CHPW 2020 Provider Orientation

A comprehensive Provider and Staff Orientation Program for new and established providers and staff

Upon completing the Orientation Program, click on the hyperlink at the end of this program to submit your Attestation.
CHPW Provider Orientation

- About CHPW
- Lines of Business
- Changes to Apple Health – Integrated Managed Care (IMC)
- Community Health Plan of Washington Medicare Advantage
- Provider Rights and Responsibilities, Credentialing, Provider Data
- Provider Directory
- Member Enrollment and PCP Assignment
- Medicaid Programs and Services
- Claims and Billing
- Appeals
- CHPW Health Services
- Pharmacy Management
- Provider Training and Education
- Patient Rights and Advance Directives
- CHPW Online Portals & Resources
- Attestation
CHPW is a Washington State Based Health Plan

For 25 years and counting, we’ve provided access to quality Medicaid and Medicare coverage to Washington’s residents in their own communities. We were founded in 1992 by Washington’s community health centers.

CHPW is the only not-for-profit plan providing managed care to Washington’s Apple Health members. CHPW invests 100% of its profits back into the Health Centers, helping them provide better care to everyone who walks in the door.

CHPW Mission

Our mission is 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. We work for patients, and we work to help providers better serve those patients.

https://www.chpw.org/about-us/who-we-are/
Apple Health – Integrated Managed Care (IMC), CHPW provides coverage to over 240,000 individuals and families.

In Apple Health Integrated Managed Care (IMC), physical health, mental health, and substance use disorder treatment are coordinated through one managed care plan.

https://www.chpw.org/

Community Health Plan of Washington Medicare Advantage (MA) and Special Needs (SNP) Plans

Our affordable Medicare Advantage HMO plans provide members valuable extended coverage and services.

https://medicare.chpw.org/
In 2020 Apple Health IMC has moved to whole-person care statewide.

Apple Health IMC now coordinates physical health, mental health, and substance use disorder treatment service under one health plan.

In 2020, CHPW is pleased to serve members in the following counties:

**King Region**: King

**North Sound Region**: Snohomish, Skagit, Whatcom, San Juan, Island

**Southwest Region**: Clark, Klickitat, Skamania

**Greater Columbia Region**: Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima

**Spokane Region**: Adams, Ferry, Lincoln, Pend Oreille, Spokane, Stevens

If you have questions about coverage, call Customer Service at 1-800-440-1561, Monday through Friday, 8 am to 5 pm, or email CustomerCare@chpw.org.
In 2020, CHPW will provide Integrated Managed Care services to the following counties:

- Whatcom
- Skagit
- Snohomish
- King
- Kittitas
- Yakima
- Benton
- Walla Walla
- Franklin
- Whitman
- Adams
- Lincoln
- Spokane
- Stevens
- Pend Oreille
- Chelan
- Okanogan
- Ferry
- Grant
- Douglas
- Pierce
- Thurston
- Mason
- Grays Harbor
- Jefferson
- Clallam
- San Juan
- Island
- Lewis
- Cowlitz
- Wahkiakum
- Pacific

*CHPW already serves Clark & Skamania Counties

**Legend:**
- Integrated Managed Care
- Not Served by CHPW
### Managed Care Organization (MCO) now cover these MH & SUD Services for Apple Health

<table>
<thead>
<tr>
<th>Contract</th>
<th>Services</th>
</tr>
</thead>
</table>
| MCO Apple Health Contract – present & future                            | • Primary Care  
• Specialty Care  
• Hospital  
• Pharmacy (including BH Rx) |
| MCO Integrated Managed Care Contract (services added with IMC implementation) | MH  
• Inpatient  
• E&T  
• Residential MH  
• High intensity treatment  
• Day support  
• Group Treatment Services  
• Family Treatment  
• Intake  
• Medication Management  
• Medication Monitoring  
• Rehab Case Management  
• Community Psych Services  
• Peer Support  
• Therapeutic Psychoeducation  
• WISe  
• PACT  

<table>
<thead>
<tr>
<th></th>
<th>SUD</th>
</tr>
</thead>
</table>
|                                           | • Assessment  
• Detox  
• Outpatient  
• Outpatient- Group  
• Opiate Sub Treatment  
• Residential |
| Behavioral Health-Administrative Services Organization (BH-ASO) | • Crisis Services  
• BH Services for non-Medicaid  
• Mental Health Ombudsman  
• Federal Block Grants |
Changes for 2020 CHPW Medicare Advantage Plan

• 2020 Service Area Map
• Medicare Advantage Member ID Card example
• Benefit Changes for Alternative Medicine and Podiatry
• Zero Cost Services ($0 - Co-Pays) for non-SNP CHPW MA members of certain chronic disease
• Zero Cost Items for some CHPW MA members with Chronic Conditions
• Medicare Dual Eligible
• Additional nutritional support for members post-discharge
• Vision Benefits

2020 Medicare Advantage Plans
Medicare ID Card Example

Medicare ID Card
Plan 010

Refer to Provider Manual for other MA plan ID Card examples
<table>
<thead>
<tr>
<th>Benefit</th>
<th>2019 Benefit</th>
<th>2020 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative Medicine</td>
<td>006, 008, 014 (SNP) $250/year for acupuncture and naturopathy combined</td>
<td>All plans 12 visits/year ($0 copay) for acupuncture, naturopathy, non-Medicare chiropractic combined</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Medicare Podiatry</td>
<td>4 visits/year regardless of diagnosis</td>
<td>8 additional visits/year for diabetic patients only</td>
</tr>
</tbody>
</table>
New in 2020 MA Non-SNP “Zero Cost Services” Reduced for members.

For members with the following diagnosis, cost share will be $0. Member must present a second “Zero Cost Services” ID Card at time of visit to receive this benefit.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Reduced Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>• PCP office visit</td>
</tr>
<tr>
<td></td>
<td>• Endocrinology office visit</td>
</tr>
<tr>
<td></td>
<td>• Retinal exam (Endocrinology or Ophthalmology)</td>
</tr>
<tr>
<td></td>
<td>• Medicare-covered Podiatry</td>
</tr>
<tr>
<td>COPD</td>
<td>• PCP office visit</td>
</tr>
<tr>
<td></td>
<td>• Pulmonology office visit</td>
</tr>
<tr>
<td></td>
<td>• Oxygen DME</td>
</tr>
<tr>
<td>CHF</td>
<td>• PCP office visit</td>
</tr>
<tr>
<td></td>
<td>• Cardiology office visit</td>
</tr>
</tbody>
</table>
Members can receive at no-cost these items for the following diagnosis and are participating in CHPW Care Management.

<table>
<thead>
<tr>
<th>No-cost Item</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale</td>
<td>Congestive Heart Failure</td>
</tr>
<tr>
<td>Blood Pressure Cuff</td>
<td>Refractory Hypertension</td>
</tr>
<tr>
<td>Personal Emergency Response System (PERS)</td>
<td>Frailty</td>
</tr>
</tbody>
</table>
Special Needs Plan (SNP)

- Dual-eligible beneficiaries refers to those qualifying for both Medicare and Medicaid benefits.
- Medicare is the primary payer for most services, but Medicaid covers benefits not offered by Medicare.
- Dual eligible Special Needs Plans (SNP) are a special Medicare Advantage plan that enrolls only dual-eligible’s.
- SNP provides beneficiaries with more intensive coordination of care and services than those offered by traditional Medicare and Medicare Advantage plans.
- Medicaid covers their Medicare premiums or cost-sharing, or both.

When a member presents to your clinic or hospital with a CHPW Medicare Advantage ID card with a **Group 014** plan type, the member should be registered in your billing system as follows:

**Community Health Plan of Washington Medicare Advantage™ as primary, Medicaid (DSHS FFS) as secondary**
### Special Needs Plan (SNP) Benefit Changes

<table>
<thead>
<tr>
<th>Benefit</th>
<th>2019 Benefit</th>
<th>2020 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTC</td>
<td>$50/quarter</td>
<td>$250/quarter</td>
</tr>
<tr>
<td>Non-Emergency Transportation</td>
<td>24 one-way trips/year</td>
<td>50 one-way trips/year</td>
</tr>
<tr>
<td>Dental</td>
<td>$1,800/year</td>
<td>$2,500/year (No limit for preventive)</td>
</tr>
<tr>
<td>Vision Hardware</td>
<td>$130/year</td>
<td>$400/two years</td>
</tr>
</tbody>
</table>

For more detailed information about Medicare Advantage benefits, please call the Customer Service team at 1 (800) 942-0247
Meals Post-Discharge - Transitions of Care (TOC)
Care Management Team will coordinate as part of the Discharge Planning Process

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 meals/day for 14 days</td>
</tr>
<tr>
<td>Upon inpatient discharge from hospital or SNF</td>
</tr>
<tr>
<td>Up to 6 occurrences/year</td>
</tr>
</tbody>
</table>

For more detailed information about Medicare Advantage benefits, please call the Customer Service team at 1 (800) 942-0247
VISION BENEFITS – VSP Choice Network

Community Health Plan of Washington™ Medicare Advantage vision benefits are administered through VISION SERVICE PLAN (VSP)

- Claims processing
- Quality
- Credentialing
- OON provider services
- Data/reporting
- Regulatory compliance
Provider Responsibilities

- Appointment Availability & Wait Times
- Credentialing
- HCA Core Provider Agreement
- Provider Rights & Responsibilities
- Early Periodic Screening Diagnosis and Treatment (EPSDT)
- Provider Data
Providers must meet the following appointment access standards:

**Primary Care, OB/GYN**
- Schedule routine or preventive visits within 30 calendar days.
- Schedule an urgent visit within 24 hours.
- Schedule transitional care visit within 7 calendar days after discharge from inpatient/institutional care facility.
- Schedule non-urgent, symptomatic care appointments within 10 calendar days.

**Pediatric Primary Care**
- Life Threatening Emergency immediately
- Provide non-life threatening emergency care within 6 hours.
- Schedule an urgent care visit within 24 hours.
- Schedule transitional care visit within 7 calendar days after discharge from inpatient/institutional care facility.
- Schedule a routine office visit within 10 business days of request.

**Behavioral & Mental Health**
- Schedule an urgent care visit within 24 hours.
- Non-Urgent within 1 month of referral or as clinically indicated.
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.
• Provider is credentialed according to NCQA, CMS and State requirements and CHPW credentialing policies and procedures.

• CHPW accepts the Washington Practitioner Application (WPA) and participates in OneHealthPort / ProviderSource.

• 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.

• CHPW will notify you when credentialing is completed.

• CHPW will not back date credentialing.

• Re-credentialing is done on a 3-year schedule, notice will be sent 5 months in advance.

  **Standard Credentialing Groups** should send their credentialing inquiries to:

  Provider.Credentialing@chpw.org

  **Delegated Credentialing Groups** should send their rosters and credentialing inquiries to:

  DelegatedCredentialing@chpw.org
CHPW is required to ensure that all contracted providers either have a signed Core Provider Agreement (CPA) with the HCA, or enroll as a ‘non-billing’ provider (if he/she does not wish to serve fee for service Medicaid clients) but **each provider must have an active NPI number with the HCA to bill independently.**

- 42 CFR 438.602(b) will require all MCO network providers to be enrolled by 1/1/2018
- Both Organizations and individuals NPI’s need to be registered
- Requirements and Instructions on enrollment can be found on HCA’s website: [www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-provider](http://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-provider)

Lack of compliance with this HCA requirement could impact claims payment so please ensure you are properly registered and obtain the ProviderOne ID!
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.
Provider Rights and Responsibilities

**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).
CHPW Provider Responsibilities (continued):

• 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
Early Periodic Screening Diagnosis and Treatment (EPSDT) services

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>1&lt;sup&gt;st&lt;/sup&gt; Screening</td>
<td>Birth to six weeks</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; Screening</td>
<td>Two to three months</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt; Screening</td>
<td>Four to five months</td>
</tr>
<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt; Screening</td>
<td>Six to seven months</td>
</tr>
<tr>
<td>5&lt;sup&gt;th&lt;/sup&gt; 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)
• It is important that the provider updates CHPW with any provider changes to allow CHPW to update all systems, notify members.
• Incorrect Provider Data can cause claim payment delays
• The accuracy of the Online Provider Directory that members use to find in-network providers is also very dependent on receiving timely provider data.
• Provider may request an extract of provider roster from our system at the TIN level.
• Please submit Provider Data updates by completing the Provider Add Change Form (PACT) to provider.changes@chpw.org (form can be accessed at www.chpw.org)
• Submit Provider Rosters monthly to Provider Data via email to provider.changes@chpw.org
All CHPW providers must give notice to CHPW at least 60 days in advance of any provider changes including, but not limited to:

- Tax identification – Updated
- NPI number (individual and/or group)
- Billing (vendor) address, office, and fax phone numbers
- Clinic Contact Information (name, phone number, fax, and email)—i.e., Credentialing Coordinator, Billing Manager, Clinic Manager
- Provider additions (include Provider effective date)
- Provider terminations (include Provider termination date)
- Clinic/facility location additions/changes, include effective and termination dates
- Open/Closed panel status for new members
- Providers may submit their termination notice to Provider.Changes@chpw.org
Search for a Provider Online

Use our Find a Doctor tool to search for health care providers. Click the button and enter your zip code, city, or county on the next page. Then, scroll through the results to find providers near you.

**FIND A DOCTOR  BUSCAR UN MÉDICO**

Providers and Locations

You can search for a variety of health care providers: primary care doctors, specialists, mental health or substance use disorder treatment providers. All providers in our directories accept Community Health Plan of Washington so you can find care close to home.

As a member of Community Health Plan of Washington, you must choose an in-network Primary Care Provider (PCP) to get your medical care. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the service area), out-of-area dialysis services, and cases in which Community Health Plan of Washington authorizes the use of out-of-network providers.
Member
Enrollment And
PCP Assignment

• Plan Selection
• Auto Assignment Process
• Clinic & Plan Change Form
• Newborns
• Verify Eligibility
• FAQ
• Retro Enrollment
Enrollees have the opportunity to select their Plan and Clinic/PCP during the initial enrollment application on WA Healthplanfinder.

If the enrollee wishes to apply any changes to their Plan selection after they made the selection on the WA Healthplanfinder, member can do so through the Healthplanfinder, Provider One portals, or through CHPW by contacting customer service or going to the online form to request.

To Make PCP/Clinic changes a member can reach out directly to CHPW online or call CHPW Customer Service number 1-800-440-1561.
Auto-Assignment Process

The initial “auto-assignment” process happens at the state. If the member hasn’t indicated which plan they prefer, the state auto-assigns them a plan based on network adequacy.
**Online Clinic Selection**

[https://www.chpw.org/resources/Providers/Clinic-PCP-Selection_Form.pdf](https://www.chpw.org/resources/Providers/Clinic-PCP-Selection_Form.pdf)

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### Health Coverage Eligibility and Plan Change Form

Submit by Fax to Community Health Plan of Washington: (206) 632-7087

<table>
<thead>
<tr>
<th>Clinic Name</th>
<th>Physician Name</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

**Please choose one:**

1. I want to APPLY for free or low cost health care coverage.

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>Zip Code</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

*All information we may call you.*

2. I want to CHANGE our current health plan to Community Health Plan of Washington.

<table>
<thead>
<tr>
<th>Provider One ID</th>
<th>Name</th>
<th>Date of Birth</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Zip Code</th>
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</table>

For more information, call Community Health Plan of Washington at 1-800-440-1561 (TTY: 1-800-440-1561) Monday through Friday, 8 a.m. – 5 p.m.
Newborns whose mothers are enrollees on the date of birth are deemed enrollees and under the same plan as the mother as follows:

- Retrospectively for the month(s) in which the first twenty-one (21) days of life occur and prospectively, beginning the first of the month after the newborn is reported to the Health Care Authority.
- If the newborn does not receive a separate client identifier from the Health Care Authority the newborn enrollment will be only available through the end of the month in which the first twenty-one (21) days of life occur.
- If the mother's enrollment is ended before the newborn receives a separate client identifier from the Health Care Authority, the newborn's enrollment shall end the last day of the month in which the twenty first (21st) day of life occurs or when the mother's enrollment ends, whichever is sooner.
Verifying member eligibility is very important to insure claim payment.

**Apple Health members can change Managed Care Organization (MCO) Plans Monthly**

To verify member eligibility, please access the ProviderOne Portal

ProviderOne – Verifying Client Eligibility Instructions (user manual)

CHPW Members are assigned to a Primary Care Provider (PCP)

If a CHPW member is assigned to a PCP clinic outside of your organization, can the member be seen without a Plan Authorized Referral?

- **No**, if the member is assigned to a clinic outside of your organization, a Plan authorized referral **would be required** (not having a PCP to PCP referral may cause claim to deny).

If a CHPW member is assigned to a PCP clinic in your organization, are they able to see any primary care provider in your group?

- **Yes**, Note: *The rendering doctor/provider must be credentialed and issued an effective date by CHPW.*
How will Providers know that a member has been enrolled retroactively?
Providers are responsible to access ProviderOne to determine retroactive eligibility.

Authorizations & Inpatient (IP) Notifications
Providers must submit a request for an Authorization or IP Notification within 90- days from the date the member was retroactively enrolled with CHPW.

Approval will be based on medical necessity.
Inpatient notifications will apply even if the member has been discharged from the hospital.
Submission of clinical information with the inpatient notification will assist in speeding up the concurrent review process.
Medicaid Programs and Services

- HCA Pregnancy /First Steps Program
- Partnership Access Line (PAL)
- Partnership Access Line (PAL) for Moms
- Psychiatry Consultation Line (PCL)
- Washington Recovery Help Line
**First Steps** helps Medicaid-eligible, pregnant, or up to 60-days postpartum women and their infants get needed health-related services.

**Medical Services:** Full medical coverage, prenatal care, delivery, post-pregnancy follow-up, and family planning with Apple Health.

**Maternity Support Services:** Preventive individual and group health-related services as early in pregnancy as possible.

**Infant Case Management:** Help learning about and getting needed medical, social, educational, and other support services.

**Childbirth Education:** Group childbirth and newborn care education generally provided during the third trimester of pregnancy.
What is the Washington Partnership Access Line?

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, where families can speak directly with a referral specialist.

The PAL program is funded by Washington's Health Care Authority and is available to providers caring for any patient in Washington, regardless of insurance type. The phone consultation is covered by HIPAA, section 45 CFR 164.506; no additional release of patient information is required to consult by phone.

- Meet the team.

Washington providers: Call 866-599-7257 Monday–Friday, 8 a.m. to 5 p.m. Pacific time, to be directly connected to a PAL child and adolescent psychiatrist.

paladmin@seattlechildrens.org
http://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/
**UW Partnership Access Line for Moms** (PAL for Moms) is a free telephone consultation service for health care providers caring for patients with mental health problems who are pregnant, postpartum, or planning pregnancy. Any health care provider in Washington State can receive consultation, recommendations, and referrals to community resources from a UW psychiatrist with expertise in perinatal mental health.

Psychiatrists will provide consultation on any mental health-related question for patients who are pregnant, in the first year postpartum, who are planning pregnancy, or who have pregnancy-related complications (e.g. pregnancy loss, infertility). Topics may include depression, anxiety, or other psychiatric disorders; adjustment to pregnancy loss, complications, or difficult life events; risks of psychiatric medications; non-medication treatments; and consulting about women on psychotropic medications who are wanting to or thinking about getting pregnant.

Our perinatal psychiatrists are also available to help any practice thinking about instituting routine screening for depression. We can come to a clinic and provide a broad overview of best practices for depression screening and follow-up in the perinatal period.

The phone line **877-725-4666 (PAL4MOM)**, is staffed weekdays from 9:00 AM - 5:00 PM Pacific Time. Providers can call at any time and receive a call back within one working day. You can also e-mail us with any questions or to set up a consultation at **ppcl@uw.edu**
The UW Psychiatry Consultation Line (PCL) helps eligible providers who are seeking advice regarding adult patients (18+) with mental health and/or substance abuse disorders. The program is fast, free, and connects community providers to psychiatrists at the University of Washington. See the information below and visit our FAQ page to learn more.

How does PCL work?
Providers call 877-WA-PSYCH (877-927-7924) and after a short intake with a UW health navigator, are connected to a UW psychiatrist. At the conclusion of the conversation, the UW psychiatrist will send a brief written documentation of the recommendations to the caller via email.

Who is eligible to call?
Prescribing health care providers in Washington State from:

- primary care clinics
- community hospitals
- county and municipal correctional facilities

What PCL psychiatrists CANNOT do:

- speak directly to patients
- review written records
- manage psychiatric emergencies or satisfy Single Bed Certification requirements

When are PCL psychiatrists available?
The consultation line (877-927-7924) is open 8 AM - 5 PM, Monday through Friday (closed on federal and UW holidays), but providers can call at any time. If calling outside of business hours, providers can leave a message which will be returned within one working day.

Questions? Email PCLWA@uw.edu
Behavioral Health is essential to health. Prevention is effective, treatment works, and people recover. If you have a patient who may be in need of Behavioral Health services, please note the resources below and share with your patients.

The WA Recovery Help Line, a service of Crisis Clinic, is a free 24-hour crisis intervention and referral line for those struggling with issues related to mental health, substance abuse, and problem gambling. Professionally trained volunteers and staff provide confidential support and referrals to detox, treatment, and recovery support groups.

https://www.warecoveryhelpline.org/

For Immediate Help, your patients could call the Washington Recovery Help Line at 1-866-789-1511

For more information about the Crisis Clinic, go to: https://www.crisisclinic.org
Claims and Billing

• Timely Filing
• Claim Submission
• Fee Schedule/Rate Updates
• Encounter Data
• Corrected Claims
• Electronic Transactions
• Rejected versus Denied
• Claims Issues – Where to send
• Coordination of Benefits (COB)
• Post Payment Review (PPR)
• Member Balance Billing
Timely Filing
Requirements

• CHPW must receive the original Medicare Advantage or Washington Apple Health IMC claim within 365 days from date of service (DOS).

• CHPW must receive Medicare Advantage corrected claims within one year of the initial process date.

• CHPW must receive Washington Apple Health corrected claims within 24 months of DOS.

• CHPW is secondary to other insurance. We must receive the claim with the primary payer’s Explanation of Benefits (EOB) within 24 months from the DOS. CHPW cannot process the claim if the primary payer denied for timely filing.
Send claims to:

- Electronic Claim - EDI 837 Transaction
  Availity Payor ID: CHPWA

- Paper Claim – Send to:
  CHPW Claims,
  PO Box 269002, Plano, TX 75026-9002

CMS-1500 Professional Claim Form
UB-04 for Institutional Claims Form
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) Claims: In Loop 2300 (Claim Information), segment CLM05-3, use Claim Frequency Type Code “7” for “Replacement.” The corrected claim will process as a replacement claim and reverse the original claim on file.

837I (Institutional) Claims: In Loop 2300 (Claim Information), segment CLM05-3, use Claim Frequency Type Code “7” for “Replacement.” The corrected claim will process as a replacement claim and reverse the original claim on file.

HealthMAPS Portal

New and corrected claims can be submitted through the HealthMAPS Portal.
How to Submit Paper Corrected Claims

Please complete this Corrected Claim – Standard Cover Sheet and attach your corrected claim form with your changes. To avoid a denial as a duplicate claim, include the claim indicator as follows:

- **CMS 1500 (Professional Claim Form):** Submit code 7 in box 22.
- **UB-04 (Facility Claim Form):** Submit Type of Bill ending in 7 in field 4 (Type of Bill).

Mail your completed cover sheet, corrected claim, and supporting documentation to:

CHP Claims
PO Box 269002
Plano, TX 75026-9002

To avoid delays in processing your corrected claims, please do not send corrected claims to our Customer Service department.

(Corrected Claims can also be submitted online through the [HealthMAPS Portal](#))
CHPW supports the following Electronic Transactions:

- **270**: Eligibility, coverage or benefit inquiry
- **271**: Eligibility, coverage or benefit response
- **276**: Health care claim status report
- **277**: Health care information status response
- **834**: Benefit enrollment and maintenance
- **835**: Health care claim payment advice
- **837**: Health care claim

To enroll in any of the electronic transactions that we support, please email:

EDI.Support@chpw.org

**ACH/EFT payments**: Automated clearing house (ACH) payments are electronic payments often referred to as direct deposit or electronic funds transfer (EFT). To register, go to www.chpw.org EDI Support under the Provider Tab, Forms and Tools, EDI Support.
Rejected versus Denied Claim

**Rejected**
Claim does not enter the adjudication system due to missing or incorrect information. No claim number will be generated.

If claim is rejected, CHPW will send a letter explaining the reason for the rejection, please correct the claim and resubmit. Please contact Customer Service if you need assistance.

**Denied**
Claim does enter the adjudication process but is denied for payment. See reason code on EOB for explanation.

Most common reasons for rejection are:
- Missing Taxonomy Code
- Provider not in CHPW System
- NPI is missing or does not match in CHPW System
We request that all providers call Customer Service first for Claim Issues

• CHPW Apple Health (Medicaid) Customer Service, (800) 440-1561

• Community Health Plan of Washington Medicare Advantage™ Customer Service, (800) 942-0247

• The Claims Investigation Unit (CIU) gives you direct contact with CHPW Claims Analysts, only after attempts to resolve issues through Customer Service have been exhausted.
The Claims Investigation Unit (CIU) gives you direct contact with CHPW Claims Analysts, only after attempts to resolve issues through Customer Service have been exhausted.

Below are examples of items for the types of inquiries you can submit via email to the CIU - cs.claimsdistribution@chpw.org

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

- Fee schedule issues
- Anesthesia pricing issues
- Negative balance issues
- Re-occurring benefit config issues
- Interim billing issues
- Endoscopic pricing issues
- Multiple surgery pricing issues
- Ambulance pricing issues
- DRG pricing issues
- Re-admission issues
- Health Home claims questions
- Applied behavioral analysis (ABA) claims
- Post Payment Review
- ICD-10 billing issues
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.

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

CHPW will not reimburse a provider for any amount greater than the amount provided for at the time of service. If a provider has received payment from another carrier or resource that has primary payment responsibility under coordination of benefits rules, and that payment is equal to or greater than the rates for services rendered, the provider may not seek additional reimbursement from CHPW.

For Medicare Advantage Plans, CHPW follows Medicare as Secondary Payer rules.
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.

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.

For more information and resources, please reference the CHPW Provider Manual, under the “Encounter Date” section.
Our goal in conducting post payment review is to:

• Be stewards of state and federal funding and as part of our due diligence to ensure that claims are paid appropriately
• Educate our provider community on appropriate billing and guidelines
• Ensure we are paying according to our contracts
• Monitor for fraud, waste, and abuse

In order to conduct a thorough review we will request copies of medical records.

• When you receive a PPR request for records, please respond within the time allotted.
• Failure to respond will result in payment being recouped
• If you disagree with findings, please contact the CIU at cs.claimsdistribution@chpw.org
• Providers are prohibited from billing a patient for the difference between Apple Health or Medicare reimbursement and the providers billed charges.

• Balance billing is not permitted unless the Provider and Member fully complete and sign the “HCA 13-879 Form – Agreement to Pay for Healthcare Services”

• Services must be rendered within 90 days of signing the HCA 13-879 Form, otherwise a new form must be completed and signed.

• For members with limited English proficiency, the agreement must be the version translated in the client's primary language and interpreted if necessary. If the agreement is translated, the interpreter must also sign it.

• All other requirements for HCA 13-879 apply, as outlined in “Billing a Client” WAC 182-502-0160
The provider is responsible for:

• Verifying whether the client is eligible to receive medical assistance services on the date the services are provided;

• Verifying the members eligibility with the Medicaid Managed Care Organization (MCO);

• Knowing the limitations of the services within the scope of the eligible client's medical program (see WAC 182-501-0050 and 182-501-0065);

• Informing the client of those limitations;

• Exhausting all applicable Medicaid agency or agency-contracted MCO processes necessary to obtain authorization for requested service(s);

• Ensuring the translation or interpretation is provided to clients with limited English proficiency (LEP) who agree to be billed for services in accordance with this section;

• Retain all documentation which demonstrates compliance.
• Medicaid Member Appeals
• Medicare Member Appeals
• Medicare Part D Drug Coverage Determination
• Provider Appeals
• Provider Appeal Timelines
• Medicare Non-Par Provider Appeals
Medicaid Member Appeal Process

An appeal is when you want us to reconsider a decision we have made about what benefits are covered under your plan or what we will pay.

Below are the steps in the appeal process:

• Enrollees have 180 calendar days from the CHPW denial letter to file an appeal.
• Enrollee may chose someone, including an attorney (at the members expense) or provider, to represent them.
• Enrollee must complete and sign a consent form if they choose a representative to appeal on their behalf, or if they initiate their appeal verbally.

Examples when an appeal may be filed by an enrollee, a representative, or a provider:

• Plan will not approve payment for care you believe should be covered
• Plan reduced or stopped payment for the medical service
• Plan ended the approval for service
• Plan was unable to provide access to specific services within a timely manner
Grievances are complaints. The enrollee can file a grievance with your health plan if you are not happy with the way you were treated, the quality of care or services you received, you have problems getting care, or billing issues.

- If you need help filing a grievance, call 1-800-440-1561

- **Email:** customercare@chpw.org

- Community Health Plan of Washington
  Attention: Customer Service
  1111 Third Avenue, Suite 400
  Seattle, WA 98101
Medicaid Member Appeals

Step 1 – Community Health Plan of Washington Appeal - CHPW will submit a decision in writing within 14 calendar days, unless CHPW notifies the enrollee that more time is needed, but within a maximum of 28 calendar days.

Step 2 - Independent Review Organization (IRO) - If the member disagrees with CHPW’s decision, member can appeal within 21 calendar days of the CHPW appeal decision letter

Step 3 - State Hearing - If the member disagrees with CHPW’s decision, member can appeal within 120 calendar days of the CHPW appeal decision letter

Step 4 - Review Judge Decision – If the member disagrees the State Hearing decision, member can appeal within 21 days of decision (Step 4 is the final appeal)

CHPW will respond within 72 hours in writing to acknowledge receipt of the appeal.

*Post Service: Per CHPW contract providers have the right to appeal on their own behalf.
Who can file a Medicare Member Appeal?

• The enrollee (including his or her representative).

• An assignee of the enrollee (i.e., a physician or other provider who rendered services to the enrollee).

• The legal representative of a deceased enrollee’s estate.

• Any other provider or entity (other than the Medicare health plan) determined to have an appealable interest in the proceeding.
Medicare Member Appeal must be submitted within 60 calendar days from the notice of denial date.

The appeals process has 5 levels:

**Level 1**: Reconsideration from the Health Plan – Standard Appeal Processed in 30 calendar days, Expedited 72 hours

**Level 2**: Review by an Independent Review Organization (IRO)

**Level 3**: Hearing before an Administrative Law Judge (ALJ)

**Level 4**: Review by the Medicare Appeals Council (Appeals Council)

**Level 5**: Judicial review by a Federal District Court

If the enrollee disagrees with the decision made at any level of the process, they can appeal to the next level.
Examples of when appeals are filed by an enrollee, enrollee representative, or a participating provider:

Pre-service Appeals
- Service request was denied for medical necessity.
- Service was denied as a non-covered benefit.

The treating provider or PCP can appeal on the enrollee's behalf without a consent.

Example: Provider orders an MRI and the Plan does not approve.
A coverage determination is the first step you take in requesting a ruling on a Medicare Part D prescription drug benefit.

- When we make a coverage determination, we are making a decision whether or not to pay for a Part D drug and what your share of the cost is.

- Member has the right to ask us for an exception if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower cost to you. (physician must provide a statement to support your request)

- For Part D appeals, either the member, the member’s authorized representative, or the prescribing physician may appeal.
Provider Appeals

Provider appeal must include:

- Member name and member ID number
- Claim number (if applicable)
- Date of service
- All pertinent supporting documentation
- Reason for requesting the appeal
- Signed authorization (if filing on behalf of a member)
- To access CHPW's [Appeal Cover Sheet](#)

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
Provider Appeal

Timelines

Participating providers have 24 months from the date of the denial or initial payment of a clean claim to file in writing a Level 1 appeal.

If provider disagrees with the decision in the Level 1 appeal, they have 60-days to file in writing a Level 2 appeal.

Unless the Providers contract includes a provision for the right to arbitration, Level 2 is the final appeal option with the Plan.

You do not have to submit an appeal for the following: DRG or Fee Schedule Disputes, Refund Requests, COB, Post Payment Review (PPR).

Please send to the CHPW Claims Investigative Unit – email cs.claimsdistribution@chpw.org
A Medicare non-par provider has the same appeal rights as an enrollee. Appeal must be submitted in writing within 90 days from the date of the notice of the denial or initial payment of clean claim.

A non-par provider is permitted to file a standard appeal for a denied claim, but only if the non-par provider completes a “Waiver of Liability Statement”.

This Waiver of Liability statement will not allow the provider to bill the enrollee regardless of the outcome of the appeal.

Physicians and suppliers who have executed a waiver of liability statement are not required to complete the Appointment of Representation (AOR/CMS-1696) form. (In this case, the physician or supplier is not representing the beneficiary, and thus does not need an AOR)
Post Service Appeals received June through August 2019
Top 10 Categories

- Billing/Claims: 13
- Post Payment Review: 22
- Claim_Paid Amount: 36
- Medical Necessity: 70
- Claim_Dup. Claim Edit: 118
- Non-covered benefit: 131
- No Referral: 141
- Claim Billing/Coding: 156
- No InPatient Notification: 183
- No Prior Authorization: 303
Referral Management

A referral is a primary care provider’s written statement of intent to refer a member to specialty care or ancillary services.

- A primary care physician (PCP) does not require approval by CHPW to refer a member to a specialty provider.
- Effective October 15, 2019, CHPW no longer requires plan approval for referrals to non-network specialists. This change will decrease administrative work for our providers and facilitate faster appointment times for our members.
- All providers are still required to follow and obtain prior authorization for some services as required by CHPW. For more information on services that require prior approval from CHPW, please see our Prior Authorization page on chpw.org: https://www.chpw.org/for-providers/prior-authorization-and-medical-review/
Referrals approved by CHPW are still required for the following:

• **PCP to PCP Referrals:** When a member needs to see a PCP outside of their assigned PCP or group, the health plan must be notified and approve this referral.

• **Emergency Room:** No referrals or authorizations are required for treatment.

• **PRC Members:** Members who are in the Patient Review and Coordination (PRC) program require referrals from their PCP approving the care that members receive from other providers or specialists. The health plan must be notified and approve all referrals for members to receive care outside of their PCP.

(PRC is a CHPW program designed to control overutilization and inappropriate use of medical services by members. This program allows restriction of members to certain providers, including primary care providers (PCPs), pharmacies, and hospitals.)
Inpatient Admission Notification

Must be provided by Facilities within 24 hours or the next business day after an admission.

https://www.chpw.org/resources/Forms_and_Tools/Inpatient_Form_writeable_100119.pdf

Exception to Rule (ETR)

A Washington Apple Health member and/or the member’s provider may request CHPW pay for a non-covered health care service. Can be requested within 90 days of the denial notification.

https://www.chpw.org/resources/Providers/Prior_Authorization/Exception_to_Rule_Request_form_508.pdf

Retro Authorizations

CHPW will not process retro authorizations or referrals.
Prior Authorization

Documentation to support medical necessity must be submitted with Prior Authorization requests.

Prior Authorization Determination 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.
Utilization Management

https://www.chpw.org/for-providers/prior-authorization-and-medical-review/
Prior Authorization Summary of Changes for 2020

The Procedure Code Lookup Tool is not intended to replace the use of the Prior Authorization list, nor is the tool necessarily complete. Providers should only use this tool as a supplement to and after first consulting the Prior Authorization list.

Please call Customer Service for any questions on Prior Authorization at 1-800-440-1561
Use the benefit grids below to learn more about program benefits, copays, prior authorizations, and more.

### 2020 Benefit Grids
- **Washington Apple Health**
- **Apple Health Behavioral Health Services Only**

| Benefit or Service                                      | Prior Authorization                                                                 | Requirements                                                        | Adults Covered Age ≥20 unless otherwise specified | Children Covered Age 20 & Younger unless otherwise specified | Medicaid coverage through HCA |
|--------------------------------------------------------|------------------------------------------------------------------------------------|                                                                    |                                                    |                                                               |                           |
| Prescriptions, Pharmacy, Drugs                         | Please visit CHPW’s searchable formulary [http://chpw.org/formulary] to look up current formulary status of medications. | Refer to searchable formulary to look up current status of medications. | Yes                                                   | Yes                                                               | See Prescriptions, Pharmacy, Covered by HCA only and EXCLUDED (Not Covered by HCA or CHPW) in this grid. |
| Medical Injectable Drugs, Injections                   | For current prior authorization requirements for injectable drugs, visit the Prior Authorization website: [http://chpw.org/providers/prior-authorization-und-medications/](http://chpw.org/providers/prior-authorization-und-medications/) | Refer to PA Sit Note: All Unclassified biologics (115590) require a prior authorization. | Yes                                                   | Yes                                                               | See Prescriptions, Pharmacy, Covered by HCA only and EXCLUDED (Not Covered by HCA or CHPW) in this grid. |
| Prescriptions, Pharmacy: Medication Assisted Therapy, MAT | Prior Authorization required:  
  - Buprenorphine monotherapy  
  - Buprenorphine not combined with naltrexone is covered only in pregnancy and naltrexone allergies (NOT nausea/ vomiting)  
  - Buprenorphine/naltrexone maximum daily dose = 12mg/day. |  
  - IF PA is required, provider and member must sign MAT form to be submitted by pharmacy to Express Scripts. Maximum approval length is 6 months.  
How to Request
Prior Authorization
Fax

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

Resources and Forms

Online prior authorization portal (JIVA)
We prefer that you submit prior authorizations through our Care Management Portal (JIVA). By using the portal, you can check eligibility and authorization status, print approval letters, and submit requests online 24/7. For registration Issues or technical assistance contact Portal Support at portal.support@chpw.org.

Access Portal  Request Portal Account

Fax prior authorization and notification forms
If you prefer to fax your prior authorization requests, fill out the appropriate form and fax it to the number listed on the form.

• Dialysis Notification form
• Exception to the Rule Request form
• Express Scripts Pharmacy forms
• Inpatient Admission form
• Integrated Managed Care Mental Health Service Request form
• Integrated Managed Care Psych/Neuropsych Testing Request form
• Integrated Managed Care Substance Use Disorder Services Request form
• Limited Extension Request form
• Prior Authorization Request form
• WISE Services Change Notification form

If you do not see the appropriate form on this list, please check our Forms and Tools page or contact customer service.
Utilization Management

Concurrent Review – Discharge Planning

• During the inpatient hospitalization, the member's clinical progress is reviewed by the CHPW clinical team using clinical criteria approved by CHPW.
• Discharge planning needs are identified through the concurrent review process or by referral from someone on the member's care team.
• No referrals or authorizations are required for treatment in an Emergency Room.

Criteria Used in Determining Authorization for Service

• Medicaid - CHPW looks first to clinical criteria established by the Health Technology Assessment (HTA) Program of the Health Care Authority (WAC 182 55 055). If no HTA exists for a service, CHPW then reviews against our internal Clinical Coverage Criteria (CCC) or national MCG guidelines if no CCC exists.
• Medicare - CHPW utilizes the Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). If no NCD or LCD exists for a service, CHPW then reviews against our internal Clinical Coverage Criteria (CCC) or national MCG guidelines if no CCC exists.
Clinical appropriateness and the medical necessity of behavioral health services requested are based on criteria guidelines used.

CHPW uses **ASAM** (American Society of Addiction) criteria for substance use disorder services or **LOCUS** (Level of Care Utilization System) or **CALOCUS** (Child and Adolescent Level of Care Utilization System) for mental health services.
Care Management

• For Members:
  - Education on Self-Management
  - Coordination of care during transitional events
  - Connection with community-based resources
  - Coaching to manage chronic illness

• For Providers:
  - Resources to manage complex members
  - Promotes adherence to provider’s treatment plans
  - Identifies clinical events between provider visits
CHPW Care Management Teams

- Transitions of Care
  - Post Discharge Phone Call
  - Difficult to Discharge
  - Jail Transitions

- Care Coordination & Community Linkages
  - Social Determinants of Health
  - Wellness & Recovery
  - Housing
  - Community Health Workers

- Case Management
  - Complex & Case Management / Care Coordination
  - ABA Services Coordination
  - NICU CM

- Population Health
  - Health Coaches
  - Lead Screening Outreach
  - Members without PCP
Our Transitions of Care (TOC) team provides proactive support to members as they move from one level of care to another. The team is staffed by medical and behavioral nurses, pharmacists and social workers. Contact for 866-418-7009 or TOCRequests@chpw.org

- Ensures coordination of services and prevent unnecessary readmissions or complications
- Supports transfers to rehab, skilled nursing, and long term care
- Ensures home health and DME are in place
- Verifies appointments to PCPs and care providers, and coordinate transportation
- Confirms member has correct medications and is able to get to pharmacy
- Assists members/caregivers in understanding care plans
- Provides referrals to case management and other community-based programs and services
Our Care Coordination & Community Linkages (CCCL) team assists members with the Social Determinates of Health needs

• Connects members to resources and services
• Assists members who are homeless or having housing insecurity
• Supports members with creating and meeting recovery goals
• Local community health workers in the member’s community
• Promotes access to primary care and behavioral health resources
• Contact us at 866-418-7006 or CareCoordCommLinkage@chpw.org
Case Management

• Case Management is a collaborative process that addresses the whole person health care needs, combining both physical and behavioral health needs. It is a free of charge program for those members who both meet criteria and choose to participate.

• A Case Manager’s role is advocacy, assessment, and coordination of care between multiple providers and the member.

• Case Managers empower the member to improve self-management of their health, provide education.

• CHPW’s Case Management team is made up of a combination of nurses, social workers and mental health professionals.
Case Management may be an appropriate service for members with:

- complex or chronic care needs
- complex discharge planning needs
- needs that are beyond the available clinic resources
- multiple conditions that require coordination with several specialty providers

Contact us via Case Management Referral Form [http://chpw.org/for-providers/documents-and-tools](http://chpw.org/for-providers/documents-and-tools) or [CareMgmtReferrals@chpw.org](mailto:CareMgmtReferrals@chpw.org)
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 in diabetes, asthma and COPD.

Contact us at: 866-418-7008 or PopHealthRequests@chpw.org
Program specific staff can be reached by phone and email:

- Case Management: 866-418-7004 or Case.Management@chpw.org
- SNP Case Management: 866-418-7005 or Case.Management@chpw.org
- Community Linkages: 866-418-7006 or CommunityLinkagesRequests@chpw.org
- Transitions of Care: 866-418-7009 or TOCRequests@chpw.org
The Health Home program offers additional care coordination services to eligible Medicaid members statewide with chronic conditions.

**How it Works**

Members enrolled in the Health Home program work with a care coordinator who is specially trained to assess the needs and goals of those they are working with comprehensive care management. Services include:

- Care coordination
- Transitional care
- Health promotion
- Individual and family supports
- Transitional care
- Referrals to community and social support services

**Eligibility**

The state determines eligibility and identifies those individuals for CHPW. CHPW members can be referred via secure email to healthhomes@chpw.org
The Mental Health Integration Program (MHIP) is a state-wide, patient-centered, integrated program serving CHPW Medicaid Members with medical, mental health, and substance abuse needs.

The program focuses on treating common mental health disorders in a primary care setting with the Collaborative Care model of care using clinic-based mental health professionals called ‘care coordinators’ provide brief interventions and care coordination to members in consultation with a psychiatrist.

For more information – email mhip.program@chpw.org
Pharmacy Management

- Apple Health Formulary
- Express Scripts (ESI) Pharmacy Benefit Manager
- Medication Assisted Treatment (MAT)
- Opioid Guidelines/Forms
- Pharmacy Newsletter
To access the Apple Health Formulary, go to www.chpw.org and click on:

- For Providers
- Pharmacy
- Search Formulary

Providers can search or browse by generic or brand name, or therapeutic class.

From this section, Providers can identify:

- formulary status,
- prior authorization requirements,
- step therapy, and
- additional notes
For coverage determinations and exceptions:

Phone: Medicaid/Medicare 844-605-8168
Fax: 877-251-5896
Electronic: www.express-scripts.com/PA
Medication Assisted Treatment (MAT)

Certain chemical dependency medications require providers to follow the HCA MAT guidelines and provide documentation.

To access information, guidelines and documents, go to www.chpw.org and click:

• For Providers
• Forms and Tools
  ➢ Medication Assisted Treatment (MAT) Program, where Providers could access:
    • Buprenorphine Monotherapy Form
    • Buprenorphine Naloxone 32 mg Form
    • MAT Guidelines
    • Patient Status and Progress Form
    • Prescribing MAT: Start Here

Please note that required documents must be signed by the prescriber and patient and sent from the pharmacy to ESI.
Opioid medications require providers to follow the HCA Opioid prescribing guidelines and provide documentation for chronic users.

To access information, guidelines and documents, go to www.chpw.org and click:

- For Providers
- Forms and Tools

- Information on the HCA Opioid Policy
- Chronic Opioid Attestation Form: Fax the completed attestation form to Express Scripts at 877-251-5896
- Pharmacy Expedited Authorization Codes
Single Preferred Drug List

**Background:** As of October 1, 2019, the below medications will become **non-preferred (non-formulary)** for CHPW Managed Medicaid members, to align with the HCA Single Preferred Drug List.

**Suggested action:** Share with your prescribers and transition patients to alternatives where appropriate.

<table>
<thead>
<tr>
<th>MISCELLANEOUS MIGRAINE ANALGESICS</th>
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<tbody>
<tr>
<td>CAFFEINE TABLET</td>
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<tr>
<td>MISERNOV TABLET</td>
</tr>
<tr>
<td>SUMATRIPTAN SLICE-NAPROXEN SOD TABLET</td>
</tr>
<tr>
<td>TREXIMET TABLET</td>
</tr>
<tr>
<td>DERMATOLOGIC SCABICIDE AND PEDICULICIDE</td>
</tr>
<tr>
<td>EURAX LOTION 10%</td>
</tr>
<tr>
<td>LINDANE SHAMPOO 1%</td>
</tr>
<tr>
<td>MALATHION LOTION 0.5%</td>
</tr>
<tr>
<td>SPINOSAD SUSP 0.9%</td>
</tr>
<tr>
<td>SULFAMYLON TOPICAL SOLN 5%</td>
</tr>
</tbody>
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The following medications will change from formulary without a PA to formulary with a PA:

<table>
<thead>
<tr>
<th>ANABOLIC STEROIDS</th>
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<tbody>
<tr>
<td>OXANDROLONE TABLET</td>
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<tr>
<td>ANADROL 50 TABLET</td>
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<tr>
<td>ANTIDIURETIC AND VASOPRESSOR HORMONES</td>
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<tr>
<td>DESMOPEXIN ACETATE INJ</td>
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<tr>
<td>MISCELLANEOUS ANTI-INFECTIVE</td>
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<tr>
<td>NEBUFENT NEBULIZATION SOLN</td>
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<tr>
<td>OPHTHALMIC DECONGESTANTS</td>
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**Patient Review and Coordination (PRC) Program**

The Patient Review and Coordination (PRC) Program is a federal and state requirement of Medicaid that focuses on the health and safety of members. It is used by both the state and the Apple Health managed care plans to control the over-utilization and inappropriate use of medical services by members, by allowing restrictions of members to certain providers. Many of the members are seen by several different providers, have a high number of duplicative medications, use several different pharmacies, and have a high emergency room usage. Based on clinical and utilization findings, members are placed on in the PRC program for at least two years.

To refer a CHPW member for a review for inclusion in the PRC program, please contact CHPW Customer Service at 1-866-907-1902.


**Making Connections**

We welcome your feedback and future topic ideas. Email us at: Pharmacy@chpw.org
Provider Training and Education

• Provider Orientation
• Training - mandatory & optional
• Education
Community Health Plan of Washington offers provider orientation and training modules. Some training modules are mandatory and others are optional.

Provider Orientation

• **New Providers (Mandatory)**

All new providers with Community Health Plan of Washington must complete orientation **within 90 days** of their contract effective date.

• **Established Providers (Optional)**

Established providers with Community Health Plan of Washington may access our orientation for a refresher and updates.
Mandatory Training

Special Needs Plan (SNP) Model of Care

Who is required to complete this training: Healthcare workers who care for the Special Needs population; i.e., Doctors, RN’s, LPN’s, Social Workers, etc.

Patient Rights and Responsibilities & Advance Directives

Who is required to complete this training: All Healthcare workers, front desk staff, medical records staff, clinic managers, doctors, clinical staff, etc.
Mandatory Training

You must also complete CMS’s General Compliance and/or Fraud, Waste and Abuse Training as directed by CMS and submit an annual Attestation to CHPW, to attest that training has been completed.

CMS requires the following to be completed every year:

- Complete General Compliance and/or Fraud, Waste and Abuse Training.
- Maintain individual training documentation for all staff members (i.e. sign-in sheets, electronic certification, etc.).
- Submit an Attestation form to CHPW, attesting that training requirements have been met.
General Compliance
Fraud, Waste and Abuse

Link to access Online Attestation (preferred) or PDF Form (found under Compliance Section)

Link to access General Compliance/Fraud, Waste & Abuse Attestation FAQ’s:
https://www.chpw.org/for-providers/training/gcfwa-attestation-form-instructions

Link to CMS’s General Compliance/Fraud, Waste & Abuse Training Program:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
The Centers for Medicare and Medicaid Services (CMS) requires all care providers who treat patients enrolled in a Special Needs Plan (SNP) to complete annual Model of Care (MOC) training.

**Model of Care Training** must be completed by: Providers and staff who render care to members who are enrolled in the Special Needs Plan (i.e. MD, DO, ARNP, RN, LPN, etc.). Training available on the CHPW website.

**Training Link**

• Providers who are interested in the following optional training programs, please go to: [http://chpw.org/for-providers/training](http://chpw.org/for-providers/training)

• Culturally and Linguistic Appropriate Service (CLAS)

• Member Balance Billing

• Integrated Managed Care Education & Training
Culturally and Linguistically Appropriate Service (CLAS)

The United States continues to grow more diverse.

• Currently, about 20% of the U.S. population speaks a language other than English at home, and 9% has limited English proficiency.

• By 2050, the United States will be a “majority minority” nation, with more than half the population coming from racial or ethnic minority backgrounds.

• Attention to these trends is critical for ensuring that health disparities narrow, rather than widen, in the future.
Office of Minority Health established 15 standards that addresses 4 key areas:

1. Ongoing commitment to equitable, effective care known as the ‘Principle Standard’.
2. Investment and commitment by governance and leadership as well as training the workforce.
3. Communication and language assistance is competent, free and promoted widely.
4. Engagement of stakeholders for continuous improvement to ensure accountability.
Patient Rights and Responsibilities & Advance Directives Training must be completed by: Providers and staff (i.e. MD, DO, ARNP, RN, LPN, Administrators, Office Managers, Medical Assistants, Receptionists, Medical Record Coordinators, Referral Coordinators, etc.).

It is important that employees, providers and enrollees understand enrollee rights and responsibilities.

Enrollees are free to exercise their rights. Exercising these rights must not adversely affect the way our organizations or any contracted providers or other subcontractors treat enrollees.

The Apple Health Managed Care Plans comply with applicable laws governing enrollee rights and responsibilities.
Patient Rights and Responsibilities

Patient have the **right** to:

- Make decisions about their health care, including refusal of care.
- Be informed about all available treatment options, regardless of cost.
- Change their Primary Care Provider.
- Request a second opinion from another contracted provider.
- Obtain services within specified appointment standards.
- Be treated with dignity and respect. Discrimination on the basis of race, color, national origin, sex, sexual preference, age, religion, creed or disability will not be tolerated.
- Speak freely about their health care and concerns about adverse results.
- Have their privacy protected and information about care remain confidential.
- Request and receive copies of their medical records.
- Request and have corrections made to medical records if an error has been made.
Patient Rights and Responsibilities

Request and receive information about:

• Their health care and covered services.
• Their provider and how referrals are made to specialists and other providers.
• How their Managed Care Plan pays providers for care provided.
• All options for care and why they are receiving certain types of care.
• Assistance with filing a grievance or complaint about their care.
• Their Apple Health Managed Care Plan’s organizational structure, policies and procedures, practice guidelines and how to recommend changes.
• Enrollee Rights and Responsibilities at least annually.

Receive a list of crisis telephone numbers.
Receive help completing mental or medical health advance directive forms.
Receive mental health and substance use disorder services.
Patients have the **responsibility** to:

- Help make decisions about their health care, including refusal of treatment.
- Keep and be on time to their appointments.
- Call their provider’s office if they will be late or need to cancel an appointment.
- Present their ProviderOne and Apple Health Managed Care Plan ID cards to their provider for billing purposes.
- Be respectful to providers.
- Learn about their plan, including covered and excluded services.
- Access care when necessary.
- Learn about their health problems and take part in making agreed upon treatment goals whenever possible.
- Provide to their provider and health plan complete information about their health to ensure appropriate care.
Patients have the **responsibility** to (continued):

- Follow their provider’s instructions.
- Use health care services appropriately.
- Renew their Apple Health coverage annually.

Inform the HCA of the following changes:

- Family size
- Address
- Income
- Other insurance
- Medicare eligibility
What is an Advance Directive?

An Advance Directive documents an individual’s health care choices. The Advance Directive tells providers and family members the type of care the enrollee does or does not wish to receive in the event:

- The enrollee loses consciousness.
- The enrollee can no longer make health care decisions.
- The enrollee can not tell their providers or family member what type of care they do or do not wish to receive.

An Advance Directive also:

- Allows an enrollee to designate someone to represent them or speak on their behalf if they are not able to represent or speak for themselves.
- Helps protect the enrollee’s loved ones or their providers from having to make difficult medical decisions.
An advance directive is a document that indicates, in writing, your choices about the treatments you want or do not want and/or who will make healthcare decisions for you if you become incapacitated and cannot express your wishes.

There are three forms of Advance Directives:

**Durable Power of Attorney (POA) for Health Care** - This names another person to make medical decisions for the enrollee if they are unable to make the decision themselves.

**Healthcare Directive (Living Will)** - This is a written document that states whether or not an enrollee wants treatment to prolong their life. An enrollee may document their request to die naturally.

**Organ Donation Request** - This allows an enrollee to donate their organs after their death.
Apple Health Medicaid

You must register as a new requester with Universal in order for HCA to pay for interpreters for your clients attending Medicaid or DSHS/DCYF social service appointments.

- In order for Language Interpreter services to be covered by HCA, you must provide Universal Language Service (Universal) the client’s ProviderOne number, client’s full name and date of birth, and your NPI in order to verify:
  - Services are an eligible Washington Apple Health (Medicaid) medical benefit; and
  - The client is an eligible Washington Apple Health (Medicaid) client; and
  - Services are authorized and provided by a HCA Medicaid Provider (Enrolled as an HCA provider)
  - Universal reviews eligibility of clients at the time of request, 48 hours prior to the appointment, and the day of the service. If you do not provide the client’s ProviderOne number or your NPI, you will be responsible for paying for the interpreter services appointment.

Sign Language

Submit your requests using the ProviderOne portal. Submit your request using the "Online Prior Authorization Submission" process in Provider One. Select the Organizational Unit type: 530-PA Sign Language

Attach a completed DSHS Request for Sign Language Interpreter form (DSHS 17-123A)

CHPW Medicare Advantage – provided by CHPW

CHPW provides this service at (866) 998-0338 with the following log in:
Enter Account Number: 14767
Enter PIN Number: 0044
Enter Cost Center: 44
CHPW Provider Web Site Resources

Apple Health
https://www.chpw.org/

CHPW Med Advantage
https://medicare.chpw.org/

- CHPW Web Site
- Provider Portals
  - HealthMAPs
  - JIVA
Go to www.chpw.org and from the homepage, click: For Providers
Provider Bulletin Board has new information on variety of updates and useful links.

- Provider Manual
- Provider Newsletters
- Portal Updates
- Forms and Tools
- Billing updates
Forms & Tools provides many links to forms and tools that can save you time and link you directly to needed resources and information.

Many of the forms can be submitted electronically.

Please sign up for Electronic Funds Transfer (EFT). This will save you time and money is directly transferred into your account.
You need your Billing Tax ID number(s) to register. It may take up to 10 calendar days for your registration to process. You will receive an email when your registration is complete.

Registration Issues and general questions: customercare@chpw.org

HealthMAPS training materials are available at CHPW.org on the Orientation, Training, and Education page. They are located under the HealthMAPS Portal heading in the Training Workbooks section.
HealthMAPS
Registered users have access to the following information:

- Eligibility and Benefit Details
- Member Rosters
- Capitation Rosters
- Other Health Information
- View Claim Status & Run Claims Reports
- The ability to send clean claims and corrected claims directly to CHPW
- Send and receive secure messages with CHPW.

Once registered, providers can access Health MAPS through a single sign-in at:

- OneHealthPort, or
- https://mychpw.chpw.org/en/provider

Support Phone Number: 1 (800) 440-1561 or portal.support@chpw.org
• Web-based system can be used from any location.
• System workflow allows for easy request submissions.
• The Dashboard enables view of status of all requests to help manage your work:
  o **Work in Progress** shows all requests, what step in the process, and days old.
  o **Requests by Type** shows type of request (e.g. Outpatient DME) and what step it is in the process.
  o **Decisions Made Today** show all requests and what decisions were rendered today.
• Easily navigate to specific request from the Dashboard.
JIVA Care Management Portal - Use and Access

- Jiva allows expedited processing for authorizations, referrals, and is the preferred method for submitting requests.
- To get started, go to CHPW’s Provider Portals webpage and click on “Register here” (see below).

On-Line Jiva Training Resources

- JIVA Portal User Guide
- JIVA Portal FAQ
- Updated JIVA portal training videos
To receive the provider newsletter, updates and notices from CHPW, please email Provider.Relations@chpw.org and provide contact information (name, title, Tax ID #, phone and email addresses) for the following staff/departments:

- Payor Contract Managers
- Billing Managers
- Clinic Managers
- Referral Coordinators
- Team Members (billers, receptionists, medical record clerks, etc.)

For an on-site visit with Provider Relations, please contact your PR Rep directly or email: Provider.Relations@chpw.org.
Department
Contacts

Credentialing
provider.credentialing@chpw.org
Check for status, questions on applications

Provider Changes
provider.changes@chpw.org
Send provider add/terms, new address locations

Appeals & Grievances
appealsgrievances@chpw.org
Confirm appeal has been received, status of appeal, questions

Provider Relations
Provider.relations@chpw.org
Go to www.chpw.org and from the homepage, click: For Members
We reward members for keeping their children healthy

Our Prenatal Program and our Well Child Program provide gift cards to members for getting care. Prenatal care and regular doctor visits throughout childhood are the foundation for life-long health.

Questions, call CHPW at 1-866-418-2803

Prenatal Program - is for CHPW members who are pregnant. The Prenatal Program offers a $65 gift card for a car seat after getting two prenatal check-ups.

Well Child Program is for kids who are CHPW members. The Well Child Program offers a $20 gift card for every Well Child check-up that includes an up-to-date immunization record.

How to Get Your Gift Cards

• Enroll online  
  Call to enroll
• Child must be a CHPW member
• Child must be 18 years old or younger
• Child must complete a well child visit as a member
• Child must have all of their doctor-recommended immunizations
Please complete the Survey Today

Which satisfies the CHPW Orientation training
IMPORTANT – ACTION REQUIRED

Please click on the following link to complete your Attestation

[Online Attestation Form]

Thank-You