CHPW 2023 Provider Orientation

A comprehensive Provider and Staff Orientation for new and established providers

Upon completing this orientation, click on the Attestation Link at the end of this program to submit and receive credit for taking this presentation
Land Acknowledgment

As we gather virtually from various locations across the state of Washington, we humbly acknowledge that we are all meeting on the traditional territories of hundreds of Indigenous tribes.

To learn more about the tribal lands you occupy, you can visit: native-land.ca/
Introduction/CHPW History

In 1992, Washington’s federally funded clinics (known as Community Health Centers) realized too many people were being neglected by traditional insurance. They got together and started Community Health Plan of Washington.

Today we provide health insurance coverage for:
- More than 250,000 Apple Health (Medicaid) members
- 15,000 Medicare Advantage members
- 4,000 Cascade Select members (through HealthPlanFinder)

CHPW is committed to reducing health disparities by removing the financial, cultural, linguistic, geographic, systemic, and other barriers to health care.

Committed to leading the way!
Quick Facts

- 21 Community Health Centers operating more than 190 clinics
- More than 3,100 primary care providers
- Nearly 15,000 medical specialists
- Nearly 8,000 behavioral health specialists
- More than 100 hospitals
- More than 130 Affiliate Providers at 393 locations
- Nearly 30 years experience providing quality, community-based care
CHPW Service Area

**Apple Health**

*All Counties*

- 255,000 Members
- Behavioral Health Services
- Only 33,000

**Medicare Advantage**

*27 counties*

- 14,700 Members
- Including Dual Medicaid/Medicare Members

**Individual & Family**

*Cascade Select*

*20 counties*

- 4,000 members

*New in 2023 Ferry & Whitman*
Preparing for End of Public Health Emergency

End of federal Public Health Emergency means Apple Health (Medicaid) recipients will have to renew eligibility with Health Plan Authority (HCA)

HCA approximates 300,000 Washingtonians could lose Apple Health coverage

CHPW is ready to transition non-eligible members to public option Cascade Select with low-cost plans and Cascade Care Savings or Medicare Advantage Plans

Keeping members in CHPW plans means they can likely remain with their same providers even as they transition

CHPW can present to your staff and/or patients about their options. Contact: Caitlin Duffy, Director, Business Development & Sales at Caitlin.Duffy@chpw.org

HCA Bulletin 1-17-2023 – Changes to AH Continued Coverage
Apple Health

- Alternative Treatments benefit
- Expansion of Vision Network
- Children’s First Rewards
- Circumcision
- Member Benefits

chpw.org
Alternative Treatments (New as of 07/01/2022)

Members asked, we listened! Get a combined total of **20 visits per calendar year** for:

- Acupuncture
- Chiropractic
- Massage*

- No referral or prior authorization required
- No age restrictions**
- Open network – Members can see *any* provider licensed in Washington who is willing to bill CHPW. Member can also pay up front and submit a claim for reimbursement if the provider doesn’t bill CHPW.

*Massage visits are based on session length of 30 minutes each. A one-hour massage, for example, would count as two visits. Optional tipping is not included in coverage.

**Chiropractic services for children ages 20 and younger are covered under Apple Health by the Washington Health Care Authority (HCA). These do not count toward the 20-visit benefit limit.
Vision Benefit: Free Glasses for Adults

CHPW offers no-cost frames and basic lenses to adult members (21+)

- Free frames and basic lenses
- Low-cost upgrades (ex: progressive lenses)
- Eye exam every two years

NEW: Benefit is now provided through Vision Service Plan (VSP) with a broader network and larger selection of frames

- Members use VSP’s network to get their free glasses and eye exams.
- If a member has had a routine eye exam within the past 24 months, they can get their free glasses without another exam.
- For medically necessary vision care, members should continue to use CHPW’s vision specialist network (found in our Provider Directory).
- No change to vision coverage for CHPW members 20 and younger.

Find an Eye Doctor Near Me | Optometrists & Ophthalmologists (vsp.com)
ChildrenFirst™
Well-Child Rewards

**Prenatal Rewards**
- See the doctor during your first 3 months of pregnancy
- Get a $60 gift card
- Make a second prenatal visit and earn a $40 gift card
- Up to $100 for prenatal visits

**Postpartum Rewards**
- Visit the doctor 1 to 12 weeks after giving birth
- Get a $50 gift card
- Enjoy rewards for taking care of your health: $50 gift card after giving birth

**Well-Child Rewards**
- Take your child for a well-child visit
- Get a $20 gift card
- 27 possible visits = 27 gift cards
- Grand total = $540
- $20 reward for each well-child checkup
Circumcision

- CHPW covers up to $200 toward non-medically necessary circumcision for each child. (Medically necessary circumcisions are covered by the state.)

- Benefit applies to children under 18. Each child assigned male at birth in the family is eligible.

- Open network: The doctor performing the procedure doesn’t have to be contracted with CHPW; they just need to be willing to bill CHPW.

- Any charges above $200 are member’s responsibility.

chpw.org/circumcision
Benefits+: More extras at no additional cost | $0

**Quit for Life**
The Quit for Life program helps CHPW members to quit smoking. Get expert coaching, online support, and programs to stop using nicotine.

**Sports Physicals**
CHPW covers one annual sports physical per child ages 6 through 18. This is in addition to your child's annual checkup.

**Boys & Girls Club**
Free membership at participating clubs for CHPW members ages 6 to 18. Includes after-school programs, free snacks, and more.

**24/7 Virtual Care**
Make a phone or video appointment with a doctor anytime. Or call our 24-hour Nurse Line at 1-866-418-2920 (TTY: Dial 711).

**Free cellphone**
You also get free monthly data and minutes.*

**Amazon Prime**
Get reduced-cost Amazon Prime membership. Free two-day shipping on millions of items plus free movies, and e-books.**

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* Available to all Apple Health members  ** For those who qualify
CHPW Individual & Family Plans Overview

- 2023 Service Area Expansion
- Eligibility Requirements & Enrollment
- Cascade Select: Three Plans

individuallandfamily.chpw.org
Beginning in 2023, Community Health Network of Washington health insurance plans are moving to Community Health Plan of Washington.

Members on CHNW Individual & Family plans will automatically be enrolled in the CHPW plan during the 2023 enrollment period (November 1, 2022, to January 15, 2023)

Minimal member impact as CHPW has been managing the plan on behalf of CHNW.
Cascade Select Eligibility & Enrollment

**Age & Income**
- People under the age of 65 (or not otherwise eligible for Medicare) who are U.S. citizens or lawfully present immigrants.
- Anyone who lives in a Cascade Select service area and does not already have employer-provided health care, can apply.
- Depending on income, some people will qualify for financial help to reduce their premiums and out-of-pocket costs.

**How to Enroll**
- **Over the Phone** - Just call 1-833-993-0181 (TTY Relay: Dial 711) from 8 a.m. and 5 p.m., Monday through Friday. State-Licensed experts will help you enroll through Washington Healthplanfinder, the state’s online health insurance marketplace.
- **Online** - Enrollment in a CHNW Cascade Select plan is done through [Washington Healthplanfinder](#).
- **Open Enrollment** - is open from November 1st, 2021, to January 15th, 2022.
Largest Cascade Select Plan Service Area

CHPW Individual & Family Cascade Select will be offered in two additional counties in 2023!

- In 2023 CHPW is expanding into Ferry and Whitman counties **Largest Cascade Select Service area (20 counties)**

- **Lowest cost silver** Cascade Care plan in 11 of 20 counties

- 1, 2, or 3 rate position for Cascade Ready to help patients no longer covered by Apple Health transition to CHPW so they can keep their doctors
Major Hospital Partners Include… (Hospital & Specialty Services Only)

- Cascade Medical Center
- Central Washington Hospital
- St. Michael’s Hospital
- Columbia Basin Hospital
- Kittitas Valley Hospital
- Lake Chelan Community Hospital
- Mid Valley Hospital
- MultiCare (All Locations)
- Quincy Valley Medical Center
- Shriners Hospital For Children
- Sunnyside Community Hospital
- Three Rivers Hospital
- Toppenish Medical Center
- Wenatchee Valley Hospital
- Yakima Valley Memorial
- Providence Health & Services
- Morton General Hospital

- Jefferson County Public Hospital District (Facility)
- Mason General Hospital
- Kadlec Regional Medical Center-Facility (All Locations)
- PacMed Clinics (All Locations)
- Swedish Health Services (All Locations)
- St. Luke’s Rehabilitation Medical Center (All Locations)

NEW
- UW Medicine
- Harborview Medical Center
- Valley Medical Center
- Ferry County Health
- Whitman Hospital
- Pullman Regional Hospital
## Cascade Select: Three Plan Levels

- **COST SHARE**

<table>
<thead>
<tr>
<th>COST SHARE</th>
<th>GOLD</th>
<th>SILVER</th>
<th>BRONZE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible (Individual/Family)</td>
<td>$600/$1,200</td>
<td>$2,500/$5,000</td>
<td>$6,000/$12,000</td>
</tr>
<tr>
<td>Annual Out of Pocket Maximum (Individual/Family)</td>
<td>$5,900/$11,800</td>
<td>$8,500/$17,000</td>
<td>$8,550/$17,100</td>
</tr>
<tr>
<td>Office Visit Cost Share</td>
<td>$15 copay</td>
<td>$30 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Specialty Visit Cost Share</td>
<td>$40 copay</td>
<td>$65 copay</td>
<td>$100 copay after deductible</td>
</tr>
<tr>
<td>Hospital Cost Share</td>
<td>$525 copay*</td>
<td>$800 copay after deductible*</td>
<td>40% coinsurance after deductible</td>
</tr>
<tr>
<td>Emergency Cost Share</td>
<td>$450 copay after deductible</td>
<td>$800 copay after deductible</td>
<td>40% coinsurance after deductible</td>
</tr>
</tbody>
</table>

*For Hospital Cost Share, the copay amount includes 40% coinsurance after deductible.
CHPW Medicare Advantage (MA) & MA Dual Plans

- 2023 Service Area
- Member Benefits
- CHPW Dual Plan

Medicare.chpw.org
2023 Service Area

- MA Dual Plan (HMO D-SNP)
- MA Plan 1 (HMO)
- MA Plan 2 (HMO)
- MA Plan 3 (HMO)
- MA Plan 4 (HMO)
- MA Freedom Plan (HMO)
**CHPW Medicare Advantage Dual Plan**

The Medicare Advantage Dual (HMO D-SNP) plan offers added support for individuals who qualify for both Medicare Parts A and B and Apple Health (Medicaid) benefits.

| NEW | Increased preventive and comprehensive **dental care** to $5,000/year |
| NEW | Open Network |
| NEW | **Grocery** benefit of up to $50/month on debit card for stores like Safeway, Albertsons, Fred Meyer and Walmart |
| NEW | 60 hours per year of free personalized support and companionship with Family on Demand |
| NEW | $0 copay exam and fitting. Up to $2,250 for hearing aids and supplies every year. One routine hearing exam per year |
| NEW | Monthly **over-the-counter (OTC) allowance** $125/month |
| NEW | **$0 copay** for up to 25 combined sessions of acupuncture, naturopathy, routine chiropractic, massage therapy, and more! * |
| NEW | Up to **$500** per year to spend on **eyewear** |
| **Vision Service Plan (VSP)** | Information, go to [Dual Plan Benefits](#) |

* $0 copay for 12 visits/year combined for acupuncture, naturopathy, routine chiropractic for Plans 1, 3, 4, and Freedom Plan. Dual Plan and Plan 2 cover a combined 25 visits.
# Medicare Plans 2023

**Health and Wellbeing Benefits by Medicare Advantage (MA) Plan**

## 2023 MA Plans

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA DUAL PLAN (HMO D-SNP)</td>
<td>Combined benefit of up to 25 acupuncture, naturopathy, massage, or chiropractor visits per year, as well as various CHPW-recommended Wellbeing programs</td>
</tr>
<tr>
<td>MA PLAN 2 (HMO)</td>
<td></td>
</tr>
<tr>
<td>MA PLAN 1 (HMO)</td>
<td></td>
</tr>
<tr>
<td>MA PLAN 3 (HMO)</td>
<td>Combined benefit of up to 12 acupuncture, naturopathy, or chiropractor visits per year, as well as various CHPW-recommended Wellbeing programs</td>
</tr>
<tr>
<td>MA PLAN 4 (HMO)</td>
<td></td>
</tr>
<tr>
<td>MA FREEDOM PLAN (HMO)</td>
<td></td>
</tr>
</tbody>
</table>
Improved Dental – More Flexible (and Higher)

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Currently</th>
<th>2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHPW MA Plan 1</td>
<td>$200</td>
<td>2 Preventive Visits</td>
</tr>
<tr>
<td>CHPW MA Plan 2</td>
<td>$200 + one</td>
<td>$500 + UP¹</td>
</tr>
<tr>
<td></td>
<td>preventive visit</td>
<td></td>
</tr>
<tr>
<td>CHPW MA Plan 3</td>
<td>$850</td>
<td>$500 + UP¹</td>
</tr>
<tr>
<td>CHPW MA Plan 4</td>
<td>$850</td>
<td>$500 + UP¹</td>
</tr>
<tr>
<td>CHPW MA Freedom Plan</td>
<td>$850</td>
<td>$500 + UP¹</td>
</tr>
<tr>
<td>CHPW MA Dual Plan</td>
<td>$4,500</td>
<td>$5,000²</td>
</tr>
</tbody>
</table>

Note: CHPW is unique in paying all dental claims, all billed amounts, i.e., no “non-par”/”network only” issues; CHPW pays denturists too.

Dental limit is per year for supplemental non-OM (non-Original Medicare) preventive and comprehensive services combined.
CHPW Member ID Cards


Life-Threatening Emergency: Call 911 or go to the nearest emergency care facility. Contact your PCP or call CHPW customer service at 1-800-446-1551 within 24 hours.


Hospital Admissions: Hospitals must notify customer service within 24 hours of hospital admission. Submit Medical & Dental Claims to CHPW Claims, PO Box 269902, Pines, TX 75260-9002.

Pharmacy Coverage Determinations: 1-844-605-0155

Vision Service plan (VSP): 1-800-877-7195

Provider: (908)408-3484

Note: The above images are examples; the actual ID cards can list specific regions, or specific plan names. See Provider Manual for more specific examples.
Provider Responsibilities

- Appointment Availability & Wait Times
- Credentialing
- Provider Rights & Responsibilities
- Early Periodic Screening Diagnosis and Treatment (EPSDT)
- Provider Data
PCPs, OB/GYN and Midwife providers appointment standards

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.

<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 and Specialist Access Standards

### 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>
Emergency Care shall be available 24 Hours a Day, Seven Days a Week

CHPW providers are required to maintain access to health care services on an ongoing basis and shall ensure that services are available to members 24 hours per day, seven days per week.

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 Credentialing

- 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.
- CHPW will notify you when credentialing is completed.
- CHPW will not backdate 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
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 Responsibilities

• Inform members of their right to self-refer for certain services.
• Provide or arrange interpretive services for members who are hearing impaired or who's 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).
Provider Responsibilities

• Ensure that members have a voice in developing individualized service plans, advance directives and crisis plans.

• 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.
Early Periodic Screening Diagnosis and Treatment (EPSDT) services

Well-Child Visits Periodicity Schedule (Jan 2023)

Infancy:
6 visits before one year of age

Early Childhood:
7 visits between one and four years of age

Middle Childhood and Adolescence:
1 visit every year (365 days) between five and up to twenty-one years of age

Before a patient can be referred to a chiropractor, a current EPSDT must have been performed for that calendar year.

EPSDT HCA Program Billing Guide Links
Provider Data

- It is important that the provider updates CHPW with any provider changes to allow CHPW to update all systems and notify members.
- Incorrect Provider Data can cause claim payment delays
- The accuracy of the Online Provider Directory that members and providers use to find in-network providers is also very dependent on receiving timely provider data.
- Provider may request a copy of the provider roster from our system at the TIN level.
- Please submit Provider Data updates by completing the Provider Add Change Term Form (PACT) online [Provider Changes Form](mailto:Provider.Changes@chpw.org)
- Provider Rosters monthly to Provider Data via email to [Provider.Changes@chpw.org](mailto:Provider.Changes@chpw.org)
Provider Data Reporting Changes

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
Online Provider Directory
Online Provider Directory – Advance Search
Apple Health Member Enrollment and PCP Assignment

- Plan Selection
- Auto Assignment Process
- Clinic & Plan Change Form
- Newborns
- Verify Eligibility
- FAQ
- Retro Enrollment
- Other Health Insurance
Apple Health Member Plan or PCP Clinic Selection

Enrollees can select their Plan and Clinic/PCP during the initial enrollment application on WA Healthplanfinder. Visit wahealthplanfinder.org or call their Support Center at 1-855-923-4633.

- 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.

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

- CHPW Apple Health Web Site link to enroll with How to enroll with CHPW
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.
Newborns Effective Date of Enrollment

Newborns whose mothers are enrollees with Community Health Plan of Washington 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.
Verify Apple Health Eligibility

- 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)
  
  ProviderOne Provider System User Manual
Q: 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 PCP clinic outside of your organization, a Plan authorized referral **would be required** (not having a PCP-to-PCP referral will cause claim to deny).

Q: 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.*

If a CHPW member wants switch to a different PCP or Clinic this can be done using the online **Clinic Selection Form**
Retro Enrollment

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 for Retro Enrolled Members**

Providers must submit a request for an Authorization or IP Notification **within 90- days from the date the member was retroactively enrolled with CHPW.** (please indicate on form that member was retro enrolled)

- 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.
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 maintains the following timely filing requirements for claim submissions:

- When CHPW is the primary payer, we must receive the original Medicare Advantage or Apple Health claim within 365 days from date of service (DOS).
- When another plan is the primary payer, CHPW must receive the original secondary claim within 365 days of the process date of the primary payer’s remittance advice (RA)/explanation of benefits (EOB). CHPW cannot process the secondary claim if the primary payer denied the claim for timely filing.
- CHPW must receive Medicare Advantage corrected claims within one year of the initial process date.
- CHPW must receive Apple Health corrected claims within 24 months of DOS.

Please consult your CHPW provider contract for information on timely filing of encounters.
Claim Submission

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
Corrected Claims Electronic

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
Corrected Claims Paper: How to Submit Paper Corrected Claims-Cover Sheet

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 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](#))
Rejected versus Denied Claim

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

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

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.

Most common reasons for rejection are:
- Missing Taxonomy Code
- Provider not in CHPW System
- NPI is missing or does not match in CHPW System
Claims Issues

We request that all providers call Customer Service first for Claim Issues

- CHPW Apple Health (Medicaid) Customer Service, (800) 440-1561
- Cascade Select Customer Service, (866) 907-1906
- Community Health Plan of Washington Medicare Advantage™ Customer Service, (800) 942-0247
- Submit question through HealthMAPS portal
Claims Investigative Unit (CIU)

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. See examples of items for the types of inquiries you can submit via email to the CIU – Please include CHPW Claim Number.

Email - 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

• 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 Schedule/Rate Updates Encounter Data

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.
Post Payment Review (PPR)

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
Member Balance Billing

• 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 for Apple Health 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
Medicaid Client Billing

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.
HCA Core Provider Agreement – How to Enroll

Core Provider Agreement – NPI Registration

All individuals and organizations are required to register their NPI number with the HCA as a billing or non-billing provider in order to serve and be reimbursed for Medicaid.

CHPW will reject claims if you are not registered.

When you enroll a provider, please use the providers start date as the effective date.

How to enroll -

Enroll as a provider | Washington State Health Care Authority
Clinical Data Repository (CDR)

Providers with certified EHRs seeing Apple Health Managed Care members must send a care summary (CCDA) from the providers EHR to the CDR. If your organization meets the following criteria, you are required to participate in the CDR:

- Your organization is part of a Managed Care Organization that serves Apple Health consumers
- Your organization has a 2014 certified EHR system
- You have received monies from either the Medicare or Medicaid EHR incentive Program

Contact OneHealthPort for details on getting CDR access. Users can complete training in one-hour or less. References are also available on the OneHealthPort website.
Appeals

• Member Grievance, Appeal and Critical Incidents
• Medicare Member Appeals
• Provider Appeals
• Provider Appeal Timelines
• Non-Par Provider Appeals
Member Grievances & Appeals

Grievances are Complaints, an Appeal is a request to review a denied service or referral.

Only members can file a grievance or designate someone to file on their behalf with written authorization.

To file a grievance or appeal please see Provider Manual or following links below for process by line of business:

Apple Health – [Grievances & Appeals](#)
CHPW Medicare Advantage – [Grievances & Appeals](#)
Cascade Select – [Grievance & Appeals](#)

Please call CHPW Customer Service if you need help at 1-800-440-1561.

A Member may express dissatisfaction pertaining to:

- quality of care,
- the way the member was treated,
- problems getting care
- billing issues
- attitude and service
Apple Health Member Appeals 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 choose 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

See CHPW Web Site for more information – Appeals and Grievances Medicaid
Appeal Consent Form – Apple Health

CHPW's contract with the Health Care Authority dictates that we must obtain written consent for any member appeal that is not determined to be medically urgent.

The member consent form was created to prevent delays in working the appeals case, which can ultimately lead to dismissal of the appeal.

All standard member appeals require the written consent of the member.

• A member can request an appeal verbally but must follow up with written consent.

• A provider may need to submit an appeal on the member’s behalf, but we will need to receive written consent before proceeding.

• If an appeal submitted as urgent is determined not to meet medically urgent criteria, written consent will need to be obtained in order to continue processing the appeal.

Consent Form
Apple Health 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. You may file an expedited appeal.

Step 2 - State Administrative Hearing - If the member disagrees with CHPW’s decision, member can appeal within 120 calendar days of the CHPW appeal decision letter.

Step 3 - 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 4 - HCA Board of Appeal – If the member disagrees the State Hearing decision, member can appeal within 21 days of decision from IRO. (Step 4 is the final appeal)

CHPW Apple Health Grievance & Appeal Process PDF

*Post Service:  Per CHPW contract providers have the right to appeal on their own behalf.
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 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: Critical Incident Form.

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.
Medicare Advantage Member Appeals

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.

See CHPW Web Site for more information – Grievances and Appeals Medicare

Medicare Consent form - Appointment of Representative Form
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.
Medicare Advantage Member Appeals

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 member disagrees with the decision made at any level of the process, member can appeal to the next level.

2023 Medicare Appeals & Grievances Policy Handbook
2023 D-SNP Appeals & Grievances Policy Handbook
Provider Appeals 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, extenuating circumstance
- Signed authorization (if filing on behalf of a member)
- To access CHPW’s Appeal Request Form

Submit appeals to:
Community Health Plan of Washington
Attention: Appeals Department
1111 3rd Ave Ste 400
Seattle, WA 98101

Fax: (206) 613-8984
Email: appealsgrievances@chpw.org
Provider Appeal Timelines

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.

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

Unless the Provider’s 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

Appeal Request Coversheet
Non-Par Provider Appeals

**Apple Health Medicaid**
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.

**Medicare Advantage**
Non-participating provider appeals must be in writing and submitted within **Sixty (60) 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 Medicare 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)*
Provider Grievance, Appeal and Critical Incident Submission Links

Contact Info:

Entity:
Community Health Plan of Washington

Contact and Links to CHPW Critical Incident Forms:
Contact email
Critical.Incidents@chpw.org

Click here → Link to Critical Incident Form

Appeals & Grievances:
Contact Number - 1-800-440-1561
Contact email - AppealsGrievances@chpw.org

Please refer to MCO Provider Manuals for additional information on the Member Grievance and Appeal process.
Health Services Utilization Management

- Referral Management
- Prior Authorization
CHPW Health Services Utilization Management

Referral Management

A referral is a primary care provider’s written statement of intent to refer a member to a specialist or other provider types.

- An approval from CHPW to refer a member to a participating and/or non-participating specialist provider is not required.
- CHPW changed its policy on non-participating referral requirements in 2019 to decrease administrative work for our providers and facilitate faster appointment times for our members.

Note:

- All providers are required to follow and obtain prior authorizations for applicable services as required by CHPW.
- For more information on services that require prior authorizations from CHPW, please see our Prior Authorization page at: Prior Authorization Lists and Utilization Guides
CHPW Health Services Utilization Management

Referrals that require pre-approval from CHPW:

PCP to PCP Referrals:
• A Plan referral is required for members to schedule visits for care with a PCP outside of their assigned PCP or group.
• CHPW must be notified and approve PCP to PCP referrals to avoid claim denials.

PRC Members:
• Members who are in the Patient Review and Coordination (PRC) program are restricted to one PCP, pharmacy and hospital. Members in PRC must go to these providers only.
• CHPW must be notified and approve referrals for members to seek care outside of the PRC program.

Note:
• PRC is an HCA controlled program designed to control overutilization and inappropriate use of medical services by members.
• For more information go to: Patient Review and Coordination Program
To access CHPW’s Procedure Code Lookup Tool, go to:

Procedure Code Lookup Tool

Note:
This 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.

To access CHPW’s Prior Authorization List and Utilization Guidelines, go to:
https://www.chpw.org/provider-center/prior-authorization/

For questions or assistance with an authorization, contact CHPW at:
Customer Service: (800) 440-1561
CHPW Health Services Utilization Management

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.
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.

**Note:**
- Documentation to support medical necessity must be submitted with Prior Authorization requests.
Emergency services do not require prior authorization and are defined as:

**Psychiatric:**
- When the patient is a danger to self, others, or is gravely disabled.

**Medical:**
- A medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention may result in placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, or serious impairment to bodily functions or serious dysfunction of any bodily organ or part.
CHPW Health Services Utilization Management

**Inpatient Admission Notification**
• Must be provided by Facilities within 24 hours or the next business day after an admission.

• To access CHPW’s Inpatient Admissions Form: [CHPW Inpatient Admission Form](#)

**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 but **must be requested prior to the service being rendered**.

• To access CHPW’s Exception to Rule Form: [CHPW ETR Form](#)

**Retro Authorizations**
• CHPW will not process retro authorizations or referrals.
CHPW Health Services 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 for Behavioral Health Services

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.

Clinical Coverage Criteria
CHPW Health Services Utilization Management

CHPW Benefit Grids

Access the links below to learn more about program benefits, copays, and more:

2022 Apple Health Integrated Managed Care
•  [WAHIMC and BHSO Medicaid Benefit Grid](#)

2022 Medicare Advantage and Dual Eligible Special Needs Plan (SNP)
•  [Medicare Benefit Grid](#)

2022 Cascade Select
•  [Cascade Select Benefit Grid](#)

Note:
2023 Benefit Grid will be available after January 1, 2023. You can access CHPW’s Provider Manual to pull the benefit grids listed above at [CHPW Provider Manual](#)
Health Services
Utilization Management

• Case Management
• Transitions of Care
• Community Programs
Case Management

CHPW Case Management is:

Focused on the whole person: teams include medical and behavioral CMs working side-by-side

Data-driven: uses real-time, predictive and pattern analysis to identify members

Consumer-centric: care plans designed to address member priorities and concerns

Community-based: fully integrated with community health centers (CHCs), behavioral health providers and resources

Regionally focused: regional teams to best support member needs
Taking Care of Members Where They Are

We’re local: We have staff in the same communities as our members

▪ Increased Regional presence in support of community-based care:
  o Regional Managers + Regional Case Managers + Community Health Workers partnering with local delivery systems

▪ Created a Community Programs Team:
  o Housing Specialists + Health Coaches + Community Health Workers – supporting members to address SDoH needs

▪ Enhanced Case Management:
  o Behavioral Health Expertise + Community Health Centers + Community and Primary Care Providers
Children’s Case Management Services

**Autism/ABA** – Assist with needs associated with Autism and therapies associated with Autism Spectrum Disorder.

**Children’s Mental Health** – Children’s Mental Health Specialist Case Manager to assist with navigating all behavioral health needs for children and their families. Including navigation and admission into WISe or CLIP.

**Transitional Aged Youth** – Case Management for our youth members, age 15-26 years old, navigating those transitional years from adolescent to adult and in need of physical, behavioral health needs or community connections for housing, education, or employment services during these transitional years.

Contact us via Case Management Referral Form [chpw.org/for-providers/documents-and-tools](http://chpw.org/for-providers/documents-and-tools) or CareMgmtReferrals@chpw.org
Transition of Care

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.

**Program Functions:**

- Coordinates services and prevent unnecessary readmissions or complications
- Provides jail transition services
- Support transfers to rehab, skilled, and long-term care
- Coordinates with health homes and care teams
- Ensures home health and Durable Medical Equipment, if needed
- Verifies appointments with PCPs and care providers, and coordinates transportation
- Confirms member has correct medications and is able to get to the pharmacy
- Provides referrals to case management and other community-based programs and services
Community Support Services

Addresses the social drivers impacting member health

CHPW’s Community Supports Services (CSS) identify and address Social Drivers of Health that have an impact on member health.

Team consists of 8 Regionally based Community Health Workers, 2 Health Homes Care Coordinators, and 2 team coordinators. Housing support, food access and insecurity support, peer services community connections for BH and SUD, and any other area that impacts a member’s ability to access care and/or their quality of life.

Provides support to internal team members (case managers) as well as members, providers and caregivers.

The locally-based team works closely with Community Health Centers (CHCS) to identify regional resources, connect the members to those services, and ensure continued support and access.

Services are conducted both telephonically and in person with the member in their community to facilitate need connections and care.
CHPW Care Management Teams Contacts

Program specific staff can be reached by phone and email:

• **Care Management:**
  866-418-7004 or CareMgmtReferrals@chpw.org

• **SNP Case Management:**
  866-418-7005 or Case.Management@chpw.org

• **Community Support Services:**
  866-418-7006 or CSSRequests@chpw.org

• **Transitions of Care:**
  866-418-7009 or TOCRequests@chpw.org

• **To request ABA therapy:**
  Please call our direct ABA line at 1-844-225-8624

• **Tribal Liaison,**
Regional Managers

CHPW has a Regional Manager that lives and works in each region to:

- Serve as the primary Regional Service Area Liaison to local organizations, customers and other entities in the region being served.
- Represent CHPW on advisory boards, Accountable Community of Health’s workgroups, and community meetings.
- Ensure appropriate systems are in place to facilitate coordination between CHPW’s departments and community-based agencies to advance integrated managed care system.
- Collaborate with staff based in the regional service area to support integrated managed care; leads design and implementation for operations of an integrated managed care system.
- Work in collaboration with Managed Care Organizations, providers and cross system partners to plan, lead, organize and implement strategies to advance health care integration.

Behavioral Health children’s System Administrator/Child Mental Health Specialist:

- Responsible for providing education, training, consultation on children’s system of care and participating in system planning targeting Apple Health Medicaid population.
- Serves as the liaison to Washington State and county agencies including the Children’s Administration, school-based BH services, and the Children’s Long-Term Inpatient Programs (CLIP) Administration.
- Ensures that children enrolled in IMC receive the full scope of physical, behavioral health, and social support services, including Wraparound with Intensive Services (WISe).
Pharmacy

- Pharmacy Resources
- Prescription Benefit Manager
- Apple Health Drug Formulary

- Medication Assisted Treatment (MAT) & Opioid Guidelines/Forms

Pharmacy Resources
Prescription Drug Coverage for your patients

Express Scripts
Phone: Medicaid/Medicare 844-605-8168
Fax: 877-251-5896

- **Apple Health Single Preferred Drug List (PDL)** is used by all managed care plans & Apple Health fee-for-service.

- **Prior Authorization** - to request prior authorization, step therapy, nonformulary, or quantity limit override, contact Express Scripts (ESI) at 1-844-605-8168, 24 hours a day, 7 days a week or use https://www.CoverMyMeds.com to start PA process.

- **Pharmacy Reimbursement Issues** – Submit inquiry to ESI through the [Pharmacist Resource Center](#).

- **Pharmacy Emergency Fills** – Emergency fills may be covered to prevent interruptions in therapy. [View our policy on emergency fills.](#)

- **Medications available for 90-day fills** – CHPW covers 90-day supplies for most chronic medications.

- **For more information**, please visit our pharmacy web site – [Provider Center for Pharmacy](#)
Pharmacy Searchable
Formulary
Community Health Plan of Washington (CHPW) uses a list of approved drugs. This is called a “formulary” or a “preferred drug list.”

Access the [CHPW Apple Health Formulary](#), go to and click on:

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
- additional notes
Medication Assisted Treatment (MAT) Program

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

To access information, guidelines and forms, go to Medication Assisted Treatment (MAT) Program links below:

- Buprenorphine Monotherapy Prior Authorization Form
- Guidelines for Buprenorphine Containing Products
- Guidelines for Naltrexone Containing Products

Opioid Prescription

- Information on the HCA Opioid Policy
- Opioid Attestation Form: Fax the completed attestation form to Express Scripts at 1-877-251-5896
- Opioid Agonists Medical Policy
- Pharmacy Expedited Authorization Codes
Apple Health 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
- UW PACC - Psychiatry & Addictions Case Conference
UW Psychiatry Consultation Line (PCL)
Connecting Care Providers in Washington with UW Psychiatrists (adult patients (18+))

The PCL offers care providers in Washington the opportunity to consult with a UW Psychiatrist about adult patients (18+) with mental health issues and/or substance use disorders. The service provides immediate “curbside consultation” followed by a brief, written summary of the recommendations sent via email to the calling provider typically within 1 business day.

Who is eligible to call
Prescribing providers in Washington can call any time 24/7. Beginning January 23, 2023, non-prescribing providers in Washington can call the line as well between 8 a.m. and 5 p.m. Monday through Friday (excluding holidays). Patients, family and caregivers are NOT eligible to call.

How do I access the PCL?
You reach the PCL by calling 877-WA-PSYCH (877-927-7924), Prescribing providers may call 24 hours a day, seven days a week. Any care provider may also schedule ahead using Calendly or email PCLWA@uw.edu to request a scheduled consultation.

Do you answer questions related to substance abuse?
Yes. Our adult psychiatrists are able to consult with you about patients with a substance use disorder, and we have addiction psychiatrists you can consult with on complex cases.

Website - Psychiatry Consultation Line – Department of Psychiatry & Behavioral Sciences (uw.edu)
The UW Psychiatry and Addictions Case Conference is a free weekly teleconference that connects community providers with UW Medicine psychiatrists and addictions experts.

Sessions include both an educational presentation and case for providers who want to improve the mental health and addictions care for their patients.

Using real-time, interactive video, providers:
• Learn new approaches and skills
• Participate in in-depth clinical case consultation
• Receive feedback and recommendations
• Provide expertise to a community of colleagues
• Earn CME credits
• Have fun!

Information, Topic Schedule and to register [HERE](#)

CME offered for nominal fee

Please feel free to forward, print, and post this [UW PACC Flyer](#)
Partnership Access Line (PAL)
Child and Adolescent

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
seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/
UW Perinatal Psychiatry Consultation Line

Faculty members in the UW Department of Psychiatry and Behavioral Sciences with expertise in perinatal mental health.

For providers with behavioral health questions about preconception planning, pregnancy, postpartum or perinatal loss.

877-PAL4MOM (877-725-4666) | ppcl@uw.edu
9am - 5pm, Monday - Friday (excluding holidays)

**UW Partnership Access Line for Moms** (PAL for Moms) is a free state-funded program providing perinatal mental health consultation, recommendations and referrals for providers caring for pregnant or postpartum patients.

**HOW DOES IT WORK?**
- Complete a brief intake
- Consult with a UW perinatal psychiatrist (usually immediately, or within 1 business day)
- Receive written documentation of recommendations and resources

**WHO CAN CALL?** Any provider in Washington State who cares for pregnant or postpartum patients.

**WHAT KIND OF QUESTIONS CAN I CALL ABOUT?**
We consult on any behavioral health-related questions for patients who are pregnant, in the first year postpartum, or who have pregnancy-related complications (e.g., pregnancy loss, infertility). Topics may include:

- Depression, anxiety, other psychiatric disorders (e.g., bipolar disorder, post-traumatic stress disorder), or co-occurring substance use disorders
- Pregnancy loss, complications, or difficult life events
- Weighing risks and benefits of psychiatric medication
- Non-medication treatments
- Local resources & referrals
- Guidance on implementing mental health screening at your workplace
HCA First Steps Program

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.
Washington Recovery Help Line

Behavioral Health is essential to health. Prevention is effective, treatment works, and people recover. If you have a patient who may need 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.

[warecoveryhelpline.org](http://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: [crisisclinic.org](http://crisisclinic.org)
Provider Training and Education

- Provider Orientation
- Training – mandatory & optional
- Education
Provider Trainings - Mandatory

Provider Orientation – Mandatory for new providers
• Community Health Plan of Washington offers a Provider Orientation to help you get started with us or to get needed information for established providers.
• Newly contracted providers must complete orientation within 90 days of their contract effective date and complete an attestation of completion.

Model of Care Training – Mandatory
• The Centers for Medicare and Medicaid Services (CMS) requires all care provider who treat patients enrolled in a Special Needs Plan (SNP) to complete annual Model of Care Training.

Patient Rights & Responsibilities & Advance Directive Training – Mandatory
• Must be completed by Providers & staff (i.e. MD, DO, ARNP, RN LPN, Administrators, Office Managers, Medical Assistants, Receptionists, Medical Record Coordinators, Referral coordinators, etc.) PR&R/Adv Dir Training

CMS Fraud, Waste and Abuse Training, General Compliance – Mandatory
• All staff must complete the CMS General Compliance and/or Fraud, Waste and Abuse Training annually under 42 CFR §438.608 (a) and (b), §422.503(vi)(C) and §423.504(b)(vi)(C). Provider is required to maintain evidence and must make evidence of training available for up to 10 years upon request. See link for more information HERE.
Provider Training - Optional

Culturally and Linguistically Appropriate Services (CLAS) Training - Optional
• Recommended for all healthcare workers (MD, DO, ARNP, RN LPN, Administrators, Office Managers, Medical Assistants, Receptionists, Medical Record Coordinators, Referral coordinators, etc)
• Currently, about 20% of the U.S. population speaks a language other than English at home.
• Attention to these trends is critical for ensuring that health disparities narrow, rather than widen, in the future

CHPW Health Management Overview
• Get to know CHPW’s different Health Management Programs. These programs can help patients who have complex or multiple conditions better manage their health.

Note – Links to all trainings can be found HERE
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:

1. **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.

2. **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.

3. **Organ Donation Request** - This allows an enrollee to donate their organs after their death.
Physician Orders for Life Sustaining Treatment (POLST)

The Physician Orders for Life Sustaining Treatment (POLST) form is for anybody who has a serious health condition and needs to make decisions about life-sustaining treatment. Your provider can use the POLST form to represent your wishes as clear and specific medical orders.

A POLST form complements the advance directive — it does not replace it. The POLST form is a medical order that tells your emergency health care professional what to do during a medical crisis when the patient cannot speak for him or herself. An Advance Directive is a legal document that tells who the patient wants making medical treatment decisions for him/her when he/she cannot speak and gives general directions on treatments the patient does or does not want to help create a treatment plan.

For more information on POLST and POLST Form, please go to the Washington State Medical Association website: [https://wsma.org/POLST](https://wsma.org/POLST)

Providers should review their obligations concerning Advance Directive in WAC 182-501-0125.

CHPW Policy (CM118) - Advance Directives and Physician Orders for Life Sustaining Treatment (POLST) Policy
Patient Rights

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.

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.
Patient Responsibilities

• 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.
• 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
Language Interpreter Assistance

Apple Health Medicaid - 
HCA Interpreter Web Site
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. During the COVID-19 State of Emergency, HCA will offer over-the-phone (OPI) interpreters. Provider can also use remote video using their own video-based technology.

Sign Language - 
HCA Sign Language Web Site
Starting July 1, 2021, ODHH has implemented a new online request form for all sign language interpreter requests for Apple Health providers. Health care providers can now enter the requests directly into the online form.

CHPW Medicare Advantage –
provided by CHPW
Language Assistance
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

Subscribe HCA Interpreter Service Newsletter
CHPW Websites & Portals
Stay up to date on the latest changes to our medical formularies, utilization policies, billing codes, and other regulations like required trainings. Find the resources you need to best care for our members - your patients.

Provider Center Web Site Resources
Provider Bulletin Board

- Provider Manual
- Billing Updates
- Newsletters
- Portal Updates
- Forms and Tools
- New Benefits
- COVID 19 Updates

Provider Bulletin Board
HealthMAPS Patient Information Portal

Registered users have access to the following information:

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

HealthMAPS Portal Training

HealthMAPS Provider User Guide

Instructions for Professional Claims Entry

Instructions for Corrected or Replacement Claims Entry

Instructions for Institutional Claims Entry

HealthMAPS FAQ

Access HealthMAPS through OneHealthPort
JIVA Care Management Portal

Registered users have access to the following:
Submit prior authorization requests, referral requests
Submit Inpatient Notification
Review Status of Requests
View Letters (approval, denial, correspondence)

Account request: Register here

JIVA is the preferred method for submitting requests.

Training
JIVA Portal User Guide
JIVA Portal FAQ
JIVA Portal Training Videos

Registration issues or technical assistance: Contact Portal Support at portal.support@chpw.org
CHPW’s member center is your main hub for all your health care needs. Find a doctor, print your ID card, learn how to renew your coverage, and get familiar with your benefits. If you have any questions, let us know.

Member Center
Provider Relations Coverage by County

Zane Switzer zane_switzer@chpw.org
Greater Columbia Region
Provider Networks – Providence Professional

Heather Gregory – heather_gregory@chpw.org
Spokane, North Central Regions
Provider Networks – MultiCare, Kootenai, Confluence

Doug Sheldon – douglas_sheldon@chpw.org
N. Sound, King, Southwest Regions
Provider Networks – Providence Facility, PeaceHealth
UW/Harborview, Seattle Children’s, Legacy, Skagit Regional

Carmen Ballmann – carmen_ballmann@chpw.org
Pierce, Salish, Great Rivers Regions
Provider Networks - Franciscan/VM, Grays Harbor, Olympic, Mason General
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.
# Contact Guide

## Washington Apple Health (Medicaid) Customer Services

<table>
<thead>
<tr>
<th>Plans Serviced</th>
<th>Receive answers on the following</th>
<th>Program Contact and Plan Numbers</th>
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</thead>
<tbody>
<tr>
<td>Apple Health</td>
<td></td>
<td>(666) 418-7006 (TTY/TDD 8771) Community Programs Services</td>
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<tr>
<td></td>
<td></td>
<td>(206) 652-7789 Community Programs Services Fax</td>
</tr>
<tr>
<td>FHCW</td>
<td>IMC, Family Coverage</td>
<td></td>
</tr>
<tr>
<td>FSCC</td>
<td>IMC, with Premium</td>
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<tr>
<td>FHCW</td>
<td>IMC, Blind/Disabled</td>
<td></td>
</tr>
<tr>
<td>FSCC</td>
<td>IMC, Adult</td>
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</tr>
<tr>
<td>HSCP</td>
<td>Behavioral Health Services Only</td>
<td></td>
</tr>
</tbody>
</table>

**Contact Numbers**

- (666) 418-7006 Internal Service
- TTY/TDD 8771
- (206) 521-8834
- (666) 418-7006 Community Programs Services Fax
- info@wahub.org
- (666) 418-7006 Community Programs Services Fax
- (206) 652-7789

## Community Health Plan of Washington (CHPW) Medicare Advantage Customer Services

<table>
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<tr>
<td>CHPW MA Plans 2</td>
<td></td>
<td>(206) 652-7789 Community Programs Services Fax</td>
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<td>CHPW MA Plans 4</td>
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<td>(206) 652-7789 Community Programs Services Fax</td>
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<tr>
<td>CHPW MA Dual Plan</td>
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**Contact Numbers**

- (666) 418-7006 Internal Service
- TTY/TDD 8771
- (206) 521-8834
- custserv@wahub.org
- (666) 418-7006 Community Programs Services Fax
- (206) 652-7789

## Cascade Select Powered by CHPW

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**Contact Numbers**

- (666) 418-7006 Internal Service
- TTY/TDD 8771
- (206) 521-8834
- custserv@wahub.org
- (666) 418-7006 Community Programs Services Fax
- (206) 652-7789

## Provider Relations/Ed

<table>
<thead>
<tr>
<th>Western Washington</th>
<th>Contact Information</th>
<th>Contact Number</th>
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<tbody>
<tr>
<td>Carmen Ballman</td>
<td></td>
<td>(206) 613-6848</td>
</tr>
<tr>
<td>Douglas Seibert</td>
<td></td>
<td>(206) 613-2113</td>
</tr>
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<table>
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<tr>
<th>Eastern Washington</th>
<th>Contact Information</th>
<th>Contact Number</th>
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<tbody>
<tr>
<td>Carol Wasington</td>
<td></td>
<td>(206) 613-8029</td>
</tr>
<tr>
<td>Mariana Staats</td>
<td></td>
<td>(206) 613-8891</td>
</tr>
</tbody>
</table>

**General Services**

- Provider Relations questions may be sent to: providerrelations@wahub.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
- General questions

CHPW Customer Service
customercare@chpw.org

CHPW Apple Health (Medicaid) Customer Service, (800) 440-1561
Community Health Plan of Washington Medicare Advantage™
Customer Service, (800) 942-0247
Thank-you for taking the CHPW Provider Orientation

IMPORTANT – ACTION REQUIRED

Please click on the following link to complete the Attestation for this training

Online Attestation Form