy records of minors receiving psychotropic medications. Requests for chart notes are communicated to providers in circumstances that medication review thresholds are exceeded. Chart notes are sent to the HCA for review. Peer-to-peer medication reviews are scheduled and conducted between health care providers and child psychiatrists at Seattle Children’s Hospital and a comprehensive care plan is developed. Recommendations included in the care plan are forwarded to CHPW for documentation and implementation in the pharmacy claims adjudication system.

The HCA provides access to consultation with a child psychiatrist through the Partnership Access Line (PAL) which may replace the need for a SON Review. The Partnership Access Line (PAL) supports PCPs (doctors, nurse practitioners and physician assistants) with questions about mental health care such as diagnostic clarification, medication adjustment or treatment planning. Child and adolescent psychiatrists at Seattle Children’s Hospital are available to consult during business hours, Monday-Friday, 8am to 5pm at 1 866-599-7257.

Review Recommendations

SON reviews include both psychotropic medication and medication regimen dosing recommendations and non-medication recommendations, such as: ABA therapy, IEP, sleep therapy, parent management training, trauma-focused CBT, behavior management training, social skills for ADHD, wraparound team, etc.
Payment
Payment to the SON provider for required reviews are the responsibility of the HCA according to the provisions of HCA’s contract with the SON provider. CHPW is responsible for payment to the prescribing practitioner for time spent engaging in medication review process with the SON.

For more information
Visit the SON website at https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/

Visit the PAL website at https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/

Pharmacy Management
Drug Formulary and Medication Utilization IMC
The CHPW drug formulary is developed by a Pharmacy and Therapeutics Committee. For medications included in the IMC Preferred Drug List, formulary status and coverage criteria are developed and approved by the WA HCA Pharmacy and Therapeutics Committee before adoption by CHPW. All other medications’ formulary status and coverage criteria are developed and approved by the CHPW Pharmacy and Therapeutics Committee. The formulary is searchable on the website at http://chpw.org/for-members/pharmacy. For more information on the IMC Preferred Drug List, please visit: https://www.hca.wa.gov/billers-providers-partners/programs-and-services/apple-health-preferred-drug-list-pdl.

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.

Community Health Plan of Washington Medicare Advantage Drug Formulary
The Community Health Plan of Washington Medicare Advantage drug formulary is developed by the Express Scripts Pharmacy and Therapeutics Committee. The formulary is available on the CHPW Medicare Advantage website: https://medicare.chpw.org/member-center/member-resources/prescription-drug-coverage/.
For all CHPW 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 Express Scripts. All standard requests will be resolved by Express Scripts within 72 hours if all required information is provided; all urgent requests will be resolved in 24 hours if all required information is provided.

Note: ESI requires a CHPW Medicare Advantage beneficiary number to process requests. You may obtain a member number from CHPW Medicare Advantage Customer Service 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 Prescription Drug Coverage web page at https://medicare.chpw.org/member-center/member-resources/prescription-drug-coverage/.

**IMC Prior Authorization**

To request a prior authorization, step therapy, non-formulary, or quantity limit override, please call Express Scripts at 1 (844) 605-8168 (Toll Free), 24/7, 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 Express Scripts, providers may appeal the decision by sending a letter and clinical documentation, including the date and reason for the denial given by Express Scripts, to:

Community Health Plan of Washington
Attn: Appeals Department
1111 Third Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 613-8983 (urgent)
Fax: (206) 613-8984 (standard)

Expedited appeals are reserved for emergency situations only; call 1 (800) 440-1561.
Community Health Plan of Washington Medicare Advantage Prior Authorization
To request a prior authorization, step therapy, non-formulary, or quantity limit override, please call Express Scripts at 1-800-605-8168 (Toll Free), 24/7, 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 Express Scripts, providers may appeal the decision by sending a letter and clinical documentation, including the date and reason for the denial given by Express Scripts, to:
Community Health Plan of Washington
Attn: Community Health Plan of Washington Medicare Advantage Appeals
1111 Third Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 613-8983 (urgent)
Fax: (206) 613-8984 (standard)

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

Pharmacy Benefit Exclusion IMC
Certain medications are benefit exclusions and are not covered
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
- Drugs both prescription and over the counter (OTC) as specified per Washington State HCA
- Drugs from a manufacturer without a Federal Rebate Agreement
Community Health Plan of Washington 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.
- Drugs from a manufacturer without a Federal Rebate Agreement
- Non-FDA approved drug products

Quality Improvement Program (QIP)

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 (IMC), 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.

**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, network adequacy as well as integrated managed care. 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/).