

2026 Provider Manual

This edition includes:

- Apple Health (Medicaid)
- Apple Health Expansion
- Medicare Advantage D-SNP
- Cascade Select (Individual & Family Plans)

COMMUNITY HEALTH PLAN of Washington™

The power of community

Contents

Welcome to Community Health Plan of Washington (CHPW) 9
Directory of Services/Contact Information 9
CHPW Plan Contacts 10
Additional External Contacts 14
Coordination of Care Contacts 15
CHPW Washington Apple Health 17
Electronic Visit Verification (EVV) for Apple Health Home Health Care Services (HHCS) Providers 17
Required Data Elements 17
Intensive Outpatient and Partial Hospitalization 18
CHPW MA Dual Eligible Special Needs Plan (HMO D-SNP) 19
CHPW Individual and Family Cascade Select Plans 19
Provider Rights and Responsibilities 20
CHPW Provider Rights 20
CHPW Provider Responsibilities 20
Non-discrimination 21
Access to Care Standards and Responsibilities 23
Access to Providers 24 Hours a Day, Seven Days a Week (24/7) 24
Apple Health Special Program - Standards and Responsibilities 25
Screening and Assessment 26
Washington State Health Screening schedule: 26
Early Childhood Mental Health (IECMH) 26
Care Standards Documents 27
Critical Incident Reporting 28
Community Behavioral Health Reporting and Data 28
Credentialing and Re-credentialing 29
Washington Practitioner Application 30
Provider Rights 30
Right to review information to support application 30
Right to correct erroneous information 30
Access to Records and Member Health Information 31
Clinical Data Repository (CDR) 32

If your organization would like to begin using this service, please contact OneHealthPort contact OneHealthPort....33
Security of Health Information....33
Medical Record Documentation Standards....33
Provider Data Quality Assurance....35
Reporting Changes in Provider Information....35
Provider Rosters....35
Practice Capacity....36
Provider Termination....36
Ownership and Control Disclosure Form....36
MA Providers in a Health Care Setting....37
Beneficiary Inducement Law....38
Apple Health, MA/MA D-SNP, CHPW Cascade Select - Service Area....39
CHPW Eligibility Department....40
Eligibility Documents....40
Clinic/PCP Assignment Procedure....40
Involuntary Disenrollment from Apple Health....41
Involuntary Disenrollment from Cascade Select....41
Member Reassignment Policy – Apple Health....41
Disenrollment Procedure – Apple Health....42
Involuntary Disenrollment – MA Plan....43
Loss of Entitlement to Apple Health (Medicaid)....44
Loss of Entitlement to Medicare Part A or Loss of Enrollment in Medicare Part B....44
Member is Deceased....44
Disruptive Behavior – MA Process....44
Failure to pay Part D Income Related Monthly Adjustment Amount (Part D-IRMAA)....45
Member ID Cards....45
Apple Health ID Cards....45
BHSO ID Cards (No Medical Services)....49
MA D-SNP ID Cards....52
Individual and Family Cascade Select ID cards....53
Member Benefits....54
Benefit Information....54
Member Materials....54

State Enrollment Materials and Publications **54**
ChildrenFirst™ **54**
CHPW's Compliance Program **55**
CHPW's Standards of Conduct **55**
1.0 RESPONSIBILITY **56**
2.0 CONFIDENTIALITY **56**
3.0 DIGNITY RESPECT AND INCLUSION **56**
4.0 MEMBER-CENTERED **57**
Reporting Concerns **58**
Compliance Education and Training Program **59**
Fraud, Waste, and Abuse Program **60**
"What is Fraud, Waste, and Abuse?" **60**
"Where Does Fraud, Waste, and Abuse occur?" **61**
Examples of Potentially Fraudulent, Wasteful, and Abusive Billing **61**
Office Inspector General (OIG), General Service Agency/System for Awards Management (GSA/SAM) Exclusion & Sanction List(s) **62**
Preclusion List MA ONLY **62**
Medicare Opt-Out **63**
Conflicts of Interest **63**
Understanding Relevant Laws **63**
Federal Civil False Claims Act (FCA) **63**
Anti-Kickback Statute (AKS) **64**
Physician Self-Referral (Stark Law) **65**
Criminal Health Care Fraud Statute **65**
Exclusion Statute **66**
Civil Monetary Penalty Law (CMPL) **66**
HIPAA Member Rights **67**
Member Rights Regarding Personal Information **67**
Notice of Privacy Practices **68**
Advance Directive, Physician Orders for Life Sustaining Treatment (POLST) **68**
Member Rights and Responsibilities **70**
Member and Balance Billing Protection Act (BBPA) **71**
Medicare Advantage – D-SNP 71
Culturally and Linguistic Appropriate Service (CLAS) Standards **72**

Interpreter Services **72**
Other Provider Responsibilities **74**
HealthMAPS Provider Portal **74**
HealthMAPS Login **74**
Your HealthMAPS Provider Account **75**
Billing and Claims Payment **76**
Governance **76**
Billing Requirements **77**
Prior Authorization **77**
Detailed Itemizations for Claims Over $100,000 ..... **77**
Apple Health Billing Guidelines **78**
Women's Health Care **78**
Women's Health Care for Apple Health members **78**
Contraception for Apple Health members **79**
Sterilization for Apple Health members **80**
Contraception for Individual and Family Cascade Select members **81**
Individual and Family Cascade Select **81**
Complex Behavioral Health Services—Apple Health **81**
Provider Status for All CHPW Plans **81**
Substitute Physicians (Locum Tenens) Billing – Apple Health **82**
Core Provider Agreement (CPA) - Apple Health (Medicaid) **82**
VSP Vision Benefit for All CHPW Plans **84**
Newborn Claims – Apple Health (Medicaid) **84**
Newborn Claims – Individual and Family Cascade Select **84**
Circumcision Claims – Apple Health **84**
Hospice Claims – Apple Health **85**
Inpatient Facility Claims - Authorized Dates for Claims Submission **86**
Skilled Nursing Facility (SNF) Services and Outpatient Institutional Services Date Requirements – Apple Health **87**
Member Eligibility and Benefits **87**
Claim Documents **87**
Corrected Claims **88**
How to Submit Electronic Corrected Claims **88**
How to Submit Hard Copy Corrected Claims **88**

Electronic Transactions / Electronic Data Interchange (EDI) **88**
Electronic Claims Submission **89**
Check Claim Processing Status **89**
Claim Message Codes **89**
Claim Issues **90**
835 Transactions **90**
ACH/EFT Payments **91**
Claims Investigation Unit (CIU) **92**
Negative Balance **92**
DRG, Fee Schedule, and Refund Request Disputes **93**
Submit Refunds **94**
Timely Filing Requirements **94**
Claims Processing Standards for Participating Providers **94**
Fee Schedules/Rate Updates **95**
Encounter Data **96**
National Drug Codes (NDC) **97**
Billing for Administration of Drugs **97**
Enhanced Ambulatory Patient Group (EAPG) Claims **98**
CHPW Billing and Rendering Provider Taxonomy Requirements **98**
Telehealth Services (Telemedicine) **98**
Apple Health 98
Medicare Advantage D-SNP Plans 98
Apple Health (Medicaid) – Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) **99**
FQHCs **99**
RHCs **99**
Enrolling as a Medical-Assistance-Certified FQHC or RHC **100**
Coordination of Benefits (COB) **101**
Payment for Opioid Treatment Programs Services **102**
Provider Responsibilities **103**
Post Payment Review (PPR)/Program Integrity Review **103**
Medical Records for Post Payment Review/Program Integrity Review **103**
Third Party Liability (TPL) (Subrogation/Reimbursement) **104**
Provider Obligations Related to TPL **104**

Appeals and Disputes **104**
Member Appeals – **104**
(Pre-Service Requests Only) **104**
Cascade Select Disputes for Non-Participating Providers **107**
Utilization Management **108**
Referral Management **108**
Prior Authorization **108**
Prior Authorization Documents **108**
Prior Authorization Determination Timelines **109**
Clinical Practice Guidelines for Behavioral Health and Medical Conditions and Preventive Services **110**
Clinical Decision-Making **113**
Non-covered Services and Benefits for Apple Health Members **113**
Early and Periodic Screening, Diagnostics, and Treatment Services (EPSDT) **113**
Limitation Extension **114**
Medicare Outpatient Observation Notice (MOON) **115**
Inpatient Admission Notification **115**
Concurrent Review **115**
Post-Service or Retrospective Review **116**
Discharge Planning Coordination **116**
Emergency Room Care/Emergency Medical Condition **116**
Criteria Used in Determining Authorization for Service **116**
Administrative Days **117**
Peer To Peer Process **117**
Care Management **118**
Apple Health Individuals with Special Health Care Needs (ISHCN) **119**
Continuity and Transition of Care **119**
MA D-SNP **120**
Transitions of Care (TOC) Programs **120**
Community Support Services **121**
Apple Health (Medicaid) Health Home Program **122**
How It Works **122**
Eligibility **122**
Clinical Eligibility Tool **123**

Questions **123**
The Mental Health Integration Program (MHIP) **123**
Washington Partnership Access Line (PAL): **124**
Patient Review and Coordination Program **124**
The Role of the PRC Care Manager in PRC **124**
The Role of the PCP in PRC **124**
PRC Documents **125**
The Role of the Pharmacy in PRC **125**
The Role of the Hospital in PRC **125**
Pharmacy **125**
Medicare Opioid Overutilization Program (MOOP) **125**
The Role of the PCP in MOOP **125**
MOOP Documents **126**
Second Opinion Network **126**
SON Review Process 126
Review Recommendations 126
Payment 127
For more information and specific medication review thresholds 127
Pharmacy Management **127**
Drug Formulary and Medication Utilization Apple Health **127**
CHPW MA Drug Formulary **127**
Apple Health Prior Authorization **128**
CHPW MA Prior Authorization **128**
Pharmacy Benefit Exclusion Apple Health **129**
CHPW MA Excluded Benefits **129**
CHPW Individual and Family Cascade Select **129**
Quality Improvement Program (QIP) **130**
Program Overview **130**
Program Structure **131**

Introduction

Welcome to Community Health Plan of Washington (CHPW)

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

CHPW's Provider Manual serves as a comprehensive resource for providers and is inclusive of this document and all other applicable CHPW manuals, policies and procedures, and documents referred to within the Provider Manual. The Provider Manual is reviewed and updated at least annually (as necessary) and includes information and guidance related to Compliance Program and Fraud, Waste and Abuse (FWA) requirements; Credentialing and Re-credentialing process; Utilization Management (including Prior Authorization requirements); Claims and Encounter data submissions; Reimbursement policies; Drug Formularies; and CHPW Provider Directories.

CHPW's Provider Manual is updated annually and as needed with relevant revisions, and new plan information. CHPW's policies and other information and resources/tools are available at: https://www.chpw.org/provider-center/

Your Role as a CHPW Provider
As a CHPW provider, you have agreed to provide care to our enrolled members. We look forward to supporting you in providing accessible, quality health care that meets the needs of your patients—our members. An outline of benefits and extended compensation are available in your Provider Agreement, in this Provider Manual, and in the policies referenced throughout this document. As part of your role, you are obligated to cooperate and participate in utilization review; quality improvement (including collection of performance data); quality assurance programs; necessity of care evaluations; clinical and service evaluations; coordination of benefit activities; health care coding reviews; care coordination; participation in provider training including clinical, operational, IMC-specific, and other training topics and cost-containment activities as described in this Provider Manual, CHPW Policies and Procedures, and in your Provider Agreement.

Directory of Services/Contact Information

Community Health Plan of Washington
1700 7th Avenue, Suite 900
Seattle, WA 98101
Phone: (206) 521-8830 (Local) or (800) 440-1561 (Toll Free)
Fax: (206) 521-8834
www.chpw.org

CHPW Plan Contacts

Service(s)	Contact Information
CHPW Apple Health (Medicaid) Customer Service Monday – Friday, 8am – 5pm **General information**: CHPW Policies & Procedures, Member benefits and eligibility verification, Member lists, Complaints, Provider Contract inquiries, Clinic/Primary Care Provider (PCP) information changes, Credentialing, Compliance, and any other provider inquiries.	(800) 440-1561 **Fax**: (206) 652-7040 www.chpw.org
CHPW Medicare Advantage (MA) - Customer Service Seven (7) days a week, 8am – 8pm Benefits and eligibility verification, Member lists, PCP changes, Provider Participation Status, Member and Provider Complaints.	(800) 942-0247 **Fax**: (206) 652-7050 medicare.chpw.org/
CHPW Individual and Family Cascade Select - Customer Service Monday - Friday, 8am - 5pm	(866) 907-1906 Fax (206) 652-7040 individualandfamily.chpw.org/
Health Services Monday – Friday, 8am – 5pm Prior authorizations, Hospital Notifications, Care Management, Pharmacy Management, Quality Improvement activities, and Utilization Management Customer Service numbers accept collect calls related to Utilization Management (UM) issues. - Apple Health Prior Authorizations Requests	(800) 440-1561 (Toll Free) Fax: (206) 613-8873

-Apple Health Inpatient Admission Notifications -Medicare Prior Authorization Requests/MA Inpatient Admission Notifications -Apple Health Prior Authorization Requests (Behavioral Health Services)	Fax: (206) 613-7078 Fax: (206) 652-7065 Fax: (206) 652-7067
Record Retrieval Questions and requests related to record retrieval (including HEDIS and Risk Adjustment) projects, in process.	Record.Retrieval@chpw.org
Medical Records for Post Payment Review/Program Integrity Review If we request records from you for post payment review/program integrity review and your provider/facility uses a third-party record vendor, send notification to this email when the records are ready for retrieval from the vendor.	Operations.Intake@chpw.org
Appeal and Grievance Disputes	(206) 521-8830 Apple Health: (800) 440-1561 Fax: (206) 613-8984 (routine) Fax: (206) 613-8983 (clinically urgent) Cascade Select: (866) 907-1906 Fax: (206) 613-8984 (routine) Fax: (206) 613-8983 (clinically urgent) Medicare Advantage D-SNP: (800) 942-0247 MA Fax: (206) 652-7010 (routine) MA Fax: (206) 652-7011 (clinically urgent) Email: Appealsgrievances@chpw.org
Provider Training & Education	Email: Provider.Relations@chpw.org

Electronic Data Interchange (EDI) Support **Questions related to:** - Inbound claims (837) - Remittance Advice (835) - Health Care Eligibility/Benefit Inquiry & Response (270/271) - Health Care Claim Status Inquiry & Response (276/277) - Refer to Additional External Contacts for Electronic Data Interchange (EDI)/Electronic Transactions/Electronic Claims Submission for additional information	edi.support@chpw.org

Claims Investigation Unit (CIU) Inquiries related to: --Fee schedule --Anesthesia pricing --Negative balance --Re-occurring benefit configuration --Interim billing --Endoscopic pricing --Multiple Surgery pricing --Ambulance pricing --DRG pricing --Re-admission --Health Homes claims --Overpayments and underpayments --Applied Behavioral Analysis (ABA) claims --Apple Health claims --RHC encounter payments --Payment disputes	cs.claimsdistribution@chpw.org Contact Customer Service for inquiries not listed CHPW Apple Health Customer Service: (800) 440-1561 (Toll Free) CHPW MA Customer Service: (800) 942-0247 (Toll Free) CHPW Individual and Family Cascade Select (866) 907-1906 Payment disputes: Email cs.claimsdistribution@chpw.org or fax (206) 652-7009
New Provider Contract Requests	NewContractRequest@chpw.org
Provider Relations and Contracting	Provider.Relations@chpw.org
Credentialing	Provider.Credentialing@chpw.org
Provider Updates Submit the following to the email listed: --Provider updates, including demographic --Group updates, including **pay-to** changes and clinic changes --Inquiries regarding a previously submitted request --Inquiries related to the online Provider Directory	Provider.Changes@chpw.org
Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) Enhancement Questions/Issues	If you have questions about these enhancements, please email: enhancement.questions@chpw.org

Additional External Contacts

Service(s)	Contact Information
Pharmacy Benefits Manager – Express Scripts, Inc.	Coverage Determination Requests: (844) 605-8168 (Toll Free), 24 hours a day, 7 days a week
Eligibility and Claims - OneHealthPort	OneHealthPort OneHealthPort Support: 1 (800) 973-4797 Use your existing OneHealthPort login credentials to access CHPW's HealthMAPS provider portal.
Health Care Eligibility Benefit Inquiry and Response (HIPAA **270/271** Batch and Real Time Transactions) and claim processing status (**276/277** Transactions)	Please contact your clearinghouse/trading partner to confirm whether they have an established connection with CHPW. If not, please request your clearinghouse/trading partner email DL_Consumerism_Services@nttdata.com to initiate connection. Payer ID for **270/271** transactions: CMTWA
All Professional, Facility, and Behavioral Health Claims	Send claims (Apple Health, MA, and Individual and Family Cascade Select) to: CHP Claims PO Box 269002 Plano, Texas 75026-9002
Electronic Claims (837 Transactions)	CHPW accepts electronic claims via the Availity Clearinghouse. Use CHPW's Payer Identifier for **837** transactions: CHPWA. Availity: availity.com or (800) 282-4548

Electronic Remittance Advices (ERA; 835 Transactions)	CHPW provides ERA via the Availity and SDS Clearinghouses. Use CHPW's Payer Identifier for **835** transactions for Availity and SDS: CHPWA. Availity: availity.com or (800) 282-4548 SDS: stream.support@sdata.us or 855-297-4436
Vision Service Provider (VSP) MA, Individual and Family Cascade Select, and Apple Health (Adult) Vision	Contact VSP
HCA Provider billing guides and fee schedules	Provider billing guides and fee schedules
The Centers for Medicaid & Medicare Services	CMS

Coordination of Care Contacts

CHPW provides on-demand Telephonic Interpreter Assistance for our providers to use with CHPW MA and Apple Health Expansion members. The telephonic interpreter service is offered through Lionbridge.

CHPW works with LanguageLine to provide scheduled in-person, virtual and ASL interpreter services for our Apple Health Expansion members.

For more information on how to use these services, refer to the **Interpreter Services section**.

Service	Contact
CHPW Care Managers	CareMgmtReferrals@chpw.org Apple Health (866) 418-7004 Medicare/D-SNP (866) 418-7005
Children Services	childcareawarewa.org/
First Steps Maternity Support Services/Infant Care Management	hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/first-steps-maternity-and-infant-care
Transportation Services	hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/transportation-services-non-emergency

Interpreter (Services for Apple Health (Medicaid) members)	hca.wa.gov/billers-providers-partners/programs-and-services/interpreter-services
WIC–Nutrition Program for Women, Infants, and Children	https://doh.wa.gov/you-and-your-family/wic
Patient Review and Coordination (PRC) Program (for members who meet WAC 182-501-0135 criteria)	hca.wa.gov/health-care-services-supports/program-administration/patient-review-and-coordination
Dental Services	hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/dental-services
Foster Care–Fostering Well-Being	https://www.dcyf.wa.gov/services/foster-parenting
Health Homes	hca.wa.gov/billers-providers-partners/programs-and-services/health-homes
Behavioral Health-covered services and primary care integration information	hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery
Substance Use Disorder (SUD) Treatment	https://www.hca.wa.gov/billers-providers-partners/program-information-providers/substance-use-treatment
Aging and Disability Services (including home & community-based services)	https://www.dshs.wa.gov/altsa
Hearing Services	Telecommunication Access Services (800) 422-7941 (TTY) (800) 422-7930 (Voice)
Long Term Care (LTC) Services	https://www.dshs.wa.gov/ALTSA/resources
DSHS Developmental Disability Services	https://www.dshs.wa.gov/dda
Early Support for Infants and Toddlers (ESIT)	https://www.dcyf.wa.gov/services/child-development-supports/esit
Early Childhood Intervention and Prevention Services (ECLIPSE)	https://dcyf.wa.gov/services/early-learning-providers/eceap/eclipse
Early Childhood and Education Assistance Program (ECEAP) and Head Start	https://dcyf.wa.gov/services/earlylearning-childcare/eceap-headstart
Department of Health and Local Health Jurisdiction Services (including Title V services for children with special health care needs)	https://www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions

CHPW Washington Apple Health

CHPW is pleased to offer Apple Health (Medicaid) coverage in all counties in Washington State. If you have any questions, please contact Customer Service at (800) 440-1561, Monday – Friday, 8 a.m. - 5 p.m., or email CustomerCare@chpw.org.

Please visit our CHPW Apple Health Plan Benefits page for a summary of Apple Health (Medicaid) benefits.

CHPW offers the state-funded Apple Health Expansion coverage in all counties. Please visit our Apple Health Expansion Plan Details page for a summary of Apple Health Expansion benefits.

Electronic Visit Verification (EVV) for Apple Health Home Health Care Services (HHCS) Providers

The Health Care Authority is providing the following guidance for MCOs regarding electronic visit verification (EVV) for home health care services (HHCS).

There will be a period of technical assistance for providers to come into compliance with EVV HHCS requirements, including enrolling individual HHCS providers with HCA. HCA will give notice to MCOs for when to begin denying claims without the required data.

MCOs have their systems ready to collect EVV data elements on claims submitted by providers and send EVV HHCS data to HCA on encounters as detailed in the EDRG and companion guides. This is necessary for HCA's EVV HHCS reporting requirements to CMS, for HCA to monitor the number of claims without EVV HHCS data, and to identify which providers are not submitting EVV HHCS data.

Any care worker providing personal care and/or respite care services funded by Medicaid payments for a client who lives at home (not in an institutional, residential or hospital care setting) and receives payments for these in-home care services must use EVV.

Required Data Elements

The following data elements must be on home health claims with a date of service on or after **January 1, 2024**.

There are three new required data elements. All data element requirements include:

- Type of service performed (*existing*)
- Individual receiving the service (*existing*)
- Date of service (*existing*)
- Location of service delivery (***new***)
- Individual providing the service (***new***)
- Time the service begins and ends (***new***)

Medicare Crossover Claims: While Medicare does not require these data elements, the HCA does require them; therefore, the data elements bulleted above must be submitted on your Medicare claims.

Please see HCA's EVV HHCS website at: hca.wa.gov/billers-providers-partners/program-information-providers/home-health-care-services-electronic-visit-verification.

Please send any questions to HCA about EVV HHCS to HCAEVVHomeHealth@hca.wa.gov.

Intensive Outpatient and Partial Hospitalization

Overview of Efforts to use Medicaid for Intensive Outpatient and Partial Hospitalization programs

In 2022, Second Substitute Senate Bill 5736 directed the Health Care Authority (HCA) to take steps necessary to cover the services provided in Intensive Outpatient and Partial Hospitalization Programs (IOP/PHP) for persons under 21 years of age by adding it to Washington's Medicaid State Plan by January 1, 2024.

IOP/PHP refers to structured behavioral health programs that provide higher level outpatient services as an alternative to inpatient care. The program models are more intense than other models ordinarily received in a doctor's or therapist's office. The patient returns home after each treatment session.

After consulting with Centers for Medicare and Medicaid Services (CMS), the State confirmed IOP/PHP for persons under 21 years of age is already allowable under Attachment 3, Section 4b. Early, Periodic Screening, Diagnosis, and Treatment (EPSDT). Therefore, it does not require a stand-alone State Plan amendment to cover services offered in IOP/PHP programs.

Medicaid Billing Options

The Health Care Authority will use current standard reimbursement methodology for the payment of these programs.

Billing for IOP/PHP Offered in Hospital Settings

- Acute care hospitals will bill for IOP/PHP by using the Outpatient Hospital Billing Guide.
    - Enhanced Ambulatory Patient Group (EAPG) methodology already allows for reimbursement of hospital outpatient PHP and IOP services under the State Plan.
    - Hospitals will use revenue codes **913 (Intensive PHP)** and **905 (IOP Psychiatric)**.

- The acute care hospital can also bill for professional services outside of the EAPG using the Physician-related Services/Health Care Professional Services Billing Guide for appropriate service completed.
    - The HCA tracks utilization by using **H0035 for PHP** and **S9480 for IOP**.
    - Billing of non-licensed staff, such as certified peer counselors, is not currently available without the hospital also being a licensed behavioral health agency.

Billing for IOP/PHP Offered in a Behavioral Health Agency (BHA)

When Billing for Managed Care Enrollees:
Behavioral health agencies (BHA) will bill in accordance with their contracting arrangements with each managed care organization as allowable within the State Plan under:

- Attachments 3.1-A and 3.1-B
- Rehabilitative Services Section 13.d
- EPSDT Section 4b

BHAs will submit encounters using the Service Encounter Reporting Instructions (SERI) Guide that will be released for an expected implementation for services on or after January 1, 2026.

HCA tracks utilization by using **H0035 for PHP** and **S9480 for IOP**. Both will require the **HK** modifier.

When billing for a fee-for-service client
IOP/PHP claims are billed on a professional claim using Part 2 of the Mental Health Billing Guide, and the specialized mental health fee-schedule.

The HCA tracks utilization by using **H0035 for PHP** and **S9480 for IOP**. Both will require the **HK** modifier.

For more information
Contact HCA at hcamcprograms@hca.wa.gov.

CHPW MA Dual Eligible Special Needs Plan (HMO D-SNP)

CHPW makes annual benefit changes to our MA Plans and MA (HMO D-SNP) plans. To see changes effective January 1, 2026, please visit Provider Resources a summary of benefit information.

Vision Service Plan (VSP) administers CHPW's vision benefit (i.e., frames, and basic lenses, within the benefit amount).

Delta Dental of Washington administers CHPW's dental benefit (i.e., preventive and comprehensive dental services, within the benefit amount).

CHPW Individual and Family Cascade Select Plans

If you have any questions, please contact Customer Service at (866) 907-1906 Monday – Friday, 8 a.m. - 5 p.m., or email CustomerCare@chpw.org.

Please visit our Provider Resources page for the benefit summaries and grids.

Provider Rights and Responsibilities

CHPW Provider Rights

- To be treated with dignity and respect by our members.
- To receive accurate and complete information/medical history for the members' care.
- To expect members to follow treatment plans and protocols.
- To file a complaint or appeal against CHPW and/or a member.
- To file a grievance on behalf of a member (with member consent).
- To have access to CHPW's Quality Improvement Program, including goals, activities, and outcomes that relate to the members care/services.
- To collaborate with other health care professionals who are involved in the care of the member.
- To have access to Provider Relations and/or Customer Service staff for issues, concerns, or questions.

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 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 their 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) or the General Services Agency (GSA)/Systems for Award Management (SAM).
- Ensure that members participate in developing their Individual Care Plan (ICP), Advance Directive/POLST and Crisis Plans. (Includes children and their families (e.g., caregivers and significant others, parents, foster parents, assigned/appointed guardians, siblings), and adults.) At a minimum, treatment goals will include the "words" of the individual. Documentation must be included in the clinical record, describing how the individual views their progress. An Individual Peer Support Plan (IPSP) may be integrated 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. Have a process to convey all necessary information to ensure continued delivery of medically necessary services.
- Facilities must notify CHPW timely of all inpatient admissions (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 do not balance bill a member for covered services. Refer to CHPW's Member/Balance Billing Training Program at chpw.org/wp-content/uploads/content/provider-center/training/Member_BillingTraining_Program_508.pdf

Non-discrimination

CHPW and Providers must comply with Section 1557 of the Affordable Care Act (ACA). Rules focus on preventing discrimination in federally funded health programs based on race, color, national origin, sex, age, or disability for implementing patient care decision tool reviews, updated policies, procedures (like grievance processes and language access), staff training, and providing nondiscrimination notices to ensure equity, though specific interpretations regarding sex/gender identity. Covered entities (providers, insurers, Marketplaces) must review tools for bias, establish comprehensive compliance policies, train staff, and offer language/accessibility services.

Key Requirements & Deadlines (2025)

- **May 1, 2025:** Deadline to review and modify patient care decision support tools for bias and conduct initial staff training.
- **July 5, 2025:** Deadline to adopt comprehensive written policies and procedures, including grievance, language access, and auxiliary aids procedures, and provide notices of nondiscrimination.
- **First plan year beginning on or after Jan 1, 2025:** Required changes to plan designs.

Who Must Comply?

- Health programs/activities receiving HHS funds (providers, insurers, Marketplaces).
- Medicare/Medicaid entities.

What's Prohibited?

- Discrimination in providing/administering health services or insurance based on protected characteristics.
- Denying/limiting coverage, claims, or using discriminatory marketing/benefit designs.

Key Compliance Actions

- **Notice & Grievance:** Provide annual nondiscrimination notices, have grievance procedures for discrimination complaints, and ensure record retention for at least 3 years.
- **Language Access:** Provide qualified interpreters (not relying on family/adults unless requested) and machine translation reviewed by humans.
- **Accessibility:** Provide auxiliary aids for individuals with disabilities, ensuring accessible facilities and ICT (telehealth, kiosks).
- **Training:** Train relevant staff (patient-facing, decision-makers) on new policies.

Providers must not discriminate against any patient in the quality of service or accessibility of services because they are our members. As a participating provider, you are also required to follow the nondiscrimination rules and guidelines set by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR).

Providers must not discriminate against any patient based on:

- Type of health insurance
- Race
- Ethnicity
- National origin
- Religion
- Sex
- Age
- Mental or physical disability or medical condition
- Sexual orientation
- Claims experience
- Medical history
- Genetic information
- Type of payment

Providers must maintain policies and procedures to demonstrate you do not discriminate in the delivery of service and provide treatment to any members in need of your service.

Americans with Disabilities Act (ADA) Guidelines

Participating care providers must have practice policies showing they accept any patient in need of the health care they provide. The organization and its care providers must make public declarations (i.e., through posters or mission statements) of their commitment to non-discriminatory behavior in conducting business with all members. These documents should explain that this expectation applies to all personnel, clinical and non-clinical, in their dealings with each member.

In this regard, you must undertake new construction and renovations, as well as barrier reductions required to achieve program accessibility, following the established accessibility standards of the ADA guidelines. For complete details go to ADA.gov > Featured Topics > A Guide to Disability Rights Laws.

We may request any of the following ADA-related descriptions of:

- Accessibility to your office or facility
- The methods you or your staff use to communicate with members who have visual or hearing impairments
- The training your staff receive to learn and implement these guidelines

Care for Members Who Are Hearing-Impaired

Refusing to provide care or interpreter services for a person with a qualifying disability is an ADA violation. Members who are hearing-impaired have the right to use sign language interpreters to help them at their care provider visits.

Access to Care Standards and Responsibilities

Access standards are developed to ensure delivery of health care services timely. CHPW is committed to following appointment and after-hours standards/requirements as set forth by the Health Care Authority (HCA) and other regulatory and accreditation agencies. CHPW members should have the same office hours of operations as commercially insured patients.

Appointment Standards

Type of Appointment	Appointment Wait Time Standards
All Providers	
Emergency Care	Immediately, and available 24/7
Transitional visit (clinical assessment or care planning)	Within seven (7) calendar days of member's discharge from an inpatient or behavioral health facility or substance use disorder treatment program.
Second Opinion	Within thirty (30) calendar days of the request unless the Enrollee requests a postponement of the second opinion to a date later than thirty (30) calendar days.
PCP, OB/GYN, Midwife	
Routine/preventative office visit	Within thirty (30) business days
Non-urgent office visit	Within seven (7) business days
Urgent, symptomatic office visit	Within twenty-four (24) hours
Behavioral Health Providers	
Care for a non-life-threatening emergency	Within six (6) hours
Urgent care	Within twenty-four (24) hours - *CS – Next Day
Initial visit, routine care	Within seven (7) business days
Follow-up, routine care	Within thirty (30) business days
Specialty Care Providers	
Specialty Care	Within thirty (30) business days

*Cascade Select

Other Requirements

- Maintain an appointment system for members for prompt access to health care.
- Maintain continuity of care.
- Inform members of their right to self-refer for certain services.
- Provide or arrange for interpretive services for members who are hearing impaired or whose primary language is not English.
- Obtain informed consent from the member, or from a person authorized to consent on behalf of the members, prior to treatment.
- Provide adult members with written information about advance directives and the right to make anatomical gifts.

Specialists:
Specialists must provide the member's PCP with a written report within 14 days of the date of service regarding the proposed treatment plan, including any proposed hospitalization or surgery and information regarding self-referred services such as women's health care services.

Behavioral Health

Behavioral Health provider phone messaging during and after-hours should inform members that for emergencies to "hang up and dial 911", and the messaging should include a local Crisis Center phone number and/or the Suicide Crisis Lifeline-988.

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.

- Provider offices must answer the phone during and after normal business hours.
- Calls being made to your office must be answered within **10 seconds**.
- Behavioral Health provider phone messaging during and after-hours should inform members that for emergencies to "hang up and dial 911", and the messaging should include a local Crisis Center phone number and/or the 988 Suicide Crisis Lifeline.

After-Hours (PCP, OBGYN, Midwife, Specialist, Behavioral Health)**:**

- After-hours requirements (after normal business hours, weekends, and/or holidays):
  1. After-hours coverage must be accessible using the medical office's daytime phone number.
  2. Must have an answering machine or on-call service
     - Recorded message must be provided in English – for practices/clinics with a high population of Spanish-speaking members, the message should be recorded in Spanish.
  3. Must have an on-call provider available:
     - After-hour coverage requires providers to connect the patient to someone who can provide a clinical decision or reach a PCP/Specialist for a clinical decision.
     - The PCP, Specialists, or on-call medical professional must respond to the initial contact within thirty (30) minutes.
- After-hours messaging requirements (live answering service or answering machine):
  1. "If this is an emergency, hang up and dial 911"
     - Behavioral Health Providers – after-hours messaging should also include a crisis center phone number and/or the 988 Suicide Crisis Lifeline .
  2. How to contact an on-call provider messaging (examples):
     - "To contact an on-call provider, dial ……."
     - "Press 1 and you will be connected to our on-call provider now"
     - "Follow the prompts and our on-call provider will contact you within 30-minutes"
     - "Please contact the nurse line at……"

CHPW Provider Access Training & Resources:
For more information and to access CHPW training programs, go to: CHPW Provider Training Programs, chpw.org/and/or refer to your contractual agreement. For questions, please contact your Provider Relations Representative or email Provider.Relations@chpw.org.

Apple Health Special Program - Standards and Responsibilities

Wraparound with Intensive Services (WISe): All contracted WISe providers must comply with the following guidelines located at:

- The Washington State WISe Program, Policy and Procedure Manual for program standards (under "Related forms and publications");
- The Service Encounter Reporting Instructions (SERI guide); and
- Related CHPW Policies and Procedures.

Program of Assertive Community Treatment (PACT): All contracted PACT providers must comply with the following guidelines located at:

- Washington state PACT Program Standards;
- SERI Guide; and
- Related CHPW Policies and Procedures.

NOTE: The WISe and PACT Programs apply to the Apple Health plans only.

Transitional Age Youth (TAY): All contracted providers serving members between the ages of fifteen (15) and twenty-five (25) years will address any noted challenges for the member identified in their assessment(s) and treatment and/or care plan. The elements in the treatment and/or care plan include:

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

CHPW notifies members, either by mail or phone, about alternatives and resources for continuing care when necessary. CHPW may assist members to obtain access to services.

Screening and Assessment

Early and Periodic Screening Diagnosis and Treatment (EPSDT) services must be structured in a way that is culturally and age appropriate, involves family, and is available to individuals under the age of 21. The *Intake evaluation* provided under an EPSDT referral must include a family needs assessment. EPSDT applies to the Apple Health (Medicaid) population, but not to the Apple Health Expansion population.

Washington State Health Screening schedule:

- Six (6) screenings during the first year of life:

Screening Visit	Age
1st Screening	First week
2nd Screening	One (1) month
3rd Screening	Two (2) months
4th Screening	Four (4) months
5th Screening	Six (6) months
6th Screening	Nine (9) months

- Seven well-child visits between ages 1-4 (12 months, 15 months, 18 months, 24 months, 30 months, 3 years, 4 years)

- One well-child visit every 365 days between ages 5-21 is recommended biennially for adults between nineteen (19) and twenty (20) years.

Early Childhood Mental Health (IECMH)

Mental health assessment for young children –

Developmentally appropriate assessment is key to effective mental health care for children birth to age five. In 2021, the Washington State Legislature passed a law aligning Apple Health policies with best practices for assessing young children's mental health. Doing mental health assessments for young children may be new for some providers. The links below include information and resources from the HCA to support best practices within the field.

Overview

How to Bill

Using the DC:0-5

Other Resources

Stay Connected

Key contacts

Topic	Link	Phone Number
EPSDT	hca.wa.gov > Program Administration > Apple Health eligibility manual > General eligibility requirements that apply to all Apple Health programs > Scope of care Early and Periodic Screening. Diagnosis and Treatment (EPSDT)	800 562-3022
Vaccines for Children	doh.wa.gov > Public Health System Resources and Services > Immunization > Childhood Vaccine Program	800 219-3224
IECMH	Developmentally appropriate assessment is key to effective mental health care for children birth to age five. In 2021, the Washington State Legislature passes a law aligning Apple Health policies with best practices for assessing young children's mental health. hca.wa.gov/billers-providers-partners/program-information-providers/mental-health-assessment-young-children	800 440-1561

Behavioral Health Screening and Assessment. If Contractor provides Behavioral Health services, Contractor shall utilize the Global Appraisal of Individual Needs-Short Screener (GAIN-SS) and assessment process, including use of the quadrant placement. If the results of the GAIN-SS are indicative of the presence of a co-occurring disorder, Contractor shall consider this information in the development of the Member's treatment plan, including appropriate referrals. In addition, Contractor shall implement and maintain the Integrated Co-Occurring Disorder Screening and Assessment process, including training for applicable staff.

The GAIN-SS Assessment Tool form(s) 14-479 and 04-416 are located at Contractor and provider resources | Washington State Health Care Authority

Care Standards Documents

Site Tools chpw.org/provider-center/forms-and-tools/
CHPW Policies and Procedures chpw.org/provider-center/forms-and-tools/policies/

Critical Incident Reporting

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

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

A. Suicide or attempted suicide.
B. **Incident to the Enrollee that occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), FQHC, or by independent behavioral health provider:**
    a. Physical or sexual assault perpetrated by another individual
    b. Abuse, neglect, or sexual/financial exploitation perpetrated by staff
    c. Death; and
    d. Severely adverse medical outcomes or death occurring within 72 hours of transfer from a contracted behavioral health facility to a medical treatment facility.
C. Violent acts allegedly committed by a member with a behavioral health diagnosis or history of behavioral health treatment within the previous 365 days. Acts include:
    1. Arson.
    2. Assault or action resulting in serious bodily harm.
    3. Homicide or attempted homicide by abuse.
    4. Kidnapping.
    5. Sexual assault.
D. Unauthorized leave from a behavioral health facility during an involuntary detention.
E. Credible threat to member safety.
F. Poisoning/overdose unintentional or intention unknown.
G. Event likely to attract media attention.

Providers must report a Critical Incident within **one (1) business day** when made aware of the event, the *Critical Incident Report Form* is located at:
https://www.chpw.org/wp-content/uploads/content/provider-center/CHPW_Universal_Critical_Incident_Form.pdf
Once completed, send the form to CHPW at Critical.Incidents@chpw.org.or via fax to 206-652-7056.

Upon receipt, if additional information is needed, CHPW will contact the provider/reporter within 45 days to complete the follow-up report through the **HCA Incident Reporting System**.

Community Behavioral Health Reporting and Data

All contracted, licensed, and certified Behavioral Health Agencies (BHAs) are required to collect and submit Behavioral Health (BH) supplemental transactions. BHAs must comply with the Data Collection and Reporting Requirements outlined in the Behavioral Health Supplemental Transaction Guide.

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

Residential/Inpatient SUD Treatment Facilities

Required policies and procedures to ensure access to FDA-approved medications for SUD

The Washington State Medicaid contract stipulates that Medicaid Managed Care Organizations may only contract with substance use treatment agencies that have specific policies and procedures in place related to FDA-approved medications for any substance use disorder.

Residential/Inpatient facilities must have policies and procedures to:

- Inform clients about their options for MAT and ensure they have access to such treatments.
- Allow individuals to seek FDA-approved medication for any SUD at any point in their course of treatment.
- Provide or facilitate the induction of any prescribed FDA-approved medications for any SUD.
- Facilitate the continuation of any prescribed FDA-approved medication for any SUD.
- Ensure individuals prescribed any of the FDA-approved medications to treat SUDs are denied services.

Facilities may not have any policies and procedures that mandate titration of any prescribed FDA-approved medication to treat any SUD as a condition of receiving or continuing behavioral health treatment.

See WAC 246-341-1108 and pages 55-56 of the Department of Health's Policy and Procedure Review Tool for Behavioral Health Agencies.

Technical Assistance Available: Treatment facilities who are encountering barriers to providing or facilitating access to FDA-approved medications for substance use treatment can receive technical assistance from CHPW's Behavioral Health clinical team.

When technical assistance is needed, please connect with your primary Provider Relations contact or email Provider.Relations@chpw.org.

Credentialing and Re-credentialing

CHPW's Credentialing Program meets the criteria outlined in CHPW's Mission Statement and the National Committee for Quality Assurance (NCQA) standards for accreditation.

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

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

The Credentialing Program includes an annual evaluation and periodic revision to the related CHPW Policies and Procedures adopted by the Credentialing Committee.

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

For credentialing status inquiries, please email Provider.Credentialing@chpw.org.

Washington Practitioner Application

When uploading a Washington Practitioner Application (WPA) to CAQH as part of credentialing/recredentialing, please notify CHPW by emailing Provider.Credentialing@chpw.org, as CHPW does not receive notification from the systems when a WPA is uploaded.

Providers can either:

1. Forward a completed WPA with provider authorization for the provider to Provider.Credentialing@CHPW.org;

-or-

2. Go to CAQH, complete the information there, and notify Provider.Credentialing@CHPW.org when the application is ready for download. As noted above, we do not receive notification from the system so please make sure to email CHPW separately at Provider.Credentialing@CHPW.org

If you choose the printed format, completed applications can be scanned/emailed to Provider.Credentialing@chpw.org or faxed to Credentialing at (206) 652-7070.

Provider Rights

Right to review information to support application

Providers who've been credentialed or are in the credentialing process have the right to review the credentialing information collected during initial credentialing, re-credentialing, and ongoing review processes.

The provider is notified of their rights in the CHPW Cover letter that accompanies CHPW's Initial Credentialing and Re-Credentialing application(s). The cover letter describes the intent of the process and the steps a provider must take to review the information collected.

Right to correct erroneous information

If information provided on the application is inconsistent with information obtained from the primary source verification, the CHPW Credentialing Specialist will send the provider written notification of the discrepancy and request formal written clarification. The notification will include a summary of the inconsistent information and a request to have the provider's response returned within ten (10) business days. Notifications are sent electronically, or certified return receipt requested, and the correspondence marked "Confidential" as applicable.

A provider cannot make any changes/corrections to an application that has been previously attested to as correct and complete. The provider has a right to submit an addendum to correct erroneous information submitted by another party. If preferred, the provider may add an explanation for the erroneous information on their application, include a signed and dated statement attesting to the accuracy of the information provided, and then return the information to the CHPW Credentialing Specialist.
Right to be informed of application status

Providers may contact the Credentialing department at (206) 515-7942 to discuss their credentialing status.

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

Documents available for review are:

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

Peer Review documents, references, or other information that is peer reviewed or protected are not shared with the applicant. CHPW's not required to reveal the source of information that's not obtained to meet the primary source verification requirements, or when law prohibits disclosure.

Upon request, CHPW will provide the status of their application. The provider's notified of this right when they receive the cover letter that accompanies CHPW's Credentialing and Re-credentialing Application. The provider may contact the Credentialing Specialist for information about the status of their credentialing application. The Credentialing Specialist will explain where the application is in the process. The Credentialing Specialist may share *other* permitted information with the provider regarding their application.

Note: As a reminder, a provider cannot provide health care services to a CHPW member if the provider has not completed the credentialing process. Any claim received will be denied if the provider has not completed the credentialing process at the time services were rendered.

Access to Records and Member Health Information

A provider shall permit reasonable access to financial records, medical records, and any other records that relate to their Provider Agreement to authorized representatives of CHPW, Payers, and state or federal agencies with applicable authority.

Access to such records shall be to the extent permitted by law and as necessary to fulfill the terms of the Provider Agreement and CHPW's state and federal contractual obligations, as well as NCQA, legal, and accreditation requirements. Retrieval and duplication of records shall be at the provider's expense.

A provider shall permit CHPW to conduct audits of member medical records for covered services rendered under their Provider Agreement. Such inspection, audit, and duplication of records are allowed with reasonable notice during regular business hours.

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

A provider must retain all member information referenced in the Provider Agreement. Member information includes medical records, claims, benefits, and other medical or administrative data that is personally identifiable to the member.

Clinical Data Repository (CDR)

The Health Care Authority (HCA) is advancing Washington's capabilities to collect, share, and use integrated physical and behavioral health information from provider's Electronic Health Record systems (EHRs) by implementing the Washington Link4Health Clinical Data Repository (CDR). The CDR aggregates clinical information from disparate EHRs in one easily accessible location. By providing access to clinical information from outside the enterprise, the CDR helps the care team gain a more comprehensive understanding of the patient's medical history.

Participation in the CDR is required for all Provider Organizations that are contracted with Managed Care Organizations, see Apple Health Managed Care Enrollees, and have a certified EHR.

HCA has partnered with OneHealthPort to develop and manage the CDR. The CDR test environment is operational and available for testing. OneHealthPort is currently working with a large number of provider organizations testing and validating submissions to the test CDR prior to moving to production.

For any questions on how or when to get started, please submit a OneHealthPort HIE Support Request Form

Getting Started

To use the OneHealthPort CDR, your organization must be registered with the OneHealthPort SSO and have a OneHealthPort Health Information Exchange (HIE) Agreement.

If your organization does not have an SSO account, learn how your organization can Register your Organization. Need assistance? Contact the OneHealthPort help desk at 1.800.973.4797 (toll free) 24 hours a day, seven days a week. You can also contact us with your questions by submitting this Form.

Don't know if your organization is already a participant with the OneHealthPort HIE? Check the Participation List. To become a participant with the OneHealthPort HIE, go to OneHealthPort HIE Contracting. Need assistance? Submit a OneHealthPort HIE Support Request Form.

- Learn more about the HIE fees

There is no setup or per transaction fees.

ORGANIZATION LEVEL	ANNUAL ORGANIZATION OPERATING REVENUE	ANNUAL SUBSCRIPTION FEE
Entry	$0 - $10 Million	$600
Small	$10 Million - $100 Million	$6,000
Mid-size	$100 Million - $500 Million	$12,000
Large	$500 Million - $1 Billion	$24,000
Leadership	$1 Billion Plus	$48,000

Submitting Data to the CDR
To collect standardized data from all organizations submitting to the CDR, each organization will be asked to work with their Electronic Health Record (EHR) vendor to prepare and test their C-CDA files. Preparing for the C-CDA Exchange provides detailed information about preparations and testing.

Viewing data in the CDR
Clinical data in the CDR can be viewed through the Clinical Portal. Since July 2018, the Clinical Portal has been open for viewing by all licensed professionals including physical and behavioral health providers and their delegates.

If your organization would like to begin using this service, please contact OneHealthPort contact OneHealthPort.

Security of Health Information

CHPW and the provider must have developed, implemented, maintain, and use administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of a member's protected health information (PHI). This applies to any formats that CHPW or the provider creates, receives, maintains, or transmits in performing duties under the Provider Agreement to protect member safety, and the privacy and security of member PHI. Further, CHPW and the provider must safeguard all member medical information including the paper and/or electronic health record against loss, defacement, theft, tampering, and from use by unauthorized individuals.

Medical Record Documentation Standards

A provider must construct and maintain a medical record for each CHPW member while the member is an active patient. If the member is an inactive patient, the medical record may be stored for a minimum of ten (10) years. This includes all medical records, X-ray films, tissue specimens, slides, and photographs which are the property of the provider.

All paper-based notes, reports, within the medical record must be secure in the member's folder or electronically attached to the member's file/record.

An active member's medical record should be kept at each provider's office. If the member becomes an inactive patient, the medical record may be kept offsite. Records must be easily retrievable. All medical records, active and inactive, must be supplied within 30 days of a request by CHPW. Medical record requests for HEDIS, Post Payment Reviews (PPR) and other regulatory reviews may be submitted as URGENT requests due to strict timelines; thus, Urgent requests should be prioritized and issued sooner than in 30 days.

CHPW providers must comply with all federal, state, and local laws and regulations related to medical records documentation/retention, as well as medical record requests. CHPW requires that documentation for all episodes of care must meet the following criteria unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise:

- Documentation must be legible to someone other than the writer.
- Documentation must be complete, dated, and timed.
- Documentation must reflect all aspects of care.
- Information identifying the member must be included on each page in the medical record.
- Each entry in the medical record must include author identification of the physician or other qualified health care provider, which may be a handwritten signature, unique electronic identifier, or initials and rendering provider credentials, as applicable.
- Timely entry of information into a medical record is expected to be completed at the time of service, or shortly thereafter and should not exceed 30 days.
- Signature date within 30 days of the date of service, and an additional entry of the signature time for services performed in a hospital setting.

To be considered complete, documentation for episodes of care will include, at a minimum, the following elements when applicable:

- Member identifying information
- Consent forms.
- Health history, including applicable drug allergies
- Physical examinations
- Physician orders
- Immunization record
- Medications prescribed
- Emergency care
- Smoking, alcohol, and substance abuse history
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports.
- Admission and discharge dates and instructions
- Preventive services provided or offered, appropriate to member's age and health status
- Evidence of coordination of care between primary and specialty physicians
- Working diagnoses consistent with findings and test results
- Treatment plans consistent with diagnoses

Provider Data Quality Assurance

Reporting Changes in Provider Information

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

- Tax identification
- NPI (National Provider Identifier) number (individual and/or group)
- Billing (vendor) address, office, phone, and fax numbers
- Clinic contact information (name, phone number, fax, and email)–i.e., Credentialing Coordinator, Billing Manager, Clinic Manager
- Provider additions (include provider effective date)
- Changes to provider locations within a group
- Provider terminations (include provider termination date)
- Clinic/facility location additions/changes (if applicable, include effective and termination dates for your clinics and/or facility)
- If telehealth services are available at your location(s), **it is important for CHPW's Provider Directory to accurately reflect the availability of these services.**

A 60-day advance notice provides CHPW time to update CHPW processing systems, give member notification, and prevent claim processing delays. Provider/Group changes must be reported to CHPW by completing the *Provider Add Change Term Form* and/or *Clinic and Group Add Change Term Form*. The form is available on our Provider Forms & Tools webpage, under **Provider Updates**. In addition, a provider can email the completed form to Provider.Changes@chpw.org or **click** the **"Submit Form**" button of the online form. For new providers requiring credentialing, please send the request to Provider.Credentialing@chpw.org.

Provider groups who have a delegated credentialing agreement with CHPW, refer to the Delegated Credentialing Agreement. Submit provider updates by email to DelegatedCredentialing@chpw.org.

Provider Rosters

CHPW appreciates the valued services that your clinic and/or facility provides to our members. In accordance with 42 C.F.R. §422.111, CHPW is committed to providing clear and accurate information to members regarding our provider network.

CHPW periodically emails a request to providers along with a provider roster from the CHPW system. The roster includes information such as: Tax IDs, NPIs, Licensure Information, Specialties, office locations, phone numbers, office hours, whether the provider is accepting new patients. CHPW also verifies the provider's demographic information such as: ADA access, any languages spoken by staff (other than English), and gender or age restrictions. **Note:** All practice locations where a provider renders services (under your Provider Agreement) must be identified on the Provider Roster.

Upon receipt of your roster, please review for accuracy, highlight or notate any changes and corrections, and return the roster to provider.changes@chpw.org. Please submit any provider additions, changes, or terminations immediately using the *Provider Add Change Term Form* or *Clinic and Group Change Term Form*.

CHPW appreciates your time in partnering with us to ensure the CHPW Provider Directory is accurate and up to date. If you have any questions, please contact provider.changes@chpw.org.

Practice Capacity

PCPs must notify CHPW when their practice reaches capacity and they are no longer accepting new patients. This notice must be in writing. It will be effective on the first day of the month following forty-five (45) days from receipt of the notice. Providers may submit their notice to provider.changes@chpw.org.

Provider Termination

If you find it necessary to terminate your contract arrangement with CHPW, refer to your contract for notice requirements. Complying with the termination notification requirements ensures compliance with the Patient Bill of Rights and allows time for CHPW to notify our members. Providers may submit their termination notice to provider.changes@chpw.org.

Ownership and Control Disclosure Form

The Centers for Medicare & Medicaid Services (CMS) and the Washington State HCA require hospitals, clinics, and other health care organizations to provide a completed *Disclosure of Ownership and Control* (O&C) form to CHPW prior to contract execution. Providers are required to submit an updated O&C within thirty-five (35) days, if the following changes occur:

- New business owner(s)
- Tax ID change
- Management (CEO) change, and/or Board of Director changes
- Other pertinent changes

The form is located at https://www.chpw.org/provider-center/forms-and-tools/. **Verify Member Eligibility and Benefits**

CHPW plan offerings have a set of rules, obligations, and contractual requirements that govern and determine eligibility of coverage, including member enrollment and termination processes/requirements. These rules are governed by the HCA (Apple Health), CMS (MA including MA D-SNP) and the Office of the Insurance Commissioner (OIC) (Individual and Family Cascade Select).

Go to the HCA I need medical, dental, or vision care page for Apple Health enrollment and eligibility information. In addition, you must verify member eligibility through *ProviderOne* **prior to providing services**. See the ProviderOne Billing and Resource Guide for more information.

For MA including the MA Dual Special Needs Plan (D-SNP) enrollment and eligibility requirements, go to the Medicare.gov Estimate my Medicare eligibility & premium page. In addition, you must contact CHPW's Medicare Customer Service department to confirm individual eligibility and benefits.

For Individual and Family Cascade Select membership and eligibility, please refer to the HealthMAPS portal. (See the "**HealthMAPS Provider Portal**" section of this manual for more information.)

Note: Providers can verify eligibility and benefits by submitting a *Health Care Eligibility Benefit Inquiry* and *Response (HIPAA 270/271 Batch and Real Time Transactions*). Refer to the "**Additional External Contacts**" or "**Member Eligibility and Benefits**" section of this manual.

MA Providers in a Health Care Setting

CHPW understands that Medicare members rely on and trust their health care providers to provide them with complete information regarding their health care choices.

To the extent of their ability, providers may assist a member in an objective assessment of the member's health care needs and potential plan options. Providers are permitted to make available and/or distribute marketing materials for all plans with which they participate and to display posters or other marketing materials announcing plan contractual relationships; however, the provider must remain neutral. Refer tocms.gov/files/document/medicare-communications-and-marketing-guidelines-3-16-2022.pdf.

The Medicare Communication Marketing Guidelines (MCMG) allow CHPW's contracted providers to:

- Distribute unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" (from https://www.medicare.gov) including in areas where care's delivered.
- Providing the names of plans with which they contract and/or participate.
- Answering questions or discussing the merits of a plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care's delivered).
- Referring patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, plan marketing representatives, State Medicaid Office, local Social Security Office, CMS' website at medicare.gov/, or 1-800-MEDICARE.
- Refer patients to plan marketing materials.
- Providing information and assistance in applying for the Low-Income Subsidy (LIS).
- Make available, distribute, and display communication materials, including in areas where care is delivered; and
- Provide or make available plan marketing materials and enrollment forms outside of the area where care's delivered (such as common entryways, vestibules, hospital or nursing home cafeterias, and community, recreational, or conference rooms).

The MCMG prohibits CHPW from allowing its contracted providers to:

- Accept or collect scope of appointment forms.
- Accept Medicare enrollment applications.
- Make phone calls or direct, urge, or attempt to persuade their patients to enroll in a specific plan based on financial or any other interests of the provider.
- Mail marketing materials on behalf of CHPW.
- Offer inducements to persuade their patients to enroll in a particular plan or organization.
- Conduct health screenings as a marketing activity.
- Distribute marketing materials/applications in areas where care is delivered.
- Offer anything of value to induce enrollees to select them as their provider; or
- Accept compensation from CHPW for any marketing or enrollment activities.

Beneficiary Inducement Law

The Beneficiary Inducement Law is a federal health care program created in 1996 as part of the Health Insurance Portability Accountability Act (HIPAA). The law makes it illegal to offer money or services that are likely to influence a member to select a particular health care provider, practitioner, or supplier. Examples include:

- Offering gifts or payments to induce members to come in for a consultation or treatment.
- Waiving copayments and deductibles.

Health care providers who violate this law may be fined up to $10,000 for each item or service for which payment may be made, and $5,000 for each individual violation. Fines may be assessed for up to 3 times the amount claimed. Violators may be excluded from participating in Medicare and Medicaid programs.

Allowable Gratuities: Items or services offered to members for free must be worth less than $15 and total less than $75 per year per beneficiary. Never give cash or gift cards to members.

Provider Directory

Use our ***Find a Doctor*** tool to search for providers and clinics by:

- Going to the CHPW Apple Health, MA, or Individual and Family Cascade Select website. Click the **Find a Doctor** tab on the homepage to search for a provider.
- Going directly to the Provider Search for Apple Health, MA, or Individual and Family Cascade Select.
- Accessing the directory from within the HealthMAPS online provider portal. Once you're logged in, click the Find/Rate a Doctor link on your dashboard.

The directory is easy to use with useful features:

- Quick search by location (zip code, city, or county), benefit plan, and provider type (doctor/medical professionals, facility, hospital, behavioral health, and durable medical equipment).
- Advanced filters accessible from the homepage.
- Additional filters allow quick and easy information about the provider.
- Ability to select more than one filter i.e., **Accepting New Patients, ADA Accessibility, Extended Hours**.

See also CHPW's Online Provider Search Tool Provider Bulletin.

The Provider Directory is subject to change and may not be a complete representation of CHPW's network. If a specialist you utilize or refer to is not contracted with CHPW, please email our Provider Contracting department at Provider.Contracting@chpw.org or call Customer Service (refer to the "**CHPW Contacts**" section of the manual). For contract termination information, refer to your Provider Agreement, contract terms.

Apple Health, MA/MA D-SNP, CHPW Cascade Select - Service Area

Apple Health:

Region	Counties
Greater Columbia Region	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, Yakima
King Region	King
North Sound Region	Island, San Juan, Skagit, Snohomish, Whatcom
Spokane Region	Adams, Ferry, Lincoln, Pend Oreille, Spokane, Stevens
Southwest Washington Region	Clark, Klickitat, and Skamania
Pierce	Pierce
North Central	Chelan, Douglas, Grant, Okanogan
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, Wahkiakum
Salish	Clallam, Jefferson, Kitsap
Thurston-Mason	Mason, Thurston

Cascade Select service area:

Counties		
Adams	Asotin	Benton
Clallam	Chelan	Columbia
Douglas	Ferry	Franklin
Grant	Jefferson	King
Kitsap	Kittitas	Lincoln
Lewis	Mason	Okanogan
Pierce	Snohomish	Stevens
Spokane	Thurston	Walla Walla
Whitman	Yakima	

MA/MAD-SNP service area:

Plan Benefit Package	Marketing Name	Counties
014	Community Health Plan of Washington MA Dual Complete (HMO D-SNP) Plan	Adams, Asotin, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, GarfieldGrant, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman, Yakima
017	Community Health Plan of Washington MA Dual Select (HMO D-SNP) Plan	Adams, Benton, Chelan, Clallam, Clark, Cowlitz, Douglas, Franklin, Grant, Grays Harbor, Jefferson, King, Kitsap, Kittitas, Lewis, Mason, Okanogan, Pacific, Pend Oreille, Pierce, Skagit, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Yakima

CHPW Eligibility Department

Eligibility Documents

Refer to the following resources for PCP assignment and Provider Roster Correction information:

- PCP assignment: Visit https://www.chpw.org/provider-center/forms-and-tools/ and look for the Clinic/PCP Selection Form under Enrollment in the header.
- Member Roster Correction: Please navigate to chpw.org/provider-center/forms-and-tools/ and click on “Enrollment” to see the list of optional forms.

Clinic/PCP Assignment Procedure

Although a member may request a specific provider assignment, all members are assigned at the Clinic level, not at the individual provider level. Clinic/PCP changes must be initiated by the member **or** at the request of the provider (with member confirmation). Members will be assigned to providers or clinics not accepting new patients ***only*** if the Provider has agreed to accept them as a patient. For information regarding PCP changes for MA, refer to the member’s EOC located at: medicare.chpw.org/.

A member can submit a PCP change (on their behalf) by logging into mychpw.chpw.org/en/member. The *PCP Selection Form* can also be faxed to (206) 652-7085 or emailed to EligibilityDept@chpw.org.

Involuntary Disenrollment from Apple Health

A member may be involuntarily disenrolled when:

- Member loses eligibility; or
- HCA provides notice that available funding for the program is exhausted (Apple Health Expansion (AHE) only).

Involuntary Disenrollment from Cascade Select

A member may be involuntarily disenrolled from Cascade Select when:

- Member fails to pay their premium

Member Reassignment Policy – Apple Health

A member reassignment occurs when a member's reassigned "involuntarily" to another provider/clinic, or when disenrolled from CHPW, due to inappropriate behavior.

If CHPW attempts to resolve the behavior issue with reasonable accommodation (of any disability) unsuccessfully; and continued enrollment would impair CHPW's ability to furnish services to the member.

Whenever possible, CHPW will provide the member an opportunity to change/improve the behavior. In the event it is determined not safe or prudent to offer medical care to the member at a plan network facility, CHPW may request a member be disenrolled from the HCA.

This applies to members who:

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

Each case is reviewed independently according to the procedures below.

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

If a contracted provider is no longer able or willing to continue to provide care for a member, CHPW will arrange and secure alternative care until another permanent provider is assigned, or until the state approves the disenrollment of the member. The care is covered by CHPW under the member's benefits as outlined in the applicable program contracts.

Members who are reassigned involuntarily to another CHPW provider are notified in writing thirty (30) days in advance. This written notice will inform the member of their right to Appeal the reassignment, except in cases when the member's conduct presents a threat of immediate harm to others.

Members who appeal any decision for reassignment or disenrollment will receive necessary covered health care arranged by their current PCP, with the assistance of appropriate CHPW staff until a decision is rendered by CHPW or the applicable state agency.

NOTE: Medicare has a similar process. However, disenrollment for disruptive behavior requires CMS approval.

Disenrollment Procedure – Apple Health

To request a member reassignment/disenrollment from your facility, follow the instructions below:

First, follow your internal policies and procedures documenting the instances of non-compliance and/or disruptive behavior. Documentation may include other providers' documented reports of disruptive behavior. A provider may request reassignment/disenrollment if the member's behavior exhibits any of the following:

- A member exhibits repeated abusive behavior toward staff or visitors. The behavior may include yelling; the use of profanity; name-calling; any inappropriate or unwelcome touch; or threatening words/actions.
- Member refuses to follow the outlined diagnostic treatment plan or continually engages in drug-seeking behavior.
- Member repeatedly refuses to follow clinic or member handbook procedures by continually missing appointments, inappropriate use of the emergency room, or self-referring to specialists without PCP consultation.

To initiate a reassignment/disenrollment, follow these steps:

1. When a PCP requests a member reassignment, a Warning Letter is sent to the member. The letter must document the disruptive behavior and outline an Action Plan the member must follow to remain with the clinic. The Warning Letter is copied to the clinic's Managed Care Coordinator and the CHPW Provider Relations department. The member is provided a written copy of the procedure to address patient behavior.
2. If the behavior continues and fails to comply with the steps outlined in the Action Plan, clinic staff (with clinic Medical Director approval) must consult with the CHPW Provider Relations department to request reassignment/disenrollment from CHPW.
3. If reassignment is not an option due to member location or circumstance, the clinic staff involved will establish a plan for resolution and follow-up that includes member education.
4. If it is determined that the member should be reassigned, the Provider Relations department will notify the member in writing. The letter provides thirty (30) day notice, along with their right to appeal, and the right to a fair hearing (under Washington Administrative Code (WAC)). The letter outlines the members' options for receiving future health care through CHPW. The Provider Relations department will coordinate with clinic staff and/or a CHPW Care Manager to arrange for ongoing care. At no time will a member be transferred to another clinic without prior agreement of that clinic. If the clinic provider/staff and CHPW Care Manager determine the member's behavior is serious enough to warrant disenrollment, the following steps are followed:

- CHPW Care Manager notifies the member of the plan's intent to request an involuntary disenrollment. The notice is in writing and provides the members with their appeal rights.
- CHPW Care Manager collaborate with the Provider Relations department to gather all necessary documentation from the PCP.
- All information provided by the PCP will be forwarded to the CHPW Medical Director.
    - If the CHPW Medical Director determines the involuntary disenrollment request meets WAC requirements, they will submit the documentation along with a letter requesting disenrollment to the HCA's Exception Care Management (ECM) Section.
- HCA ECM decides within thirty (30) days of receiving the request. If approved, HCA ECM will notify CHPW and the member with at least ten (10) days' notice of termination.
- The member will remain enrolled until the HCA ECM notifies CHPW.

Clinic staff must:

- Document member misbehavior.
- Create a written corrective action plan to improve the behavior, if applicable.
- Provide members with a written notice of the action the clinic will take.
- Provide members with written policies and procedures for Member Responsibilities.
- Report criminal behavior to law enforcement.

CHPW staff are responsible for reviewing documentation and consulting with clinic staff to identify alternatives for providing health care services to the members. The CHPW Care Manager serves as a liaison to the HCA in requesting disenrollment with the HCA.

Involuntary Disenrollment – MA Plan

Involuntarily disenrollment for a MA member may occur if:

- Change in residence outside CHPW's service area or temporary absence from the service area for more than six (6) consecutive months.
- Loss of entitlement to Washington Apple Health (Medicaid) (MA D-SNP plan).
- Loss of entitlement to Medicare Part A or loss of enrollment in Part B.
- Death.
- Disruptive behavior (CMS approval required).
- Incarceration.
- Failure to pay premium.
- Failure to Pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA).
- Enrollee Fraud.
- Contract termination.
- Member provides false information or withholds information about other insurance (medical and prescription drug coverage)

The CHPW Eligibility Coordinator (EC) will document receipt of all disenrollment requests.

When a member or legal representative contacts CHPW with an address change outside the service area, the EC will determine the effective date of disenrollment and send the member a *Disenrollment Due to Permanent Move* notice.

When CHPW receives a member address change from a source other than the member or member's authorized representative, the disenrollment will not occur without confirmation from the member or authorized representative that the out-of-area move is permanent, or six (6) months have passed. The EC will contact the member to verify the address change.

If the EC is unable to reach the member by phone, the EC will mail the member a *Verification of Change in Address* notice. If the EC does not receive a response to the notice by the sixth (6^{th}) month, the EC will mail the *Upcoming Disenrollment Due to Out of Area Over 6 Month* notice. The EC will determine the disenrollment effective date and send a Disenrollment Transaction to CMS. Upon receipt of the TRR transaction a *Final Confirmation of Disenrollment Due to Out of Area for 6 Month* notice will be generated.

Loss of Entitlement to Apple Health (Medicaid)

If the member is in a MA D-SNP plan and no longer eligible with Apple Health (Medicaid), the EC will send the member a *Disenrollment from the Special Needs Plan Due to Loss of Medicaid* notice. The member may be eligible for a Special Election Period (SEP) for two (2) months following disenrollment from the D-SNP to apply for another MA plan.

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

When the EC receives a *CMS Reply Listing* indicating loss of Medicare Part A or Part B benefits, the EC will send the *Disenrollment Due to Loss of Part A or Part B Coverage* notice to the member.

Member is Deceased

When the EC receives the *CMS Reply Listing* that indicates a member is deceased, the EC will send a *Disenrollment Due to Death* notice to the estate of the member. If a member contacts CHPW regarding an erroneous disenrollment, the EC will follow the *Enrollment Reinstatement procedure*.

Cascade Select members' disenrollment is automatic if notification is received from the Washington Health Benefit Exchange (WAHBE). If the member's family contacts CHPW with notice of death, the family members directed to WAHBE.

Disruptive Behavior – MA Process

If CHPW determines that a member exhibits disruptive behavior impairs CHPW's ability to arrange for or provide care, the EC will investigate the issue.

The EC's Manager determines if the member's behavior may be related to the use of medical services or diminished mental capacity. If not, the Manager attempts to resolve the issue with the member (while documenting all information). **Note**: If CHPW elects to disenroll, the EC Manager will contact CHPW's Compliance Officer to request approval from CHPW's CMS Account Manager.

If the CMS Account Manager advises CHPW to proceed with disenrolling, the EC will send the member a *Warning of Potential Disenrollment Due to Disruptive Behavior* notice and continue to work to resolve the issue.

If the disruptive behavior continues, the EC will send the *Intent to Disenroll* notice. The EC will send the disenrollment request to CMS. **Note**: CMS will either approve or deny the request within twenty (20) business days. If CMS denies the request, CHPW will notify the member and member will remain enrolled.

If the disenrollment requests are approved, the EC will send the *Disenrollment for Disruptive Behavior* notice.

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

Members with Part D-IRMAA must pay an additional premium directly to the government. CMS has established a 3-month initial grace period before disenrolling the member.

Member ID Cards

Below are samples of Member ID cards. Members who have lost or need a replacement ID card may contact: Apple Health (800) 440-1561, Medicare Advantage D-SNP (800) 942-0247 or Cascade Select (866) 907-1906.

Apple Health ID Cards

Please be sure to verify eligibility in ProviderOne for members prior to rendering services for all visits.

By Region:

Southwest



Great Rivers



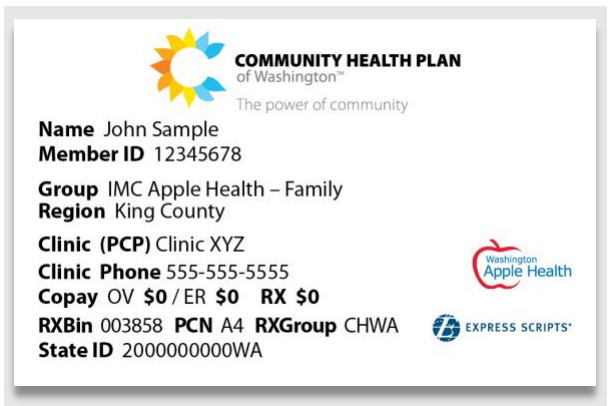


Greater Columbia





King County



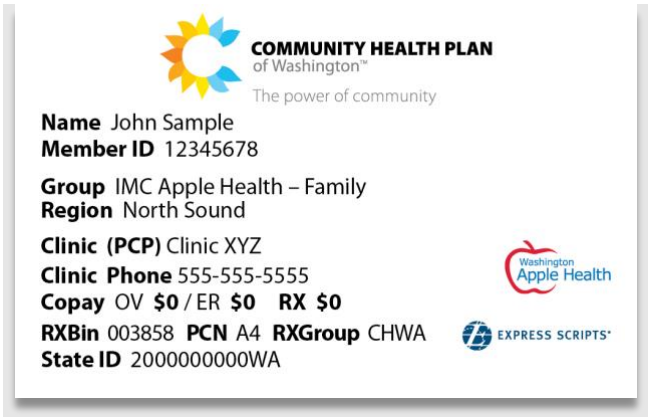


North Central





North Sound





Pierce





Spokane



Salish



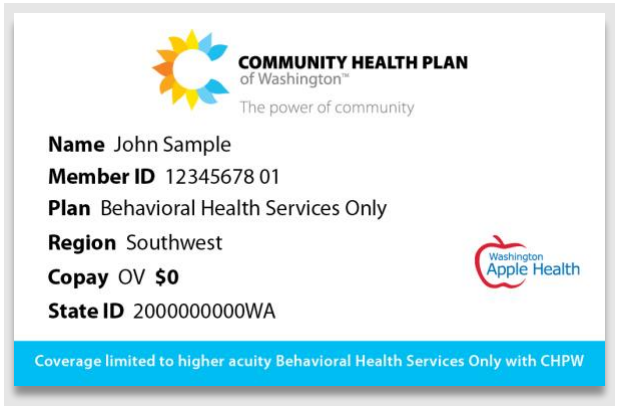
Thurston & Mason



BHSO ID Cards (No Medical Services)

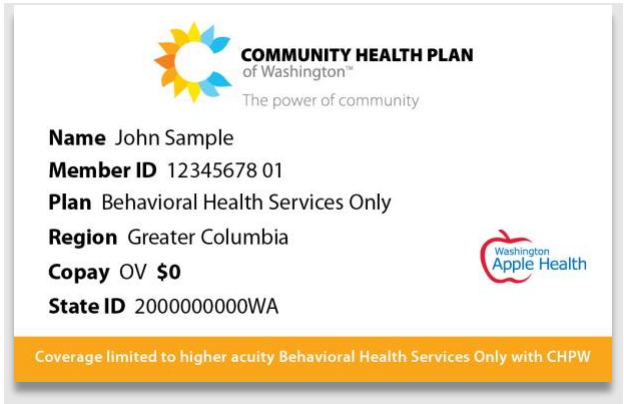
By Region:

Southwest





Greater Columbia



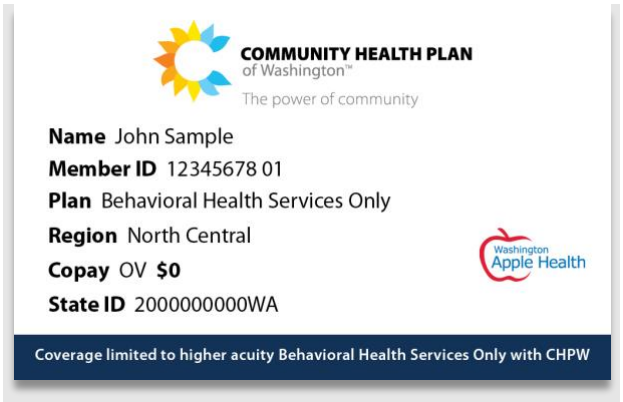


King County



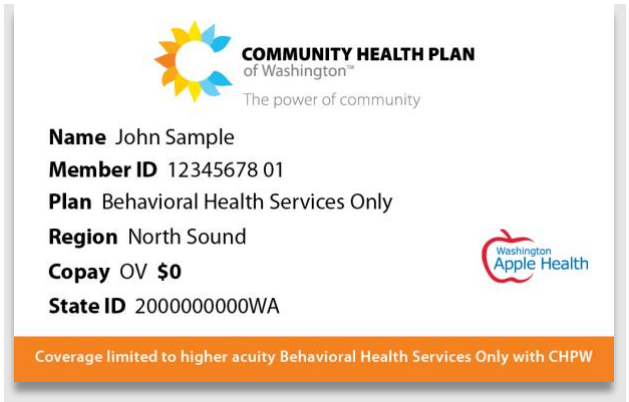


North Central



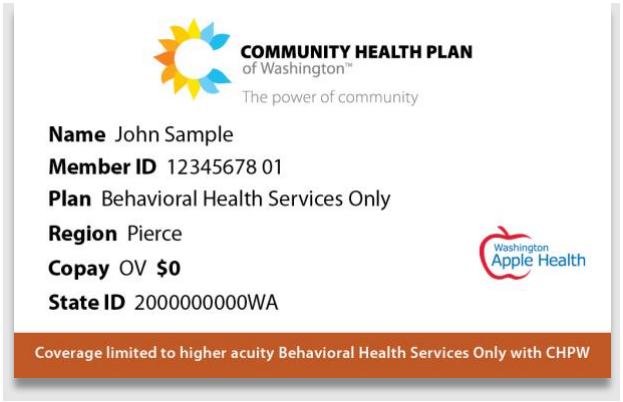


North Sound



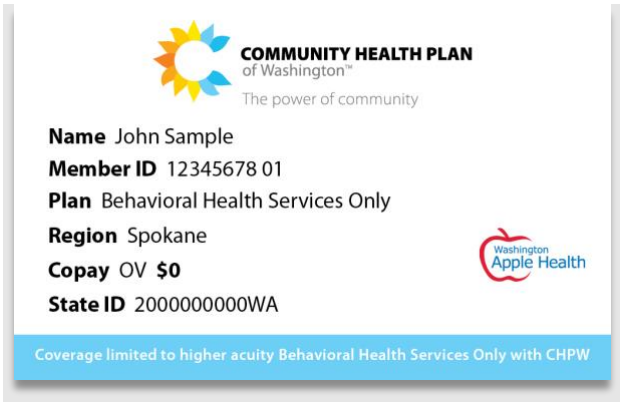


Pierce



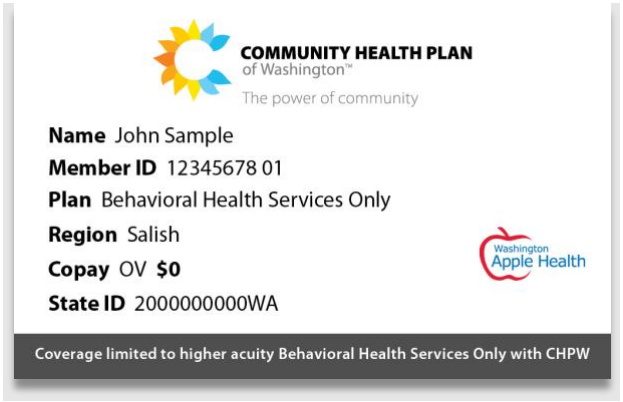


Spokane



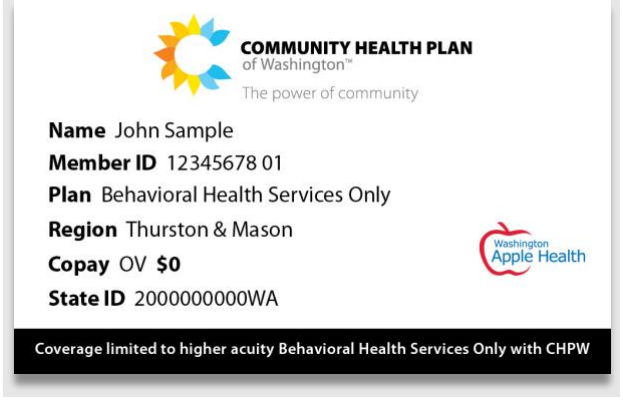


Salish



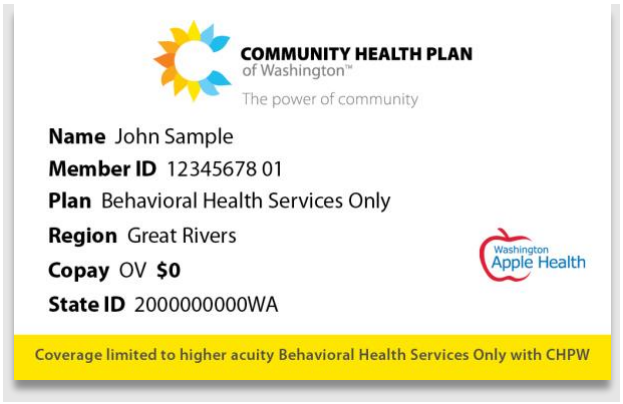


Thurston & Mason





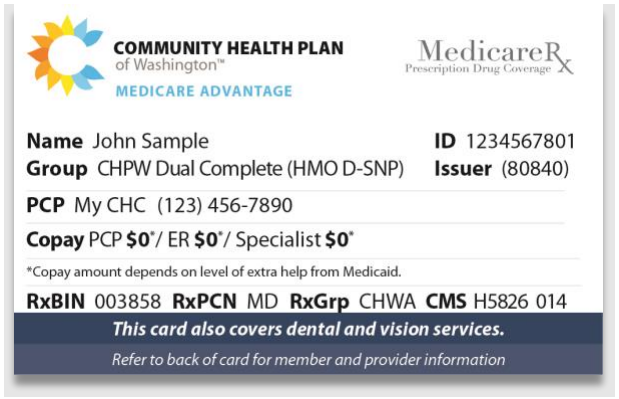
Great Rivers





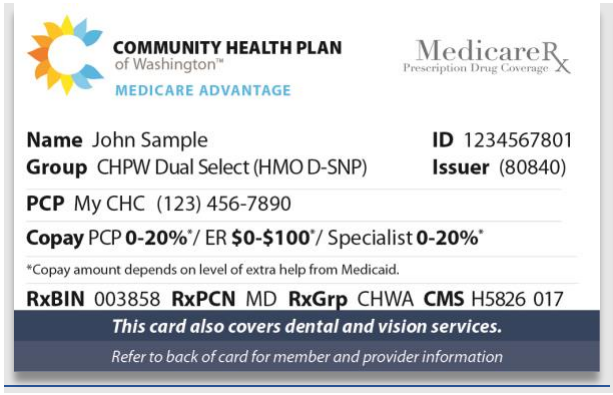
MA D-SNP ID Cards

Medicare – Dual Complete (HMO D-SNP)





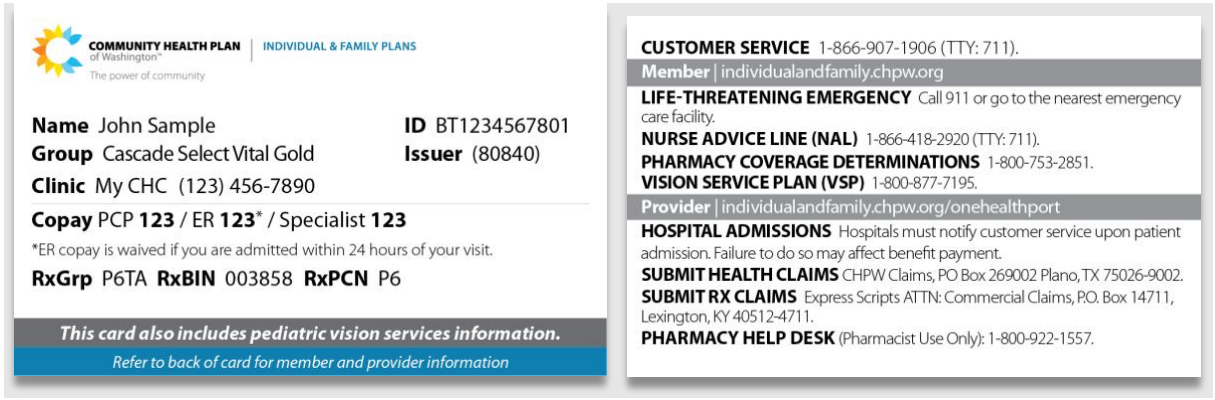
Medicare – Dual Select (HMO D-SNP)



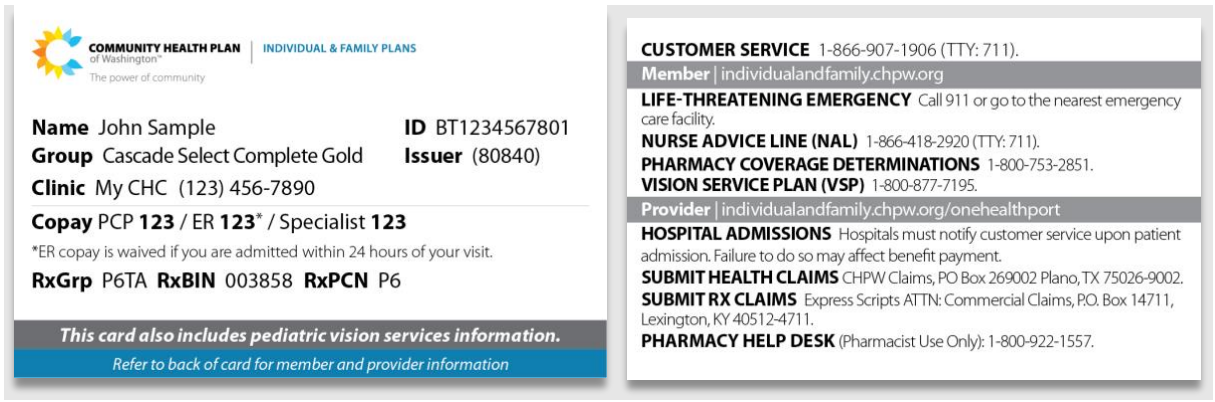


Individual and Family Cascade Select ID cards

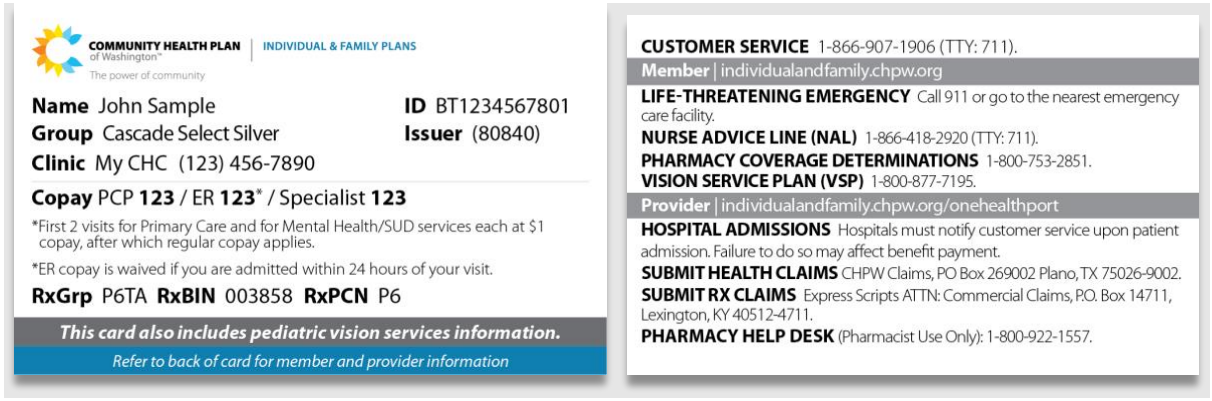
Cascade Select – Vital Gold



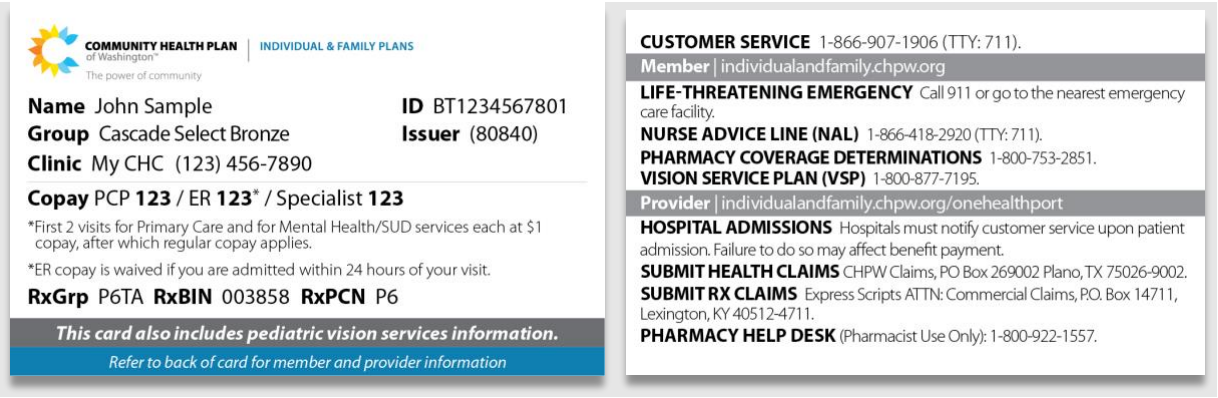
Cascade Select- Complete Gold



Cascade Select – Silver



Cascade Select – Bronze



Member Benefits

Member Materials

Member materials are available on CHPW website(s). These materials include the Member Handbook(s), Evidence of Coverage booklet(s), Provider Manual, Provider Directories, and Formularies.

State Enrollment Materials and Publications

Please refer to the HCA website for enrollment materials, publications, order forms, and directions at hca.wa.gov/medicaid/Pages/index.aspx.

ChildrenFirst™

CHPW rewards members who have regularly scheduled checkups and preventive care through their scheduled well-child, prenatal, and postpartum visits. ChildrenFirst™ is our reward program for children and pregnant members who receive scheduled care.

The **Prenatal Program**: Members can receive a $60 gift card for visiting their doctor during the first trimester, and a $40 gift card for a second prenatal visit.

The **Postpartum Program**: Members can receive a $50 gift card for a checkup between seven (7) to eighty-four (84) days/one (1) and twelve (12) weeks, after birth.

The **Well-Child Program**: Parents are eligible to receive a $20 gift card for every well-child checkup from age two (2) weeks to eighteen (18) years.

For more information about ChildrenFirst™, contact CHPW's Customer Service department at 1-800-440-1561 (TTY: 711) or visit https://chpw.org/chpw-benefits-plus/children-first/.it patient information for a ChildrenFirst™ reward, please use the online forms located at https://www.chpw.org/chpw-benefits-plus/children-first/prenatal-and- postnatal/ (Prenatal), https://www.chpw.org/chpw-benefits-plus/children-first/postpartum-reward-program/ (Postpartum), and https://www.chpw.org/chpw-benefits-plus/children-first/well-child- program/ (Well Child). The gift card will be sent to the address submitted on the form.

For information about the status of a ChildrenFirst or reward submission, patients, and providers can contact CHPW's Customer Service team toll free at 1-800-440-1561 (TTY: 711).

CHPW's Compliance Program

CHPW maintains a comprehensive, mandatory compliance program tailored to promote an organizational culture of ethical behavior. The Compliance Program is designed to prevent, detect, and correct conduct that does not comply with federal and state laws, rules, contract requirements, or sound and ethical business practices.

The Compliance Program strives to articulate and practically apply standards, processes, and programs that support and drive CHPW's commitment to integrity and adherence to the spirit and intent of the law.

The Compliance Program is aligned to the Seven Elements of an Effective Compliance Program as expressed in Chapter 8 of the US Federal Sentencing Guidelines, section 1902(a)(68) of the Social Security Act, 42 CFR 422.503(b)(4)(vi)(A), 423.504(b)(4)(vi)(A), and 438.608(a), the Compliance Program creates a framework for compliance through:

1. Written Policies, Procedures, and Standards of Conduct
2. Compliance Officer, Compliance Committee, and High-Level Oversight
3. Effective Compliance Education and Training
4. Effective Lines of Communication
5. Well Publicized Disciplinary Standards
6. Effective System for Routine Monitoring, Auditing, and Identification of Compliance Risks
7. Procedures and System for Prompt Response to Compliance Issues

CHPW's Standards of Conduct

CHPW's Standards of Conduct apply to CHPW workforce members and contractors (FDRs). The Standards of Conduct state the overarching principles and values by which CHPW operates and define the underlying framework for Compliance policies and procedures. Providers are encouraged to adopt standards of conduct to demonstrate a commitment to operate in an ethical manner; emphasize that issues of noncompliance and potential fraud, waste, and abuse are reported through appropriate channels; and to commit to detecting, preventing, and correcting issues of noncompliance.

1.0 RESPONSIBILITY

Community Health Plan of Washington (CHPW) serves a critical role in the community – delivering accessible managed health care to those enrolled in government-sponsored health insurance programs. We work hard to maintain the public's trust and to keep the privilege of serving our members. To keep this privilege, we act responsibly and are accountable for our actions.

1.1 Stewardship of Taxpayer Dollars. We responsibly use financial resources and other company assets to achieve long-term company goals and increase our members' equitable access to high quality health care services. We make every effort to utilize our resources efficiently.

1.2 Legal and Procedural Compliance. Complying with the law is a fundamental element of our daily operations. Each of us actively evaluates our understanding of and compliance with the company policies and legal obligations that apply to our work. If in doubt, we seek guidance from our manager or Compliance Officer.

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

2.0 CONFIDENTIALITY

Proper management of confidential information and the protection of privacy as it relates to our members, workforce members and business interests are critical to CHPW's success.

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

2.2 Protect Member Privacy. We value our members, their rights to privacy, and the trust they have in us. Dedicated to complying with state and federal laws, rules, regulations, and CHPW policies and procedures to protect the privacy and security of member information from unlawful Use and Disclosure.

2.3 Workforce Members Confidentiality. We are committed to promoting an environment that retains the full trust and confidence of all workforce members. To the extent possible, the confidentiality of sensitive information communicated by a workforce member to their manager, the Hotline, the Compliance Officer, or to Human Resources (HR) is vigilantly protected.

3.0 DIGNITY RESPECT AND INCLUSION

We conduct ourselves in a dignified and respectful manner in every human interaction, relationship, and business transaction. We strive to treat every individual with respect.

3.1 Foster a Safe, Equitable and Supportive Workplace. Our conditions of employment and management practices earn and promote exceptional performance by our workforce members. Individual contributions are respected, acknowledged, and rewarded. We strive to provide an equitable workplace where everyone is valued, respected and treated fairly.

3.2 Our Working Environment Behavior. CHPW is committed to maintaining a working environment that is free from unlawful harassment or actual or threatened violence. Our working environment should promote trust, respect, and collaboration. We do not tolerate any type of unlawful harassment of our staff members and expect our staff and board members to treat one another with the utmost respect and support. CHPW will not tolerate unlawful discrimination based on race, color, religion, sex (including pregnancy), age, sexual orientation, national origin, marital status, disability, gender expression or identity, veteran/military status, genetic information, or any other protected category under applicable laws. Furthermore, CHPW will not tolerate violence, or threats of violence bullying or unlawful harassment in any form in our working environment, at work-related functions, or outside of work when representing CHPW. CHPW expects everyone covered by these Standards of Conduct to comply with CHPW's anti-harassment and anti-discrimination policy.

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

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

4.0 MEMBER-CENTERED

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

4.1 Respectful. We treat our members with courtesy, politeness, and kindness.

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

4.3 Empathy. We put ourselves in our members' place. The member's experience is a key driver of how we organize and conduct our business.

4.4 Population Health. We recognize the social systemic and institutional barriers to our members health and well-being. We work to advance health equity and reduce disparities in health that result from these barriers.

4.5 Community Focus. We address the whole person needs of our members through a community focused approach and collaboration with community partners.

4.6 Equity. We recognize that equity is dependent on the core values of respect, dignity, fairness, inclusion, and diverse representation.

Reporting Concerns

CHPW provides multiple mechanisms for reporting suspected ethical, criminal, or illegal activities, privacy, or security risks, and suspected FWA. Workforce members must report suspected or known criminal or ethical violations. Depending on the nature and severity of the issue, failure to report may result in employment/contract termination.

Provider staff may report suspected violations by:

Completing the ***Report Potential Fraud/ID Theft*** **form** at: chpw.org/member-center/member-rights/fraud-waste-and-abuse/

Mail: Community Health Plan of Washington
Attention: Compliance Officer
1700 7th Avenue, Suite 900
Seattle, WA 98101

Phone: (206) 613-5091, Fax: (206) 652-7017

Email: compliance.officer@chpw.org

Report **anonymously** by:

Phone: CHPW's Customer Service Department:

- (800) 440-1561 (Apple Health)
- (800) 942-0247 (MA)

Email Compliance Officer from proxy email at compliance.officer@chpw.org

Fax form to Compliance Officer at (206) 652-7017.

OIG Hotline:

Phone: 1-800-HHS-TIPS (1-800-447-8477) or TTY 1-800-377-4950

Fax: 1-800-223-8164

Online: **https://oig.hhs.gov/fraud/report-fraud/**

Mail: U.S. Department of Health & Human Services
Office of Inspector General
ATTN: OIG Hotline Operations
P.O. Box 23489
Washington, DC 20026

Washington Apple Health Eligibility Fraud:

Phone: 1-360-725-0934

Fax: 360-725-1158

Online: https://www.hca.wa.gov/about-hca/medicaid-fraud-prevention/

Mail: Health Care Authority
Attention: OMEP
P.O. Box 45534
Olympia, WA 98504-5534

Email: **WAHEligibilityFraud@hca.wa.gov**

Report Medicaid providers:

Phone: Toll free 1-833-794-2345

Email: hottips@hca.wa.gov/

Compliance Education and Training Program

CHPW is required by contract with CMS and the HCA to provide its contracted provider network with Compliance Program and Fraud, Waste, and Abuse training that satisfy the requirements under 42 CFR §438.608 (a) and (b), §422.503(vi)(C) and §423.504(b)(vi)(C).

- CHPW's contracted providers must maintain evidence of Compliance training and must make available evidence of training for up to ten (10) years. ***You must be able to provide evidence of training upon request from CHPW and/or the HCA or CMS.***
- Training and education must occur within 90 days of hire or contract, and annually thereafter.
- All staff, including senior leadership, managers, clerical/admin staff, billing, physicians, and other clinical staff must receive training.

Providers can develop their own Compliance Program training materials as long as the training meets the requirements under 42 CFR §438.608 (a) and (b), §422.503(b)(vi)(C), and §423.504(b)(vi)(C). Refer to chpw.org/provider-center/provider-training-and-resources/hca-and-cms-training/. CHPW's Provider Relations team offers Provider Workshops and New Provider Orientations.

CHPW is committed to maintaining a comprehensive HIPAA Privacy & Security Program in compliance with the Health Insurance Portability and Accountability Act (HIPAA), including the Administrative Simplification provisions. As required by Health and Human Services (HHS), CHPW and its contracted providers must comply with the national standards for electronic health care transactions and code sets, unique health identifiers, and security, as well as complying with the Federal privacy protections for individually identifiable health information.

Note: HHS published the final **Privacy Rule** setting the national standards for the protection of individually identifiable health information for three (3) types of covered entities*: health plans, health care clearinghouses, and health care providers* who conduct the standard health care transactions electronically. HHS also published the final **Security Rule** setting the national standards for protecting the confidentiality, integrity, and availability of electronic protected health information (PHI).

As a CHPW provider, you must implement appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Nonpublic Information that are accessible to, or held by, your facility

Administrative Safeguards

Administrative safeguards are administrative actions, policies, and procedures (P&Ps) in place to manage the selection, development, implementation, and maintenance of security measures to protect PHI and to manage the conduct of your staff to protect information.

Technical Safeguards

As a provider you can determine which security measures and technologies are reasonable and appropriate for your facility. Providers should conducting an annual Risk Assessment and have a

Risk Management process in place to assist the provider in making informed decisions related to security measures.

Physical Safeguards

Physical safeguards are physical measures, policies, and procedures to protect electronic information systems, related facilities, remote workers (if applicable), or other physical environment and equipment from natural and environmental hazards and unauthorized access.

Fraud, Waste, and Abuse Program

CHPW's Compliance department maintains a FWA program to prevent, detect, and correct FWA to ensure compliance with applicable laws, including those provisions outlined in 42 CFR §§ 422.503, 423.504, and 438.608, the Federal False Claims Act (31 USC §§3279-3733), §6032 of the Federal Deficit Reduction Act of 2005 (42 USC§1396(a)(68)), and the Washington State Health Care False Claims Act (RCW 48.80).

Additional information for providers on how to prevent health care fraud and a form for making a report is available at https://www.chpw.org/member-center/member-rights/fraud-waste-and- abuse/.

"What is Fraud, Waste, and Abuse?"

Fraud: Intentional deception or misrepresentation made by an individual who knows that the false information reported could result in an unauthorized benefit to him/herself or another person. Fraud is determined by intent and action. Examples include:

- Misrepresent the diagnosis for higher payment.
- Falsify certificate of medical necessity, plan of care, or other records.
- Knowingly submitting a duplicate claim for reimbursement.
- Solicit, offer, or receive a kickback.
- Unbundled services for increased reimbursement.

Waste: Overutilization of services or improper billing practices that result in unnecessary costs. Waste "generally" caused by the misuse of resources. Examples include:

- An organization's culture fails to identify waste vulnerabilities and protect company resources.
- Submitting inaccurate claims that cause unnecessary rebilling or the reprocessing of a claim.
- Inaccurate claims payment causing unnecessary member appeals or provider disputes.
- Employees attending conferences that are unrelated to their work or unnecessary to perform their job function.
- Overuse or underuse, and ineffective use of health care services.

Abuse: Gross negligence or reckless disregard for the truth in a manner that could result in an unauthorized benefit and unnecessary costs either directly or indirectly. Examples include:

- Providing excessive or unnecessary services.
- Routinely waiving coinsurance and deductibles.
- Billing Medicaid and Medicare patients at a higher rate than non-Medicaid/Medicare patients.

"Where Does Fraud, Waste, and Abuse occur?"

FWA can occur by a:

- Patient
- Claims Processing Contractor
- Pharmacy/Pharmacist
- Home Health Agency
- PCP
- Hospital
- Contractor/Subcontractor
- Dentist
- Specialist
- Billing Agency
- Ancillary Provider
- Coworker
- Supplier

Examples of Potentially Fraudulent, Wasteful, and Abusive Billing

- Waiver of copay/coinsurance – Prohibited.
- Providing medically unnecessary services or treatment.
- Duplicate claims billing.
- Billing for services not rendered.
- Offering inducements to patients.
- Unbundling - Billing each component of a service when a comprehensive code is available.
- Patient brokering – Using "brokers" who offer money to beneficiaries for use of their ID cards.
- Balance Billing.
- Phantom billing – Billing by a "phantom" or nonexistent health care provider for services not rendered.
- Upcoding – Billing at a higher level of service than provided.
- Misrepresentation – Misrepresenting the diagnoses and/or services provided to obtain higher reimbursement or payment for noncovered services.

Office Inspector General (OIG), General Service Agency/System for Awards Management (GSA/SAM) Exclusion & Sanction List(s)

- Providers must screen employees and health care-related subcontractors prior to hire or contract and monthly thereafter. Screening must be conducted to ensure employees, independent contractors, individuals, and entities that assist in the administration or delivery of services are not excluded. The exclusions list is located here: Department of Health and Human Services – Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov
- General Services Administration (GSA) System for Award Management at sam.gov

Notify CHPW immediately if you identify an individual or entity on the exclusion lists
Maintain evidence of exclusion screening for ten (10) years. CHPW, CMS, or the HCA may request documentation to verify completed.

Preclusion List MA ONLY

The CMS Preclusion List applies to claims with dates of service on or after April 1, 2019.
The Preclusion List applies to both MA Part C and Part D plans.
The Preclusion List is a list of prescribers, individuals, or entities identified by CMS who:

- Revoked from Medicare under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.
- Have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent possible if they'd been enrolled in Medicare, and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.
- Convicted of a felony under federal or state law within the previous ten (10) years and that CMS deems detrimental to the best interests of the Medicare program.

Health care providers receive a letter from CMS notifying them of their placement on the Preclusion List. They can appeal with CMS before the preclusion effective date. There is no opportunity to appeal at CHPW. CMS updates the Preclusion List monthly notifying plans of the claim-rejection date, date upon which a plan will reject or deny a provider's claim due to precluded status. Once the claim-rejection date is effective, the provider's claims are no longer payable, pharmacy claims will be rejected, and the health care provider will be terminated as a CHPW contracted network. The precluded provider must hold the member/patient harmless (no balance billing) from financial liability for services provided on or after the claim-rejection date.

As contracted health care provider of CHPW, you must ensure that payment for health care services or items are not made to individuals or entities on the Preclusion List, including employed or contracted individuals or entities.

For more information on the Preclusion List, visit cms.gov/

Medicare Opt-Out

If you opt out of Medicare, you ***may not*** accept federal reimbursement. Providers who opt out of Medicare (non-participating in Medicare) cannot bill Original Medicare or a Medicare Advantage plan during the opt-out period of two (2) years from the date of opt-out.

CHPW cannot contract with, or pay claims to, providers who have opted out of Medicare. *Exception: Emergent or urgent care only. You cannot charge the member more than the non-participating provider allowed charge.*

Conflicts of Interest

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

Providers should require managers, officers, and directors involved in work that relates to CHPW members to report potential conflicts. The provider should require a *Conflict-of-Interest Statement* at the time of hire, and annually thereafter.

Understanding Relevant Laws

Federal Civil False Claims Act (FCA)

The civil FCA (31 United States Code (U.S.C.) Sections 3729–3733), protects the Federal Government from overcharge or sold substandard goods or services. The civil FCA imposes civil liability on any person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal Government.

The terms "knowing" and "knowingly" mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim. No specific intent to defraud is required to violate the civil FCA.

Examples: A physician knowingly submits claims to Medicare for medical services not provided or for a higher level of medical services than provided.

Penalties: Civil penalties for violating the civil FCA may include recovery of up to **three** times the amount of damages sustained by the Government as a result of the false claims, plus financial penalties per false claim filed.

Additionally, under the criminal FCA (18 U.S.C. Section 287), individuals or entities may face criminal penalties for submitting false, fictitious, or fraudulent claims, including fines, imprisonment, or both.

The False Claims Act allows people who are not affiliated with the government to file actions claiming fraud against a government contractor on the government's behalf for:

- Presenting to the government a false claim for payment.
- Causing someone else to submit a false claim for payment.
- Making or using a false record or statement to get a claim paid by the government.
- Conspiring to get a false claim paid by the government.
- Making or using a false record to avoid or decrease an obligation to pay or reimburse the government.

The False Claims Act provides protections for "whistleblowers." A whistleblower is a person who raises a concern about wrongdoing occurring in an organization or body of people, usually from that same organization. Whistleblower protections:

- Allow individuals to report fraud anonymously, sue an entity on behalf of the government, and collect a portion of any resulting settlement.
- Prohibit employers from threatening, intimidating, or retaliating against employees, who in good faith report misconduct or wrongdoing.

Violations of the False Claims Act result in social and business consequences, causing irreparable damage to one's reputation, and loss of business. In addition, violations may result in civil and monetary penalties, including:

- Civil penalties, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note: Public Law 104–410).
- Exclusion from participation in Medicare and Medicaid.
- Plus, treble damages suffered by the government.
- Possible criminal prosecution and imprisonment.
- Trial costs

Refer to https://www.govinfo.gov/app/details/USCODE-2011-title31/USCODE-2011-title31-subtitleIII-chap37-subchapIII-sec3730

Anti-Kickback Statute (AKS)

The AKS (42 U.S.C. Section 1320a-7b(b)) makes it a crime to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward patient referrals or the generation of business involving any item or service reimbursable by a Federal health care program. When a provider offers, pays, solicits, or receives unlawful remuneration, the provider violates the AKS.

NOTE: Remuneration includes anything of value, such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.

Example: A provider receives cash or below-fair-market-value rent for medical office space in exchange for referrals.

Penalties: Criminal penalties and administrative sanctions for violating the AKS may include fines, imprisonment, and exclusion from participation in the Federal health care program. Under the CMPL, penalties for violating the AKS may include **three** times the amount of the kickback.

The "safe harbor" regulations (42 CFR Section 1001.952), describe various payment and business practices that, although they potentially implicate the AKS, are not treated as offenses under the AKS if they meet certain requirements specified in the regulations. Individuals and entities remain responsible for complying with all other laws, regulations, and guidance that apply to their businesses. Refer to https://www.govinfo.gov/app/details/USCODE-2010-title42/USCODE- -2010-title42-chap7-subchapXI- partA-sec1320a-7 or https://oig.hhs.gov/compliance/safe-harbor-regulations/ for safe harbor protections.

Physician Self-Referral (Stark Law)

The Physician Self-Referral Law (42 U.S.C. Section 1395nn), often referred to as the Stark Law, prohibits a physician from referring patients to receive "designated health services" payable by Medicare or Medicaid to an entity with which the physician or a member of the physician's immediate family has a financial relationship, unless an exception applies.

Example: Physician referral for a designated health service to a clinic where the physician has an investment interest.

Penalties: Penalties for physicians who violate the Stark Law may include fines, CMPs for each service, repayment of claims, and potential exclusion from participation in the Federal health care programs.

For more information, refer to https://www.govinfo.gov/app/details/USCODE- 2010-title42/USCODE-2010-title42-chap7-subchapXVIII-partE-sec1395nn.

Criminal Health Care Fraud Statute

The Criminal Health Care Fraud Statute (18 U.S.C. Section 1347) prohibits knowingly and willfully executing, or attempting to execute, a scheme or lie in connection with the delivery of, or payment for, health care benefits, items, or services to either:

- Defraud any health care benefit program.
- Obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the control of, any health care benefit program.

Example: Several doctors and medical clinics conspire in a coordinated scheme to defraud the Medicare Program by submitting medically unnecessary claims for power wheelchairs.

Penalties: Penalties for violating the Criminal Health Care Fraud Statute may include fines, imprisonment, or both.

Exclusion Statute

The Exclusion Statute (42 U.S.C. Section 1320a-7), requires the OIG to exclude individuals and entities convicted of any of the following offenses from participation in all Federal health care programs:

- Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid.
- Patient abuse or neglect.
- Felony convictions for other health care-related fraud, theft, or other financial misconduct.
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing controlled substances.

The OIG may impose permissive exclusions on other grounds, including:

- Misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud, or misdemeanor convictions for unlawfully manufacturing, distributing, prescribing, or dispensing controlled substances.
- Suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity.
- Providing unnecessary or substandard services.
- Submitting false or fraudulent claims to a Federal health care program.
- Engaging in unlawful kickback arrangements.
- Defaulting on health education loans or scholarship obligations.

Excluded providers may not participate in the Federal health care programs for a designated period. If you have been excluded by OIG, then Federal health care programs, including Medicare and Medicaid, will not pay for items or services that you furnish, order, or prescribe. Excluded providers may not bill directly for treating Medicare and Medicaid patients, and an employer or a group practice may not bill for an excluded provider's services. At the end of an exclusion period, an excluded provider must seek reinstatement; reinstatement is not automatic.

CHPW's contracted providers must screen individual and entities it hires or contracts with against the List of Excluded Individuals and Entities (LEIE) maintained by the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) at http://oig.hhs.gov/exclusions/ and the System for Award Management (SAM) maintained by the U.S. General Services Administration (GSA) at https://www.sam.gov/.

Civil Monetary Penalty Law (CMPL)

The CMP (42 U.S.C. Section 1320a-7a) authorizes OIG to seek CMPs and sometimes exclusion for a variety of health care fraud violations. Different amounts of penalties and assessments apply based on the type of violation. CMPs also may include an assessment of up to three times the amount claimed for each item or service, or up to three times the amount of remuneration offered, paid, solicited, or received. Violations that may justify CMPs include:

- Presenting a claim, you know, or should know, is for an item or service not provided as claimed or that is false and fraudulent.
- Violating the AKS
- Making false statements or misrepresentations on applications or contracts to participate in the Federal health care programs.

HIPAA Member Rights

Under the HIPAA Privacy Rule, members have the right to:

- Access and inspect their own PHI.
- Request changes/corrections to their own PHI.
- Request restrictions on use and disclosure of their own PHI.
- Obtain an accounting of certain PHI disclosures shared with others.
- Request alternate ways to receive communications about their own PHI.
- Receive a Notice of Privacy Practices

Right of Access

CHPW members have the right of access to inspect and obtain a copy of their own PHI in the form of a **designated record set**. A designated record set includes information used to make decisions about a member's care, such as: records about enrollment, claims, care management, medical management, or pharmacy information.

A member must request access to their PHI **in writing** or by using the "Request to Access Protected Health Information (PHI)" form located at:

- Apple Health: chpw.org/member-center/member-rights/
- MA: medicare.chpw.org/member-center/member-rights/
- CS: individualandfamily.chpw.org/member-center/member-rights/

Member Rights Regarding Personal Information

CHPW members have the following rights regarding personal information:

Restriction Request: The right to request a restriction or limitation on the personal information used or disclosed for treatment; payment; and health care operations, activities, or disclosures to individuals involved in their care.

Confidential Communications: If a member believes that disclosure of all or part of their personal information may endanger them, they have the right to request that they are communicated about health matters at an alternative location. For example, members can ask that they are contacted only at their work address.

Inspection: Members have the right to request inspection and to receive a copy of a record of their personal information. If the record is maintained electronically, they have the right to request the copy be in the electronic format of their choice. If the record is not readily provided in the format requested, it should be provided in an agreed electronic format.

Amendment: If a member believes that the personal information maintained by your office is incorrect or incomplete, they have the right to request amendment to their personal information.

Accounting of Disclosures: Members have the right to an accounting of disclosures made for purposes other than for treatment, payment, health care operations, or that the member specifically authorized. CHPW provides the first request by the member within a 12-month period free of charge. CHPW may charge a fee for the cost of copying, mailing for additional requests.

Note: Except for an Accounting of Disclosures, request is evaluated and a response sent to the member on whether the request can be fulfilled. There are instances when a request will not be fulfilled. For example, an amendment to personal information not created by the entity where the request is made, unless the person or entity that created the information is no longer available to make the amendment.

Notice of Privacy Practices

Notice of Privacy Practices (NPPs) describe an individual's rights under HIPAA. Refer to:

- Apple Health: chpw.org/member-center/member-rights/
- MA: medicare.chpw.org/member-center/member-rights/
- CS: individualandfamily.chpw.org/member-center/member-rights/

Advance Directive, Physician Orders for Life Sustaining Treatment (POLST)

CHPW is required to educate and inform providers about a patient's rights to an Advance Directive and Physician Orders for Life Sustaining Treatment (POLST).

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

The **Physician Orders for Life Sustaining Treatment (POLST)** form is an option for anybody who has a serious health condition and needs to make decisions about life-sustaining treatment.

Unlike the other directives on this list, the POLST form contains **specific medical orders**. Additional information regarding POLST, the POLST Form and other end-of-life resources is on the Washington State Medical Association's website: wsma.org/polst.

CHPW provides Advance Directive information for members on the CHPW website.

PCPs are encouraged to discuss advance directives with adult patients and are required to document the discussion in the member's medical record. Providers of medical or behavioral health services for CHPW members must:

- Review each member's medical record prior to admittance or enrollment to determine if the member has an advance directive,
- clearly document on the member's medical record whether the member has executed an advance directive,

- honor the advance directive or follow the process explained under the section "Conflicts and Conscientious Objections" below; and
- not refuse, put conditions on care, or otherwise discriminate against a member based on whether the member has completed an advance directive.

Providers must document in a prominent place in an adult member's medical record whether an Advance Directive exists. If an Advance Directive exists, a copy of the directive should be with the medical record.

At the time of enrollment, CHPW notifies its members in writing that they or their authorized representative have a right to make decisions concerning their care, including decisions to withhold resuscitative services, to decline or withdraw from life-sustaining treatment, to accept or refuse surgical or medical treatment, to implement an Advance Directive, and to cancel an Advance Directive at any time.

Information should be provided to patients at the time of admission to hospitals and nursing facilities; the start of in-home care services before the member is transferred to the care of the provider; or at the time of the first home visit. This information must include the following:

- That a provider cannot refuse care or otherwise discriminate against a member based on whether the member has executed an Advance Directive.
- That members have the right to file a complaint about the provider's noncompliance with Advance Directive requirements, and where to file the complaint.
- That the provider must document in a prominent part of the member's current medical record whether the member has executed an Advance Directive.
- Describe how the provider's required to comply with WAC 182-501-0125.
- Describe provider responsibility to educate staff about their policies and procedures for Advance Directives.
- If a provider is unable to implement an Advance Directive as a matter of conscience, the provider must issue a clear and precise written statement of this limitation to CHPW. The statement must include the following characteristics:
    - Clarifies the differences between institution-wide objections based on conscience and those that may be raised by individual physicians,
    - Identifies the State legal authority permitting such objection,and
    - Explains the range of medical conditions or procedures affected.

Providers whose policy/practice would prevent them from honoring an Advance Directive should:

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

Providers should review their Advance Directives obligations (WAC 182-501-0125). For more information, refer to CHPW's Advance Directives and Physician Orders for Life Sustaining Treatment (POLST) policy.

Member Rights and Responsibilities

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

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

Members' Rights and Responsibilities should not be confused with **Member Rights under HIPAA**. Member Rights and Responsibilities may vary by line of business:

- For Apple Health programs, Member Rights and Responsibilities can be found for each product on CHPW's website at https://www.chpw.org/member-center/member-rights/
- For CHPW Medicare Advantage, Member Rights can be found on the CHPW website at Member Rights.
- For CHPW Cascade Select, Member Rights can be found on the CHPW website at individualandfamily.chpw.org/member-center/member-rights/

Second Opinion

A member and/or the PCP may request a second opinion where there is a question concerning a diagnosis, options for surgery, or other health care treatment, including behavioral health. If the member desires a second opinion, they must request that the PCP or their behavioral health provider arrange one. The member may request a referral directly from CHPW, if necessary. For Apple Health, MA, and MA D-SNP members, a PCP-to-PCP referral is **required**. CHPW Individual and Family Cascade Select members must see an in-network provider or obtain a referral for a non-network provider.

If the member requests a second opinion, the PCP, behavioral health provider, or CHPW shall promptly refer the member to an appropriate participating provider of a similar specialty and authorize the referral if applicable. If there is not a participating provider with the expertise required for the condition, the members referred to an appropriate non-networked specialist.

The requirement for a second opinion has been satisfied when the PCP recommends treatment by a specialist and that specialist agrees with the treatment plan. This is considered a first and second opinion. If the specialist presents a treatment plan and the PCP agrees with that plan, this is also considered to be a first and second opinion. In the case of a second opinion regarding a behavioral health diagnosis or treatment plan, the treating behavioral health provider must consider the recommendations of the provider of equal or higher credentials rendering a second opinion but is not obligated to follow them.

Member and Balance Billing Protection Act (BBPA)

Washington state law protects patients from balance or surprise billing. Patients are protected under state and federal law from getting surprise medical bills for emergency services, including behavioral health emergencies and when they have a scheduled procedure at an in-network hospital or surgery facility and are seen by an out-of-network provider. For more information refer to the Washington State Office of the Insurance Commissioner webpage for consumer/patients on "What consumers need to know about surprise or balance billing."

CHPW contracted providers must accept payment as payment in full for all LOBs. Providers are prohibited from "balance billing" a client, i.e., charging the member for any difference between the provider's usual, customary rates and the amount of CHPW's payment. However, these rules do not affect the provider's ability to collect from the member any applicable cost-sharing obligations, such as co-payments or co-insurance amounts.

For **Individual and Family Cascade Select** members, the BBPA prohibits non-contracted providers from billing those members for any difference between usual, customary rates and CHPW's payment for physical and behavioral health emergency services, post-stabilization services, or for scheduled procedures performed at an in-network facility.

In **Apple Health**, a provider must not bill a member, or anyone on the member's behalf, for any services until the provider has completed all requirements, including the conditions of payment (i.e., prior authorization, plan authorized referral), and until the provider has then fully informed the member of their covered options.

Providers must not bill an Apple Health member for:

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

The Agreement to Pay for Healthcare Services covered in WAC 182-502-0160 ("Billing a Client") is an agreement between a "client" and a "provider," and where an HCA 13-879 form must be completed, signed, and dated before the service(s) are rendered. The member agrees to pay the provider for health care service(s) that the HCA will not pay. For the purposes of this Agreement, "services" include, but are not limited to health care treatment, equipment, supplies, and medications. Please review WAC 182-502-0160 for a complete understanding.

Medicare Advantage – D-SNP

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

Providers who inappropriately bill Qualified Medicare Beneficiaries for Medicare cost-sharing are subject to sanctions. Please review CHPW's Balance Billing Training on our Provider Billing and Claims webpage.

CHPW members are held harmless for payment of any fees that are the legal obligation of CHPW. For any member eligible for both Medicare and Medicaid, the member is held harmless for Medicare Part A and B cost sharing when the state is responsible for paying such amounts (42 CFR 422.504 (i)(3)(i) and 422.504 (g)(1)(i).

Culturally and Linguistic Appropriate Service (CLAS) Standards

CHPW serves many unique communities and focus significant effort to help remove the barriers—economic, cultural, linguistic, geographic, and otherwise -- that prevent people from getting needed medical attention. Our membership includes low-income families, diverse ethnic groups, recent immigrants, and people with disabilities. We recognize that access to and delivery of culturally competent services is key to delivering equitable care and are committed to advancing health equity through promotion of the Culturally and Linguistically Appropriate Services (CLAS) Standards. CHPW contracted providers are responsible for considering all cultural and linguistic needs when caring for our members, and we ensure providers have access to information on requirements to meet CLAS national standards through orientation, online and/or on-site training programs, annual workshops, newsletters, and other resources. For more information on CLAS and other trainings, visit the CHPW website at chpw.org/provider-center/provider-training-and-resources/hca-and-cms-training/.

Interpreter Services

All members who are eligible for Apple Health through HCA are eligible for interpreter services, including those who are deaf, deaf-blind, or hard of speaking. Apple Health (Medicaid) members are eligible for services through Universal Language Service. Please note, Apple Heath Expansion (AHE) members are eligible for interpreter services through a separate process, detailed below. A complete guide on HCA interpreter services may be found on the HCA website.

- Medicare Advantage: CHPW is providing Telephonic Interpreter Assistance for our providers to use with CHPW Medicare Advantage members. This is free of charge. Clinic staff is responsible for verifying a member is a CHPW Medicare Advantage member. The telephonic interpreter service is offered through Lionbridge.

  To access Lionbridge Interpreter Services:

  - Dial: 1 855-461-1323 (Toll Free)
  - Department Code: 60

  Document the interpreter's name and ID number for reference. Brief the interpreter and give any special instructions.

  Apple Health Expansion (AHE): CHPW provides in-person, virtual, and over-the-phone Interpreter Assistance for our providers to use with Apple Health Expansion members. This is free of charge. Clinic staff are responsible for verifying a member is a CHPW Apple Health

Expansion member in ProviderOne. Scheduled in-person and virtual interpreter services are available through LanguageLine. On-demand over-the-phone interpreter service is available through Lionbridge.

To schedule in person and virtual appointments through LanguageLine:

- Dial: 1 888-225-6056 (Toll Free)
- Select Option 1
- Enter Client ID: 705722
- Enter Fund Code: Member's CHPW ID Number

Please note that all in-person and virtual appointments must be made at least two hours in advance. Cancelation of in-person and virtual appointments must be done with at least one full business day's notice.

To access on demand over-the-phone interpretation through Lionbridge:

- Dial: 1 855-461-1323 (Toll Free)
- Department Code: 11

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

Medical Provider Responsibilities

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

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

Other Provider Responsibilities

When necessary, the provider may also be responsible for:

- Apple Health (Medicaid): Contacting the HCA's Universal Language Service. For more information, visit hcauniversal.com/requester-hcaopi/. Contacting the Washington State Relay Service for TDD connection (711) to communicate with a person who is deaf, deaf-blind, or hard of hearing.
- Apple Health Expansion: Contacting CHPW's vendor, LanguageLine, to schedule in-person, virtual and ASL interpretation services for Apple Health Expansion members, or Lionbridge, for on-demand telephonic interpretation for Apple Health Expansion members.
- Medicare Advantage: Contacting Lionbridge for Telephonic Interpreter Assistance for our providers to use with CHPW Medicare Advantage members.

HealthMAPS Provider Portal

CHPW's HealthMAPS online provider portal lets you enter and view member claims, check eligibility, view and report a member's other health insurance (OHI), access your explanation of payment (EOP), view claim rejection letters, view roster reports, and more.

HealthMAPS Login

CHPW has implemented Multi-Factor Authentication for all provider-facing portals, including HealthMAPS. This enhances the safety and security of CHPW's provider and membership data.

What is OneHealthPort?

CHPW uses OneHealthPort for HealthMAPS Multi-Factor Authentication. You must sign in directly to OneHealthPort for access to HealthMAPS.

What is Multi-Factor Authentication?

Multi-Factor Authentication (MFA) means a user must verify their identity by multiple methods to log into an account or system. Methods can include something you know, such as your username and password, plus something you have, such as a unique code that is generated by an app and sent to you via email or text. You enter the necessary information to verify your identity and approve your login. This can help prevent someone else from accessing your account, even if they know your username and password. Please see OneHealthPort's Multi-Factor Authentication page for more information.

How to check if your organization has a OneHealthPort account

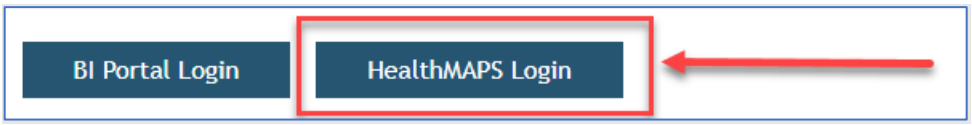
Please see the OneHealthPort Frequently Asked Questions page for more information.

- To check if your organization is registered with OneHealthPort, follow the instructions under "What if I don't know whether my Organization is registered yet or who is my Administrator?"
- If you do not have a OneHealthPort account, follow the instructions under "How do I register to use OneHealthPort?" or go directly to Register Your Organization.

If you try to create a new HealthMAPS account or log into HealthMAPS directly, the system will redirect you to OneHealthPort. You will then need to log into OneHealthPort to access HealthMAPS.

To log into HealthMAPS from OneHealthPort:

1. Go to the Community Health Plan of Washington page on OneHealthPort.
2. Select the button that reads HealthMAPS Login as in the screenshot below.



3. Enter your OneHealthPort logon credentials.

Questions?

If you have questions about OneHealthPort, including how to register or how to access your account, you can contact OneHealthPort Help Desk at 1-800-973-4797.

If you have questions about CHPW's HealthMAPS portal, please see our Provider Portal Training page or call:

- Apple Health Customer Service, 1-800-440-1561 (TTY: 711), Monday through Friday, 8am to 5pm
- Medicare Advantage Customer Service, 1-800-942-0247 (TTY: 711), 7 days a week, 8am to 8pm
- Individual and Family Cascade Select Customer Service, 1-866-907-1906 (TTY: 711), 8am to 5pm, Monday through Friday

Your HealthMAPS Provider Account

Please note, it may take up to five (5) calendar days to process your HealthMAPS registration.

You will receive an email when your registration is complete.

Once you have an account, these features are available immediately:

- Your dashboard, which has news and notifications, claims and membership information, and more, specific to ***you***; no other CHPW providers can see your notifications.
- Customize your dashboard based on your preferred tax ID(s) so you can see the information that you are most interested in each time you log in.
- The Provider News area has general information that ***all*** CHPW providers can view.
- View/review authorizations and referrals in HealthMAPS that have been processed by our Utilization Management Intake team. **Please continue to request authorizations and referrals via the Jiva portal**; you will need a Jiva portal account login. The Authorizations Request button in HealthMAPS links to Jiva. Jiva training materials are available our Provider Portal Training page, under JIVA Portal.
- Enhanced ability to send and receive benefit/eligibility (270/271) and claim status (276/277) transactions.
- Search for and view claim details.
- Request claim reviews.
- View and report other health insurance.

Note: Other health insurance (OHI) information in the state's ProviderOne system may be inaccurate or out of date. CHPW collects, verifies, and then reports other health insurance for our members back to the Health Care Authority via a monthly update file. There may be a window of time where member third party liability (TPL)/OHI information has changed in HealthMAPS but has not yet been reported to the HCA. Please always consider HealthMAPS as the system of truth concerning our members' other health insurance information. Providers are in violation of State Code when they refuse to provide services to CHPW members based on TPL information in ProviderOne, HealthMAPS and/or etc. Delaying or stopping a member from receiving healthcare due to private insurance is addressed in WAC 182-501-0200 (9) as follows:
(9) A Provider cannot refuse to furnish covered services to a client because of a third-party's potential liability for the services. For more information, please contact CHPW's Customer Service at 800 440-1561.

- Enter a new claim.
- Enter a corrected claim.
- Submit claims with attachments.
- Access your explanation of payment (EOP).
- View claim rejection letters.
- View capitation and member roster reports.
- Send an inquiry or other secure message to a CHPW Customer Service Representative. In some screens, you can attach a file to your message.
- Get quick access to different forms and tools housed on the CHPW website via the Provider Resources Quick Link menu option.

Billing and Claims Payment

See our Provider Billing and Claims webpage for additional information, including billing guidelines.

Governance

CHPW processes and will adjust claims (if applicable) in accordance with:

1. All federal and state laws;
2. CHPW provider contract language;
3. Contract obligations, rules, and laws as defined and published by Medicare and the Centers for Medicare & Medicaid Services (CMS), the Washington State HCA, and the Office of the Insurance Commissioner (OIC);
4. Nationally recognized coding standards and National Correct Coding Initiative (NCCI) payment system edits;
5. CHPW established policies; and
6. Health insurance industry standard best practices.

For Individual and Family Cascade Select, CHPW shall follow CMS billing rules and guidelines; in the absence of a relevant CMS rule or guideline, CHPW Individual and Family Cascade Select Benefit Plans follow HCA billing guidelines. Depending on the specific benefit or circumstances, CHPW has the discretion to vary from the CMS or HCA guidelines to ensure that CHPW applies the best option for the member.

Billing Requirements

CHPW providers are required to follow appropriate billing guidelines. This includes ensuring that claims have the rendering service location address. Visit the following for additional information related to billing:

- Provider Bulletin Board for Apple Health, Medicare Advantage or Individual and Family Cascade Select
- Provider Billing and Claims page

Prior Authorization

Certain services require prior authorization (PA) from CHPW; that is, the Plan must approve the service before the member receives the service. A claim may be denied if the service received is not authorized in advance. Refer to the Prior Authorization Lists on chpw.org; the lists include all of the services that require prior authorization. CHPW maintains and follows its own PA list for all lines of business. For Apple Health, the CHPW PA list is not required to match the Washington State Health Care Authority (HCA) PA list. If a PA is required and not obtained, then all related services shall be denied even if the related services do not require a PA.

Detailed Itemizations for Claims Over $100,000

Community Health Plan of Washington (CHPW) requires providers to submit detailed itemizations for all claims with billed charges exceeding $100,000.00.

Why This Matters

This requirement applies to all lines of business and is essential to ensure accurate calculation of outlier payments and to verify that CHPW is reimbursing only those services that are separately reimbursable under applicable Apple Health and Medicare guidelines and program limitations.
This policy supports CHPW's commitment to:

- Ensuring compliance with state and federal reimbursement guidelines;
- Promoting transparency in billing practices;
- Preventing overpayments; and
- Ensuring program integrity.

Itemization Format Requirements

To facilitate efficient review and processing, CHPW strongly prefers itemizations to be submitted in one of the following formats:

- .xml
- .csv
- .xls
- .xlsx

Itemizations must:

- Include the claim number(s);
- Clearly outline all billed charges associated with the claim(s); and
- Include CPT and HCPC codes where appropriate.

Please email itemizations to cs.claimsdistribution@chpw.org. Claims submitted without the required itemization may be delayed or denied pending receipt of the necessary documentation.

If you have questions or need assistance with submitting itemizations, please contact our Provider Relations team at Provider.Relations@chpw.org.

Apple Health Billing Guidelines

Billing guidelines in this Provider Manual labeled for Medicaid or Apple Health apply for both Apple Health and Apple Health Expansion, unless noted otherwise.

Women's Health Care

Female members on an **Apple Health, MA, or MA D-SNP** plan can self-refer to any women's health care provider without needing a referral from their PCP. Female members on an **Individual and Family Cascade Select** plan must obtain an authorization or referral to receive services from an **out-of-network provider**.

Women's Health Care for Apple Health members

CHPW provides female members with direct access to network women's health care specialists for covered services necessary to provide women's routine and preventive health care services in accordance with the provisions of WAC 284-170-350 and 42 CFR 438.206(b)(2). Women's health care services are defined as organized services to provide health care to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The services include, but are not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, as well as medically appropriate follow-up visits for these services. Women's health care services also include any appropriate health care service for other health problems discovered and treated during a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For the purposes of determining a woman's right to direct access to covered maternity, reproductive health, and preventive services, including contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast- or chest feeding, and complications of pregnancy.

Abortion access for HCA (Medicaid)-covered individuals: HCA covers abortion services through fee-for-service. Clients enrolled in an HCA managed care organization (MCO) may self-refer to any fee-for-service provider. Claims for abortion services must be submitted through ProviderOne, not the MCO. Please contact the HCA, Fee for Service for voluntary termination of pregnancy services or see the following HCA webpages for more information: Abortion services and Abortion access for HCA-covered individuals.

Covered women's health care services for **Apple Health** members include:

- Maternity care, including prenatal, delivery, and postnatal care
- Routine gynecological exams
- Examination and treatment of disorders of the female reproductive system, except as specifically excluded.
- Family planning (infertility is not covered)
- Advice on birth control methods
- Other health problems discovered and treated during the member's office visit, if the treatment is within the provider's scope of practice, and the service provided is not excluded.
- Hysterectomy. All inpatient services require prior authorization. Completed consent forms (no wait period) with signatures are required for payment of Apple Health claims for hysterectomy services. Signature stamps are not accepted on consent forms. Completed and signed consent forms must be submitted with the claim. The *Hysterectomy Consent Form* is available on our Provider Forms and Tools webpage, under Claims. Please note:
    - CHPW must have a consent form on file for a member who has a hysterectomy performed (the form can come with the surgeon's claim, anesthesiologist, facility, etc.). Claims that do not have a consent form on file shall be denied.
    - A *Sterilization Consent* form is a separate form and is not the correct form for hysterectomies. The *Hysterectomy Consent Form* is the correct form for hysterectomies.

Apple Health Expansion members with a reported pregnancy have the option to remain in Managed Care for the duration of the pregnancy (including prenatal and postpartum care) or can choose to alternatively enroll in the State Pregnancy Fee for Service Program. Please note: Based on the current state of the AHE program as of December 2nd, 2025, if a pregnant member moves to the State Fee for Service program, they will need to reapply for AHE and wait for slots to open. If the member remains under Managed Care, they will retain their AHE coverage throughout pregnancy and after.

Contraception for Apple Health members

Apple Health covers over the counter (OTC) contraception, including most emergency contraception, with or without a prescription for members.

Emergency contraceptive pills are a safe and effective way to prevent pregnancy. They can be taken up to 120 hours (5 days) after unprotected sex. Emergency contraceptive pills are available at most pharmacies in Washington State and at clinics, doctor offices, or online.

OTC contraceptives must be billed by a pharmacy for members to receive at no cost. Please read the OTC Contraception for Members provider bulletin for more information.

Sterilization for Apple Health members

An Apple Health client who is age 21 or older may not self-refer outside their MCO for sterilization. Sterilization requires a signed consent form from the member. Completed consent forms and a 30-day wait period after signature are required for payment of Apple Health claims for sterilization services. Signature stamps are not accepted on consent forms. The *Sterilization Consent* forms (English and Spanish) are available on our Provider Forms and Tools webpage, under Claims.

Billing and payment for sterilization and hysterectomy for Apple Health

A properly completed Sterilization Consent Form (HHS-687) is ***required*** for all sterilization-related claims. This includes hospital claims and professional services (surgeon and anesthesia). All other requirements and instructions for the Sterilization Consent Form must be followed to ensure the consent form is valid. Please see the Washington Apple Health Sterilization Billing Guide, Appendix A: Consent Form Instructions, for additional information.

Hysterectomy also requires a completed, valid consent form, and all inpatient services require prior authorization. A sterilization consent form is a separate form and is not the correct form for hysterectomies. The Hysterectomy Consent Form (HCA 13-365) is the correct, ***required*** form for hysterectomies. Please see the Washington Apple Health Physician-Related Services/Health Care Professional Services Billing Guide, Hysterectomies section, for additional information.

CHPW will not pay for sterilization or hysterectomy services without a consent form. Payment will exclude any service related to sterilization or hysterectomy if a valid sterilization or hysterectomy claim does not have a completed, signed consent form.

As stated in the Washington Apple Health Sterilization Billing Guide:

- ***"****When labor/delivery (including C-section) and a sterilization are performed during the same hospital stay, HCA pays only for the labor/delivery (including C-section) if the sterilization did not comply with the informed consent requirement."*
    - *"For hospital claims priced by ratio of costs-to-charges, the hospital must indicate on the claim all charges that are associated with the sterilization on their own line with the appropriate revenue code as noncovered. The hospital must add the following note to the claim: 'Sterilization charges moved to noncovered'."*

For purposes of this CHPW communication, use of "sterilization" in the above quote from the HCA billing guide includes hysterectomy.

In addition:

- Hospitals priced by ratio of cost to charges (RCC) must indicate on the claim all charges that are associated with the sterilization. Those charges are required to be billed on their own line with the appropriate revenue code as noncovered. CHPW will reimburse the hospital for covered labor/delivery charges. If the claim is not billed correctly, it will be denied for proper billing and the provider would need to submit a corrected claim.
- Hospitals priced by diagnosis related group (DRG) have a different calculation method. CHPW will reduce the payment of the claim by removing the sterilization services.

Consent forms are available on our Provider Forms & Tools webpage, under "Claims."

Women's health care for MA D-SNP members

CHPW covers Original Medicare preventive services for female **MA D-SNP** members, including screening for cervical cancer, mammography, pap tests, and pelvic examinations. Additional information is located on the Medicare Preventive Services webpage. Female members on an **MA D-SNP** plan can self-refer to any women's health care provider without needing a referral from their PCP.

Women's health care for Individual and Family Cascade Select members

Female members on an **Individual and Family Cascade Select** plan can self-refer to any in-network women's health care provider without needing a referral from their PCP. The member must obtain an authorization or referral to receive services from an **out-of-network provider**.

Contraception for Individual and Family Cascade Select members

Individual and Family Cascade Select covers over-the-counter (OTC) contraception, including most emergency contraception, with or without a prescription for members.

Emergency contraceptive pills are a safe and effective way to prevent pregnancy. They can be taken up to 120 hours (5 days) after unprotected sex. Emergency contraceptive pills are available at most pharmacies in Washington State and at clinics, doctor offices, or online.

OTC contraceptives must be billed by a contracted provider or pharmacy for members to receive at no cost. Please see our Prescription Drug Coverage page for more information.

Find a women's health care provider (all CHPW plans)

To find a women's health care provider within our network, please go to **Find a Doctor**:

- Apple Health
- Medicare Advantage D-SNP
- Individual and Family Cascade Select

Individual and Family Cascade Select

Complex Behavioral Health Services—Apple Health

CHPW uses the SERI guide (Service Encounter Reporting Instructions) for complex behavioral health services billing requirements for CHPW-contracted behavioral health providers. The guide includes CPT and HCPCS codes, modifiers, and other billing requirements.

Provider Status for All CHPW Plans

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

The submission of a credentialing application does not allow a provider to treat CHPW members. The provider must have completed the credentialing/recredentialing status prior to treating CHPW members and submitting claims, otherwise claims will be denied. See the "Credentialing and Recredentialing" section of this manual for more information. For credentialing status inquiries, please contact provider.credentialing@chpw.org.

For all claims (electronic and paper), the Billing Provider Address must be a physical location (street address). This is Box 33 for paper claims, or Loop 2010AA for electronic claims. The Pay-To Address (Loop 2010AB) can be a PO Box or a different location than the service address. If the Service Location is different than the Billing Provider (physical location), the 2310C Loop must be populated. See the *Claims Entry, Corrected Claims, and Viewing Prior Authorizations and Referrals* training guide for more information. Go to our Provider Portal Training page, under HealthMAPS FAQs and Training.

Provider changes may be reported to CHPW by completing a *Provider Add Change Term Form*, available on our Provider Forms & Tools page, and emailing it directly to provider.changes@CHPW.org.

Substitute Physicians (Locum Tenens) Billing – Apple Health

The HCA previously provided the following guidance for locum tenens billing: "*Physicians may bill under certain circumstances for services provided on a temporary basis (i.e., locum tenens) to their patients by another physician…Any provider that will perform as a locum tenens provider that will treat an Apple Health client must be enrolled as a Washington Apple Health provider for claims to be paid*." Please refer to the Physician-Related Services/Health Care Professional Services billing guide for more information.

Core Provider Agreement (CPA) - Apple Health (Medicaid)

The Code of Federal Regulations (federal law) mandates that eligible providers who see Medicaid clients obtain a Core Provider Agreement (CPA) with the HCA. The HCA must enroll eligible providers in its Apple Health (Medicaid) program to pay those providers for covered services, supplies, and equipment rendered to eligible Apple Health (Medicaid) and BHSO clients. In addition, Washington Administrative Code (WAC) allows the option for providers who do not bill Medicaid but write orders and prescriptions for services Medicaid pays for to have "an approved agreement with the agency [HCA] as a non-billing provider." Providers and CHPW must comply with the federal mandate.

The HCA also requires eligible providers who see Apple Health Expansion clients to be an enrolled provider with HCA as a condition of payment for services rendered to Apple Health Expansion members. Providers who are enrolled with HCA for Medicaid will be deemed to be enrolled providers for Apple Health Expansion.

The CPA/non-billing agreement requirement applies only to MCO-contracted providers who bill fee-for-service through the state's ProviderOne system. Non-contracted and out-of-state providers are not required to enroll with the HCA.

- **Intensive Behavioral Supportive Supervision (IBSS) providers:** The paper CPA application is discontinued and replaced with an online CPA application through the ProviderOne system. This change is for ***IBSS*** providers only and allows the HCA to assign an Atypical Provider Identifier (API) for providers who do not have a National Provider Identifier (NPI) right away. The HCA's Encounter Data Reporting Guide defines API and NPI as follows:
    - Atypical Providers – Providers who do not provide medical services (e.g., non-emergency transportation, case management, environmental modifications, etc.) and are not eligible to receive a National Provider Identifier (NPI).
    - National Provider Identifier (NPI) – The standard unique identifier for all healthcare providers that was implemented as a requirement of the Health Information Portability & Accountability Act (HIPAA) of 1996 (45 CFR Part 162).

The paper CPA application remains an option for other provider types (non-IBSS providers). Providers cannot bill the health plan member unless the member was informed prior to receiving services that the provider is not an active Apple Health provider. The member must agree to receive and pay for the services, and this agreement must be documented in the member's record.

The following resources have more information:

- CHPW's Balance Billing Training and the "Member and Balance Billing Protection Act (BBPA)" section of this Provider Manual
- CHPW's Core Provider Agreement and NPI Status FAQ
- The HCA's Enrollment overview page
- The HCA's Enroll as a Nonbilling provider page
- The HCA's FAQ - Medicaid requirement for ordering, prescribing, and referring providers
- The HCA has a separate FAQ for licensed behavioral health agencies: You can go directly to How to enroll a National Provider Identifier (NPI), or you can go to the HCA Resources page under "Claims billing – encounter data".

VSP Vision Benefit for All CHPW Plans

Log onto vsp.com to find a VSP Washington network provider for Apple Health, Medicare Advantage, Special Needs Plan (D-SNP), and Individual and Family Cascade Select Members.

Newborn Claims – Apple Health (Medicaid)

For **Apple Health (Medicaid),** providers should bill for newborn care using the mother's Medicaid/ProviderOne Client ID number until the newborn's 21st day of life occurs. After the 21st day, the newborn should have their own Member ID number to bill claims with. **Note**: Newborns whose mothers are enrolled on the date of birth shall be deemed a member and enrolled in the same plan as the mother as follows:

- Retrospectively for the month(s) in which the first twenty-one (21) days of life occur and prospectively, beginning the first of the month after the newborn is reported to the HCA.
- If the newborn does not receive a separate client identifier from the HCA, the newborn enrollment will be only available through the end of the month in which the first twenty- one (21) days of life occur.
- For electronic claims, Loop 2000B is the subscriber information and for Apple Health (Medicaid), the subscriber and patient are the same. Therefore, for Apple Health (Medicaid) baby claims using the mother's ID, all the baby's information (name, address, date of birth, and gender) must go in the Loop 2000B segment along with the mother's ID. When you do this for a Medicaid newborn, ensure the Loop 2300 has an NTE*ADD*SCI=B note also.

Newborns are not covered for Apple Health Expansion as the program is designed to be for those 19 years of age and older.

Newborn Claims – Individual and Family Cascade Select

For **Individual and Family Cascade Select**, the newborn record is created using the claim and the mother's information. That record is then matched up with the incoming Health Benefit Exchange (HBE) enrollment file. Eligibility for newborns not yet enrolled with the Exchange ends on the 21st day of life.

Circumcision Claims – Apple Health

CHPW reimburses up to $200.00 (non-medically necessary circumcision). Circumcision services are not covered for Apple Health Expansion.

Billing Details

- Children <18 years of age (eligible).
- $200.00 maximum benefit, one per lifetime (per child).
- Members may obtain this service from an open network. Provider is not required to be contracted with CHPW. However, provider must agree to submit claim to CHPW and must have a Core Provider Agreement with the HCA.
- Once the $200.00 is met, any subsequent claims for the same circumcision procedure code(s) received for the same child will be denied as "benefit maximum reached" and the charges will be patient's responsibility.
- If CHPW receives the professional claim first, we will pay that in full up to the allowed amount and apply any remaining dollars up to the $200.00 maximum on a subsequent claim.
  Example

  $75.00 Professional fee billed
  $50.00 Allowed amount

  $50.00 CHPW payment amount *subtotal*

  $300.00 Facility claim billed
  $250.00 Allowed amount

  $150.00 CHPW payment amount *subtotal*

  $200.00 total CHPW payment amount (professional + facility fees)

- CHPW will reimburse related services (because of a complication).
- Claims for non-medically necessary circumcisions prior to February 1, 2021, are not covered.

Hospice Claims – Apple Health

Hospice providers are reimbursed through the Washington State Health Care Authority's (HCA) hospice daily rate. The daily rate includes core services and supplies such as drugs, home health care, durable medical equipment (DME), and skilled nursing care. The HCA Hospice services billing guide includes a list of all covered services and supplies.

There are four distinct levels of hospice care. Each level has a designated revenue (REV) code with general billing requirements. The place of service specified on the claim determines payment. If services are provided in a member's residence, then the payment is based on the county location of the home. If the member is an inpatient in a nursing facility/skilled nursing facility, hospital, or hospice care center, then payment is determined by the county location of the hospice provider. CHPW's payment is based on the HCA hospice fee schedule where each REV code has an assigned rate by county. If a specific county is not listed, then payment is processed under the "all other areas" rate.

All Apple Health hospice claims are held for manual review and pricing to ensure that the region (county) for the place of service is verified, and the correct rate is applied to the claim.

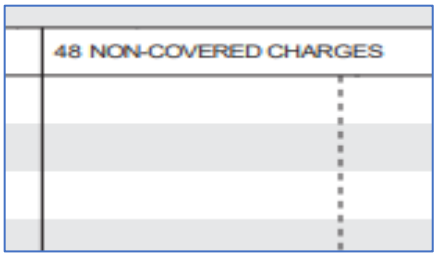
End of life and hospice care shall not be denied as readmissions.

Inpatient Facility Claims - Authorized Dates for Claims Submission

As of October 2024, CHPW has revised our guidance regarding authorized dates for claims submission for inpatient facility claims.

If a facility has an inpatient claim where the prior authorization does not cover the full length of stay, the facility must submit an itemized bill to CHPW in addition to the claim. The bill should include the entire length of stay and note which dates were approved and which dates were not approved.

Enter the non-covered services in box 48 of the UB-billing claim form.



Note that this applies in specific situations, such as DRG claims and percent of billed claims (for example, Critical Access Hospitals). It does not apply to readmissions within 48 hours.

Example

- CHPW authorized/approved an inpatient facility admission for 18 days.
- The patient is admitted to the facility as an inpatient for a total of 21 days.
- The facility must send an itemized bill to CHPW so the plan can clearly identify the 18 days that were authorized and the 3 days that were not approved.

If you have questions, please contact Customer Service (refer to the "**CHPW Contacts**" section of the manual).

Skilled Nursing Facility (SNF) Services and Outpatient Institutional Services Date Requirements – Apple Health

The date of service is required on every claim line item for skilled nursing facility (SNF) services and outpatient institutional services, per the HCA encounter regulations. Claims without the date of service on every claim line will reject with the HCA; therefore, claims that are not billed correctly will be denied in CHPW's claims system.
Per HCA guidelines:

- Date of service (DOS) is required at the header level and the line level.
- The Line DOS is required on institutional (INST) claim forms for*:
  - Nursing home claims
  - Swing bed claims
  - All outpatient services
- The HCA does not require the Line DOS when the services are **inpatient**.
- Nursing Home claims and swing bed claims can be designated either inpatient or outpatient services. While Medicare designates them as inpatient, the HCA has always designated theirs as outpatient.

***Note:** The HCA does not differentiate between Critical Access Hospitals that bill for swing bed claims any differently than nursing facilities that bill for swing beds claims. Both are considered outpatient, and both must list the DOS at header and each service line.

Refer to the HCA Nursing Home billing guide for more information.

Member Eligibility and Benefits

To check member eligibility and make a benefit inquiry (270/271 transaction), your clearinghouse/trading partner needs to have a signed trading partner agreement with NTT Data. Please have your clearinghouse/trading partner contact NTT Data at DL_Consumerism_Services@nttdata.com to set up connectivity. Our payer ID for 270/271 transactions is CMTWA.

You can also check eligibility through the CHPW HealthMAPS online provider portal. Please see the "HealthMAPS Provider Portal" section of this manual for more information.

Claim Documents

See the Provider Forms & Tools page on our website for a complete list of forms for our Apple Health, Medicare Advantage, and Individual and Family Cascade Select plans. The forms listed below are located under **Claims**:

- *Claims Supporting Documentation Cover Sheet*
- *Corrected Claim – Standard Cover Sheet*
- *Hysterectomy Consent Form* as noted in the "Women's Health Care" section of the manual (**Apple Health** only)
- *Sterilization Consent Form*; noted in the "Sterilization for Apple Health members" section of the manual (**Apple Health** only)
- *1500 Claim Form and Instructions (02-12)*
- *UB-04 Claim Form and Instructions*

Corrected Claims

A corrected claim (previously billed and processed) either paid or denied requiring reprocessing with corrected information, i.e., date of service, patient information, procedure codes. Note: If a previously process claim is not submitted as a "corrected" claim, it will be denied as a duplicate claim. The *Corrected Claim – Standard Cover Sheet* is available on our Provider Forms & Tools page, under "Claims."

CHPW prefers providers to submit corrected claims electronically, versus hard copy. The *Claims Entry, Corrected Claims, and Viewing Prior Authorizations and Referrals* training guide, available on our Provider Portal Training page, includes instructions for adding attachments to an electronic claim.

How to Submit Electronic Corrected Claims

Complete the following steps when electronically submitting a corrected claim in the ANSI-837 professional or institutional format:

> 837P (Professional) and 837I (Institutional) Claims: In Loop 2300 (Claim Information), segment CLM05-3, use Claim Frequency Type Code "7" for "Replacement."

The corrected claim will process as a replacement claim and reverse the original claim on file.

You can also submit corrected claims through the HealthMAPS provider portal. See our Provider Portal Training page, *Claims Entry, Corrected Claims, and Viewing Prior Authorizations and Referrals* training guide, for instructions.

How to Submit Hard Copy Corrected Claims

For paper claims, please:

1. Complete a *Corrected Claim – Standard Cover Sheet*, available from our Provider Forms & Tools page.
2. Make sure to include the original claim number as indicated on the cover sheet.
3. Attach any necessary supporting documentation.
4. Mail the cover sheet, corrected claim, and any supporting documentation to:
   CHP Claims
   PO Box 269002
   Plano, TX 75026-9002

Do not send corrected claims(s) to Customer Service, it will delay receipt and claim(s) processing.

Electronic Transactions / Electronic Data Interchange (EDI)

Benefits of electronic transactions:

- Environmentally and financially friendly, reducing paper consumption and related costs i.e., envelope, postage.
- 24-hour submission availability.
- Access to timely benefit, eligibility, and claim status information.
- Faster claim submission.
- Eliminate time waiting for mail delivery of Remittance Advice (RA) and check.

- Automatic availability of funds, without manual deposit,
- Elimination of lost or misplaced RA or check.
- CHPW supports the following electronic transactions:
    - 270: Eligibility, coverage, or benefit inquiry.
    - 271: Eligibility, coverage, or benefit response.
    - 276: Health care claim status inquiry.
    - 277: Health care information status response.
    - 834: Benefit enrollment and maintenance.
    - 835: Health care claim payment advice; electronic remittance advice, or ERA; payment details for your claim(s)***.**
    - 837: Health care claim.
- ACH/EFT payments: Automated clearinghouse (ACH) payments* made by electronic funds transfer (EFT); known as direct deposit or electronic banking.

*Note that the 835 ERA and ACH/EFT payments are separate transactions, and each requires a separate enrollment. If you enroll in one of these transactions, you are **not** automatically enrolled in the other; you can have ERA and not ACH/EFT or vice versa. Refer to the "835 transactions" and "ACH/EFT Payments" sections below for more information.

Providers may contact edi.support@chpw.org with questions relating to any of these transactions.

Electronic Claims Submission

CHPW uses Availity and Smart Solutions (SDS) for electronic claims submission, or 837 transactions. To start submitting electronic claims, contact your software vendor to learn about options for electronic claims systems and to choose a clearinghouse.

Our **Availity** Payer ID is *CHPWA*. Your clearinghouse will work directly with Availity to connect you to these transactions. If you have questions, you can either go to the Availity website or call -800-AVAILITY (282-4548) or the SDS website or call (855) 297-4436.

Check Claim Processing Status

You can check claim processing status (276/277 transaction). Please have your clearinghouse/trading partner contact NTT Data at DL_Consumerism_Services@nttdata.com to enroll. In addition, you can check claim processing status on a claim-by-claim basis through the CHPW HealthMAPS online provider portal. Please see the "HealthMAPS Provider Portal" section of this manual for more information.

Note: When checking the **processing** status of a claim, it may not have the final **payment** status (i.e., allowed, adjusted, denied) if claim adjudication is not complete.

Claim Message Codes

Contact edi.support@chpw.org for questions related to CHPW Reason Codes, Claim Adjustment Reason Codes (CARCs), or Remittance Advice Remark Codes (RARCs).

Claim Issues

First, contact Customer Service (see the "CHPW Contacts" section of this manual).

If Customer Service is unable to assist or resolve the issue, contact the Claims Investigation Unit (CIU). (See the "Claims Investigation Unit (CIU)" section of this manual).

835 Transactions

CHPW uses Availity or SDS for electronic remittance advice (ERA), or 835 transactions. The 835 is also known as a health care claim payment advice. You or your clearinghouse need to enroll in ERA directly with Availity or SDS. Our Payer ID for Availity and SDS is *CHPWA*.

To enroll in ERA:

- Go to Availity.com or call 1-800-AVAILITY (282-4548)
- Go to https://portal.smartdatastream.us/ or call 855-297-4436

Availity

Once you're registered with Availity and have submitted your Availity Identity Verification Form, follow these steps to complete a check/EFT validation in order to gain access to your CHPW ERAs.

1. Log in to the Availity website.
2. Click on **Remittance Viewer**.
3. Click **Manage Access**.
4. Click **Get Access**.
5. Enter check/EFT details from a recent payment from CHPW.
6. Once the check/EFT details display, click **Accept**.
7. Log out and log back in.
8. Go back to **Remittance Viewer**, then search for **CHPWA** for best results. (Other health plans have names similar to "Community Health Plan".)

Go to Availity's Training and Education page for a training demo.

Be advised, once you're enrolled to receive electronic RAs/835, CHPW will discontinue sending paper RAs. Once CHPW receives confirmation of enrollment in ERA, electronic RAs are generated. Contact EDI.Support@chpw.org if you prefer to continue receiving paper RAs.

If you have questions about enrolling for 835/ERA files or if you previously enrolled and would like to stop receiving the paper RA, contact EDI.Support@chpw.org.

Smart Data Solutions (SDS)

The ERA enrollment process through SDS is available for select payers that directly use Smart Data Solutions' services.

Follow these steps to complete enrollment with SDS:

1. Log into the SDS portal.
2. Click **Start Enrollment**.
3. Click the **Remits** tab and click **Manage Enrollments**.
4. Click the **Account Management** tab and click **Provider Enrollments**.
    a. If the account was created through a specific payer/payment vendor's enrollment process, then the home page will automatically redirect to the **ERA (835) Enrollment**.
    b. Either **Start Enrollment** or **Continue Enrollment** will display.
5. After navigating to the home page, if the **ERA (835) Enrollment Start Enrollment** option does not display, click the **Remits** tab and then click **Manage Enrollments**.
6. If the **Remit** tab does not display and you were not directed to the **ERA (835) Enrollment** option, click on the **Account Management** tab and then **Provider Enrollments**.
7. Click **Enrollment Form Completion** and follow the prompts on the screen to complete enrollment.

Missing Remits

For missing 835/ERA or paper remits, contact EDI.Support@chpw.org.

ACH/EFT Payments

You can submit EFT requests using CHPW's HealthMAPS portal. You may also email EDI.Support@chpw.org and request an EFT enrollment form to complete and return to CHPW for processing.

To sign up or request changes via HealthMAPS:

1. First, you'll need to go to CHPW's OneHealthPort page.
2. Click "HealthMAPS Login."
3. Once you're logged in, click on "Tools and resources".
4. Choose "EFT Enrollment and Updates."
5. Simply complete the online form to request changes to your existing EFT account or to file a new application for EFT.

CHPW will review your request, and you will receive notification when your application has been processed.

If you do not have access to OneHealthPort, learn more through CHPW's HealthMAPS Provider User Guide.

Claims Investigation Unit (CIU)

CHPW providers can submit *complex* claim inquiries to the Claims Investigation Unit at cs.claimsdistribution@chpw.org or fax (206)-652-7009.

This includes claim inquiries related to:

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

All other inquiries should be directed to the CHPW Customer Service Team(s) at:

- Apple Health Customer Service: 1-800-440-1561
- MA Customer Service: 1-800-942-0247
- Individual and Family Cascade Select Customer Service: 1-866-907-1906
- Email customercare@chpw.org

Note: You can also check the status of claims through the CHPW HealthMAPS provider portal. See the "HealthMAPS Provider Portal" section of this manual for more information.

Negative Balance

There may be times when a provider has a negative balance with CHPW, meaning a provider owes money to CHPW. This can occur due to claim adjustments. For example: If CHPW were to request a refund or initiate a recoupment and the provider did not have enough new claim activity to offset the balance due, a negative balance could result. "Paid" claims would apply to the negative balance, thereby reducing it.

When CHPW applies adjustments to modify or correct claim billing errors, we use these basic accounting principles, and two transactions will display on the provider's remittance advice(s):

- The provider may receive a single remittance advice (RA) with both the negative and offsetting transactions; or the provider may receive two RA, one for each transaction.
- The negative balance transaction is a copy of the original claim with dollar amounts listed as a negative.
- The offsetting transaction is a repayment that displays the modification, or corrections made to the original claim and the associated repayment dollar amounts.
- CHPW will then subtract the original payment amount from the adjusted claim payment amount and include this difference in the current payment amount.
- CHPW sends a negative balance letter indicating the provider's weekly remittance advice shows positive payment, and the provider will not receive a check. The letter states a claim adjustment has occurred and no check will be issued until the negative balance has been repaid.
- All future claim(s) payments will offset against this negative balance until the entire negative balance has been fulfilled.
- The provider will not receive any detailed remits showing the offset claims until the entire negative balance is cleared.
- Providers can refund the negative balance by sending a check for the negative amount to:

  WF Lockbox
  Attn: Claims Refunds
  PO Box 94751
  Seattle, WA 98124-7051

This is CHPW's policy for all lines of business: Apple Health, Medicare Advantage, and Individual and Family Cascade Select.

DRG, Fee Schedule, and Refund Request Disputes

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

Community Health Plan of Washington
Attention: Claims Investigation Unit (CIU)
1700 7th Avenue, Suite 900
Seattle, WA 98101

Fax: (206) 652-7009
Email: cs.claimsdistribution@chpw.org

This ensures more efficient processing and faster response time for issue resolution. You may also view the Overpayment and Underpayment Recoveries section of your Provider Agreement or the Dispute Resolution section of your facility agreement for more information.

To contest a refund request, refer to the Overpayment and Underpayment Recoveries section of your Provider Agreement or the Dispute Resolution section of your facility agreement.

Submit Refunds

Please submit checks for overpayment refunds to:

CHPW
PO Box 94751
Seattle, WA 98124-7051

Timely Filing Requirements

Following are the timely filing requirements by line of business:

- When CHPW is the primary payer, we must receive the **original Medicare Advantage** or **Individual and Family Cascade Select** claim no later than twelve (12) months* from the date of service (DOS). CHPW must receive **Medicare Advantage** or **Individual and Family Cascade Select corrected** claims within one year of the initial process date.
- When CHPW is the primary payer, we must receive the **original Apple Health** claim no later than twelve (12) months* from the date of service. Claims that require resubmission, such as incorrectly denied or incorrectly paid claims, are excluded from this provision. CHPW must receive **Apple Health corrected** claims within 24 months of initial process date.
- For **Medicare Advantage**, **Individual and Family Cascade Select**, or **Apple Health**: 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.

  ***Note:** "No later than 12 months from DOS" is the same as 365 days from the DOS. For example, a claim with a 12/01/2025 DOS must be submitted by 12/**01**/2026. A 12/31/2026 deadline is ruled out because anything after 12/01/2026 would be more than 12 months after the DOS.

Refer to your CHPW provider contract for information related to timely filing requirements for claims submissions.

Claims Processing Standards for Participating Providers

CHPW adjudicates claims based on receipt date and according to state and federal regulatory requirements:

Apple Health and Apple Health Expansion	• 90% of clean claims within thirty (30) calendar days of receipt • 99% of clean claims within 90 calendar days of receipt
Medicare	• 95% of clean claims within thirty (30) calendar days of receipt • 100% of unclean claims within sixty (60) days
Individual and Family Cascade Select	• 95% of clean claims within 30 calendar days of receipt • 95% of all claims within 60 calendar days of receipt • 99% of clean claims within 90 calendar days of receipt

Fee Schedules/Rate Updates

Throughout any given year, numerous government payer rate changes occur, sometimes with retroactive effective dates. 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 date that CHPW completed the reconfiguration of its claim system **or** the published effective date of the new rates provided by the governmental entity, whichever occurs later.

CHPW shall use Medicare and appropriate Apple Health fee schedules for Individual and Family Cascade Select pricing/rates and follow the same protocol for fee schedule updates.

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

Note: Claims for the same DOS could be paid from differing fee schedule dates due to when the fee schedule was implemented and when the provider submitted the claim.

Please contact your Contract Administrator if you have questions about this policy.

Encounter Data

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

Encounter data is conceptually equivalent to paid, capitated, and denied claims records for Apple Health, Medicare, and Individual and Family Cascade Select. They are records of the health care services for which MCOs pay and the amounts MCOs pay to providers of those services. Federal law requires this data to be submitted electronically in specific formats for each. Refer to your CHPW provider contract for information related to timely filing requirements for encounter data submissions.

Please refer to the following resources for more information about encounter data:

- HIPAA 837I and 837P Implementation Guide available for purchase from Washington Publishing Company or call (425) 562-2245.
- HCA's Encounter Data Reporting Guide
- HCA's 837 Encounter Data companion guide for Professional and Institutional
- HCA's SERI guide
- NCPDP Standards or call (480) 477-1000.

Please see the resources listed below for information on how to prevent some of the most common errors we've identified based on billed encounter data:

- NUCC Taxonomy Codes
- HCA Revenue Code/Procedure Code Grid (click on "Inpatient Prospective Payment System (IPPS)", then scroll down to "HCA revenue code grids" and choose the one that applies for the date of service); use the grid to help determine which revenue codes require you to include procedure codes
- CMS quarterly NDC-HCPCS Crosswalk (select the appropriate year, then scroll down on the resulting page to the crosswalks)
- NPI provider directory

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

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

Refer to the National Uniform Claim Committee (NUCC) Health Insurance Claim Form for more information.

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

Visit the CMS website for more information about the 837-I form.

National Drug Codes (NDC)

All MCOs are required to report in their encounter data the NDC of drugs provided in outpatient settings. Encounters with a missing or invalid NDC will be rejected. If CHPW paid the encounter and the HCA then rejects it, CHPW may recoup the amount that we paid the provider.

Please see the CMS Medicare Part B Drug Average Sales Price page for more information.

Billing for Administration of Drugs

When billing for the administration (injection) of a drug that you did not supply (dispense) or was not purchased, but free from the Washington State Department of Health (DOH), please make sure to follow these guidelines to ensure appropriate billing.

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

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

Enhanced Ambulatory Patient Group (EAPG) Claims

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

Patients in each EAPG have similar clinical characteristics, resource use, and cost. These groups were developed to encompass the full range of ambulatory settings including same day surgery units, hospital emergency rooms, and outpatient clinics. EAPGs cannot address nursing home services, inpatient services, or miscellaneous services such as transportation.

CHPW processes Individual and Family Cascade Select outpatient claims per the provider's contract. EAPG may not always apply.

Contact our Customer Service department if you have questions related to EAPG pricing. Refer to the "CHPW Contacts" section of this manual for phone numbers.

Please see the HCA's Hospital reimbursement page for the Washington State Medicaid Outpatient Hospital Rates Fee-For-Service.

CHPW Billing and Rendering Provider Taxonomy Requirements

All clinics and providers are required to submit claims with valid, appropriate taxonomy codes for the billing provider and, when applicable, the rendering provider. See our Billing and Rendering Taxonomy Requirements page for more information.

Telehealth Services (Telemedicine)

CHPW reimburses providers for telemedicine services meeting the approved telemedicine criteria.

Apple Health

As stated in the HCA Telemedicine Policy and Billing guide: The HCA, working with Apple Health managed care organizations, expanded the use of a variety of telemedicine technologies to meet the health care needs of clients, families, and providers. In the health care community, the words telehealth and telemedicine are often used interchangeably. However, for Apple Health, telemedicine is defined in a very specific way. Please refer to the HCA Telemedicine policy and billing guide for telemedicine criteria, claim information, and additional details.

Refer to the SERI guide for additional information about Apple Health behavioral health services. Limitations apply for any provider providing telemedicine services. The provider must be operating within the scope of their license; they must be at an approved originating site, and using HIPAA compliant, interactive, real-time audio and video telecommunications (including web-based applications) or store and forward technology. The services must be covered services that are within the scope of the provider's license. Additional limitations apply for drug monitoring.

Medicare Advantage D-SNP Plans

These services must meet Original Medicare requirements for MA and D-SNP members. See the CMS List of Telehealth Services for more information.

Individual and Family Cascade Select Plans
Telemedicine services include audio and video communication services between a distant site provider, the patient, and a consulting practitioner. Such services are covered if the originating site is one of the following:

- Hospital,
- Rural Health Clinic,
- Federally Qualified Health Center,
- Physician's or other health care provider's office,
- Community mental health center,
- Skilled Nursing Facility,
- Home or any location determined by the individual receiving the services, or
- Renal dialysis center, Medicare certified facility.

Care provided by phone, fax, email, or internet, other than covered telemedicine visits, is not covered, except as required by applicable state or federal law or regulation.

Apple Health (Medicaid) – Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

FQHCs
Health plans are responsible for reporting members that are assigned to an FQHC in a monthly per member, per month (PMPM) report. Once a month, CHPW sends a report of members assigned to FQHCs to the HCA.

RHCs
RHCs will be paid their full encounter rate on eligible claims.

HCA reimburses MCOs for the T1015 via service-based enhancement (SBE) through ProviderOne. The service-based enhancement provides MCOs with reimbursement for T1015 paid amounts on RHC encounter eligible claims. SBEs are generated after the paid claim billed with a T1015 is submitted to and accepted by ProviderOne.

Note: RHC SBEs do not apply for Apple Health Expansion.

To ensure correct adjudication of claims/encounters to generate the SBE:

1. RHCs must use billing taxonomy 261QR1300X.
2. Specific Z codes cannot be billed as the primary diagnosis code for RHC claims. Please see the Z Codes as Primary Diagnosis - Denials for RHCs billing guideline for a list of Z codes that will be denied if billed as the primary diagnosis (on our Provider Billing and Claims page, under "Billing Guidelines").

Enrolling as a Medical-Assistance-Certified FQHC or RHC

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

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

Note: A center must receive federal designation as a Medicare-certified FQHC before the Agency can enroll the center as a medical assistance-certified FQHC. Go to the CMS Federally Qualified Health Centers (FQHC) Center for information on Medicare provider enrollment. When adding a new site or service, indicate on the CPA that you are an FQHC.

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

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

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

Note: A clinic must receive federal designation as a Medicare-certified RHC before the Agency can enroll the clinic as a medical-assistance-certified RHC. Go to the CMS Rural Health Clinics Center for information on Medicare provider enrollment.

Questions related to FQHC/RHC enhancement payments can be emailed to: enhancement.questions@chpw.org.

If you have questions about enrolling as a medical-assistance-certified FQHC or RHC, overall management of the program, or specific payment rates, please contact:

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

Additional information is available in the HCA's FQHC and RHC billing guides.

Coordination of Benefits (COB)

When there is more than one payer, "coordination of benefits" rules decide who pays first. The "primary payer" pays what it owes on your bills first and then sends the rest to the "secondary payer" to pay. In rare cases, there may also be a third payer.

What it means to pay primary/secondary

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The one that pays second (secondary payer) only pays if there are costs the primary insurer did not cover.
- The secondary payer may or may not pay all the remaining costs.
- Behavioral Health Services Only (BHSO) refers to a member who is enrolled in Medicaid managed care for behavioral health benefits only; medical care is covered under a different health plan. CHPW cannot coordinate benefits on medical claims for members on the BHSO plan.

At the time of patient registration, providers should ask patients if they have other insurance coverage. If there is another possible source of insurance identified, the provider should bill the other insurance company as the primary payer and submit an Explanation of Benefits (EOB) to CHPW as the secondary payer.

CHPW will coordinate benefit payments with any other group plan, Apple Health plan, or Medicare plan that covers the member. In some circumstances, members could have dual CHPW coverage with the Medicare Advantage D-SNP as primary and the Apple Health (Medicaid) plan as secondary. In such cases, CHPW pays as primary under the D-SNP and Apple Health (Medicaid) as the secondary payer.

If CHPW is not the primary insurance (payer), and the primary payer does not cover a specific service (for example, maternity), you must bill the primary payer first. When you receive the primary payer's denial, you may then send the claim to CHPW along with the primary payer's EOB. CHPW will then evaluate the claim for processing as the secondary payer. An EOB is not required for behavioral health services that are not covered by Medicare.

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

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

1. When both plans coordinate benefits, the plan covering the person as a subscriber provides benefits first.
2. Dependent children are covered first under the plan of the parent whose birthday is earlier in the calendar year. If the parents are divorced or separated, the following rules determine which plan pays first:
    a) Plan of the parent with custody.
    b) Plan of the spouse of the parent with custody.
    c) Plan of the parent without custody.

d) Plan of the spouse of the parent without custody.
e) If there is a court decree that establishes responsibility for the child's health care, the plan of the parent with that responsibility provides benefits first.

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

Individual and Family Cascade Select plans follow the same rules as listed above per WAC 284-51-205, Rules for Coordination of benefits:

CHPW will not reimburse a provider any amount greater than the amount billed.

For Apple Health, if a provider has received payment from another carrier, and that payment is equal to or greater than the CHPW rates for services rendered, the provider will not receive payment from CHPW.

Payment for Opioid Treatment Programs Services
CHPW would like to remind providers that **Medicare** is the primary payer for dually eligible beneficiaries who receive Opioid Treatment Programs (OTP) services.

- "Dual-eligible beneficiaries" means people enrolled in both Medicare and Medicaid.
- Medicare pays for OTP through bundled payments for opioid use disorder (OUD) treatment services.
- OUD services include toxicology testing, medication-assisted treatment (MAT), and counseling.

Medicare
Providers must be enrolled as an OTP provider under Medicare. Medicare allows providers to retroactively (retro) enroll back to 30 days prior to the date of the decision that the provider is qualified. The provider can then bill for dates of service (DOS) effective back to the 30 days.

HCPCS G codes are used for reimbursement by Medicare.

Please see the Centers for Medicare & Medicaid Services (CMS) Opioid Treatment Programs (OTP) Billing and Payment webpage for more information.

Apple Health
The Washington State Health Care Authority (HCA) has identified that code H0020 should not be billed to Apple Health if the provider is enrolled as an OTP provider with Medicare; those providers must bill Medicare as the primary payer. If the provider is enrolled as an OTP provider, claims submitted to CHPW will be denied for Medicare Explanation of Benefits (EOB). Please see the HCA Substance Use Disorder Billing Guide, "Opioid Treatment Programs (Opiate Substitution Therapy)" section.

Provider Responsibilities
Medicare-enrolled providers should notify the HCA upon approval of Medicare enrollment.

If providers have the capacity to do so, they may complete a self-audit, review their own claims, and submit adjustments or voids after Medicare has made payment. Providers who self-audit and send a check as an adjustment should include supporting documentation indicating the claim(s) to which the check is applicable.

Providers will submit claims to CHPW along with the Medicare EOB per the standard Coordination of Benefits (COB) process. This includes claims that are within the 30-day retro enrollment timeframe.

If you have questions about payment of OTP/OUD services, please contact our Customer Service Department.

Post Payment Review (PPR)/Program Integrity Review

CHPW strives to be stewards of state and federal funding as well as taxpayer dollars. As part of our due diligence to ensure that claims are paid appropriately, we conduct post payment reviews.

Our goal in conducting PPR is to:

- Educate our provider community on appropriate billing and guidelines
- Ensure we are paying according to our contracts
- Monitor for potential fraud, waste, and abuse (FWA)

Our PPR includes, but is not limited to:

- Medical necessity of the admission and/or procedure(s) performed.
- Appropriateness of the treatment setting or length of treatment.
- Patient's status upon discharge.
- All patient diagnosis-related group (AP-DRG) validation.
- General quality of care delivered.
- Validation of the procedure(s) and diagnosis codes submitted.

CHPW requires providers/facilities to provide complete/accurate records timely. Retrieval and duplication of records will be at the provider's expense.

Medical Records for Post Payment Review/Program Integrity Review

CHPW prefers that medical record documentation be sent electronically via fax, secure email, CD, or thumb drive.

Sending records electronically means we'll receive them faster, reducing your risk of having claims denied for non-receipt of records. CHPW will eventually stop allowing paper records. We haven't set a date yet, but when we do, we'll let you know through our Provider Bulletin Board (for Apple Health, Individual and Family Cascade Select, or Medicare Advantage) and other means.

CHPW does not check third party portals or websites for records that were requested for post payment review. Providers must notify CHPW when records are ready for retrieval from the third-party vendor. Send notifications to Operations.Intake@chpw.org.

Third Party Liability (TPL) (Subrogation/Reimbursement)

CHPW benefits are available to a member who is injured or becomes ill because of a third party's action or omission. CHPW has subrogation rights and other rights to recovery against any third party liable for the illness or injury. This means CHPW:

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

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

- Providing information to CHPW concerning the facts of the illness or injury and the identity and address of the third party or parties who may be liable for the illness or injury, their liability insurers, and their attorneys.
- Providing reasonable advance notice to CHPW of any trial or other hearing, or any intended settlement, of a claim against any such third party.
- Repaying CHPW from the proceeds of any recovery from or on behalf of any such third party.

Provider Obligations Related to TPL

A provider is responsible for notifying CHPW when they become aware that a member has a right to reimbursement from a third party and to assist in arranging for assignment of such right to CHPW for collection.

The following information, to the extent that the provider is aware, should be reported to CHPW:

- Facts of the member's condition or injury.
- Any changes in the member's condition or injury.
- Name of any person responsible for the member's condition or injury and that person's insurance carrier.

Appeals and Disputes

Member Appeals –

(Pre-Service Requests Only)

A member appeal may be submitted by the member, a *representative acting on behalf of and with permission from the member*, or a *provider acting on behalf of and with written authorization* from the member within the timeframe outlined in the Grievances and Appeals Guide or member EOC. When assisting a member with an appeal, providers should:

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

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

IMPORTANT: Per HIPAA requirements, a signed member consent is required for a representative to file an appeal on a member's behalf. Member appeals submitted without the appropriate consent are dismissed.

Member Grievance and Appeal Rights

Apple Health (all CHPW Medicaid products) members have the right to file a grievance or appeal a decision. For more information and consent documents on member appeals go to: chpw.org/member-center/member-rights/grievances-and-appeals/

Apple Health Expansion members have the right to file a grievance or appeal a decision. For more information and consent documents on member appeals go to: chpw.org/member-center/member-rights/grievances-and-appeals/

Medicare Advantage Dual Plans (HMO D-SNP) enrollees have the right to voice a complaint if they have a problem or concern about their health care or health care coverage. For more information and consent documents on member appeals go to: medicare.chpw.org/member-center/member-rights/grievances-appeals/

Cascade Select (Individual & Family Plans) - If a service was denied, reduced, or ended early, members can appeal that decision with a CHPW Cascade Select Standard or Expedited Appeal. For more information and consent documents on member appeals go to: individualandfamily.chpw.org/member-center/member-rights/grievances-appeals/

Provider Appeals and Disputes

A provider may appeal a CHPW decision that they believe is incorrect.

Participating provider appeals must be in writing and submitted within twenty-four (24) months from the date of the notice of denial of a clean claim or denied line(s) on a partially paid claim. For denied pre-service authorization requests, please visit the links for the appropriate Line of Business in the Member Appeals section above.

Non-participating provider appeals must be in writing and submitted within sixty (60) days from the date of the notice of the denial of a clean claim or denied line(s) of a partially paid claim for Apple Health members; within sixty-five (65) days for Medicare members; or within one hundred eighty (180) days for Cascade Select members (submit directly to the Claims Investigative Unit). For denied pre-service authorization requests, please visit the links for the appropriate Line of Business in the Member Appeals section above.

An appeal must include at minimum:

- CHPW's Appeal Request Cover Sheet or Letter
- Member name and member ID number
- CHPW Claim number(s) (if applicable)
- Date of service
- A contact from the provider appealing office – **phone/fax**
- All supporting documentation pertinent to the reason for denial –
    - Provider/vendor should note or tag which pages are pertinent to the appeal (*especially important when filing with a large number of pages*).
- Reason for requesting the appeal **(please be clear and concise).**

Appeal Rejections: Incomplete appeals may be rejected and will require the provider to resubmit the appeal with the applicable information bulleted above (at minimum). Please note the following:

- Providers will be notified if your appeal is rejected.
- Rejected appeals will not be counted as an appeal.

In the event your appeal is rejected, the provider will be required to follow the established timelines to submit an appeal – 1st Level 24-months and 2nd Level 60-days.

To access CHPW's appeal cover sheet, go to: https://www.chpw.org/provider-center/forms-and-tools/.

Providers may submit appeals via fax or email:

Apple Health:
Fax: (206) 613-8984 (routine)
Fax: (206) 613-8983 (clinically urgent)
Email: Appealsgrievances@chpw.org

Medicare Advantage & D-SNP
Fax: (206) 652-7010 (routine)
Fax: (206) 652-7011 (clinically urgent)
Email: Appealsgrievances@chpw.org

Cascade Select - Individual & Family Plans:
Fax: (206) 613-8984 (routine)
Fax: (206) 613-8983 (clinically urgent)
Email: Appealsgrievances@chpw.org

When not to submit an Appeal

Please do not file an appeal for the following:

- DRG Disputes
- Fee Schedule Disputes
- Claims Disputes (a processed claim with no denied line items)
- Refund Requests/Negative Balances
- COB/OHI
- Post Payment Review (PPR)

Please send the disputes as described and bulleted above to CHPW's Claims Investigative Unit via email or fax:
Email: cs.claimsdistribution@chpw.org
Fax: 206 652-7009

Cascade Select Disputes for Non-Participating Providers

Payment Disputes
Non-contracted providers may dispute denied or underpaid claims for services provided to Cascade Select members.

Eligible Disputes

- Denied claims believed to be payable
- Underpaid claims
- Processing errors or coordination of benefits issues

Submission Guidelines

- Submit within 90 days of processed date
- Include remittance advice, relevant documentation, and a clear explanation
- Use the fax or email listed on the remittance advice; mail submissions are discouraged

Please send the disputes as described and bulleted above to CHPW's Claims Investigative Unit via email or fax:

Email: cs.claimsdistribution@chpw.org
FAX: 206 652-7009

Additional Information

- Expedited appeals and medical necessity denials with member signatures follow the Appeals process.
- CHPW may initiate a Single Case Agreement (SCA) if contracting is appropriate.

Non-par providers may submit appeals via fax or email*:*

Cascade Select - Individual & Family Plans:
Fax: (206) 613-8984 (routine)
Fax: (206) 613-8983 (clinically urgent)
Email: Appealsgrievances@chpw.org

Non-par providers may submit appeals on behalf of the member to:

Cascade Select - Individual & Family Plans:
Fax: (206) 613-8984 (routine)
Fax: (206) 613-8983 (clinically urgent)
Email: Appealsgrievances@chpw.org

Utilization Management

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

Referral Management

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

Prior Authorization

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

Prior Authorization is required for all scheduled (planned) inpatient admissions, as well as certain predetermined services, medical pharmaceuticals, surgical, diagnostic, therapy, and imaging procedures. Lists of procedures and services requiring prior authorization is maintained separately and may change from time to time based on utilization performance. The lists are updated at least annually at a minimum based on changes in standards of medical care, new technologies, or denial rates. No authorizations are required for treatment in an emergency room. Please see also the "Emergency Room Care/Emergency Medical Condition" section of this manual.

The most current Prior Authorization lists (Medical & Surgical, Behavioral Health, and Professionally Administered Medications) may be found on our website at:
chpw.org/provider-center/prior-authorization/

Authorization Documents

Prior authorizations can be submitted online via the Jiva Portal: jiva.chpw.org. Additionally, requests for Medicare, Apple Health, and Cascade Select members can be faxed to (206) 652-7077.

Prior Authorization Request Forms

Prior Authorization Request Form:
https://www.chpw.org/wp-content/uploads/2020/05/2021-Prior-Authorization-Request-Form.pdf

Mental Health Prior Authorization Form:
https://www.chpw.org/wp-content/uploads/content/provider-center/prior-authorization/Mental-Health-Service-Request-Form.pdf

Substance Use Disorder Prior Authorization Form:
https://www.chpw.org/wp-content/uploads/content/provider-center/Substance-Use-Disorder-Services-PA-Request-Form.pdf

Prior Authorization List and Utilization Guidelines

https://www.chpw.org/provider-center/prior-authorization/

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

Prior Authorization Determination Timelines

CHPW strives to process authorization requests within Washington State, Federal, and National Committee for Quality Assurance (NCQA) requirements for timeliness, and in accordance with our member's health care needs. Periodic increases in request volume may affect turnaround times. CHPW strives to adhere to the following processing timelines:

- Apple Health and Cascade Select: Standard portal prior authorization requests are processed within 3-14 calendar days, standard faxed requests 5-14 days. Clinically urgent requests are processed within 1-5 calendar days. Timeline dependent on mode of submission and clinical documentation being submitted with the request.
- Medicare: Standard prior authorization requests are processed within 14 calendar days. Clinically urgent requests are processed within 72 hours.

Requests are processed in the order received using clinical information submitted by the provider. Processing times for both standard and expedited requests may be delayed if sufficient information is not provided.

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

Clinical Practice Guidelines for Behavioral Health and Medical Conditions and Preventive Services

Community Health Plan of Washington uses guidelines for chronic diseases (including medical and behavioral health conditions) and for preventive services, as listed below. Reference is made to the pertinent evidence-based, peer-reviewed guidelines from Nationally recognized agencies. The guidelines are intended to help guide providers in their care of our members including Medicare, Apple Health, Cascade Select, and Behavioral Health Services Only members. The guidelines also ensure that the Clinical Coverage Criteria used for utilization management (UM) decisions are aligned with the current evidence-based guidelines.

All guidelines are reviewed at a minimum of once every two years. The Clinical Quality Improvement Committee (CQIC), which includes network medical and behavioral health providers and quality specialists, participates in this review, and approves any changes. All internal clinical coverage criteria used for UM decisions are reviewed annually by the UM Policy Sub-Committee which includes network and internal medical and behavioral health providers. Paper copies of the guidelines and criteria are available for members or providers on request, as well as at the links provided.

UM leadership encourages the involvement of network practitioners in the development, adoption, and review of all guidelines for care and criteria used in determining coverage or care. Network providers who wish to discuss criteria with CHPW physicians are encouraged to contact CHPW Apple Health Customer Service Department at 1-800-440-1561, Medicare Customer Service Department at 1-800-942-0247, or Cascade Select Customer Service Department at 1-866-907-1906. from 8 a.m. to 5 p.m., Monday through Friday and request a peer to peer to review specific criteria. CHPW also participates and follows recommendations of the Bree Collaborative. Every year, the Bree Collaborative identifies health care services with high variation in the way that care is delivered, that are frequently used but do not lead to better care or patient health, or that have patient safety issues. Topics that are selected for review are reviewed by an expert workgroup to develop evidence-based recommendations. Recommendations take into account existing quality improvement programs and the work done by other organizations and are then sent to the Washington State Health Care Authority to guide the type of health care provided to Apple Health enrollees, state employees, and other groups. Topics include behavioral health, pain management, oncology, surgery, reproductive health, and aging. Providers should review the recommendations from the Bree Collaborative to ensure that they are delivering care that follows best practices.

➔Download the current Clinical Practice Guidelines

Provider Training

The goal of CHPW Provider training is to provide ongoing learning opportunities to ensure the delivery of culturally and linguistically appropriate quality care to our members. Per CHPW's contract with the Health Care Authority, CHPW is required to ensure that its provider network has access to the following training courses.

CHPW is committed to advancing health equity by supporting our provider network with the tools and resources to address inequities. We believe cultural humility training is an important tool to ensure lifelong learning and critical self-reflection and require providers maintain records of completion.

Behavioral Health Provider training and requirements:

a. The use of Evidence Based Practices, research based, Promising Practices related to the assessment and treatment of behavioral health conditions. CHPW will provide assistance to providers as needed to submit EBP claims.
b. Incorporation of Recovery and Resiliency principles into services and policies.
c. Screening, identification, and referral for treatment for medical conditions and risk factors commonly occurring in individuals with severe and persistent behavioral health conditions. For individuals on medication, screening includes review of Enrollee medical and medication history, and for individuals on psychotropic medication, vital signs, weight, and BMI. Screening tools used with children and youth shall be developmentally age appropriate.
d. Certified Peer Specialist training is in accordance with DBHR policies. Policy requirements include the use of DBHR approved curriculum, trainers, testers, and applicants.
e. Providers are required to participate in training when requested by HCA. Requests for HCA to allow an exception to participation in required training must be in writing and include a plan for how the required information will be provided to targeted staff.
f. Annually, all providers who work directly with Enrollees must be provided with training on safety and violence prevention topics described in RCW 49.19.030. We require all providers to maintain records of completion.
g. Provide HIPAA compliant encounters.

Primary Care Provider training and requirements:

a. Screening for behavioral health conditions using developmentally, age-appropriate screening tools.
b. Brief Intervention and Referral to Treatment for Enrollees aged 13 years and older.
c. Application of Evidence-Based, Research-Based, and Promising Practices (including those from Bree Collaborative) for Behavioral Health Conditions commonly occurring in Primary Care.
d. Identification of individuals with First Episode Psychosis (FEP) and referral to appropriate FEP services.

Behavioral Health and Medical Provider training and requirements: Effective approaches to managing individuals with co-occurring conditions including individuals with behavioral health and co-occurring medical conditions or co-occurring intellectual and developmental disabilities. Training provided shall address the following requirements:

a. Care Coordination requirements, including, but not limited to creating and maintaining a shared care plan;
b. Collaborative care or similar research-based models for Care Coordination;
c. Discharge planning for Enrollees transitioning from the hospital to the community; and
d. Accurate diagnosis and appropriate treatment for individuals with I/DD.
e. Inclusion of culturally and linguistically appropriate service to delivery of behavioral health services and behavioral health-medical integration initiatives.
f. Support for advancement of bi-directional integrated care in alignment with the Washington Integrated Care Assessment (WA-ICA).

CHPW will provide education to providers and correctional facilities about CAA requirements and health care available to enrollees who are incarcerated, the MTP 2.0 reentry demonstration initiative, and payment mechanisms for embedded correctional facility providers in collaboration with HCA. CHPW is available to provide technical assistance to providers upon request.

CHPW will offer access to Trauma Informed Care Education and Training to all provider types and subcontractors at no charge. This education makes providers and subcontractors aware of the importance of providing services in a manner that is based on an understanding of the vulnerabilities and triggers of trauma so that services may be supportive and avoid traumatization.

CHPW welcomes and requests feedback on specific training requests within or outside of these parameters. CHPW seeks to provide comprehensive resources to all providers. These training requirements apply to our contractor and subcontractors across types (IMC, Apple Health Expansion, etc.).

CHPW will inform providers of trainings available through various platforms: direct emails of CHPW offerings or partner offerings, CHPW Provider Bulletin, training calendar, training materials are available on the CHPW Clinical Practice Training and Resources, Joint MCO (Managed Care Organization) AWHP (Association of Washington Healthcare Plans) website, and access may be provided to Relias on request. Trainings include links to the following materials (including but not limited to those listed). We encourage providers to utilize the resources provided.

Required Clinical Information

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

- Current history and/or physician examination notes that address the problem and need for services requested.
- Relevant lab and/or radiology results
- Relevant specialty consultation notes

- Relevant medication history
- Other pertinent information to aid in decision-making process.

CHPW Utilization Management staff may request specific additional clinical information via fax or telephonically to complete the authorization process.

Clinical Decision-Making

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

CHPW does not reward anyone, providers or others involved in the UM process, for denying coverage or care. UM decision-making is based on appropriateness of care and service and existence of coverage. Any financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

CHPW staff is available to discuss the clinical decision-making process. An appropriate peer reviewer (Medical Director, Pharmacist, or Associate Clinical Director) is available to discuss any authorization or denial by contacting the CHPW Apple Health Customer Service Department at 1-800-440-1561, Medicare Customer Service Department at 1-800-942-0247, or Cascade Select Customer Service Department at 1-866-907-1906.

Non-covered Services and Benefits for Apple Health Members

An Apple Health member and/or the member's provider may request CHPW to pay for a non-covered health care service by submitting an **exception to rule** (ETR) request with supporting medical records. The provider must submit documentation that the service would benefit the member's clinical condition through cost-effective treatment and there is not an equally effective (less costly) covered service/equipment available that meets the member's needs (WAC 182-501-0160). Members and/or providers ***do not*** have a right to a fair hearing or appeal on ETR determinations. ETR is not applicable to EPSDT members. If a non-covered service is requested for a 19–20-year-old Apple Health Expansion member, an ETR will be required.

An ETR request can be initiated after a service has been denied. The request must be made within ninety (90) days of denial notification. Refer to chpw.org/provider-center/forms-and-tools/ for a form.

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

EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for Apple Health (Medicaid) members under the age of twenty-one (21). EPSDT rules require coverage for members under age twenty-one (21) when they are medically necessary, safe, and effective; generally recognized as accepted medical practice; and not experimental or investigational. Services which are not covered for adult Apple Health (Medicaid) members are reviewed for medical necessity under EPSDT requirements for members under age twenty-one (21). If the service is medically necessary, then it is approved; if not, then it is denied for medical necessity, and appeal rights are provided. EPSDT does not apply to Apple Health Expansion members; 19-20-year-old Apple Health Expansion members have well-child exams and chiropractic care as covered services.

Limitation Extension

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

CHPW will accept LE requests when the benefit limit will be exhausted within one (1) week.

- Limitation Extension Request Form: chpw.org/provider-center/forms-and-tools/

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

Pediatric Lead Testing

To better protect children from the harms of lead and to prevent lead exposure, the Washington State Department of Health (DOH) is lowering the state blood lead action level from 5 micrograms per deciliter (µg/dL) to 3.5 µg/dL. This action level aligns with federal guidance and identifies children with lead levels that are higher than 97.5% of 1–5-year-old U.S. children. There is no safe blood lead level, and even low levels of exposure can harm a child's health and development.

Blood lead testing continues to be critical for addressing childhood lead exposure. Because young children are particularly vulnerable to the damaging effects of lead exposure, DOH recommends testing all children with risk factors as outlined in the clinical algorithm . Lead exposure is more common among children living in poverty, refugees or recent arrivals, and children living near current or former industrial areas. Additionally, **federal regulations require all children enrolled in Medicaid to receive blood lead tests at 12 and 24 months of age,** or once between 24 to 72 months of age if no record of a previous test exists.

Though you may hear that lead is not an issue for Washington children, the fact is that we have some of the lowest testing rates in the nation and therefore do not have enough data to accurately assess the burden of lead exposure.

DOH recommends providers conduct confirmatory and follow-up testing starting at ≥3.5 µg/dL, to align with the new action level. Please follow the Pediatric Environmental Health Specialty Unit's Recommendations on Management of Childhood Lead Exposure. While your local health jurisdiction's response may vary depending on capacity and resources, you can support families of any child exposed to lead by providing DOH materials (available at doh.wa.gov/lead-publications), offering education about potential exposure sources, monitoring the child's development, and continuing to test children to ensure their blood lead levels are going down.

Laboratories (including facilities that use point-of-care machines) must report all blood lead test results for patients of all ages to the DOH. The required reporting timeframes for blood lead levels tests outlined in the Notifiable Conditions rule WAC 246-101-201 have not changed: report blood lead levels ≥5 µg/dL within two days and all other test results within 30 days.

For more guidance, visit Blood Lead Testing Information for Health Care Providers | Washington State Department of Health and contact the Childhood Lead Poisoning Prevention Program at lead@doh.wa.gov or 360-236-4280 for assistance reporting or with any other questions.

Medicare Outpatient Observation Notice (MOON)

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

Inpatient Admission Notification

Facilities must provide notification of inpatient admissions within twenty-four (24) hours or the next business day. This allows CHPW the opportunity to assist with management and coordination of care, including appropriateness of services and discharge planning, as well as to facilitation discharges to an appropriate setting.

Member eligibility for Inpatient services may be verified through One Health Port at www.onehealthport.com or the CHPW Medical Management Portal at jiva.chpw.org/cms/ProviderPortal/Controller/providerLogin. For those organizations that do not have internet access, please contact Customer Service at 1-800-440-1561 (TTY: 711).

Inpatient Admission Documents

The *Inpatient Admission Notification Form* is available online at chpw.org/provider-center/forms-and-tools/

Inpatient Admission notifications for Apple Health members may be faxed to (206) 652-7078.
Inpatient Admission notifications for Medicare Advantage members may be faxed to (206) 652-7065.
Inpatient Admission notifications for Cascade Select members may be faxed to (206) 652-7050.

Concurrent Review

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

Post-Service or Retrospective Review

These are requests for an initial review of services after services have been provided to a member. Failure to obtain authorization when required will result in denial for those services. Only possible exceptions to accept these requests are due to extenuating circumstances (i.e., member eligibility issue, member was granted retroactive enrollment, services authorized by another payor who subsequently determined that the member was not eligible at the time of service, or member was unconscious at presentation).

Coverage decisions will be based on the medical necessity and appropriateness of care or service as defined by clinical criteria used in making determination of service. Decision will be made within thirty (30) calendar days following receipt of request.

Discharge Planning Coordination

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

Emergency Room Care/Emergency Medical Condition

No referrals or authorizations are required for treatment in an Emergency Room. An emergency medical condition is a condition that manifests itself by acute symptoms of sufficient severity (i.e., severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the patient, or with respect to a pregnant woman (the health of the woman or the unborn child), in jeopardy,
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part Clinical Care Management Criteria.

Criteria Used in Determining Authorization for Service

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

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

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

Cases that cannot be approved using the designated criteria are sent to CHPW Medical Directors for determination of medical necessity. Our Medical Directors ensure that requests for care are consistent with accepted current evidence-based community medical practice. When appropriate, cases may be sent for pertinent specialty or sub-specialty medical review prior to a clinical coverage decision being made.

All Clinical Criteria are available online for review on our Prior Authorization webpage under the section "How CHPW Determines Prior Authorization": https://www.chpw.org/provider-center/prior-authorization/

In addition, all criteria can be requested by contacting CHPW Apple Health Customer Service Department at 1-800-440-1561, Medicare Customer Service Department at 1-800-942-0247, or Cascade Select Customer Service Department at 1-866-907-1906.

Administrative Days

Administrative Days (applicable for Apple Health members) are requested as a separate authorization request from inpatient acute hospital or post-acute care setting (e.g., inpatient rehabilitation, Long Term Acute Care, or inpatient or residential behavioral health level of care) is no longer medically necessary or appropriate, and non-hospital placement is not readily available or is awaiting placement into a lower level of care or home.

The Administrative Days must be billed on a separate claim with the following Revenue Codes:

- For acute inpatient stays use revenue code 0191
- For inpatient rehab, long term acute care or inpatient psych facilities use revenue code 0169

Peer To Peer Process

To avoid appealing an adverse benefit determination, the requesting provider has an option to request a peer-to-peer consult with a medical director when there is additional information or context not provided in the clinical information that may result in an approval. The request must be made within 10 calendar days from the adverse benefit determination. To schedule a Peer to Peer, call Customer Service Department at 1-800-440-1561 (TTY: 711).

If the peer-to-peer results in an approval, the requesting provider and member will receive an approval letter of the service that was overturned. If the peer-to-peer result remains a denial, no new letter will be sent out to member and provider.

Care Management

Care Management at CHPW is a comprehensive method of member assessment and support. The goal is to provide a systematic approach to managing the member's health care needs, which may include member advocacy, coordination of care, and support of the member-provider relationship.

The Care Management Team consists of clinical and non-clinical staff in the following areas:

- Care Management
- Complex Discharge
- Carceral Transitions of Care
- Community Support Services
- Diabetes Care Program
- Patient Review and Coordination (PRC)
- Maternal Child Health

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

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

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

- Locating providers,
- Being a health advocate, and
- Supporting members in understanding benefits, identifying community resources, coordination of information and services with medical team, and providing education materials and information.

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

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

Care Management may be an appropriate service for members with:

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

Members can be referred to Care Management by:

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

For more information, or to make a referral to Care Management, call the CHPW Apple Health Customer Service team at 1-800-440-1561 (TTY: 711), or the Medicare Customer Service Team at 1-800-942-0247 (TTY: 711). You may also refer online by using the *Care Management Referral Form*.

For more information on Care Management, please see the Care Management section of the CHPW webpage.

Apple Health Individuals with Special Health Care Needs (ISHCN)

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

Continuity and Transition of Care

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

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

- Care Managers
- First Steps Maternity Support Services/Infant Care Management
- Transportation and Interpreter Services
- Patient Review and Coordination (PRC) program, for members who meet the criteria identified in WAC 182-501-0135
- Dental services
- Foster Care – Fostering Well-Being

- Health Homes
- Behavioral Health providers for mental health services
- Substance Use Disorder services.
- Aging and Disability Services, including home and community-based services.
- Skilled Nursing Facilities (SNFs) and community based residential programs.
- Early Support for Infants and Toddlers (ESIT)
- Department of Health and Local Health Jurisdiction services, including Title V services for Children with special health care needs

MA D-SNP

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

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

For more information, call the CHPW Washington Medicare Customer Service Team at 1-800-942-0247 or the D-SNP Care Management Department at 1-866-418-7005, or by fax at 206-652-7088.

Transitions of Care (TOC) Programs

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

CHPW's TOC program promotes the safe and timely transition between care settings for our members with complex health and social service needs who are particularly vulnerable to breakdowns in care and thus most likely to readmit or seek emergency services. Care settings include hospitals, mental health facilities, substance use treatment, SNFs, long-term care and rehabilitation facilities, and corrections facilities. TOC services ensure that necessary care, services, and supports are in place for the member once discharged or transitioning from one care setting to the next.

Services offered by the TOC team include discharge planning, coordination of post-discharge care and services, medication consultations, and follow-up calls. CHPW's TOC team engages members, families, and caregivers in the discharge process to ensure goals are realistic and attainable.

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

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

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

Community Support Services

Social drivers of health (SDoH) are conditions in the environments in which people are born, live, learn, work, play and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The Community Support Services team addresses the social needs of members by creating and/or supporting sustainable, effective linkages to clinical care and social services.

Community Support Services teams coordinate care and links members to community-based resources and health care services, including behavioral health, oral health, and other specialty care.

Community Support Services staff ensure that health care providers are connected, work together on an integrated service plan, and coordinate with involved community resource organizations engaged with the member to ensure the delivery of quality health care and social support services.

Community Support Services may be an appropriate service for members requiring short-term care coordination and:

- Members with housing or transportation needs
- Members with food or caregiving needs
- Members with employment or education needs
- Members who would benefit from behavioral health recovery journey support.

For more information, call the CHPW Community Supports team at 1-866-418-7006 (TTY: 711).

Apple Health (Medicaid) Health Home Program

The Health Home program offers additional care coordination services to eligible Apple Health (Medicaid) members with chronic conditions and D-SNP Plan members. The goal is to make things easier for members with complex needs by increasing coordination between health and social service providers.

Health Home services include:

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

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

How It Works

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

Care Coordinators are affiliated with CHPW and work in the community. Many are located in Community Health Clinics (CHCs), while others in local community-based organizations (including Area Agencies on Aging, behavioral health, and general social service providers).

Health Home care coordination services do not replace or change any of the benefits currently received as an Apple Health (Medicaid) member. They do not cost extra. These services are there to support members in managing their health goals. This should ultimately result in fewer hospital stays, fewer emergency room visits, and a greater number of primary and specialty care visits.

Eligibility

Health Home services are available for eligible individuals with Apple Health (Medicaid) or fee-for-service dual coverage with Apple Health (Medicaid) and Medicare. Eligible individuals have high service needs and complex chronic conditions like asthma, diabetes, cancer, and depression.

The State determines eligibility and identifies those individuals for CHPW. Those members are then assigned to local Care Coordination Organizations (CCOs) to provide direct services according to the member's needs. When members become eligible, they will receive a letter and will be contacted by a local Care Coordinator. Once eligible, members may opt in and out of the program at any time.

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

Clinical Eligibility Tool

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

The Clinical Eligibility Tool can be found on the HCA Health Home website at: hca.wa.gov/billers-providers-partners/program-information-providers/health-home

Questions

If you have questions about eligibility, call CHPW Customer Service at 1-800-440-1561 (TTY: 711), Monday – Friday, 8 a.m. to 5 p.m.

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

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

Partnership with Washington State Hospital Association (WSHA) for Transitional Care Training: Care coordination and follow-up after hospitalization is one of the key Health Home services in reducing costs and assuring a safe and effective hospital discharge. Current research shows that around twenty (20) percent of patients in the U.S. are re-hospitalized within thirty (30) days of discharge, and many researchers believe that this percentage is even higher for Medicaid patients. CHPW partners with WSHA and other organizations to support implementation of WSHA's Care Transitions toolkit wsha.org/?s=transitional+care to reduce readmissions through effective transitional care. WSHA offers tools for both hospitals and PCPs, many of which are being used in Washington State's health homes strategies.

The Mental Health Integration Program (MHIP)

The Mental Health Integration Program (MHIP) is a state-wide, patient-centered, integrated program serving CHPW Apple Health, Medicare, and Cascade Select Members with medical, mental health, and substance abuse needs. The program focuses on treating common, mild-to-moderate mental health disorders in a primary care setting with the Collaborative Care Model (CoCM) of care, a model endorsed by the Healthcare Authority and Bree Collaborative. This model is evidence- and outcome-based and incorporates the use of a clinical registry and regular psychiatric care consultation to support high quality mental health screening and treatment to target. Primary care clinic-based mental health professionals called 'behavioral health care managers' support the PCP in care of the member by providing brief interventions and care coordination to members in consultation with a psychiatric provider. This team-based approach to behavioral health care helps to achieve improvements in whole-person health and well-being.

Washington Partnership Access Line (PAL):

The Partnership Access Line (PAL) supports PCPs (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 seattlechildrens.org/healthcare-professionals/community-providers/pal/ where families can speak directly with a referral specialist.

The PAL consultation program is funded by Washington's HCA and is available to providers caring for any patient in Washington, regardless of insurance type. Washington providers may call 1-866-599-7257 (TTY: 711), Monday–Friday, 8 a.m. to 5 p.m. Pacific Time, to be directly connected to a PAL child and adolescent psychiatrist. For more information, please visit the PAL website seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/
Additional provider psychiatric consultation lines for adults are also provided by the University of Washington. For more information, please visit: perc.psychiatry.uw.edu/perinatal-pcl/ or call 1-877-725-4666 and Psychiatric Consultation Line (PCL) or call 1-877-927-7924.

Patient Review and Coordination Program

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

PRC focuses on the health and safety of these members, who are often seen by several different prescribers, have a high number of duplicate medications, use several different pharmacies, and have high emergency room usage. Based on clinical and utilization findings, members are placed in PRC for at least two (2) years. All members in the PRC program are assigned to a care manager for care coordination services.

The Role of the PRC Care Manager in PRC

The PRC Care Manager coordinates care for members in the PRC Program. The Program includes a comprehensive assessment of needs, creating an Individualized Care Plan, and collaboration with the member's medical team to ensure appropriate utilization of services to meet the members physical/behavioral health care needs. PRC Care Managers provide a member health education and connect the member to community resources.

The Role of the PCP in PRC

The PCP plays a key role in managing the member's health care. When a member is restricted, the member's PCP must approve any care that member receives from other providers or specialists, which may include prescriptions for scheduled drugs (CII–CIV).

A major focus of PRC is to educate the member about:

- Appropriate use of services
- Relevance of office visits
- Accessing resources in the community and within HCA
- The importance of maintaining one provider to manage and monitor one's health care

PRC Documents

PRC Program policy can be found online.

The Role of the Pharmacy in PRC

The primary pharmacy is a key player in managing the member's prescriptions. The Pharmacist will be able to alert the member's PCP, the CHPW PRC staff, or the HCA PRC staff of misuse or potential problems with the member's prescriptions. All pharmacy policies remain in effect. If the member goes to a non-assigned pharmacy for scheduled drugs (CII–CIV), the claim will be rejected.

The Role of the Hospital in PRC

The hospital, particularly the emergency room staff, is a key player in assisting the member's PCP to more effectively manage the member's care to avoid unnecessary and costly services, especially emergency room services. By being aware of the member's restriction, the hospital can assist in the coordination of care by referring the member back to their PCP and/or pharmacy, whether treatment is provided or not. We welcome referrals of members who may benefit from the PRC program. Please contact us at:

Patient Review and Coordination Program (PRC)
Community Health Plan of Washington
1700 7th Avenue, Suite 900
Seattle, WA 98101

Phone: 1-866-907-1902 (TTY: 711)

Members may self-refer to the PRC by calling the CHPW PRC staff: 1-866-907-1902 (TTY: 711), Monday – Friday, 8 a.m. to 5 p.m. Voicemail may be left after hours.

Pharmacy

Medicare Opioid Overutilization Program (MOOP)

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

The Role of the PCP in MOOP

The PCP plays a key role in managing the member's health care. When a member is restricted, the PCP must provide alternative treatments, care management, or pain management.

MOOP Documents

The MOOP Policy can be found online at medicare.chpw.org/provider-center/provider-resources/.

We welcome referrals of members who may benefit from this program. Please contact us at:

Medicare Opioid Overutilization Program
Community Health Plan of Washington
1700 7th Avenue, Suite 900
Seattle, WA 98101

Phone: 1 (800) 942-0247

Medicare members may self-refer by calling the MOOP Staff at 1-800-942-0247 (TTY: 711), Monday – Friday, 8 a.m. to 8 p.m.

Second Opinion Network

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

SON Review Process

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

Recommendations included in the care plan are forwarded to CHPW for documentation and implementation in the pharmacy claims adjudication system.

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

Review Recommendations

SON reviews include **both** psychotropic medications and their dosing, as well as non-medication recommendations, such as: ABA therapy, IEP, sleep therapy, parent management training, trauma-focused CBT, behavior management training, social skills for ADHD, wraparound team, etc.

Payment

Payment to the SON provider is the responsibility of the HCA according to the provisions of HCA's contract with the SON provider.

CHPW is responsible for payment to the prescribing practitioner for time spent engaging in medication review process with the SON.

For more information and specific medication review thresholds

Visit the SON website at hca.wa.gov/billers-providers-partners/programs-and-services/apple-health-second-opinion-program.

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

Pharmacy Management

Drug Formulary and Medication Utilization Apple Health

The CHPW drug formulary is developed by a Pharmacy and Therapeutics Committee. For medications included in the Apple Health Preferred Drug List, formulary status and coverage criteria are developed and approved by the WA HCA Pharmacy and Therapeutics Committee before adoption by CHPW. All other medications' formulary status and coverage criteria are developed and approved by the CHPW Pharmacy and Therapeutics Committee. The formulary is searchable on the website at chpw.org/member-center/member-resources/plan-and-coverage/prescription-drug-benefits/. For more information on the Apple Health Preferred Drug List, please visit: hca.wa.gov/billers-providers-partners/programs-and-services/apple-health-preferred-drug-list-pdl.

For all CHPW members, submit prior authorization, step therapy, and non-formulary medication requests as well as requests for quantity overrides for review to CHPW's Pharmacy Benefit Manager, Express Scripts.

CHPW MA Drug Formulary

The CHPW Medicare Advantage Drug Formulary is developed by the Express Scripts (ESI) Pharmacy and Therapeutics (P&T) Committee. The formulary is available on the CHPW Medicare Advantage website: medicare.chpw.org/member-center/member-resources/prescription-drug-coverage/. For all CHPW Medicare Advantage Part D beneficiaries, submit prior authorization, step therapy, and non-formulary medication requests, as well as requests for quantity overrides for review to Express Scripts. All standard requests will be resolved by Express Scripts within 72 hours if all required information is provided; all urgent requests will be resolved in 24 hours if all required information is provided.

Note: ESI requires a CHPW Medicare Advantage beneficiary number to process requests. You may obtain a member number from CHPW Medicare Advantage Customer Service at 1-800-942-0247 (TTY: 711).

Notification Regarding Formulary Changes: For updates regarding periodic changes to the formulary and other pharmaceutical management programs, please see the member Prescription Drug Coverage web page at medicare.chpw.org/member-center/member-resources/prescription-drug-coverage/ .

Apple Health Prior Authorization

To request a prior authorization, step therapy, non-formulary, or quantity limit override, please call Express Scripts at 1-844-605-8168 (Toll Free), 24/7, and speak to a Prior Authorization Service Specialist. This Specialist will review medical information and criteria with the provider or designee regarding the need for the requested drug.

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

Community Health Plan of Washington
Attn: Appeals Department
1700 7th Avenue, Suite 900
Seattle, WA 98101

Fax: (206) 613-8983 (urgent)

Fax: (206) 613-8984 (standard)

Expedited appeals are reserved for emergency situations only; call 1-800-440-1561.

CHPW MA Prior Authorization

To request a prior authorization, step therapy, non-formulary, or quantity limit override, please call Express Scripts at 1-844-605-8168, 24/7, and speak to a Prior Authorization Service Specialist. The Specialist will review medical information and criteria with the provider or designee regarding the need for the requested drug.

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

Community Health Plan of Washington
Attn: Community Health Plan of Washington Medicare Advantage Appeals
1700 7th Avenue, Suite 900
Seattle, WA 98101

Fax: (206) 652-7011 (urgent)

Fax: (206) 652-7010 (standard)

Note: Expedited appeals are available for emergent situations, call 1-800-942-0247, 8 a.m. – 8 p.m., 7 days a week.

Pharmacy Benefit Exclusion Apple Health

Certain medications are excluded. These include:

- Non-FDA approved drug products
- Experimental and investigational (E & I) drugs
- Compounded drugs with non-FDA approved ingredients
- Drugs for weight loss or appetite suppression
- Drugs for impotence or sexual dysfunction
- Drugs to treat cosmetic conditions.
- Infertility drugs
- Drugs both prescription and over the counter (OTC) as specified per Washington State HCA
- Drugs from a manufacturer without a Federal Rebate Agreement

CHPW MA Excluded Benefits

Certain medications are not covered by Part D. These include:

- Drugs for anorexia, weight loss, or weight gain
- Drugs used to promote fertility.
- Drugs used for cosmetic purposes or for hair growth.
- Drugs used for symptomatic relief of cough and colds.
- Drugs for erectile dysfunction
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparation products
- Non-prescription or over the counter (OTC) drugs
- Drugs for which the manufacturer seeks to require, as a condition of purchase, that associated test and monitoring services be purchased exclusively from the manufacturer or its designee.
- Drugs from a manufacturer without a Federal Rebate Agreement
- Non-FDA approved drug products

CHPW Individual and Family Cascade Select

The CHPW Cascade Select formulary is developed by the Express Scripts Pharmacy and Therapeutics Committee. The formulary is available on the Individual and Family Cascade Select site: individualandfamily.chpw.org/member-center/member-resources/prescription-drug-coverage/

To request a prior authorization, step therapy, non-formulary, or quantity limit override, please call Express Scripts at 1-844-605-8168, 24/7, and speak to a Prior Authorization Service Specialist. The Specialist will review medical information and criteria with the provider or designee regarding the need for the requested drug.

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

Community Health Plan of Washington
1700 7th Avenue, Suite 900
Seattle, WA 98101

Fax: (206) 613-8983 (urgent)

Fax: (206) 613-8984 (standard)

Expedited appeals are available for emergent situations. Please call 1-866-907-1906.

Smoking Cessation

Smoking cessation services are covered for all members 18 years and older with or without a PCP referral or pre-approval. Call CHPW at 1-800-440-1561 (TTY:711) for more information or visit chpw.org/quit-for-life/

Quality Improvement Program (QIP)

Program Overview

The CHPW Quality Improvement Program (QIP) is designed to objectively monitor, systematically evaluate, and effectively improve the health, care, and experience of those being served. The QIP aims to respect the member in a holistic manner and respond to each member's health needs and preferences by adhering to the National Committee for Quality Assurance's (NCQA) Health Plan Accreditation (HPA) and Health Outcomes Accreditation Standards and the Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) Standards. The QIP has three focus areas of *Quality of Clinical Care, Safety of Clinical Care,* and *Quality of Service and Experience*. Nearly every program and function at CHPW is essential to achieving the overarching goals of the QIP to improve quality and experience, advance health equity, and eliminate health care disparities.

The achievement of goals and objectives is primarily accomplished through the QIP governance structure, quality improvement activities, and cross-collaboration.

Program Scope

The scope of CHPW's QIP includes all CHPW line of businesses (LOBs) including Apple Health, Apple Health Expansion, BHSO, D-SNP, and Individual and Family plans. Quality performance oversight is not a function that is delegated to any other organization

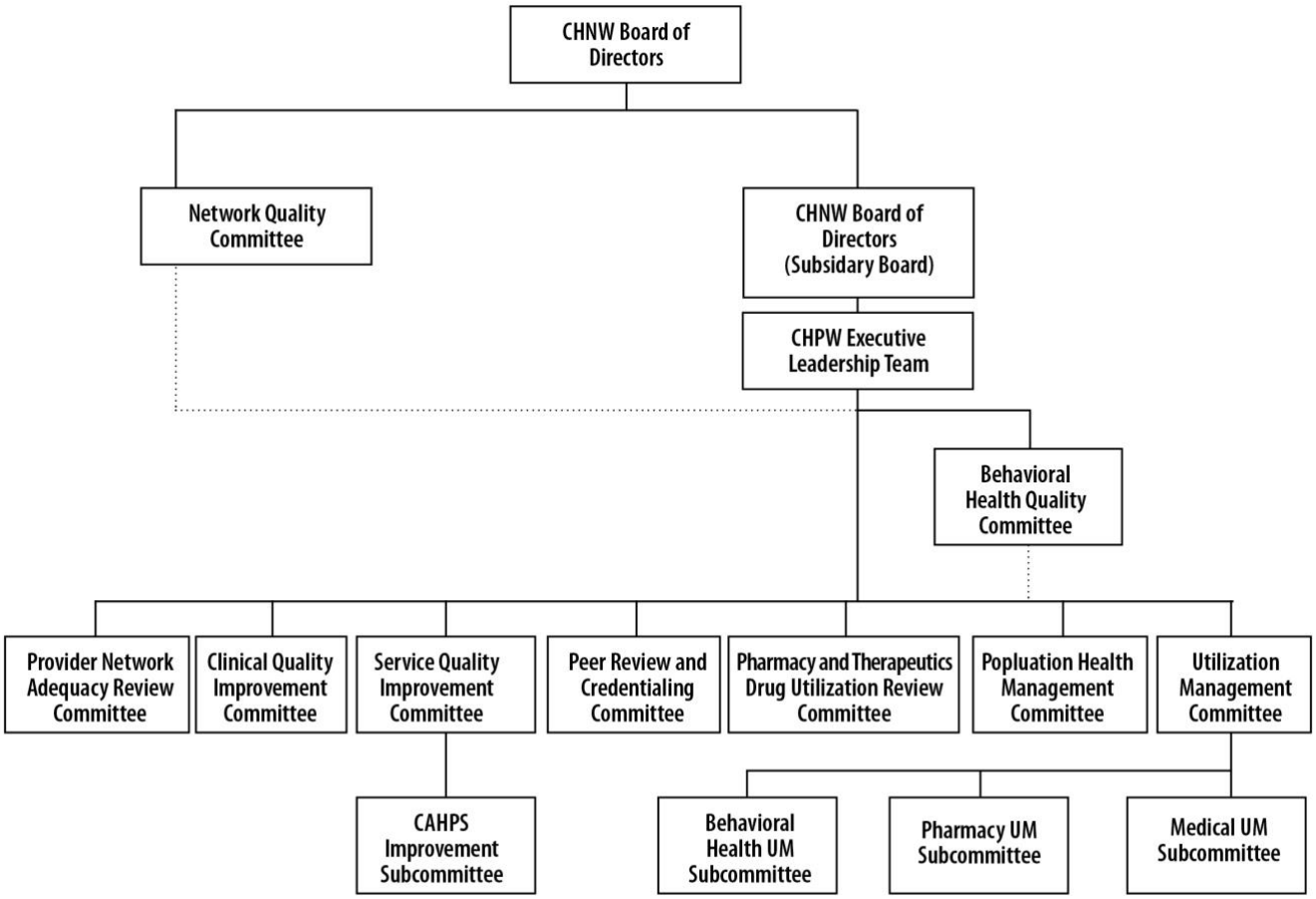
The CHPW Board of Directors has ultimate responsibility for quality of care, and reviews and approves CHPW's QIP annually. Direct oversight of the QIP activities is delegated to CHPW's Plan Quality Council. CHPW's Quality and Population Health Department manages CHPW's QIP and oversees activities undertaken by CHPW and affiliated providers to achieve the program goals.

The annual delegation of authority from the Board of Directors allows the QIP to fulfill its goals and objectives while effectively using resources. A particular focus is given to populations at higher risk to reduce health disparities and ensure high quality outcomes for all communities across Washington. Health promotion, health management, and patient safety activities are also an integral part of the QIP and are specialized according to regulatory requirements, population needs, and delivery models.

The QIP is integrated into the activities of CHPW. This includes, but is not limited to, interactions with affiliated providers, as well as departments within CHPW delivering on projects essential to the QIP's success.

Program Structure

CHPW supports the QIP by providing a governance structure over Plan activities that improve health, care, and experience. The Plan Quality Council has delegated authority from the Board of Directors annually to execute the QIP. The CHPW quality committees provide review of key plan activities, such as service use by members, prescription formulary, provider credentialing and peer review, complaint review, network adequacy, and behavioral health. The CHPW structures pertaining to the QIP are shown in the diagram below.



For more information about the QIP, please visit:
chpw.org/member-center/member-resources/quality-improvement/



COMMUNITY HEALTH PLAN
of Washington™

The power of community

1700 7th Ave, Suite 900 | Seattle, WA 98101-1317 | chpw.org

AH_MK1257_Provider_Manual_1_2026