



PROVIDER OPERATIONS MANUAL

**WASHINGTON APPLE HEALTH
(MEDICAID)**

**FOSTER CARE &
APPLE HEALTH EXPANSION**

MANAGED CARE

JULY 2025

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01 INTRODUCTION

1.1 Welcome

Welcome to Coordinated Care of Washington, Inc. (Coordinated Care). Thank you for participating in our network of physicians, hospitals, and healthcare professionals. This provider manual content and requirements are applicable to contracted providers. We respect the role of Indian Health Care Providers, whether contracted or not, in providing health care services for the American Indian and Alaska Native population. We are committed to improving the health of the community, one person at a time, by treating the whole person and breaking down barriers to accessing care. By partnering with providers like you, we can reach this goal together.

1.2 About Coordinated Care

Coordinated Care is an Apple Health (Medicaid) Managed Care Organization (MCO) contracted with the Washington State Health Care Authority (HCA) to serve Apple Health (Medicaid) eligible members of Integrated Managed Care (IMC), Integrated Foster Care (IFC), and Apple Health Expansion. Our management company, Centene Corporation (Centene), has been managing the provision of healthcare services for individuals receiving benefits under Apple Health (Medicaid) and other government-sponsored healthcare programs since 1984. Coordinated Care is managed and operated locally throughout Washington and offers health insurance solutions for individuals and families. We are committed to building collaborative partnerships with providers throughout Washington. HCA selected Coordinated Care as the single MCO to administer Apple Health (Medicaid) benefits for Foster Care members in Washington due to our unique expertise and dedication to helping Washingtonians improve their health and quality of life.

1.3 Our Mission

Coordinated Care strives to achieve successful outcomes in improving health, and member and provider satisfaction with a focus on care coordination. As a contractor of HCA and partner with local healthcare providers, Coordinated Care seeks to achieve the following goals for our members:

- Ensure access to primary and preventive care services in accordance with HCA standards
- Ensure care is delivered in the best setting to achieve optimal outcomes
- Improve access to specialty services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All our programs, policies, and procedures are designed with these goals in mind. We trust that our network providers share our commitment to serving our members.

1.4 How to Use This Provider Manual

Coordinated Care is dedicated to supporting the provider community's efforts to deliver high quality healthcare to our members. This Provider Manual includes comprehensive information

related to Coordinated Care's operations, benefits, policies, and procedures. Updates to this manual are posted at CoordinatedCareHealth.com. Additionally, providers will be notified via bulletins and notices posted on our secure portal.

In compliance with Washington State statutes and OIC regulations regarding mental health parity, this provider manual outlines the obligations of Coordinated Care in delivering services to members under our contract. Coordinated Care is prohibited from imposing Non-Quantitative Treatment Limits (NQTL) for mental health or substance use disorder (SUD) benefits unless such limitations are comparable to those applied to medical/surgical benefits. Regular monitoring of these NQTLs is required to ensure parity in application. Additionally, access to out-of-network providers for mental health or SUD benefits must align with the standards set for medical/surgical benefits. Coordinated Care may extend coverage beyond Medicaid State Plan services to ensure compliance with parity requirements, subject to agreement terms. Furthermore, mental health or SUD benefits must be provided in parity with medical/surgical benefits across all classifications. Prior authorization processes should adhere to parity standards, and Coordinated Care must furnish necessary documentation for compliance verification. Criteria for medical necessity determinations must be accessible to members and providers upon request. Finally, financial limitations, including aggregate lifetime or annual dollar caps, are prohibited for mental health and SUD benefits, regardless of coverage status.

If you need more information on any topics in this manual or hard copies of the Provider Manual, please contact the Provider Services department at 1-877-644-4613 (TTY: 711).

1.5 Key Contacts and Important Phone Numbers

The following chart includes several important telephone and fax numbers available to providers and their office staff. When calling Coordinated Care, it is helpful to have the following information available:

- The provider's National Provider Identifier (NPI) number
- The practice Tax ID Number (TIN)
- The member's Coordinated Care ID number or Apple Health (Medicaid) ID number

Health Plan Information		
Web Address:	www.CoordinatedCareHealth.com	
Main Address:	Coordinated Care 1145 Broadway, Suite 700 Tacoma, WA 98402	
Paper Claims, Reconsiderations & Disputes:	P.O. Box 4030 Farmington, MO 63640	
Department	Telephone Number	Fax Number
Provider Services	1-877-644-4613 (TTY: 711) (8 am - 5 pm PT)	1-877-212-7289
Apple Health Core Connections Provider Services (Foster Care)	1-844-354-9876 (TTY: 711) (8 am - 5 pm PT)	1-877-212-7289

Member Services for Apple Health Members	1-877-644-4613 (TTY: 711) (8 am - 5 pm PT)	1-866-270-8008
Apple Health Core Connections Member Services (foster care)	1-844-354-9876 (TTY: 711) (8 am - 5 pm PT)	1-844-807-9258
Prior Authorization (PA) Except Pharmacy and Medical Pharmacy	1-877-644-4613 ext. 69617 (8 am - 5 pm PT, M - F)	PA: 1-877-212-6669
Concurrent Review (CR)	1-877-644-4613 ext. 69617 (8 am - 5 pm PT, M - F)	1-877-212-6113
NICU Authorizations	1-877-644-4613 ext. 69617 (8 am - 5 pm PT, M - F)	1-833-247-1270
Bariatric (stage 2)	CM: 1-877-270-2631	1-855-678-6980
Pharmacy and Medical Pharmacy Prior Authorization	Centene Pharmacy Services Prior Authorization Phone: 1-866-716-5099 (7 am - 5 pm PT, M - F) Pharmacy Peer to Peer: 1-866-399-0928 Medical Pharmacy Peer to Peer: 1-833-661-0642.	Pharmacy: 1-833-645-2734 Medical Pharmacy 1-844-235-5090
Discharge Planning & Utilization Management (UM)	1-877-644-4613 ext. 69626 (8 am - 5 pm PT)	
Behavioral Health (BH) Utilization Management and Discharge Planning	1-844-208-8885 (8 am - 5 pm PT)	1-833-286-1086
Exception To the Rule Requests (ETR)	1-877-644-4613	1-855-678-6980 Pharmacy ETR: 1-866-270-0122
Transplant Prior Authorization		1-833-552-0998
Peer to Peer (Except Pharmacy and Medical Pharmacy)	VM: 1-253-442-1505 Live: 1-833-661-0642	1-844-965-0317
Potentially Preventable Readmissions		1-833-693-0033
Case Management (CM)	1-877-644-4613 ext. 69617 (8 am - 5 pm PT, M - F)	1-877-270-2631
24-Hour Nurse Advice Line	1-877-644-4613 (TTY: 711)	

Apple Health (Medicaid) Core Connections 24-Hour Nurse Advice Line	1-844-354-9876 (TTY: 711)	
WA Health Care Authority (HCA) Customer Service	1-800-562-3022	
Health Care Authority Foster Care and Adoption Support (FCAS)	1-800-562-3022 ext. 15480	360-562-1158
To report suspected Apple Health fraud, waste, abuse to HCA	1-800-562-6906	
To report suspected fraud, waste, abuse to Coordinated Care	1-866-685-8664	
Electronic Claims Submission		
Coordinated Care Centene EDI Department 1-800-225-2573, ext. 25525 Or by e-mail to: EDIBA@centene.com		

1.6 Coordinated Care Website

[CoordinatedCareHealth.com/providers](https://www.coordinatedcarehealth.com/providers) and our secure provider portal is designed to reduce administrative burdens for providers and optimize access to information.

[CoordinatedCareHealth.com](https://www.coordinatedcarehealth.com) contains forms, reference materials, data, learning tools, and other information for providers, such as:

- Provider Claims Tools
- Provider Update Tools
- Quick Reference Guides
- Billing & Claims Filing Reference Material
- Pre-Auth Check (by CPT, HCPC or Rev Code)
- Administrative Forms
- Clinical Practice Guidelines
- Clinical & Payment Policies
- Newsletters & Announcements
- HEDIS Guidelines
- Grievance Process
- Preferred Drug List

Please contact your Provider Engagement Administrator at <https://www.coordinatedcarehealth.com/providers/regional-contacts.html> or our Provider Services department at 1-877-644-4613 (TTY: 711) with any questions or concerns regarding the website. Visit the provider events page at www.CoordinatedCareHealth.com/providers/provider-events.html for upcoming training opportunities and take advantage of no-cost Continuing Education credits by attending live

interactive webinars. We continually update our website with the latest news and information, so check back often.

To subscribe to our monthly provider news blast via email, visit www.CoordinatedCareHealth.com/providers/provider-news.html

1.7 Secure Provider Portal

Through the **secure provider portal**, providers can:

- Check member eligibility
- View members' health records
- View the PCP panel
- Identify PRC Lock-In members
- View and submit claims and adjustments
- View payment history
- View and request prior authorizations for physical health services (BH prior auth requests are faxed)
- Providers can complete their own InterQual Connect (IQC) reviews and receive either approvals, or notice that the health plan will complete review on selected codes
- View member gaps in care
- View care plans
- View Health Risk Screening and Health Risk Assessment
- Complete assessments including Notification of Pregnancy
- View quality scorecard
- Contact Coordinated Care representatives securely and confidentially
- Access policies and procedures for medical necessity

The secure provider portal is accessible to participating providers and their office staff who have completed the registration process, once the contract is complete. Non-participating providers, including any Indian Health Care Provider, who have submitted a claim to Coordinated Care may also access the portal. Registration is quick and easy. On the home page, select the Login link to start the registration process.

1.8 Coordinated Care Community Educators

The Coordinated Care Community Education team is located throughout the state to provide no-cost training for providers, caregivers, parents, and community partners on topics related to the needs of children in the child welfare system. Childhood trauma can have [long-term health impacts](#) on cognition, mental health, and physical health. Providing healthcare services using a Trauma Informed Care approach is critical to treating the whole person, breaking down access to care barriers, and improving the health of every member.

Coordinated Care encourages all providers to view members' healthcare needs through a trauma-informed lens. Training topics include Trauma Informed Care, Adverse Childhood Experiences Study (ACEs), Resilience, and Things I Wish My Therapist Knew. Contact communityeducation@coordinatedhealth.com to learn more or request training.

Substance Abuse and Mental Health Services (SAMSHA):

[SAMSHA's Six Key Principles of a Trauma-Informed Approach](#)

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting or sector-specific:

- Safety
- Trustworthiness and Transparency
- Peer Support
- Collaboration and Mutuality
- Empowerment, Voice, and Choice
- Cultural, Historical, and Gender Issues

Use the following websites to learn more about traumatic stress reactions, the long-term impact of trauma, and evidence-based practices:

- [Substance Abuse and Mental Health Services Administration \(SAMSHA\) - Understanding Child Trauma](#)
- [National Child Traumatic Stress Network](#)
- [Health Care Toolbox - Helping Children and Families Cope with Illness and Injury](#)
- [CDC - Adverse Childhood Experiences \(ACEs\)](#)
- [Center for Youth Wellness](#)
- [Mental Health First Aid](#)

1.9 Washington Apple Health (Medicaid) Program Summary

Health Care Authority (HCA) has oversight and manages the provision of health care services for all Apple Health (Medicaid) beneficiaries in Washington. Effective July 1, 2012, HCA contracted with Coordinated Care and several other health plans, to manage access to covered services and provider networks for those who qualify for the state's Washington Apple Health (Medicaid) program. Effective April 2016, HCA selected Coordinated Care as the single MCO to administer Apple Health (Medicaid) benefits for Foster Care members in Washington due to our unique expertise and dedication to helping Washingtonians improve their health and quality of life. These programs cover medical and behavioral health care for individuals, families, pregnant members, and children who qualify for government-sponsored assistance through IFC (Integrated Foster Care), TANF (Temporary Assistance for Needy Families) and CHIP (Children's Health Insurance Program) and eligible adults through Expanded Apple Health (Medicaid).

Members can choose their Managed Care Organization (MCO) at the time of enrollment at the wahealthplanfinder.org website. If a new member does not select an MCO, they are auto assigned to an MCO by HCA. Some members, such as American Indians/Alaskan Natives, may opt in or out of MCO coverage at any time. When these members opt out or do not opt in to MCO coverage, then they would use Fee-for-Service (FFS) Medicaid. More information can be found at [HCA's website](#) or at wahealthplanfinder.org.

Washington Apple Health (Medicaid) Program

Serves adults, children and families who are income eligible:

- Single Adults (under 138% FPL)
 - Apple Health (Medicaid) population under Medicaid expansion
- TANF
 - Age Range for TANF includes all ages, but mainly persons under age 65
- CHIP
 - Ages 0 – 19
- Blind and Disabled
- Foster Care and Adoption Support – Apple Health Core Connections (AHCC)
 - Children and youth in foster care (dependencies with Washington State), Department of Children, Youth, and Families (formerly Children’s Administration)
 - Children and youth in adoption support
 - Young adults in extended foster care (18–21-year-olds)
 - Young adults 18-26 who aged out of foster care on or after their 18th birthday
 - Children and youth living with their bio families. Eligible for up to 12 months after leaving foster care and returning to their bio family.
 - Unaccompanied Refugee Minors up to age 21
- BHSO
 - Behavioral Health Services Only
 - Members on FFS Medicaid that are not otherwise eligible for or who have opted out of MCO integrated medical coverage

Coordinated Care follows specific federal regulations for Indian Health Care Providers.

02 APPLE HEALTH EXPANSION

At the direction of the legislature, Health Care Authority (HCA) is expanding health care coverage by implementing Apple Health Expansion to adults, regardless of immigration status.

Members may be eligible if they:

- Are a Washington resident age 19 or older,
- Have countable income under 138% of the federal poverty level,
- Do not qualify for other Apple Health programs based on **immigration status**,
- Are not pregnant or did not have a pregnancy end in the last 12 months, and
- Are not eligible for qualified health plans with advance premium tax credits (APTC), federally funded medical assistance programs

03 CREDENTIALING and RE-CREDENTIALING

Note: In order to maintain a current provider profile, providers are required to notify Coordinated Care of any relevant changes to their credentialing/demographic information in a timely manner.

The purpose of the credentialing and re-credentialing process is to help ensure that Coordinated Care maintains a high-quality healthcare delivery system. The credentialing and re-credentialing process validates the professional competency and conduct of our providers. This includes verifying licensure, board certification, education, and identifying adverse actions, including billing malpractices, through the applicable state and federal agencies and

the National Practitioner Data Bank. Please submit any credentialing re-credentialing request to: JoinOurNetwork@coordinatedcarehealth.com

All physicians must submit at a minimum the following information when applying for participation with Coordinated Care:

- Completed, signed and dated OneHealthPort or CAQH credentialing application (or give authorization to Coordinated Care to access the provider's application on the OneHealthPort or CAQH website)
- Signed attestation of application correctness and completeness; history of loss of license, clinical privileges, disciplinary actions, and felony convictions; lack of current illegal substance registration or alcohol use; mental and physical competence; and ability to perform essential functions with or without accommodation
- Copy of current malpractice insurance policy fact sheet or evidence of compliance with Washington regulations regarding malpractice coverage or alternate coverage
- Copy of current WA Controlled Substance registration certificate, if applicable
- Copy of current Drug Enforcement Administration (DEA) registration certificate
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted medical license to practice in the State of Washington
- Current copy of specialty board certification certificate, if applicable
- Curriculum vitae listing, at minimum, a five (5) year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than 120 days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Core Provider Agreement ProviderOne ID number or "Non-billing" registration

Coordinated Care will verify the following information submitted for Credentialing and Re-credentialing:

- Washington license through appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing or alternate admitting arrangements
- Review five (5) year work history
- Review federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General and GSA-General Services Administration)

Once the application review is completed, the Coordinated Care Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting and within 15 days of the Committee's decision.

Providers must be credentialed prior to accepting or treating members. PCPs cannot accept member assignments until they are fully credentialed.

A locum tenens practitioner who does not have an independent relationship with Coordinated Care and is covering for a participating provider does not require credentialing.

If applying as an individual practitioner or group practice, please submit the following information along with your signed participation agreement:

- Completed, signed, and dated OneHealthPort or CAQH credentialing application (or give authorization to Coordinated Care to access the provider's application on the OHP or CAQH website) with required information for all physicians practicing at the contracted locations
- Copy of W-9
- Disclosure of Ownership & Controlling Interest Statement

If applying as an ancillary or clinic provider, please submit the following information along with your signed participation agreement:

- Completed Ancillary/Clinic Provider Credentialing Application (one per Ancillary/Clinic provider)
- Copy of State Operational License
- Copy of Accreditation/Certification (by a nationally recognized accrediting body, e.g., TJC/JCAHO) or Site Evaluation Results by a government agency
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage)
- Copy of Apple Health (Medicaid)/Medicare Certification (if not certified, provide proof of participation)
- Disclosure of Ownership & Controlling Interest Statement
- Other applicable State/Federal/Licensures (e.g., CLIA, DEA, Pharmacy, or DOH)
- Copy of W-9

If applying as a hospital, please submit the following information along with your signed participation agreement:

- Completed Hospital Provider Credentialing Application (one per Facility/Hospital provider)
- Copy of State Operational License
- Copy of Accreditation/Certification (by a nationally recognized accrediting body, e.g., TJC/JCAHO) or Site Evaluation Results by a government agency
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage)
- Copy of Apple Health (Medicaid) (Medicaid)/Medicare Certification (if not certified, provide proof of participation)
- Disclosure of Ownership & Controlling Interest Statement
- Copy of W-9

3.1 Washington Apple Health (Medicaid) Core Provider Agreement

The federal regulation (42 C.F.R. 455.410(b)) requires the Washington State Health Care Authority (HCA) to enroll all providers that are under contract with MCOs and serve the Apple Health (Medicaid) population. All Apple Health (Medicaid) providers must have a Core Provider Agreement (CPA) or register as a "non-billing provider." Providers not registered and/or without a CPA will not be eligible to join the network.

Ordering, referring, and prescribing healthcare professionals may register as a “Non-billing Individual Provider.” For additional information, refer to the Non-billing Individual Provider Agreement and WAC 182-502-0006.

Note: An existing Core Provider Agreement and/or an enrollment under a group of providers for the individual will be terminated and replaced by the Non-billing Individual Provider Agreement.

Visit HCA’s website for further information: www.hca.wa.gov

- Billers and providers > Enroll as a provider

3.2 Credentialing Committee

The Coordinated Care Credentialing Committee, including the Medical Director or their physician designee, has the responsibility to establish and adopt necessary criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination. Committee meetings are held at least quarterly and more often as deemed necessary.

Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Site visits are performed at practitioner offices within sixty (60) calendar days of identification of two or more member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining room space. If the practitioner’s site visit score is less than 80 percent, the practitioner may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices, and safety procedures.

3.3 Re-credentialing

Coordinated Care conducts provider re-credentialing at least every 36 months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner’s licensure, sanctions, certification, competence, or health status, which may affect the provider’s ability to perform services under the contract. This process includes all practitioners, primary care providers, specialists, facilities, and ancillary providers previously credentialed and currently participating in the Coordinated Care network. Coordinated Care Credentialing Committee will render a final decision on re-credentialing following its next regularly scheduled meeting, but no more one hundred twenty (120) calendar days from the submission of the re-credentialing application, provided the application is complete upon submission.

If the Coordinated Care Credentialing Committee is unable to re-credential a practitioner due to military leave, maternity leave, or sabbatical, the contract remains in place and the practitioner will be re-credentialed upon his/her return. The Credentialing Committee will document the reason for this delay in the practitioner’s file. The re-credentialing must be completed within sixty (60) calendar days of when the practitioner resumes practice.

In between credentialing cycles, Coordinated Care conducts provider performance monitoring activities on all network providers. This includes an inquiry to the appropriate Washington State

Licensing Agency for a review of newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry ensures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Coordinated Care reviews monthly reports released by the Office of Inspector General to identify any network providers who have been newly sanctioned or excluded from participation in Medicare or Apple Health (Medicaid). All materials should be provided to Coordinated Care at WAProviderUpdates@coordinatedcarehealth.com.

A provider's agreement may be terminated if at any time it is determined by the Coordinated Care Credentialing Committee that credentialing requirements or standards are no longer being met. Practitioners who are terminated or voluntarily withdraw from the network and subsequently seek to be reinstated, must complete the initial credentialing process if the break in service is more than thirty (30) calendar days or if it has been more than thirty-six (36) months since they were last credentialed.

3.4 Provider Right to Review and Correct Information

All providers participating within the Coordinated Care network have the right to review information obtained by Coordinated Care to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, OneHealthPort, malpractice insurance carriers, and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Providers have the right to request correction of any erroneous information submitted by another party in the event the provider believes any of the information used in the credentialing or re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the provider. To request release of such information, a written request must be submitted to the Coordinated Care credentialing department. Upon receipt of this information, the provider will have fourteen (14) calendar days to provide a written explanation detailing the error or the difference in information to the Credentialing Committee. The Coordinated Care Credentialing Committee will then include this information as part of the credentialing or re-credentialing process.

3.5 Provider Right to Be Informed of Application Status

All providers who have applied to join Coordinated Care have the right to be informed of the status of their application upon request. New practitioners who are denied participation for non-administrative reasons have the right to request a reconsideration of the decision within thirty (30) calendar days of the date of receipt of the denial letter. To obtain application status, contact the Coordinated Care Provider Services department at 1-877-644-4613.

3.6 Provider Right to Appeal Adverse Credentialing Determinations

Applicants who are declined participation or existing providers who are declined continued participation due to adverse credentialing or re-credentialing determinations (for reasons such as quality of care or liability claims issues) have the right to request reconsideration of the decision. Reconsideration requests must be made in writing within fourteen (14) calendar days

of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the Coordinated Care network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and no later than sixty (60) days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within fourteen (14) calendar days of the final decision.

04 PRIMARY CARE PROVIDER RESPONSIBILITIES

4.1 Role of Primary Care Providers (PCP)

Primary Care Providers (PCP) are the cornerstone of Coordinated Care's service delivery model. We have built a network of PCPs in Washington with the goal of giving every member the opportunity to establish a stable medical home led by their PCP. Coordinated Care's medical home model facilitates a strong patient-provider bond with PCP involvement in every aspect of the patient's health care, including an emphasis on wellness, safety and the prevention of injuries and illness. The medical home concept further supports continuity of care, reduction in redundant services, and results in cost-effective care and better health outcomes for members.

Coordinated Care's parent company, Centene, is committed to supporting Coordinated Care and our contracted PCPs in the delivery of comprehensive, evidence-based, and culturally sensitive health care for patients in coordination with specialists, facilities, ancillary providers, Centene health plan affiliates and the families or caregivers of patients. We believe our medical home model for Washington will improve provider satisfaction, health care outcomes, care quality and patients' overall health while reducing preventable emergency room (ER) visits and hospitalizations and the associated costs.

In Washington, Coordinated Care will work in partnership with the state and local providers to create a patient-centered medical home model built around NCQA or Joint Commission Association of Hospital Organizations (JCAHO) accreditation standards and state requirements. All PCPs are invited to participate in the medical home model. Once a PCP expresses interest in becoming an officially designated medical home, Coordinated Care will begin evaluating and assessing the PCP's ability and level of readiness to participate (described below).

4.2 Primary Care Provider (PCP) Responsibilities

Regardless of a participating PCP's status as a Medical Home, all PCPs are responsible for the provision of primary care services for Coordinated Care's members including but not limited to:

- Supervision, coordination, and provision of care to each assigned member
- Initiation and coordination of referrals for medically necessary specialty care
- Maintaining continuity of care for each assigned member
- Screening for behavioral health needs at each Early Periodic Screening Diagnosis and Treatment (EPSDT) visit and, when appropriate, initiate a behavioral health referral

- Establish and maintain hospital admitting privileges sufficient to meet the needs of their members
- Manage the medical and healthcare needs of members to ensure that all medically necessary services are made available in a culturally responsive and timely manner while ensuring patient safety at all times, including members with special needs and chronic conditions
- Educate members on how to maintain healthy lifestyles and prevent serious illness
- Provide screening, well-care and referrals to community health departments and other agencies in accordance with HCA requirements and public health initiatives
- Offer days and hours of operation, appointment times, and wait times that are indistinguishable from those offered to non-Apple Health (Medicaid) patients or patients with commercial health plan coverage
- Ensure follow-up and documentation of all referrals including services available under the State's fee for service program (such as Early Support for Infants and Toddlers)
- Collaborate with the Coordinated Care Case Management team regarding services such as member screening, assessment, and development of plan of care to address risks, medical needs, and access to other support services as needed
- Maintain a current and complete medical record for the member in a confidential manner, including but not limited to documentation of all services and referrals provided to the member by the PCP, specialists, and ancillary service providers
- Adhere to the EPSDT periodicity schedule for members under age twenty-one (21)
- Follow established procedures for coordination of and/or transition of care for in-network and out-of-network (provided by an out-of-network or non-participating provider) services. This includes obtaining authorizations for selected inpatient or outpatient services (except emergency services up to the point of stabilization) as well as coordinating services the member receives from another health plan during transition of care
- Share the results of identification and assessment for any member with special health care needs with another health plan to which a member may be transitioning or has transitioned so that those services are not duplicated
- Actively participate in and cooperate with all Coordinated Care quality initiatives and programs

PCP Providers shall:

- In consultation with other appropriate health care professionals such as care managers, community health workers or community-based care managers, be responsible for the provision, coordination, and supervision of health care to meet the needs of each member, including initiation and coordination of referrals for Medically Necessary specialty care.
- Ensure all health information relating to members is shared with other providers in a manner that facilitates the coordination of care while protecting members privacy and confidentiality.

- Coordinate with community-based services and the State Department of Social and Health Services, the Department of Children, Youth, and Families, the Department of Health, local health jurisdictions and HCA services/programs, including but not limited to the following:
 - First Steps Maternity Support Services/Infant Case Management
 - Transportation and Apple Health (Medicaid) Interpreter services
 - Patient Review and Coordination (PRC) program, for members who meet the criteria identified in WAC 388-500135
 - Dental services
 - Foster Care – Fostering Well-Being
 - Behavioral Health Administrative Services Organizations for crisis services
 - Aging and Disability Services, including home and community-based services
 - Skilled nursing facilities and community-based residential programs
 - Early Support for Infants and Toddlers
 - Department of Health and Local Health Jurisdiction services, including Title V services for children with special health care needs
 - Tribal Child Welfare Programs
 - Indian Health Care Providers
- Comply with Coordinated Care’s policies and procedures that address the day-to-day operational requirements to coordinate the physical and behavioral health services and share the responsibility for members health care.
- In consultation with other appropriate health care professionals, assess and develop individualized treatment plans for children with special health care needs, which ensure integration of clinical and non-clinical disciplines and services in the overall plan of care.
- Identify those members with special health care needs in the course of any contact with members or any members-initiated health care visit and report such members to Coordinated Care.
- Reasonably cooperate with the applicable care manager to conduct an Initial Health Assessment (IHA) of members within the timeframes set forth in the Apple Health (Medicaid) Contract, and to ensure arrangements are made for follow-up services that reflect the findings in the IHA, such as consultations with mental health and/or substance use disorder providers.
- In consultation with the care manager and other treating providers, develop, document and maintain, for all members with Special Health Care Needs, an individualized treatment plan in the members s medical record. Elements required in the treatment plan shall include, at minimum:
 - The members self-management goals
 - Short and long-term treatment goals, and identification of barriers to meeting goals or complying with the treatment plan
 - Time schedule for follow-up treatment and communication with the member
 - Clinical and non-clinical services accessed by the member or recommended by Provider or care manager
 - Integration and coordination of clinical and non-clinical services, including follow-up to ensure disciplines and services are accessed

- Modifications as needed to address emerging needs of the member
- Participation of the member in the development of the treatment plan
- Progress or reason for lack of progress on self-management or treatment plan goals
- Communication with specialty care providers, including mental health and substance use disorder providers
- Identification of barriers to achieving self-management or treatment planning goals and how such barriers were addressed
- Health promotion activities, including scheduling of appointments for preventive care
- Approval of the care plan, if required by Coordinated Care

4.3 Provider Types That May Serve As PCPs

Providers who may serve as PCPs include family practitioners, general practitioners, internists, OB-GYNs, pediatricians, naturopathic physicians, and nurse practitioners. In addition, physician assistants (PAs) working under the supervision of a participating PCP may also serve as a PCP as an extension of the services performed by PCPs. The PCP may practice in a solo or group setting or at a Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Department of Health Clinic, Indian Health Care Provider, or similar outpatient clinic. With prior written approval, Coordinated Care may allow a specialist to serve as a PCP for members with special health care needs, multiple disabilities, or with acute or chronic conditions as long as the specialist is willing to perform the responsibilities of a PCP as outlined in this manual.

4.4 Member Panel Capacity

All PCPs reserve the right to state the number of members they are willing to accept into their panel. Coordinated Care does not and is not permitted to guarantee any provider will receive a certain number of members.

The PCP-to-member ratio shall not exceed the following:

- Physicians 1:1,200
- Nurse Practitioner 1:1,200
- Physician Assistant 1:1,200

If a PCP has reached the capacity limit for his/her practice and wants to make a change to their open panel status, the PCP must notify Coordinated Care Provider Services by contacting their dedicated Provider Engagement Administrator or calling 1-877-644-4613 or emailing WAProviderUpdates@coordinatedcarehealth.com. A PCP shall not refuse new members for addition to his/her panel as long as the PCP has not reached their specified capacity limit.

In accordance with the Coordinated Care Participating Provider Agreement, PCPs shall notify Coordinated Care in writing at least forty-five (45) days in advance of their inability to accept additional Coordinated Care members. In no event shall any established patient who becomes a Coordinated Care member be considered a new patient. Coordinated Care prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Apple Health (Medicaid) or non-Coordinated Care members.

At the election of an Urban Indian Health Program (UIHP), Coordinated Care will not assign members. However, members may select assignment to an UIHP.

4.5 Member Selection or Assignment of PCP

HCA gives all Washington Apple Health (Medicaid) Members the opportunity to select a health plan from the list of its contracted Apple Health (Medicaid) MCOs. Once the Member has selected a health plan, they are given the opportunity to select a PCP from the health plan's list of participating PCPs. If the Member fails to select a health plan at the time of enrollment, HCA will select a health plan on their behalf through auto-assignment.

Upon assignment to Coordinated Care, we in turn must ensure the member has selected a PCP within reasonable proximity to the member's home, no later than fifteen (15) business days after coverage begins. For those members who have not selected a PCP during enrollment, Coordinated Care will use a PCP auto-assignment algorithm, approved by HCA, to assign a PCP for the member. The algorithm assigns members to a PCP according to the following criteria, and in the sequence presented below:

1. **Member history with a PCP.** The algorithm will first look to see if the member is a returning member and attempt to match them to previous PCP. If the member is new to Coordinated Care, claim history provided by the state is used to match a member to a PCP that the member had a previous relationship with, where possible.
2. **Family history with a PCP.** If the member has no previous relationship with a PCP, the algorithm will look for a PCP that someone in the member's family, such as a sibling, is or was assigned to.
3. **Geographic proximity of PCP to member residence.** The auto-assignment logic will ensure members travel no more than twenty-five (25) miles in non-urban regions and ten (10) miles in urban regions of the service area.
4. **Appropriate PCP type.** The algorithm will use age, gender, and other criteria to ensure an appropriate match, such as children assigned to pediatricians.

Pregnant members should select a pediatrician or other appropriate PCP for their newborn baby before the beginning of the last trimester of pregnancy. In the event the pregnant member does not select a PCP, Coordinated Care will auto-assign one for the newborn.

The member may change their PCP at any time with the change becoming effective no later than the beginning of the month following the member's request for change.

Coordinated Care respects Indian Health Care Provider's ability to determine who they will serve. If an American Indian/Alaska Native (AI/AN) wishes to have an IHCP assigned as a PCP, the IHCP can submit the PCP Selection and Change Form to Coordinated Care. Coordinated Care treats the IHCP as an in-network PCP for the members regardless of whether or not such IHCP has a Participating Provider Agreement with Coordinated Care.

4.6 PCP Referrals to Specialists

PCPs are encouraged to refer members to an appropriate specialist provider when care is medically necessary and beyond the scope of what the PCP can provide. The PCP must obtain prior authorization from Coordinated Care for referrals to certain specialty providers as noted on the prior authorization list found in this manual. Coordinated Care helps members with multiple or complex conditions to obtain access to care and services and coordinates their care through multiple avenues to be considered for complex case management services, including population health and clinical operations program referral, discharge planner referral, member or caregiver referral, and practitioner referral. **All providers—whether a PCP or specialist—are also required to promptly notify Coordinated Care when giving prenatal care for the first time to a member.**

In accordance with State Law, participating providers are prohibited from making referrals for designated health services to healthcare providers or entities with which the participating provider, the participating provider's family, the member, or the member's family has a financial relationship.

4.7 Member Self-Referral Options

Members may initiate access to certain services without first obtaining authorization, PCP referral, or health plan approval for the following services:

- Emergency services whether in or out-of-network
- Urgent Care facilities
- OB/GYN (in-network) for women's routine and preventive health care services
- Women's health services provided by participating Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), or Certified Nurse Practitioners (CNP)
- Family Planning services and supplies, including screening and treatment services for sexually transmitted diseases provided by in-network or out-of-network providers
- Non-Medical Vision Care (i.e., vision exam, eyeglasses)
- Outpatient behavioral health services
- Crisis Response Services, including crisis intervention; crisis respite; investigation and detention services; and evaluation and treatment services
- Any HCA-sponsored services or programs (such as dental care, transportation, Apple Health (Medicaid) interpreter, and substance use disorder services)
- HIV/AIDS testing
- Sexually transmitted infection (STI) screening and follow-ups
- Immunizations
- Tuberculosis screening and follow-ups
- General optometric services (preventive eye care)
- All services received by American Indian or Alaska Native members at an IHCP

PCPs are obligated to coordinate access to these services if the member or a Coordinated Care representative requests assistance with accessing these services.

4.8 Specialists as PCPs

Primary Care Physicians in consultation with other appropriate health care professionals must assess and develop individualized clinical treatment plans for children with special health care needs, which ensure integration of clinical and non-clinical disciplines and services in the overall plan of care.

Members with special health care needs often require regular monitoring and treatment from a specialist. When we identify a member whose care plan indicates the need for frequent utilization or a course of treatment with, or monitoring by, a specialist, we will provide prior authorization and direct access to the specialist through the end of the course of treatment or for a specific number of visits. We will allow members with such treatment plans to retain the specialist as their PCP. The specialist must agree in writing to perform all PCP functions including, but not limited to, performing, or coordinating preventive care (including EPSDT services) and referral to other specialists as indicated.

In addition, members with disabling conditions, chronic illness and other special health care needs, parents/caregivers, foster care case workers, or providers may request, at any time, that the member be assigned a specialist as their PCP. When such a request is made, a Care Manager will contact the member within three (3) business days of the request for an assessment. Our Medical Directors will review results and approve requests after determining that meeting the request is reasonably feasible and the specialist is willing to fulfill the PCP role. Prior to the specialist serving as the member's PCP, we will execute a PCP Agreement with the specialist and offer a Provider Directory to the member. The Care Manager will work with the member and previous PCP to safely transfer care to the specialist.

4.9 Specialist Provider Responsibilities

Coordinated Care requires specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the member's care and ensures the referred specialist is a participating provider within the Coordinated Care network and that the PCP is aware of the additional service request. The specialist may order diagnostic tests without PCP involvement by following Coordinated Care referral guidelines.

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

- Maintain contact and open communication with the member's referring PCP
- Obtain authorization from the Coordinated Care Population Health and Clinical Operations Department, if needed, before providing services
- Coordinate the member's care with the referring PCP
- Provide the referring PCP with consultation reports and other appropriate patient records within five (5) business days of receipt of such reports or test results
- Be available for or provide on-call coverage through another source twenty-four (24) hours a day for management of member care
- Maintain the confidentiality of patient medical information
- Actively participate in and cooperate with all Coordinated Care quality initiatives and programs
- Coordinate with a member's Indian Health Care Provider with their consent

Coordinated Care specialists should refer to their Participating Provider Agreement, contact their dedicated Provider Engagement Administrator, or call the Coordinated Care Provider Services department at 1-877-644-4613 for complete information regarding the specialist providers' obligations and mode of reimbursement or if they have any questions or concerns regarding referrals, claims, prior authorization requirements and other administrative issues.

4.10 Appointment Availability and Wait Times

Coordinated Care follows the accessibility and appointment wait time requirements set forth by HCA and applicable regulatory and accrediting agencies. Coordinated Care monitors network provider compliance with these standards at least annually. The results of appointment standards monitoring are used to ensure adequate appointment availability and access to care and to reduce inappropriate emergency room use. The table below depicts the appointment availability and wait time standards for Coordinated Care members. Appointment availability and wait times do not apply to Indian Health Care Providers.

Type of Appointment	Scheduling Time Frame
All Providers	
Emergency Care	Immediately, and available 24/7
Primary Care Providers	
Non-Symptomatic, Preventive, Well visit	Within thirty (30) calendar days of appointment request
Non-Urgent, Symptomatic visit	Within ten (10) calendar days of appointment request
Urgent, Symptomatic visit	Within twenty-four (24) hours of appointment request
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
Prenatal Care Providers	
Initial visit for newly enrolled pregnant women within their first trimester	Within fourteen (14) calendar days of the postmark date from the member's enrollment material
Initial visit for newly enrolled pregnant women within the second trimester	Within seven (7) calendar days of the postmark date from the member's enrollment material
Initial visit for newly enrolled pregnant women within the third trimester	Within three (3) calendar days of postmark date from the member's enrollment material
High risk pregnancies	Within three (3) calendar days of identification of high risk by Coordinated Care or prenatal care provider, or immediately if an emergency exists
Established members who become pregnant	Within thirty (30) calendar days of request
Notice of Pregnancy (NOP) to Coordinated Care	Complete and Submit NOP form within ten (10) calendar days of member's first appointment with prenatal care provider

Type of Appointment	Scheduling Time Frame
Behavior Health Providers	
Care for a non-life-threatening emergency	Within six (6) hours
Urgent, Symptomatic visit	Within twenty-four (24) hours
Non-Urgent, Symptomatic visit	Within ten (10) calendar days of appointment request
Initial Visit, Routine Care	Within ten (10) calendar days
Follow-up, Routine Care	Within thirty (30) calendar days for established patients
Specialty Care Providers	
Urgent, Symptomatic Care	Within twenty-four (24) hours
Non-Urgent, Symptomatic Care	Within ten (10) calendar days of referral or as clinically indicated
Home Care Providers	
Home Care Services as part of Transitional Care (clinical assessment or care planning ordered by PCP)	Within seven (7) calendar days of member's discharge from an inpatient or institutional care for physical or behavioral health care, if ordered by the PCP or as part of the discharge plan
Diagnostic Service Providers	
Outpatient Imaging and X-ray Services	Not to exceed three (3) weeks for usual and customary and twenty-four (24) hours for urgent care or as clinically indicated
Follow-up visits	In accordance with Emergency Department attending provider discharge instructions
Second Opinions	
Second opinion appointments	Within thirty (30) calendar days of request
Wait Time Standards for ALL PROVIDER TYPES	
Office waiting time for scheduled appointments Not to exceed sixty (60) minutes – If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than ninety (90) minutes, the patient shall be offered a new appointment.	

Coordinated Care requests that PCPs inform our Member Services department at 1-877-644-4613 (TTY: 711) when a Coordinated Care member misses an appointment so we may note it in our system and provide outreach to the member on the importance of keeping appointments. This will assist our providers in reducing missed appointments and reduce the inappropriate use of Emergency Department services.

4.11 Travel Distance and Access Standards

(Distance does not apply to Apple Health Expansion—see Apple Health Expansion Time Standards below)

Coordinated Care offers a comprehensive network of PCPs, Specialist Physicians, Hospitals, Behavioral Health Care Providers, Diagnostic and Ancillary Services Providers to ensure every member has access to Covered Services within the time and travel distance standards established by HCA. These standards are listed below:

- Access Standards for Primary Care Services:
 - Urban Areas: 80% of all members must have access to at least 2 PCPs (including Family Practice, General Practice, Pediatrics) within 10 miles of their residence
 - Non-Urban Areas: 80% of all members must have access to at least 1 PCP within 25 miles of their residence
- Access Standards for Obstetrical/Prenatal Care, including birthing services:
 - Urban Areas: 80% of female members must have access to at least 2 OB providers within 10 miles of their residence
 - Non-Urban Areas: 80% of female members must have access to at least 1 OB provider within 25 miles of their residence
- Access Standards for Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services:
 - Urban Areas: 80% of pediatric members must have access to at least 2 pediatric providers within 10 miles of their residence
 - Non-urban Areas: 80% of pediatric members must have access to at least 1 pediatric provider within 25 miles of their residence
- Access Standards for Hospital Services:
 - Urban Areas: 80% of all members must have access to at least 1 hospital within 25 miles of their residence
 - Non-Urban Areas: 80% of all members must have access to at least 1 hospital within 25 miles of their residence
- Access Standards for Pharmacy Services:
 - Urban Areas: 80% of all members must have access to at least 2 pharmacy within 10 miles of their residence
 - Non-Urban Areas: 80% of all members must have access to at least 1 pharmacy within 25 miles of their residence
- Access Standards for Mental Health Professionals and SUDPs (includes outpatient and intensive outpatient behavioral health):
 - Urban Areas: 80% of all members must have access to at least 1 provider within 25 miles of their residence
 - Non-Urban Areas: 80% of all members must have access to at least 1 provider 25 miles of their residence
- Access Standards for Outpatient Behavioral Health Agency Providers:
 - Urban Areas: 80% of all members must have access to at least 1 provider within 25 miles of their residence
 - Non-Urban Areas: 80% of all members must have access to at least 1 provider 25 miles of their residence

Provider Network – Apple Health Expansion Drive Time Standards

Coordinated Care will ensure that when members travel to service sites, the drive time to the closest provider of the service the members is seeking is within a standard of not more than:

- In Urban Areas, service sites are accessible by public transportation with the total trip, including transfers, not to exceed ninety minutes each way;
- In Rural Areas, a thirty-minute drive from the members primary residence to the service site; and
- In Large Rural Geographic Areas, a ninety-minute drive from the members primary residence to the service site.
- These travel standards do not apply under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages or delayed ferry service).

Participating providers must offer access comparable to that offered to commercial members or if the participating provider serves only Apple Health (Medicaid) members, comparable to Medicaid fee-for-service. Coordinated Care routinely monitors compliance with this requirement and may initiate corrective action if there is a failure to comply with this requirement.

4.12 Covering Providers

PCPs and specialty providers must arrange for coverage with another provider during scheduled or unscheduled time off and preferably with another Coordinated Care network provider. In the event of unscheduled time off, please notify Provider Relations of coverage arrangements as soon as possible. The covering provider is compensated in accordance with the fee schedule in their agreement. Non-participating covering providers are reimbursed per Coordinated Care policies for non-participating providers.

4.13 Provider Phone Call Protocol

PCPs and Specialists must:

- Answer the member's telephone inquiries on a timely basis
- Schedule appointments in accordance with Coordinated Care and HCA appointment standards and guidelines
- Schedule a series of appointments and follow-up appointments as needed by a member and in accordance with accepted practices for timely occurrence of follow-up appointments for non-Apple Health (Medicaid) beneficiaries
- Identify and, when possible, reschedule cancelled and no-show appointments
- Identify member's special needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or persons with cognitive impairments)
- Adhere to the following response time for telephone call-back wait times:
 - After hours for non-emergent, symptomatic issues: within thirty (30) minutes
 - Same day for all other calls during normal office hours
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal office hours
- Protocols shall be in place to provide coverage in the event of a provider's absence
- After-hour calls should be documented in a written format in an after-hour call log and then transferred to the member's medical record

Note: *If after-hours urgent or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department to notify the facility of the patient's impending arrival. Coordinated Care does not require notification or prior-authorization for urgent or emergent care.*

Coordinated Care will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (QIP). *Provider Phone Protocol does not apply to Indian Health Care Providers.*

4.14 24-Hour Access to Providers

Coordinated Care PCPs and specialty providers are required to maintain sufficient access to needed health care services on an ongoing basis and shall ensure that such services are accessible to members as needed twenty-four (24) hours a day, three hundred sixty-five (365) days a year as follows:

- A provider's office phone must be answered during normal business hours
- After normal business hours and on weekends, a provider must have:
 - A covering physician
 - An answering service
 - A triage service or voicemail message that provides a second phone number that is answered
 - Any recorded message must be provided in English and Spanish if the provider's practice includes a high population of Spanish speaking members

Examples of Unacceptable After-Hours Coverage include, but are not limited to:

- Calls received after-hours are answered by a recording telling callers to leave a message
- Calls received after-hours are answered by a recording directing patients to go to an Emergency Room for any services needed
- Not returning calls or responding to messages left by patients after-hours within thirty (30) minutes

The selected method of twenty-four (24) hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. A PCP, specialty provider, or covering medical professional must return the call within thirty (30) minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

Coordinated Care will monitor providers' offices through scheduled and unscheduled visits and audits conducted by Coordinated Care Provider Relations staff. Twenty-four-hour access to providers does not apply to Indian Health Care Providers.

4.15 Hospital Responsibilities

Coordinated Care has established a comprehensive network of hospitals to provide services to Coordinated Care members. Hospital services and hospital-based providers must be qualified to provide services under the Apple Health (Medicaid) program. All services must be provided

in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth by HCA.

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit.
- Obtain prior authorizations for all inpatient elective admissions and selected outpatient services as verified on the current Pre-Auth Check tool, except for emergency stabilization services.
- Notify Coordinated Care Population Health and Clinical Operations department by sending an electronic file of the hospital admission within one (1) business day of the admission. The electronic file should include the member's name, Apple Health (Medicaid) ID, presenting symptoms/diagnosis, date of service, and member's phone number along with medical records needed to conduct utilization management activities.
- Notify Coordinated Care Population Health and Clinical Operations department of all newborn deliveries within one (1) business day of the admission.
- Provide daily Discharge Summaries.
- Coordinate with a member's Indian Health Care Provider with their consent.

Coordinated Care hospital administrators should refer to their Coordinated Care contract for complete information regarding hospital obligations, rights, and responsibilities.

4.16 Provider Network Development and Maintenance

Coordinated Care will ensure the provision of covered services as specified by the State of Washington's Health Care Authority (HCA). Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of HCA's network adequacy requirements. Coordinated Care will develop and maintain a network of qualified providers in sufficient numbers and locations that is adequate and reasonable to meet the medical needs of its members without excessive travel requirements and in compliance with HCA.

Coordinated Care offers a network of primary care providers (PCPs) to ensure every member has access to care. PCPs are participating providers who have the responsibility for supervising, coordinating, and providing primary health care to members. PCPs include, but are not limited to Pediatricians, Family and General Practitioners, Internists, Physician Assistants (under the supervision of a primary care physician) or Advanced Registered Nurse Practitioners (ARNP). In addition, Coordinated Care will have available, at a minimum, the following specialists for both adult and pediatric members on at least a referral basis:

- Allergists/Immunologists
- Anesthesiologists and Certified Registered Nurse Anesthetists
- Audiologists
- Behavioral health (including substance use disorder prevention and treatment providers)
- Cardiologists
- Chiropractors - pediatric ONLY
- Dermatologists

- Diagnostic Imaging Providers (X-Ray, Radiology, MRI, etc.)
- Emergency Medicine Providers
- Endocrinologists
- Gastroenterologists
- General surgeons
- Hematologists/Oncologists
- Home Care Providers
- Hospitals, including Delivery Services
- Infectious Disease Specialists
- Laboratory Services Providers
- Long-term Care Providers
- Neonatologists
- Nephrologists
- Neurologists
- Neurosurgeons
- Nuclear Medicine Specialists
- Obstetrics and gynecology, including high-risk perinatologists, maternal and fetal medicine specialists, certified nurse midwife
- Oncologists
- Ophthalmologists
- Optometrists
- Orthopedic surgeons
- Otolaryngologists (ENT)
- Pathologists
- Pharmacies
- Pharmacists
- Physical Medicine and Rehabilitation Specialists (speech, physical, occupational therapists, and physiatrists)
- Podiatrists
- Psychiatrists
- Psychologists
- Pulmonologists
- Respiratory therapists
- Rheumatologists
- Surgery subspecialists, including cardiac/thoracic, plastic/reconstructive, pediatric, vascular, hand, etc.

Many services are available through telehealth with an in-network provider. In the event the Coordinated Care provider network is insufficient (according to HCA established standards), Coordinated Care shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is available and will ensure coordination with respect to authorization and payment issues in these circumstances. For assistance with referrals to specialists for a Coordinated Care member, please contact our Population Health and Clinical Operations team at 1-877-644-4613 (TTY: 711).

4.17 Behavioral Health Network

Coordinated Care contracts with behavioral health practitioners, providers, and community mental health agencies (CMHAs) that consistently meet or exceed clinical quality standards, and are comfortable practicing within the managed care arena, including an understanding of Coordinated Care covered benefits and utilization.

Regional Behavioral Health entities must develop and implement plans for improving access to timely and appropriate treatment for members with Behavioral Health needs and current or prior criminal justice involvement.

Integrated Managed Care Members

Coordinated Care has contracted with HCA to provide the full continuum of behavioral health services statewide for Apple Health Core Connections Members.

Children's Mental Health Evidence Based Practices (EBPs)

All providers are required to use the appropriate EBP or EPA number for Children's Mental Health Evidence-Based Practices such as cognitive behavioral therapy (CBT) or Positive Parent Program (Triple P) when billing for clients under age 21. Health Care Authority is required by law to collect data on EBPs in Washington State.

Guides on Reporting EBPs can be found at <https://www.hca.wa.gov/about-hca/behavioral-health-recovery/evidence-based-and-research-based-practices> and in HCA's Billing Guides Mental Health Services Guide found on the Provider Billing Guides and Fee Schedules page <https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules>.

CBT+ Training at UW <https://depts.washington.edu/uwhatc/for-professionals/cbt-notebook/>

Coordinated Care consistently monitors network adequacy. Network providers are selected based on the following standards:

- Clinical expertise
- Geographic location considering distance, travel time, means of transportation, and access for members with physical disabilities
- Potential for high volume referrals
- Specialties that best meet our members' needs
- Ability to accept new patients

In addition to hospitals, Coordinated Care also contracts with behavioral health/substance use disorder treatment agencies, and clinically licensed behavioral health practitioners, including psychiatrists, psychologists, counselors/social workers, and nurse practitioners.

Coordinated Care contracts its provider network to support and meet the linguistic, cultural, and other unique needs of every individual member, including the capacity to communicate with members in languages other than English and communicate with those members who are deaf or hearing impaired.

Primary Care and Behavioral Health Integration Resources

- <http://integratedcareforkids.org/> Pediatric Integrated Care
- https://www.aacap.org/AACAP/Clinical_Practice_Center/Systems_of_Care/Collaboration_with_Primary_Care.aspx AACAP PCP Integration
- <https://www.thenationalcouncil.org/program/center-of-excellence/> AIMS Center Toolkit for Integration

4.18 The Network Provider's Office

Site visit audits are usually conducted as a result of member dissatisfaction or as part of a chart audit. The site visit auditor reviews the quality of the location where care is provided. The reviewer assesses the accessibility and adequacy of the treatment and waiting areas.

We respect Tribal sovereignty and will not conduct on-site reviews of Tribal service providers without advanced invitation from the Tribe and without prior notice to, and coordination with, the HCA Office of Tribal Affairs.

4.19 General Network Practitioner Office Standards

- Signs identifying office must be visible
- Office must be clean, and free of clutter with unobstructed passageways
- Office must have a separate waiting area with adequate seating
- Clean restrooms must be available
- Office environment must be physically safe
- Network Practitioners/providers must have a professional and fully confidential telephone line and twenty-four (24) hour availability
- Member records and other confidential information must be locked up and out of sight during the workday
- Medication prescription pads and sample medications must be locked up and inaccessible to members

General network practitioner office standards do not apply to Indian Health Care Providers.

4.20 Network Provider Concerns

Network Providers who have concerns about Coordinated Care should contact Provider Services at 1-877-644-4613 (TTY: 711) to register these complaints. All concerns are investigated, and a written resolution is provided to the Network Provider on a timely basis. Indian Health Care Providers may submit complaints directly to HCA for resolution.

4.21 Network Provider Standards of Practice

Network Providers are required to:

- Refer members with known or suspected physical health problems or disorders to the member's PCP for examination and treatment
- Only provide services if such services are within the scope of the Network Provider's clinical licensure
- Ensure members who are discharging from inpatient care are scheduled for outpatient follow-up and/or continuing treatment prior to the member's discharge. The outpatient treatment must occur within seven (7) calendar days from the date of discharge.

- Ensure all members receive effective, understandable, and respectful treatment provided in a manner compatible with their cultural health beliefs and practices and preferred language
- Make referrals or admissions of members for covered behavioral health services only to other in-network providers when the plan specifically authorizes the referral, except in the need for Emergency Care or as otherwise required by law
- Comply with all state and federal requirements governing emergency, screening, and post-stabilization services
- Provide member's clinical information to other providers treating the member, as necessary to ensure proper coordination and treatment of members who express suicidal or homicidal ideation or intent, consistent with State law
- Cooperate with QI Program (allow review of or submit requested charts, receive feedback)
- Notify Coordinated Care of any changes in licensure, any malpractice allegations, and any actions by your licensing board (including, but not limited to, probation, reprimand, suspension or revocation of license and changes in status, such as death)

Network Providers are requested to:

- Submit all documentation in a timely fashion
- Comply with Utilization Management process
- Support access standards
- Use the concept of Medical Necessity and evidence-based best practices when formulating a treatment plan and requesting ongoing care
- Coordinate care with other clinicians as appropriate, including consistent communication with the PCP
- Coordinate with a member's Indian Health Care Provider with their consent
- Assist members in identifying and utilizing community support groups and resources
- Maintain confidentiality of records and treatment. When required by state and/or federal law, obtain written consent from members to communicate with others regarding member treatment
- Notify Coordinated Care of any critical incidents (detailed below)
- Notify Coordinated Care of any changes in malpractice insurance coverage
- Complete credentialing and re-credentialing materials as requested
- Maintain an office that meets all standards of professional practice

Critical Incident Reporting

Individual Incident Reporting: The Provider must immediately report in writing (on the Coordinated Care approved form) upon becoming aware of the occurrence of any of the following incidents involving any Coordinated Care member that was served within 365 days of the incident.

Applicable incidents include:

- Happened to a client, and occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), FQHC, or by independent behavioral health provider:

- Abuse, neglect, or sexual/financial exploitation
- Death
- Severely adverse medical outcome or death occurring within 72 hours of transfer from a contracted behavioral facility to a medical treatment setting
- Allegedly perpetrated by a client, with a behavioral health diagnosis or history of behavioral health treatment within the previous 365 days. Acts allegedly committed, to include:
 - Homicide or attempted homicide
 - Arson
 - Assault or action resulting in serious bodily harm which has the potential to cause prolonged disability or death
 - Kidnapping
 - Sexual assault
- Unauthorized leave from a behavioral health facility during an involuntary detention.
- Any event involving a client that has attracted or is likely to attract media coverage. (Provider shall include the link to the source of the media, as available).

Additional Incident Reporting: The provider must submit a report on the Coordinated Care approved form within one (1) working day of becoming aware that any applicable incident has occurred, involving a Coordinated Care member.

Applicable incidents include:

- Incidents posing a credible threat to client safety
- Suicide or attempted suicide by a client
- Poisonings and overdoses whether unintentional or intention unknown

4.22 Referrals to Specialists

A cornerstone of managed care places PCPs in the central role of initiating and coordinating access to healthcare services for his/her panel of Coordinated Care members. PCPs can refer a member to a specialist when care is needed. **Paper referrals are not required by Coordinated Care.** To better coordinate a member's healthcare, Coordinated Care encourages specialists to communicate to the PCP the need for a referral to another specialist rather than making such a referral themselves.

4.23 Hospital and Tertiary Care

Coordinated Care offers a comprehensive network of hospitals, medical centers and tertiary care facilities and providers, including trauma centers, burn centers, level III (high-risk) nurseries, rehabilitation facilities and medical subspecialists available 24-hours per day. In the event a Coordinated Care network provider is unavailable to provide necessary tertiary care services, Coordinated Care shall ensure timely and adequate coverage of these services through an out-of-network provider and/or facility until a network provider is available and will ensure coordination with respect to authorization and payment issues in these circumstances.

4.24 Marketing Requirements

All materials directed towards members mentioning HCA, Medicaid, or Apple Health (Medicaid) and distributed by Coordinated Care or its contracted providers must be reviewed by HCA prior to distribution. Additionally:

- Neither Coordinated Care nor its contracted providers will offer anything of value as an inducement to enrollment including the sale of other insurance to attempt to influence enrollment.
- Coordinated Care or its contracted providers will not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment.
- Coordinated Care or its contracted providers may not make any written or verbal statements in marketing materials that a potential member must enroll with Coordinated Care in order to obtain benefits or in order not to lose benefits.
- Coordinated Care or its contracted providers may not make any assertion or statement in marketing materials that Coordinated Care is endorsed by CMS, the Federal or State government or similar entity.
- Marketing materials from Coordinated Care or its contracted providers may not contain an invitation for AI/ANs to change from Fee-for-Service Medicaid program.

Should you have any questions regarding member material requirements, please feel free to contact Provider Services or your Provider Engagement Administrator.

4.25 Advance Directives/POLST

Coordinated Care is committed to ensuring members are aware of and are able to avail themselves of their rights to execute Advance Directives, including Mental Health Advanced Directives. Coordinated Care is equally committed to ensuring participating providers and their staff are aware of and comply with federal and state law regarding Advance Directives. Information and forms can be found on the website at www.CoordinatedCareHealth.com.

PCPs and providers delivering care to Coordinated Care members must ensure members age eighteen (18) years and older receive information on Advance Directives/Mental Health Advanced Directives and are informed of their right to execute an Advance Directive or to have Physician Orders of Life Saving Treatment (POLST) clearly identified in their medical record. Providers must document such information in the patient's permanent medical record.

Coordinated Care recommends to its PCPs and providers that:

- The first point of contact for the member in the PCP's office should ask if the member has executed an Advance, and the member's response should be documented in the medical record.
- If the member has executed an Advance Directive, the first point of contact should ask the member to supply a copy of it for inclusion in the member's medical record. NOTE: The date of the request for the Advance Directive should be noted in the member's medical record. It is recommended that if the Advance Directive is not received within thirty (30) days of the request, the PCP should contact the patient to re-request the Advance Directive.
- An Advance Directive should be made a part of the member's medical record and include mental health directives.
- If an Advance Directive exists, the provider should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the Advance Directive and if available) and with the referring provider, if applicable. Any such discussion should be documented in the medical record.

4.26 Member Self-Determination

All providers are required to obtain informed consent prior to treatment from members, or persons authorized to consent on behalf of a member. Providers must comply with the provisions of the Natural Death Act (RCW 70.122) and state and federal Medicaid rules concerning Advance Directives. When appropriate, members should be informed of their right to make anatomical gifts.

4.27 Interpreter Services

All Coordinated Care members or potential members with a primary language other than English, or who are Deaf, Deaf-blind, or Hard of Hearing are entitled to receive interpreter services free of charge. Interpreter services shall be provided as needed for all interactions with members including, but not limited to:

- Customer Service
- When receiving covered services from any provider
- Emergency Services
- Steps necessary to file grievances and appeals

For Apple Health (Medicaid) members, providers must use [Universal Language Services \(Universal\)](#) or sign language service providers managed by the Office of the Deaf and Hard of Hearing (ODHH) in order for HCA to pay for interpreters for appointments. Universal will send all requesters an email notification with their login credentials.

HCA offers sign language interpreters to various health care appointments for eligible Apple Health clients and HCA Medicaid enrolled health care providers. HCA is responsible for payment of interpreter services provided when the interpreter service is requested through, authorized, and provided by HCA's Interpreter Services program vendor, Universal, or ODHH and complies with all program rules. Providers will be required to pay for interpreter services if the service is not requested through Universal, ODHH, or does not meet program rules. If there are any questions about eligibility for the services, providers can review HCA's web page at <https://www.hca.wa.gov/billers-providers-partners/program-information-providers/interpreter-services-providers>.

If you need an interpreter at your medical appointment for Apple Health Expansion members, contact Coordinated Care Provider Services at 1-877-644-4613 or submit a completed Interpreter Form to InterpreterRequest@centene.com at least seven days before your appointment. We will arrange for one to be at your appointment.

Hospitals are responsible for providing interpreter services during inpatient stays. Public entities, such as Public Health Departments, are responsible for providing interpreter services at their facilities or affiliated sites.

Coordinated Care currently contracts with several vendors for face-to-face interpreter services, to assist members with a grievance or appeal, member visiting in a Coordinated Care office, and extenuating circumstances.

4.28 Provider Network Termination

Providers must give Coordinated Care written notice prior to their intent to voluntarily terminate their network participation in accordance with the terms of the participating provider agreement (PPA). The provider must send a written termination notice via certified mail (return receipt requested) or overnight courier to Attn: Plan President, as outlined in your PPA. In addition, providers must supply copies of medical records to each member's new provider upon request and cooperate in the coordination of patient care transitions at no charge or disruption and delay in services to affected Coordinated Care members.

Coordinated Care will make best efforts to notify affected members in writing of a provider's termination within fifteen (15) calendar days of the receipt of the termination notice from the provider, provided that such notice from the provider was timely. If the terminating provider is a PCP, Coordinated Care will request that the member elect a new PCP within fifteen (15) business days of the postmark date of the termination of the PCP notice to members and provide information on options for selecting a new PCP. If a member does not elect a PCP prior to the provider's termination date, Coordinated Care will automatically assign one to the member.

Providers must continue to render covered services to members who are receiving care at the time of termination until a) completion of the treatment or b) Coordinated Care can arrange for appropriate healthcare for the member with a participating provider, as determined by the medical director or as required by applicable law or the contract. If a practitioner's contract is discontinued, then Coordinated Care allows affected members continued access to the practitioner, as follows:

- Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition
- Continuation of care through the postpartum period for members in their second or third trimester of pregnancy

05 PROVIDER RIGHTS AND RESPONSIBILITIES

5.1 Provider Rights

- To be treated by their patients, who are Coordinated Care members, and other healthcare workers with dignity and respect
- To receive accurate and complete information and medical histories for members' care
- To have their patients, who are Coordinated Care members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
- To expect other network providers to act as partners in members' treatment plans
- To expect members to follow their health care instructions and directions, such as taking the right amount of medication at the right times
- To file a dispute or make a complaint against Coordinated Care and/or a member
- To file a grievance on behalf of a member with the member's written consent

- To have access to information about Coordinated Care quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
- To contact Provider Services with any questions, comments, or problems
- To collaborate with other healthcare professionals who are involved in the care of members
- To not be excluded, penalized, or terminated from participating with Coordinated Care for having developed or accumulated a substantial number of patients with coverage through Coordinated Care who have high-cost medical conditions
- To object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds
- For Indian Health Care Providers, to have trained staff to handle calls or inquiries regarding their unique reimbursement process and how to ensure that claims for services to AI/AN members are correctly processed.

5.2 Provider Responsibilities

- To help or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the responsibility to:
 - Recommend new or experimental treatments
 - Provide information regarding the nature of treatment options
 - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered
 - Inform the member of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options
- To treat members with fairness, dignity, and respect
- To not discriminate against members on the basis of race, color, national origin, limited language proficiency, religion, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high-cost care
- To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service
- To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- To allow members to request restriction on the use and disclosure of their personal health information
- To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
- To provide clear and complete information to members - in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process

- To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
- To allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
- To respect members' Advance Directives, Mental Health Advance Directives, and POLST and include these documents in their medical record
- To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions
- To allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately
- To follow all state and federal laws and regulations related to patient care and rights
- To participate in Coordinated Care data collection initiatives, such as HEDIS and other contractual or regulatory programs
- To review clinical practice guidelines distributed by Coordinated Care
- To comply with Coordinated Care Population Health and Clinical Operations program as outlined herein
- To disclose overpayments or improper payments to Coordinated Care
- To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
- To obtain and report to Coordinated Care information regarding other insurance coverage the member has or may have
- To give Coordinated Care timely, written notice if provider is leaving/closing a practice
- To contact Coordinated Care to verify member eligibility and benefits, if appropriate
- To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
- To provide members with information regarding office location, hours of operation, accessibility, and translation services
- To coordinate and cooperate with other state agencies and providers also serving members through various home and community-based programs
- To coordinate with Tribes and Indian Health Care Providers. Psychiatric hospitals and Evaluation and Treatment Facilities shall notify and coordinate with an American Indian/Alaska Native's Indian Health Care Provider for discharge planning.
- To refrain from billing Coordinated Care members for covered services

5.3 Privacy Responsibilities

Coordinated Care and providers are subject to federal and state health information privacy laws including, for example, HIPAA, 42 CFR Part 2, and Washington's health care information privacy laws. Providers are responsible for knowing and fulfilling their obligations under all applicable health information privacy laws.

Generally, State and federal health information laws allow for the use and disclosure of most member health information by and between providers and Coordinated Care for treatment,

payment and health care operations purposes without written authorization by a member; however, written authorization must be obtained from a member prior to disclosing the following types of health information:

- Psychotherapy notes
- Information related to diagnosis, treatment, or referral for treatment of substance use disorders (SUD) that is subject to 42 CFR Part 2
- Sexually transmitted disease information except when disclosed for treatment, payment, or the disclosing entity's healthcare operations purposes
- Mental health information except when disclosed for treatment, payment, or the disclosing entity's healthcare operations purposes

For any use or disclosure, only the minimum amount of information needed to fulfill the intended purpose should be used or disclosed.

In Washington State, minors, not their parents or other personal representative, have the right to obtain certain types of health care services and must authorize disclosure of information pertaining to those services:

- **Any age:** Reproductive rights (birth control, prenatal care, abortion)
- **Age 13 and older:** Behavioral health
 - Mental health
 - Substance use disorders (SUD)
- **Age 14 and older:** Sexually transmitted diseases (STD)

Disclosure to parents (or, for foster children, Caseworkers/Caregivers) or other third parties is not allowed without the minor's authorization if consent of PHI relates to the categories above.

Coordinated Care maintains authorization forms for the use and disclosure of sensitive information on its website. To facilitate whole-person care, providers are encouraged to work with members and Coordinated Care to complete authorizations to use/disclose health information (ADHI) forms, especially for those members with complex needs. Coordinated Care will also accept valid, complete authorization forms created by other entities/agencies.

Completed ADHI forms may be sent by:

Fax: 1-877-644-4602
Mail: Coordinated Care
Compliance Department
1145 Broadway, Suite 700
Tacoma, WA 98402

Authorizations may be revoked at any time.

5.4 Physician Incentive Plans

Coordinated Care is required by law and regulation to monitor physician incentive plans in order to protect members by placing limitations of physician incentive plans that could potentially impact a physician's care management of members or impact the solvency of the provider or provider group. Annually, Coordinated Care will require providers or provider

groups to disclose the details of their physician incentive plan. The following definitions shall be reviewed by Coordinated Care:

- Risk – means the loss of potential payments made as part of a physician incentive plan
- Substantial Financial Risk – means when more than 25% of the total maximum potential payments to the physician or physician group depend on the use of referral services

For more information on physician incentive plan law and regulation, please contact Provider Services at 1-877-644-4613 (TTY: 711) or your Provider Engagement Administrator.

06 CULTURAL AWARENESS & RESPONSIVENESS

Coordinated Care views Cultural Awareness & Responsiveness as a person or organization's willingness and ability to learn about, understand and provide excellent customer service to all. It is the active implementation of a system-wide philosophy valuing differences among individuals and responding to diversity at all levels in the community, within and outside an organization and at all service levels. A sincere and successful Cultural Awareness & Responsiveness Program evolves to address continual changes occurring within communities and families. In terms of health care delivery, Cultural Awareness & Responsiveness is the promotion of access and delivery of services that are provided in a culturally competent manner to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity, Cultural Awareness & Responsiveness is the promotion of sensitivity to patient needs of various racial, religious, age, gender, and/or ethnic groups and accommodate the cultural-based attitudes, beliefs and needs within the framework of access to health care services; the development of diagnostic and treatment plans; and communication methods. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff, to ensure that services are delivered in a culturally responsive manner. Coordinated Care is committed to identifying underserved populations who experience health disparities at a higher rate and implementing focused interventions to address the disparities.

Coordinated Care is committed to the development, strengthening and maintenance of healthy provider/member relationships. Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable, fearful, or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

Coordinated Care has incorporated an evaluation of each provider's cultural responsiveness level within its credentialing program. By virtue of their participation status, all in-network providers have been evaluated regarding their cultural responsiveness level and have been approved for participation in the Coordinated Care network. Nevertheless, we offer all in-network providers access to reference materials, training programs and toolkits to assist each provider to further develop culturally responsive staff and culturally proficient practices.

As part of Coordinated Care's Cultural Awareness & Responsiveness Program, we require our employees and in-network providers to ensure that:

- Members understand they have access to certified medical interpreters, signers, translation, and TTY services to facilitate communication without cost to them.
- Medical care is provided with consideration of the members' primary language, race and/or ethnicity as it relates to the members' health or illness.
- Service to a culturally and linguistically diverse membership, including recommendations from the Tribal Liaison.
- Office staff routinely interacting with members have been given the opportunity to participate in, and have participated in, cultural responsiveness training and development offered by Coordinated Care which is based on national Culturally and Linguistically Appropriate Services (CLAS) standards.
- Office staff responsible for data collection make reasonable attempts to collect race- and language-specific information for each member. Staff will also explain race categories to a member in order to assist the member in accurately identifying their race or ethnicity.
- Provision of easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
- Treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on healthcare.
- Office sites have posted and printed materials in English and Spanish and, if required by HCA, any other required non-English language.
- Cultural competency is incorporated into provider training specific to delivery of behavioral health services and behavioral health-medical integration initiatives.

Health Equity Resources

- APA Guide for Treating Racial and Ethnic Minority Groups <https://www.apa.org/pi/families/resources/mental-health-needs.pdf>
- HHS Cultural Competency https://thinkculturalhealth.hhs.gov/education/behavioral-health?utm_medium=email&utm_source=govdelivery
- APA Diversity and Health Equity <https://www.psychiatry.org/psychiatrists/cultural-competency/education>

6.1 Mainstreaming

Coordinated Care considers mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, and physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a member a covered service or availability of a facility
- Denying a member access to an available bed in a facility due to current MOUD therapies or continuation of an MOUD therapy
- Providing a Coordinated Care member a covered service that is different or in a different manner, at a different time, or at a different location than to other "public" or private pay members (examples: separate waiting rooms, delayed appointment times)

Coordinated Care respects Indian Health Care Provider's ability to determine who they will serve. IHCPs/UIHPs can choose to treat AI/AN members according to their political status (Tribal affiliation).

07 VERIFYING MEMBER ELIGIBILITY

7.1 Member Eligibility Verification

All Coordinated Care members receive a plan ID card. Washington Apple Health (Medicaid) members will keep their state issued ProviderOne ID card to receive services not covered by the plan (such as most dental services and transportation). Coordinated Care will issue new cards to members if the information on their card changes, to replace a lost card, or if a member requests additional cards.

NOTE: *Presentation of a member ID card is not a guarantee of eligibility. Providers should always verify eligibility on the same day services are to be rendered.*

To verify a patient's eligibility with Coordinated Care, providers can choose one of the following methods:

- **ProviderOne** – Eligibility for Washington Apple Health members can be verified electronically through the ProviderOne Provider Portal or at 1-800-562-3022.
- **Log on to www.CoordinatedCareHealth.com** – Using our secure provider web portal, providers can quickly check member eligibility. Eligibility information loaded onto this website is received from HCA and reflective of all changes made within the last 24 hours. The eligibility search can be performed using the date of service, patient name and date of birth (DOB), or Apple Health ID and DOB or Coordinated Care ID number and DOB.
- **Call 1-877-644-4613 (TTY: 711)** – Calling our 24-hour toll-free interactive voice response (IVR) line from any touch-tone phone is a convenient way to obtain eligibility information about a patient. The automated system will prompt you to enter the member Apple Health ID and the month of service to check eligibility or follow the menu prompts to speak to a Provider Services Representative. Provider Services will require the member's name, date of birth, and Apple Health (Medicaid) ID or Coordinated Care ID to verify eligibility.

7.2 Member Identification Card

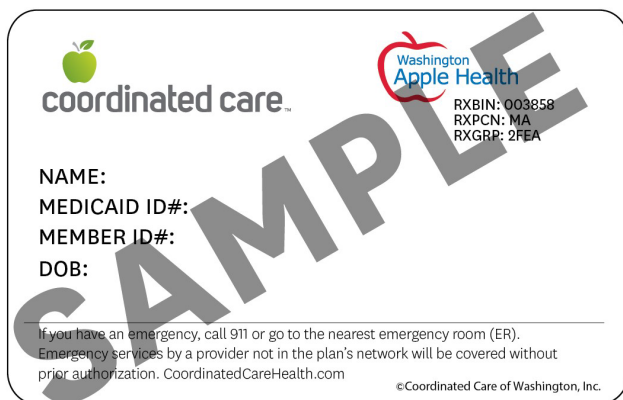
Whenever possible, members should present a photo ID card each time services are rendered by a provider. If you are not familiar with the person seeking care as a member of Coordinated Care, please ask to see photo identification. If you suspect fraud, please contact Provider Services at 1-877-644-4613 (TTY: 711) immediately.

Washington Apple Health members must keep the state-issued ProviderOne ID card in order to receive benefits not covered by Coordinated Care.

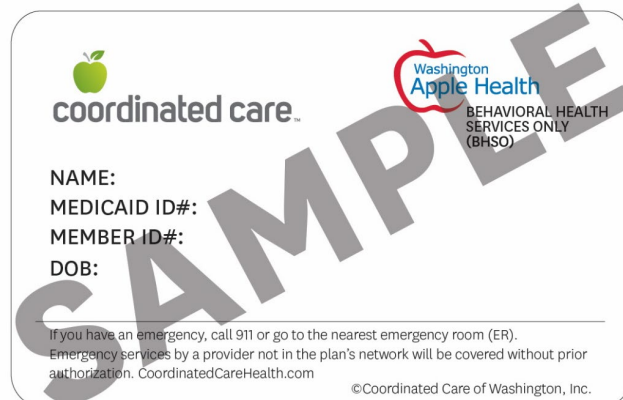
Members who register an account at CoordinatedCareHealth.com have access to a digital ID card that can be printed or saved to their smart phone or computer. A digital member ID card should be accepted by providers as an option to a printed ID card.

Below are samples of the Coordinated Care Member ID cards:

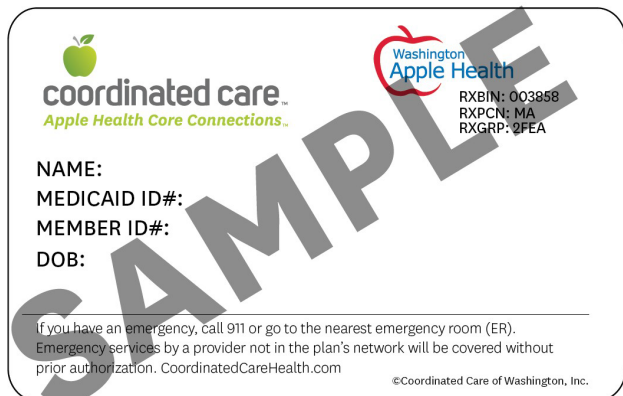
Washington Apple Health ID Card



Behavioral Health Services Only (BHSO) ID Card



Apple Health Core Connections ID Card



Apple Health Core Connections: Children who are removed from their homes and placed in foster care will use an Interim Voucher until they show up in the ProviderOne and Coordinated Care systems. If you have any questions about seeing a member who shows up with an Interim Voucher, please call Apple Health Core Connections at 1-844-354-9876.

Use Interim Voucher to:

- Confirm the child is in foster care and guarantee payment for Apple Health Core Connections covered services.
- Identify the Department of Children, Youth, and Families (DCYF) or Tribal case worker and foster parent/caregiver if the child is not showing in ProviderOne or our Secure Provider Portal.
- Receive services from Coordinated Care contracted providers for clinic visits, medical and behavioral health services, and pharmacy.

NOTE: Case workers complete as much as possible; missing info accepted.

Interim Voucher is located at

<https://www.CoordinatedCareHealth.com/providers/resources/core-connections-resources.html>

08 MEMBER RIGHTS AND RESPONSIBILITIES

8.1 Member Rights

- Ask for and get information about:
 - Your health care and covered services.
 - Your provider and how referrals are made to specialists and other providers.
 - How we pay your providers for your medical care.
 - All options for care and why you are getting certain kinds of care.
 - How to get help with filing a grievance or complaint about your care or help in asking for a review of a denial of services or an appeal.
 - Our organizational structure including policies and procedures, practice guidelines, and how to recommend changes.
- Be treated with respect and dignity. Discrimination is not allowed. No one can be treated differently or unfairly because of their race, color, religion, creed, culture, ancestry, national origin, gender, sex, sexual orientation or preference, marital status, age, physical or mental disability, health status, or requirements for health care services.
- Be informed about all treatment options available, regardless of cost. This includes clinical trials, experimental treatments, and any clinical authorization rules that apply.
- Make decisions with your provider about your healthcare, including behavioral health.
- Refuse or accept any health service, diagnosis or treatment based on religious grounds.
- Speak freely about your health care and concerns without any bad results.
- Ask for and get copies of your medical records. Ask for and have corrections made to your medical records when needed.
- Choose or change primary care provider (PCP) or to choose to see any provider that gives you care whenever possible and appropriate, including behavioral health care providers.

- For American Indian/Alaska Native members, the right to choose any Indian Health Care Provider enrolled with HCA for primary care, behavioral health care, or other services.
- Get a second opinion from another provider in your health plan.
- Get services in a timely manner.
- Have your privacy protected and information about your care kept confidential.
- Receive plan policies, benefits, services and Members' Rights and Responsibilities at least yearly.
- Make recommendations regarding your rights and responsibilities as a Coordinated Care member.
- To receive assistance in understanding the requirements and benefits of Coordinated Care.
- Express a concern or appeal about Coordinated Care or the care it provides and get a response in a reasonable amount of time.
- Receive a list of crisis phone numbers.
- To ask for and get help with completing mental or medical advance directive forms.
- To ask for and get all written member information from Coordinated Care:
 - At no cost to you
 - In your preferred language
 - In other ways, to help members who may have trouble reading the information for any reason.
- Be notified that oral interpretation is available at no cost to you and how to access those services.

8.2 Member Responsibilities

- Talk with your providers about your health and health care needs.
- Help make decisions about your health care, including refusing treatment.
- Know your health problems and take part in agreed-upon treatment goals as much as possible.
- Give your providers and Coordinated Care complete information about your health.
- Follow your provider's instructions for care that you have agreed to.
- Keep appointments and be on time. Call your provider's office if you are going to be late or if you have to cancel the appointment.
- Give your providers information they need to be paid for providing services to you.
- Bring your ProviderOne services card and Coordinated Care member ID card to all your appointments.
- Learn about your health plan and what services are covered.
- Use health care services when you need them.
- Use health care services appropriately. If you do not, you may be enrolled in the Patient Review and Coordination Program. In this program, you are assigned to one PCP, one pharmacy, one prescriber for controlled substances, and one hospital for non-emergency care. You must stay in the same plan for at least 12 months.
- Inform the Health Care Authority if your family size or situation changes, such as pregnancy, births, adoptions, address changes, or you become eligible for Medicare or other insurance.

- Renew your coverage annually using the Washington Healthplanfinder at wahealthplanfinder.org, and report changes to your account such as income, marital status, births, adoptions, address changes, become eligible for Medicare or other insurance.

09 BENEFIT EXPLANATION AND LIMITATIONS

9.1 Coordinated Care Benefits

Coordinated Care network providers supply a variety of medical benefits and services. For specific information not found in this Provider Manual, please contact Provider Services at 1-877-644-4613 (TTY: 711) from 8:00 a.m. to 5:00 p.m. Monday - Friday. A Provider Services Specialist will assist you in understanding the benefits.

Coordinated Care covers, at a minimum, those core benefits and services specified in our Agreement with HCA and mirrors the covered benefits for persons whom HCA has deemed eligible for the Washington Apple Health (Medicaid) program and Apple Health Expansion program. Coordinated Care members may not be charged, or balance billed for covered services.

In general, services provided out-of-network (by an out-of-network or non-participating provider) or outside of the service area may require prior authorization, excluding emergency room and family planning services. The [Prior Authorization tool](#) on our website can give more details on what services require prior authorization.

The cost to the Coordinated Care member can be no greater for services from non-participating providers than services provided by participating providers.

9.2 HCA Apple Health (Medicaid) Reimbursement Policy & Benefit Changes

Effective 01/01/2020 – Benefit Changes for Dental Services:

Providers should bill HCA's contracted Apple Health (Medicaid) MCOs instead of HCA (ProviderOne) for the following services:

- Pharmaceuticals prescribed by a dentist for a dental visit.
- Facility fees including Hospital out-patient & in-patient, Emergency Room, Urgent Care Centers, and Ambulatory Surgery Centers.
 - Provide a copy of HCA's approval letter with your billing to the MCO.
 - Enter the prior authorization number or EPA number on your billing to the MCO.
- CMS1500/HCFA claims for medical services for care and treatment of dental conditions billed with a CPT code and rendered by a medical provider, including verbal surgeons.
 - Exceptions: Provider taxonomy begins with a '12' or the claim is billed with a CDT (Dental code).
 - Fluoride varnish billed with CPT code 99188 and modifier DA.
 - Access to Baby and Child Dentistry (ABCD): For children 5 and under, covered services provided by a PCP using the following CPT codes with modifier DA will include:
 - Family Oral Health Education – 99499
 - Family Verbal Health Education – 99429

- Fluoride Varnish Application – 99188

NOTE: All professional services billed with a CDT code are not covered by MCOs and will remain covered by FFS.

Effective 01/01/2022 - Benefit changes for Dementia Care Planning Services:

Comprehensive assessment and care planning for persons living with cognitive impairment (CPT® code 99483)

HCA considers the comprehensive assessment and care planning for persons living with cognitive impairment to be medically necessary with the following limitations:

- Face-to-face visits via an in-person or audio-visual encounter are allowed, but HCA does not allow telephonic and email encounters.
- Clients must have a cognitive impairment as defined by one of the following ICD diagnosis codes: G300, G301, G309, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, G31.01, G31.09, G31.85, G31.83, and G31.84.
- Services must be billed by physicians, physician assistants, nurse practitioners, clinical nurse specialists, or certified nurse midwives.
- Services must include an independent historian—most often the client's caregiver.
- The comprehensive clinical visit must result in a written plan of care.
- Components of the visit include an independent historian; multidimensional assessment that includes cognition, functions, and safety; evaluation of neuropsychiatric and behavior symptoms; review and reconciliation of medications; and an assessment of the needs of the client's caregiver.
- Service is billable as a 50-minute visit, once every 180 days.

The following CPT® codes may be billed with CPT® code 99483 on the same day of service.

CPT Code	Short Description
99358	Prolonged Service without contact
99359	Prolonged Service without Contact add
99487	Complex Chronic care first 60 minutes
99489	Complex Chronic care each additional 30 minutes
99490	Chronic Care Management staff first 20 minutes

9.3 Washington Apple Health (Medicaid) Benefits

All services are subject to benefit coverage, limitations, and exclusions. **For the most current guidelines, please refer to HCA guides for covered benefits and details.** Some services require prior authorizations, which can be verified on the Coordinated Care Pre-Auth Check tool.

For behavioral health providers that serve Integrated Managed Care, Integrated Foster Care, or Behavioral Health Services Only Members, please also refer to the Service Encounter Reporting Instructions (SERI) Guide maintained by Health Care Authority.

Washington Apple Health Expansion Benefits

All services are subject to benefit coverage, limitations, and exclusions. **For the most current guidelines, please refer to [HCA guides](#) for covered benefits and details.** Some services require prior authorizations, which can be verified on the Coordinated Care Pre-Auth Check tool.

Apple Health Expansion members are not covered for benefits operated by other state agencies as Medicaid State Plan services (not allocated in other state agency budgets) including:

- Intermediate Care Facilities/ICF (DSHS)
- Private Duty Nursing for Adults, including 19-20y* (DSHS/DDA)
- Behavioral Rehabilitative Services/BRS (DCYF)
- Medicaid Personal Care/MPC (DSHS)
- Community First Choice (1915k SPA authority) (DSHS)
- Targeted Case Management operated by DOH/DSHS/DCYF (including HIV/AIDS Case Management operated by DOH)

> Intensive Behavioral Supportive Supervision (IBSS) (as this ILOS supports 1915i and it is not applicable to Apple Health Expansion); Note: Future In Lieu Of Services will be considered for Apple Health Expansion appropriateness.

> Assisted Suicide (directed to mirror Medicaid)

> Health Homes

Differences in Coverage from Apple Health			
Category	Covered Services		Not Covered Services
	Covered & Carved In	Covered & Carved Out (and who covers)	Not Covered (and why)
General Scope of Services	Health care for young adults: Defined services carved in to plan and paid by HCA budget to mirror IMC covered for Apple Health Expansion (for 19-20 year olds) *Note: 0-18yr is not applicable to contract due to age range of Apple		EPSDT-like requirements and EPSDT-like benefits for SPA services covered by other state agencies (not funded for Apple Health Expansion young adult services) Benefits operated by other state agencies as Medicaid State Plan services (not allocated in other state agency budgets): including - Intermediate Care Facilities/ICF (DSHS)

	Health Expansion contract being 19yr+		<ul style="list-style-type: none"> - Private Duty Nursing for Adults, including 19-20y* (DSHS/DDA) - Behavioral Rehabilitative Services/BRS (DCYF) - Medicaid Personal Care/MPC (DSHS) - Community First Choice (1915k SPA authority) (DSHS) - HIV case management (DOH) Intensive Behavioral Supportive Supervision (IBSS) (as this ILOS supports 1915i and it is not applicable to Apple Health Expansion); <p>*Note: Future In Lieu Of Services will be considered for Apple Health Expansion appropriateness.</p> <p>Health Homes</p>
General Physical Health	<p>*Note: CPE is not applicable to this population.</p> <p>*Note: Apple Health Expansion eligible clients who are incarcerated will have eligibility suspended (similar to Medicaid prior to MTP 2.0) thus hospitalizations for inpatient care of enrolled and suspended clients is covered and contracted when admission occurring during the month of enrollment.</p>		<p>Physical health benefits, including</p> <p>*Note: habilitation benefits are not applicable to this population. Services offered under this program are available under the rehabilitation benefit.</p>

Behavioral Health	IMD settings of all lengths of stay (unless in state contracted LTCC facilities), no recoupment process/all GFS paid		*Note: BHSO is not applicable to this population.
Dental			
Long-Term Care		<p>Long-Term SNF (DSHS/HCS)</p> <p>When it is not medically necessary (Long-Term Care) (Note: DSHS is funded for a limited number of beds – 42 beds – and a waiting list for these services may exist)</p>	
Pharmacy	Apple Health Expansion PDL Pharmacy		
Medical Transportation			
Waiver Services			<p>Medicaid Waiver Services (Waiver authority does not include population), including:</p> <p>Medicaid Transformation services (e.g., Re-entry & HRSN services)</p> <p>1915c Home and Community Based Services (HCBS)</p> <p>1915b for Behavioral Health Services Only (BHSO) program</p> <p>1915i for Supportive Supervision and Skills Restoration</p>

9.4 Non-Emergency Medical Transportation

Non-Emergency Medical Transportation (NEMT) is a covered benefit for all Apple Health (Medicaid) beneficiaries and Apple Health Expansion members, including Coordinated Care members, who have no other way to get to their healthcare appointments. *It is important to note that NEMT services and the provision of NEMT are coordinated through HCA's network of regional transportation brokers.* HCA pays for transportation services to get members to and from needed non-emergency healthcare appointments, (www.hca.wa.gov). Coordinated Care members who need to arrange NEMT services must do so through the regional transportation broker serving the county in which the member resides. Members should contact the regional broker directly to arrange NEMT services at least 7 to 14 days in advance of their scheduled healthcare appointment.

Members or providers can call DSHS directly with any questions or concerns regarding non-emergency medical transportation services at 1-800-562-3022. The transportation provider is required to ensure the member arrives on time for their medical appointment, but no more than one (1) hour before the scheduled appointment time. For the ride home following an appointment, the member should not have to wait more than one (1) hour from the time they call the driver for the ride home.

Coordinated Care requests its participating providers, and the regional transportation brokers, to inform our Member Services department when a member misses a transportation appointment so that it can monitor and educate the member on the importance of keeping medical appointments.

Note: There is a county-by-county list of the Regional Brokers on the HCA website complete with toll free numbers, web addresses, and faxes. The web address is www.hca.wa.gov/medicaid/transportation/pages/phone.aspx.

9.5 Early Periodic Screening Diagnosis and Treatment (not an Apple Health Expansion benefit)

The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program is Apple Health (Medicaid)'s comprehensive and preventive child health program for individuals under the age of 21. EPSDT is a mandated benefit for all Apple Health (Medicaid) recipients in accordance with state and federal law. EPSDT services include periodic screening, including physical, mental, developmental, dental, hearing, vision and other screening tests to help identify potential physical and/or behavioral health conditions. In addition, diagnostic testing and medically necessary treatment to correct or improve physical and mental illnesses or conditions are also available through the EPSDT program. EPSDT encourages early and continuing access to health care for children and youth. EPSDT-like requirements and EPSDT-like benefits for State Plan Amendment (SPA) services covered by other state agencies are not funded for Apple Health Expansion young adult services.

Coordinated Care and its providers will provide the full range of EPSDT services as defined and in accordance with Washington state regulations and HCA policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up-to-date immunization using the Advisory Committee on Immunization Practices'

(ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventive and well-child care. This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein. The following minimum elements are to be included in the EPSDT periodic health screening assessment:

- Comprehensive health and developmental history (including assessment of both physical and mental development)
- Comprehensive unclothed physical examination
- Appropriate behavioral health and substance use disorder screening
- Immunizations appropriate to age and health history
- Laboratory tests, including blood lead screening. All children 12 – 24 months of age should be tested for the risk of lead poisoning. This testing is a Federally mandated preventative health benefit.

For more information, please visit the Department of Health's website:

<https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/ProfessionalResources/BloodLeadTestingandReporting>

- Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses
- Dental screening and services
- Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids
- Health education, counseling and anticipatory guidance based on age and health history

EPSDT screening elements must be performed or ordered for the visit to be considered an EPSDT screening. Providers must clearly document the provision of all components of the EPSDT benefit in the member's medical record.

If a recommendation for non-covered services comes as the result of an EPSDT the requesting provider should submit a Prior Authorization form supporting medical necessity and/or including medical documentation. Coordinated Care will review and approve, if medically necessary. If denied for medical necessity, appeal rights are provided.

Coordinated Care requires providers to fully cooperate with Coordinated Care's and HCA's efforts to improve the health of Washington citizens, and to actively assist increasing the number of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. Coordinated Care will cooperate and assist providers to identify and immunize all members whose medical records do not indicate up-to-date immunizations.

Providers shall participate in the Medicaid Vaccines for Children (VFC) program. Refer to the Immunizations section for billing information.

Apple Health Core Connections Requirements:

- Children in an initial foster care placement require an Initial Health Screen by a medical provider within five (5) calendar days to identify and address any medical concerns.

Foster Care Initial Health Screen Form is used to document an Initial Health Screen (HCA form 13-843).

- If an EPSDT / Well-Child exam can be completed within the first five (5) calendar days, then the Initial Health Screen is not necessary.
- Each child who is new to foster care must receive an EPSDT exam within thirty (30) calendar days of placement.
- Appointment and documentation must be completed within 30 days of the youth being removed from their home.
- Bill as EPSDT exam, not as establishing care or office visit.
- There is no benefit maximum on EPSDT exams.
- Payment for the EPSDT will be made even if the provider is not the assigned PCP.
- EPSDT exams for foster youth are reimbursed at a higher rate with Modifier TJ.

Case worker, caregiver/parent, members or providers can call or email AHCCTeam@coordinatedcarehealth.com to request help with a specific need, from the Coordinated Care Health Care Coordination team.

EPSDT and CHET (this does not apply to Apple Health Expansion members)

Child Health Education and Tracking (CHET) Specialists at the Department of Children, Youth and Families (DCYF) will require a copy of the EPSDT to put into the state-required Child Health Education and Tracking (CHET) screening. There are specific regulatory requirements associated with the CHET Screening that require cooperation from providers as follows:

- Completed CHET report is **due thirty (30) days** from the day a youth enters foster care
 - We encourage your organization to consider a process to ensure copies are sent to CHET Screeners promptly. Larger provider organizations with centralized filing systems may want to designate a point person to handle CHET record requests.
- CHET report must include the record from the EPSDT well-child exam
 - Exam must be billed only as EPSDT
- CHET Screeners will send a fax request noting WAC 182-502-0020, which authorizes them to receive records
 - It's critical to send records as soon as possible
- Finally, a complete EPSDT record that fulfills the state requirement must include all of the following:
 - Vitals
 - Review of symptoms
 - Include any abnormal findings
 - Recommendations/Referrals
 - Including anticipatory guidance
- Make sure all referrals are in Coordinated Care's network
- Tribes may or may not do CHET screenings.

If you need any help in ensuring that recommendations are followed up on from the EPSDT please call 1-844-354-9876 or email AHCCTeam@coordinatedcarehealth.com to request assistance from the Health Care Coordination team.

Foster Care Centers of Excellence

Coordinated Care is working to certify Foster Care Centers of Excellence (COE) in each region of Washington state. COEs are recognized as multi-disciplinary medical centers where youth in the child welfare system can receive coordinated healthcare services. To qualify as a COE, a healthcare provider must meet more than 50 criteria, including customized program processes and staff requirements, such as annual training in trauma-informed care.

Through the COE designation, providers serve as a coordinated entry point for healthcare by providing:

- Early and Periodic Screening, Diagnosis and Treatment within 30 days of entering care
- Behavioral health services
- Referrals to specialists
- Assistance with securing medical equipment
- Prescriptions
- Lab tests and x-rays

COEs can refer youth to Coordinated Care Health Care Coordination for additional support as needed. As a COE, the provider will also meet regularly with the Washington State Department of Children, Youth, & Families and Coordinated Care to ensure quality delivery of care and continuous process improvement.

For more information on Foster Care Centers of Excellence please email AHCCTeam@coordinatedcarehealth.com

9.6 Emergency Care Services

Definition of Emergency Medical Condition

Coordinated Care defines *emergency medical condition* consistent with the Washington Health Care Authority as follows:

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 the following: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. (42 U.S.C. 1396-u2(b)(2)(C), as amended).

Definition of Emergency Care for Behavioral Health Condition

Emergency Care for Behavioral Health Condition means services provided for an individual, that, if not provided, would likely result in the need for crisis intervention or inpatient hospital admission due to concerns of potential danger to self, others, or grave disability.

Members may access emergency services at any time without prior authorization or prior contact with Coordinated Care. If members are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Provider (PCP) and/or

Coordinated Care's 24-hour Nurse Advice Line at 1-877-644-4613 (TTY: 711) for assistance. However, this is not a requirement to access emergency services.

Emergency services are covered by Coordinated Care when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Coordinated Care. Emergency services will be covered and will be reimbursed regardless of whether the provider is in Coordinated Care's provider network. Coordinated Care will not deny payment for treatment obtained under either of the following circumstances:

- A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition; or
- A representative from the Plan instructs the member to seek emergency services.

Once the member's emergency medical condition is stabilized, Coordinated Care requires notification for hospital admission or Prior Authorization for follow-up care as noted elsewhere in this handbook.

9.7 Women's Health Care Benefits

"Women's Health Care Services" is defined to include, but not be limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. For Apple Health Expansion eligible individuals who report being pregnant, they may contact the Health Care Authority to learn about other Women's Health Care coverage options through the Fee For Service Apple Health for Pregnant Individuals program. General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations. Women's health care services also include any appropriate health care service for other health problems discovered and treated during the course of a visit to a women's health care practitioner for women's health care service, and which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by Coordinated Care, women's health care services include contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding and complications of pregnancy.

All pregnant members who are covered under Washington Apple Health (Medicaid) are eligible to receive Maternity Support Services (MSS) through the First Steps program. First Steps is a preventive health program designed to ensure healthy birth outcomes. MSS is voluntary and offers a variety of services for low-income pregnant members to help them have a healthy pregnancy and a healthy baby. Some services include:

- A screening and assessment to determine risk factors
- Patient centered interventions for determined risk factors
- Brief counseling
- Basic health messages related to pregnancy and infant care
- Referral to community resources

MSS can be provided in the clinic, at the patient's home, or in a community setting, and they are provided by an interdisciplinary team who coordinates and supports the medical provider's plan of care for the pregnant member and/or infant. This team includes a:

- Community Health Nurse
- Doula
- Behavioral Health Specialist
- Registered Dietitian
- Community Health Worker (some locations)

After the infant is born and MSS has ended, the family may be eligible to receive Infant Case Management (ICM) services to help them learn about and how to use needed medical, social, educational and other resources in their community so the baby and family can thrive.

If you would like more information about First Steps, or to find a provider in the area, visit hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/first-steps-maternity-and-infant-care. You can also direct your patients to this website or refer them to Coordinated Care at 1-877-644-4316. Coordinated Care recommends that all pregnant members be referred to the First Steps program.

9.8 Family Planning

Family Planning services, including testing, screening and contraceptives, are covered for all Coordinated Care members. Members can obtain family planning services through their own PCP, local departments of health, or they can go to any family planning service provider – whether in or out of network – without a referral or prior authorization. Family planning services include examinations, assessments, traditional contraceptive services, preconception and inter-conception care services. Coordinated Care will make every effort to contract with all local family planning clinics and providers and will ensure reimbursement whether the provider is in or out of network.

The Affordable Care Act (ACA) has helped make prevention more affordable and accessible for all Americans by requiring health plans to cover preventive services, as well as eliminating cost sharing for those services. This includes coverage for over-the-counter (OTC) emergency contraceptives as well as Long-Acting Reversible Contraception (LARC) at no cost to our members as required by law:

Provider-assisted Long-Acting Reversible Contraception (LARC) methods as well as services related to prescribed method, with no authorization:

- Intrauterine devices (IUD)
- Hormone contraceptive injections
- Inserted contraceptive devices
- Implanted contraceptive devices
- Shot/injections

Members can receive all Over the Counter (OTC) contraceptives without a prescription. This includes but is not limited to condoms, spermicides, sponges, and any emergency contraceptive drug that is FDA-approved to be dispensed over the counter. There are no limits

to these OTC contraceptives. OTC contraceptives must be covered without authorization or quantity limits.

Providers are encouraged to write a prescription for contraceptives to dispense a 12-month supply. Members may receive a 12-month supply of contraceptives at one time.

9.9 Obstetrical Care

Coordinated Care members who are pregnant have direct access to prenatal/maternal (obstetrical) care providers and do not need to obtain a referral from Coordinated Care or their PCP to seek care from an obstetrical care provider. Apple Health Expansion members who report being pregnant are referred to the Health Care Authority to determine if the Apple Health Pregnant Individuals program is appropriate. Apple Health Expansion members may transition to the Apple Health for Pregnant Individuals and After Pregnancy coverage or may maintain Apple Health Expansion coverage.

9.10 Identifying Pregnant Members

Coordinated Care relies on our providers to inform us of the pregnant members they are treating. Coordinated Care has developed a Notification of Pregnancy (NOP) process specifically to assist providers in helping us to identify pregnant members. By informing us of the member's pregnancy, we can better assist the provider to identify members who might be at risk for complications. We also work to establish a relationship between the member, the obstetrical care provider, and health plan staff as early as possible. **We require all providers to notify Coordinated Care when prenatal care is rendered for the first time.** This notification should occur through completion and submission of the **Notification of Pregnancy (NOP)** form, which assesses more than 20 obstetric history factors and can be downloaded from our website.

Completion of the NOP will enroll the member in the Start Smart for Your Baby® program and, if completed at least 6 weeks prior to the due date, the member will receive a free car seat, Pack n' Play, or stroller. Providers can notify us online, via fax, mail, or telephone as soon as they become aware of a pregnancy. Early notification of pregnancy allows us to assist the member with prenatal care coordination of services.

Pregnant members identified as high risk will be referred to our Maternal Health Integrated Care Team (ICT) for follow-up and management. The Notification of Pregnancy (NOP) Form can be found on the secure portal via our website <http://www.coordinatedcarehealth.com/>.

Members may also complete the NOP form by calling the Member Services department. We also encourage our members to notify us when they are pregnant through ongoing educational programs and member outreach efforts (such as member newsletters) to keep members informed about the importance of early prenatal care and the benefits of the Start Smart program. Any Population Health and Clinical Operations or Member Services staff person who identifies a pregnant member will help them complete the NOP form. We will use this information to stratify and determine intensity of interventions in coordination with the member's primary obstetrical care provider.

We may also identify pregnant members through other sources including routine review of enrollment information supplied by the State of Washington and monthly claim reports that indicate pregnancy diagnoses or prenatal vitamin prescriptions. When we identify a member with an unconfirmed pregnancy, we send audio postcards to the member describing our Start Smart for Your Baby® Program and encourage them to call our toll-free number if they are pregnant.

9.11 Prenatal Care from Out of Network Providers (not an Apple Health Expansion benefit)

For pregnant members (does not apply to Apple Health Expansion members) at high risk for complications, particularly those with serious mental illness or developmental disabilities, Coordinated Care's policy emphasizes the critical importance of early and consistent prenatal and postnatal care for the health of women and their children. *We allow out-of-network prenatal and postpartum care with an authorization to all pregnant members who enroll with Coordinated Care in their second trimester of pregnancy, offering them the option to remain with their out-of-network obstetrical care provider for the duration of their pregnancy and postpartum care.* Additionally, we do not require medical necessity review for prenatal or postpartum care.

9.12 Wraparound with Intensive Services (WISe)

Wraparound with Intensive Services (WISe) means a range of services that are individualized, intensive, coordinated, comprehensive, culturally competent, and provided in the home and community. The WISe Program serves children and youth, under the age of 21, who are experiencing mental health symptoms that are causing severe disruptions in behavior and/or interfering with their functioning in family, school, or with peers requiring: a) the involvement of the mental health system and other child-serving systems and supports; b) intensive care collaboration; and c) ongoing intervention to stabilize the youth and family in order to prevent more restrictive or institutional placement. Note, WISe only applies to Apple Health Expansion members ages 19-20 because Apple Health Expansion is only available to individuals ages 19+. Providers that deliver this important covered service must:

- Adhere to the most current version of the WISe Manual maintained by the Health Care Authority (<https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf>).
 - Coordinated Care will only make WISe payments if both of these requirements are met:
 - Receipt and validation of a T1041 encounter with a U8 modifier and
 - Receipt and validation of a qualified service encounter as outlined in the SERI, published by the Health Care Authority.
- Participate in all WISe-related quality activities as directed by the Health Care Authority or Coordinated Care, including a review of WISe services conducted using the WISe Quality Improvement Review Tool (QIRT).
- Complete WISe attestation to become a WISe provider
- Conduct a Child Adolescent Needs and Strengths (CANS) screening for every child and youth referred for WISe services and submit the screening results to the health plan for

all members that did not meet algorithm to enroll in WISE. WISE providers may use the early childhood version of the CANS, referred to as the CANS B-5 for children under the age of six.

- In order to meet Health Care Authority WISE reporting requirements, providers must still submit member rosters to SOCTeam@coordinatedcarehealth.com or through SFTP by the 5th of each month. There are no changes to roster reporting requirements.
- Training on providing WISE services to children birth to age five is available via [The Bridge](#)
- For more information on WISE services go to the [WISE Workforce Collaborative](#) website.

Behavior Rehabilitation Services (BRS) and WISE Screens

WISE screens are required for all youth entering Behavior Rehabilitation Services (BRS), at 6 month intervals once in BRS and at discharge from BRS.

BRS WISE screens should be done by WISE providers and can occur telephonically.

Starting January 1, 2020, WISE providers will be able to offer WISE services to children and youth who screen eligible that are entering BRS or screen eligible at their 6-month screen.

Apple Health Expansion members are not eligible for BRS.

9.13 Alien Emergency Medical

Per [WAC 182-507-0115](#) Alien emergency medical program (AEM), a person nineteen years of age or older who is not pregnant and meets the eligibility criteria under [WAC 182-507-0110](#) is eligible for the AEM's scope of covered services. AEM is a FFS program for individuals who have a qualifying medical emergency and do not qualify for any other Apple Health program due to citizenship/immigration requirements under [WAC 182-503-0535](#). This includes qualified aliens who have not met the 5-year and are not exempt from the 5-year bar, nonpregnant nonqualified aliens, and undocumented individuals who don't qualify for Apple Health Expansion. To qualify for FFS AEM, an individual must have or need at least one of the following:

- A qualifying emergent medical condition such as emergency room care, inpatient admission, or outpatient surgery;
- A cancer treatment plan;
- Dialysis treatment;
- Antirejection medication for a past organ transplant;
- Assessment and treatment of COVID-19 as a qualifying emergency ended with the public health emergency on May 11, 2023.

There is no precertification or prior authorization for eligibility under this program. Eligibility for the AEM program does not have to be established before an individual begins receiving emergency treatment. Under AEM, certification is only valid for the period of time the person is

receiving services. Providers must not bill for visits or services that do not meet the qualifying criteria.

Individuals who qualify for Apple Health Expansion receive coverage for the same benefit categories as AEM (emergency medical care, cancer treatment, dialysis, and anti-rejection drugs) through Apple Health Expansion Emergency Medical Care (AHE-EMC). Note, retroactive enrollment to prior months does not apply to Apple Health Expansion. If a hospitalization occurs during the month Apple Health Expansion coverage is established, it is covered by the Apple Health Expansion Plan. If the date of admission occurs in the month prior to enrollment in Apple Health Expansion, then AEM applies to that admission not AHE-EMC.

9.14 Health-Related Social Needs

Intensive Behavioral Supportive Supervision (IBSS)

A new program as of January 1, 2024, Intensive Behavioral Supportive Supervision (IBSS) is a voluntary In Lieu of Service (ILOS) available to Apple Health (Medicaid) clients enrolled with a managed care organizations (MCO) who have complex behaviors and cognitive impairment experiencing high risk of institutionalization and hospitalization and requiring direct staffing supports to prevent harm to self or others.

What is IBSS?

- In person monitoring, redirection, diversion, cueing to prevent high risk behaviors – staffing to support the individual’s behavior stabilization in community residential settings.
- Person-centered assistance to build skills and resiliency to support stabilized living and integration.
- Interventions that are not direct personal care.

Prior Authorization is required for using IBSS. Clients must meet specific target population and coverage criteria as defined in the Health Related [Social Needs \(HRSN\) Policy Guide](#). Further information about IBSS can be found in the [HCA guide to IBSS](#).

Community Behavioral Health Support (CBHS)

Community Behavioral Health Support (CBHS) services is a new program beginning July 1, 2024. This benefit will help people who have a significant mental health diagnosis and need additional support to live in a community setting like an adult family home, assisted living facility, or residential living facility providing enhance or clinical stabilization services.

This new service will replace Behavioral Health Personal Care (BHPC) managed care organization (MCO) wrap-around funding. Throughout the next year, home and community services will stop authorizing BHPC in a residential facility at the time the resident’s CARE assessment is due for renewal. A CARE assessment completed annually by HCS will now be submitted along with a request for CBHS to Coordinated Care for our membership.

More information about this new program, including how to apply to provide services and how to request services can be found at [Health Care Authority CBHS information for Providers](#)

Medical Respite Care

Medical Respite Care (recuperative care and short term post hospitalization) is a new program under the 1115 Waiver beginning July 1, 2025. This benefit provides a safe and stable place for eligible individuals to receive treatment on a short term basis who are transitioning out of institutions and are at risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits.

More information about Medical Respite Care and the 1115 Waiver can be found at [Health Care Authority's Medicaid Transformation Project](#).

9.15 In Lieu of Service

In Lieu of Services is an Apple Health service that allows MCOs to substitute a non-covered service for a **contracted covered service if it meets the following criteria:**

- Medically appropriate;
- Cost effective: In Lieu of Services must meet program-wide cost-effective requirements; and
- Voluntary: The MCO is not required to offer, and the client is not required to accept a service "in lieu of" a covered service.

IBSS became available under ILOS in January 2024. This service is administered by MCOs and available to all Apple Health clients who meet the clinical criteria and are enrolled in Integrated Managed Care (IMC) or Behavioral Health Services Only (BHSO).

010 VALUE ADDED SERVICES FOR MEMBERS

10.1 Coordinated Care Harvest Bucks™

This is Coordinated Care's fruit & vegetable prescription program in partnership with the Washington State DOH and Safeway. The program is designed to address food insecurity by increasing access to fruit and vegetables. Members are eligible for prescription vouchers valued at \$10 each. Vouchers can be used to buy fresh, canned (no added sugar or salt), and frozen vegetables at any Safeway in Washington. Call 1-877-644-4613 (TTY: 711) or send questions to foodRx@CoordinatedCareHealth.com.

10.2 24/7 Nurse Advice Line

We offer a 24-hour nurse advice line to help members proactively manage their health needs, decide on the most appropriate care, and encourage members to talk with their physician about preventive care. The toll-free number for Apple Health (Medicaid) members is 1-877-644-4613 (TTY: 711) or for Apple Health Core Connections members 1-844-354-9876 (TTY: 711).

The nurse advice line is *always open and always available* for members. Registered nurses provide basic health education, nurse triage, and answer questions about access to urgent and emergent care services, using nationally recognized protocols. The nurse advice line will refer

members with chronic problems, like asthma or diabetes, to our case management or Member Services for follow-up assistance, education, and encouragement to improve their health. Members can call the nurse advice line to request information about providers and services available in the community after hours, when the Coordinated Care Member Services department is closed. The nurse advice line staff are proficient in both English and Spanish and can provide additional translation services if necessary.

10.3 Member Rewards Program

The Coordinated Care rewards program is a member incentive program widely used to promote personal healthcare responsibility. The program is designed to increase utilization of preventive services by rewarding members for completing a healthy activity.

Members receive reward dollars on a prepaid card that they can use to pay for:

- Utilities
- Transportation
- Telecommunications
- Childcare services
- Education
- Rent

Or

- Shop for everyday items at Walmart stores across Washington.

When a member completes a qualifying activity, we load the reward onto a health plan-issued rewards card. Our rewards program supports the positions taken by the American College of Physicians for ethical use of incentives to promote personal responsibility for health. Visit www.CoordinatedCareHealth.com/rewards for details.

10.4 Member Cell Phone Program (not an Apple Health Expansion benefit)

The Cell Phone Program includes minutes, data, and unlimited texting. In addition, calls to Coordinated Care's Member Services line or our 24/7 Nurse Advice line do not count towards minutes. Most Coordinated Care members* are eligible for this federally funded Lifeline program.

**Members under the age of 18 in a foster care out-of-home placement are not eligible for this program. CHIP is not eligible.*

Eligible Members receive:

- Minutes, data and unlimited text messages.
- The ability to make and receive calls from doctors, nurses, 911, family and friends.
- Communication access 24 hours a day.
- Calls to Coordinated Care toll-free number, 1-877-644-4613 (TTY: 711), will not count towards minutes.

10.5 MemberConnections®

MemberConnections® is Coordinated Care's program designed to inform our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. MemberConnections® is integrated with our care management program. We recruit staff from the local community being served to establish grassroots support and awareness of Coordinated Care programs and resources within that community.

MemberConnections® staff are trained as non-clinical, Community Health Workers (CHW). Coordinated Care's CHWs support our care management team, working closely with both physical and behavioral health staff. CHWs provide care coordination, health coaching, in person member and community support, and provide community resource information.

Members can be referred to MemberConnections® through various sources, including our Member Services department, and care managers who know a member would benefit from MemberConnections® support. Providers may request MemberConnections® referrals directly to the CHW team by emailing ccw_chw@coordinatedcarehealth.com or through their assigned care manager. Community groups may request that a CHW come to their facility to present to groups or at special events or gatherings.

10.6 ConnectionsPlus®

ConnectionsPlus® is a part of the MemberConnections® program that provides temporary, no-cost, cell phones and cell service, to select high-risk members, as identified by our Population Health and Clinical Operations team, who do not have safe, reliable access to a telephone and are not eligible for the federally funded Lifeline program or have an immediate need for phone communication to coordinate their care. Through our ConnectionsPlus® Program, we provide cell phones to certain high-risk members who have complex conditions and or social needs. We pre-program the phones with important telephone numbers, such as their PCP office number, other treating physicians, Coordinated Care contact numbers, the nurse advice line, and 911. By ensuring a member has reliable phone access, we provide them with the means to contact key individuals on their health care team and empower them to take an active part in their health care journey and care coordination.

10.7 Start Smart for Your Baby® (SSFB) (does not apply to Apple Health Expansion)

SSFB is a comprehensive program for pregnant members to promote healthy pregnancies and births. The objective of our SSFB program is to reduce the risk factors to pregnant and/or lactating mothers and newborn infants.

Interventions: We educate and provide access to resources by offering pregnancy support in all areas including medical, social, emotional, and infant care. The goal of our SSFB program is healthy pregnancies, deliveries and infants accomplished by identifying and impacting any risk factors.

SSFB program route of Delivery: The SSFB program is a Telephonic Case Management program consisting of Registered Nurses with experience in Obstetrics and NICU care. Participating members (does not apply to Apple Health Expansion members) get a breast pump and a choice between a car seat, pack and play or stroller if a Notice of Pregnancy form

is completed 6 weeks prior to their due date. Text4Baby program is available for members to opt-in and receive weekly messages about pregnancy, breastfeeding, labor, and delivery, eating healthy, newborn care and development timed with the members delivery date and/or baby's age.

10.8 Pacify (not an Apple Health Expansion benefit)

Coordinated Care offers membership to Pacify at no cost, to support our members from pregnancy to parenthood. Through the Pacify app, they can connect 24/7 with Birth Doula's via video, lactation consultants, crisis help line, and educational resources, in addition to connecting with Care Management from 8am to 5pm PST, M-F, to help find a doctor, assist with benefits, or scheduling appointments.

10.9 After-Pregnancy Coverage (APC) (not an Apple Health Expansion benefit)

Apple Health (Medicaid) After-Pregnancy Coverage (APC) offers services to help members recover mentally, physically, and emotionally after a pregnancy in the last 12 months.

Apple Health Expansion members who complete a NOP will be disenrolled from the Apple Health Expansion plan and enrolled in FFS Apple Health for Pregnant Individuals and FFS Apple Health for After-Pregnancy.

Apple Health Expansion members who do not report being pregnant receive coverage for the birth and are then disenrolled from Apple Health Expansion and enrolled in FFS Apple Health After Pregnancy Coverage.

Benefits and Services

APC offers postpartum follow-up care and provides additional services including dental, contraception, preventive care, behavioral health, and other services covered by Apple Health up to 12 months after a member's pregnancy ends. Visit hca.wa.gov/apple-health-services to learn what services are covered under Apple Health. Learn more at hca.wa.gov/apc.

10.10 Healthy Beginnings Program for Addiction in Pregnancy (not an Apple Health Expansion benefit)

Coordinated Care assists pregnant patients and their doctors with support for substance use in pregnancy, with our Healthy Beginnings (HB) program which is a program under Start Smart for Your Baby® (SSFB). Heroin, prescription narcotics, methamphetamines, opioids, and many other substances are used in pregnancy today more than ever.

Objectives: Coordinated Care wants to make a positive impact on important measures such as infant mortality and low birth weight by supporting our pregnant members with these pregnancy challenges. A more collaborative effort is necessary if we are going to affect lives. We are partnering with OB providers to make sure we can remove barriers to identification and care of our shared pregnant women using drugs or alcohol.

Route of Delivery: We contact OB/Provider offices and pregnant members to identify their needs in this area and to review our programs.

Interventions: Healthy Beginnings (HB) members will enjoy all the same benefits of the Start Smart for Baby® (SSFB), with additional support, benefits and resources specific to their pregnancy.

A member is enrolled after the completion of a notification of pregnancy (NOP) assessment, that can be filled out by the member, the member's provider (NOP form available on Coordinated Care's secure portal) or download from the public site; or member will be contacted by Coordinated Care SSFB outreach team to complete the NOP over the phone.

Referrals: Members and providers can call 1-877-644-4613 (TTY: 711) and ask for SSFB Team. The team can fill out the NOP over the phone, then load it into the member's electronic file and enrollment has begun. Referral requests can also be emailed to WASSFB@centene.com

10.11 Adult Eyeglasses

Coordinated Care offers \$100 toward eyeglasses or contacts for members ages 21+. The \$100 allowance is provided every other year and is outside of the fitting fee. Members must go to an in-network Centene Vision Services vision provider. Members can use their \$100 allowance toward any eyeglasses or contacts available through the Centene Vision Services provider.

Note: For members who are incarcerated, access to VABs can vary. Members can call Coordinated Care at 1-877-644-4613 (TTY: 711) for more information.

11 POPULATION HEALTH AND CLINICAL OPERATIONS

11.1 Overview

Population Health and Clinical Operations (PHCO) hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m. Pacific Time (excluding holidays). Calls made to our PHCO department after normal business hours, on weekends, and holidays are automatically routed to Coordinated Care's after-hours nurse advice line. Nurse advice staff are made up of RNs who can answer questions about prior authorization requirements and offer guidance to members regarding urgent and emergent needs. The care management team reviews all calls handled by the nurse advice line and provides a follow-up call to members the next business day regarding their health concerns. PHCO services include the areas of utilization management, care management, behavioral health, care coordination, and disease management. The PHCO department seeks to provide resources that will provide members with the most efficient and cost-effective health options to improve their overall healthcare and well-being. The department's clinical services are overseen by the Coordinated Care Medical Director who has responsibility for direct supervision and operation of the department. To reach the Medical Director of Population Health and Clinical Operations call 1-877-644-4613 (TTY: 711).

11.2 Utilization Management

The Coordinated Care Utilization Management (UM) program is designed to ensure members receive access to the right care at the right place and right time. Our UM department supports the health plan in healthcare management by evaluating medical necessity, appropriateness,

and efficient use of health care services, resources, and facilities. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UM program incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, post-acute care, psychiatric care, substance use disorder care, short-term care, and ancillary care services.

Coordinated Care does not specifically reward practitioners or other individuals for issuing denials of coverage. UM decision-making is based only on appropriateness of care and service and existence of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Our UM initiatives are focused on optimizing each member's health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing utilization trends. The UM program aims to provide Covered Services that are medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Our UM program goals include:

- Monitoring utilization patterns to guard against over- or under-utilization.
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction.
- Identification and provision of case and/or disease management for members at risk for significant health expenses or ongoing care.
- Development of an infrastructure to ensure that all Coordinated Care members establish a relationship with their PCP to obtain preventive care.
- Implementation of programs that encourage preventive services and chronic condition self-management.
- Creation of partnerships with members/providers to enhance cooperation and support for UM goals.
- Focus for members and their families' centers on promoting resiliency and hope.
- Recognize and respect the cultural needs of diverse populations as reflected in Health Disparities, risk factors (such as ACEs for members of any age), Historical Trauma, and the need for Culturally Appropriate Care.
- Monitoring and ensuring parity between behavioral health and medical processes and procedures in utilization management.
- Ensuring cultural appropriateness of services and procedures for all members.

Access to Staff

- UM staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
- UM staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.
- TTY services are available for members who need them.
- Language assistance is available for members to discuss UM issues.
- UM Staff can receive inbound communication regarding UM issues after normal business hours. UM staff can be reached via our toll-free number 1-877-644-4613 (TTY:

711). Communications received after normal business hours are returned on the next business day and communications received after midnight on Monday–Friday are responded to on the same business day. For members who request language services, the organization provides language services, free of charge, in the requested language through bilingual staff or an interpreter.

Continuity of Care: When members are either newly enrolled and have been previously receiving services or have received emergency care or services Coordinated Care will continue to authorize care as needed to minimize disruption and promote continuity of care. Coordinated Care will work with non-participating providers (those that are not contracted and credentialed in Coordinated Care’s provider network) to continue treatment or create a transition plan to facilitate transfer to a participating Network Provider. In the event of a change of MCO for the member during an episode of care, the health plan will work with the provider and the new MCO to ensure any needed continued authorization of care that is medically necessary is in place.

Non-Covered Benefits: Providers can request coverage of non-covered benefits by submitting an exception to the rule (ETR) form and all applicable medical records to support the need for the benefit. ETR requests are reviewed in accordance with WAC 182-501-0160. A member does not have a right to a fair hearing on ETR decisions. Non-Covered DME (Durable Medical Equipment) is not reviewed under the ETR process. DME will be reviewed per standard Prior Authorization review process.

The request must meet the following criteria to be approved:

- The service cannot be excluded under state statute
- Falls within accepted standards and precepts of good medical practice
- Represents cost-effective use of public funds
- Includes member-specific information and documentation which demonstrates that the member’s clinical condition is so different from the majority that there is no equally effective, less costly covered service or equipment that meets the member's needs
- Includes documentation that medical treatment or items of service which are covered under the member's benefits and which, under accepted standards of medical practice, are indicated as appropriate for the treatment of the illness or condition, have been found to be:
- Medically ineffective in the treatment of the member's condition; or
- Inappropriate for that specific member.

Requests for members 20 years old and under will be reviewed using WAC 182-534-010, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). This is applicable to Apple Health Medicaid members only. Requests for Apple Health Expansion members 19 years of age and older will be evaluated through ETR.

11.3 Prior Authorization and Notifications

Prior authorization (PA, or Pre-Auth) is a request to the Coordinated Care Utilization Management (UM) department for approval of certain services before the service is rendered. Authorization must be obtained prior to the delivery of certain non-emergent and scheduled

services. Our website offers a Pre-Auth Check tool that provides authorization requirements at the billing code level. Authorizations can be submitted through the secure web portal or by use of a fax form available on our website under Provider Resources. Fax forms are preferred for behavioral health authorization requests. When utilizing a fax request form, failure to entirely complete the required fields may result in rejections, delays, or denials. **Prior authorization should be requested at least five (5) business days before the scheduled service delivery date or as soon as need for service is identified.**

The below table provides examples of services that may require Coordinated Care's prior authorization (*refer to the Pre-Auth Check tool on the Coordinated Care website for definitive requirements*):

ANCILLARY SERVICES
<ul style="list-style-type: none"> • Pharmacy and Medical Pharmacy, see Pharmacy Services section for more information. • High dollar DME/Orthotics/Prosthetics • TPN and Oral Enteral Nutrition • Non-covered DME and Supplies (ETR no longer applies to non-covered DME and non-durables) • Home healthcare services including home hospice, skilled nursing, private duty nursing (for members under 18 years of age), and home health aide services • Genetic Testing • Outpatient quantitative (definitive) urine drug testing, for more than 7 drug classes
PROCEDURES/SERVICES
<ul style="list-style-type: none"> • Procedures and services performed by out-of-network providers or at out-of-network facilities (except ER, urgent care, office visits, and family planning) • Medically necessary, potentially cosmetic procedures, including but not limited to: blepharoplasty, mammoplasty, otoplasty, rhinoplasty, septoplasty, varicose vein procedures, reconstructive or plastic surgery • Bariatric Surgery (Stage 2 and Stage 3) • Experimental or investigational • High tech imaging (i.e., CT, MRI administered by Evolent) • Interventional pain management (administered by Evolent) Spinal Surgeries in all settings (administered by Evolent). • Orthopedic procedures such as arthroplasty (administered by Evolent). • Physical, Occupational, and Speech Therapy • Elective cardiac stenting in outpatient hospital • Tonsillectomy and Adenoidectomy • Elective (non-emergent) surgery/procedures • Facility Attended Sleep Studies

INPATIENT

- Skilled Nursing Facilities
- Long-Term Acute Care
- All Inpatient Elective Admissions
- Inpatient Rehabilitation (Except SUD residential treatment facilities operated by the Indian Health Service or by Tribes or Tribal organizations under a contract or compact with the Indian Health Service.)

INTEGRATED MANAGED CARE AND BEHAVIORAL HEALTH SERVICES

- Partial Hospitalization or Day Treatment/Support
- Electroconvulsive Therapy
- Withdrawal Management
- Residential Treatment for Mental Health and Substance Use
- Inpatient Psychiatric Admissions for Transcranial Magnetic Stimulation
- Psychological Testing
- Neuropsych Testing
- Applied Behavioral Analysis (certain billing codes)
- WISE/PACT – Require notification upon start of services and concurrent review every 6 months (WISE) to a year (PACT) thereafter
- Health Related Social Needs – Intensive Behavioral Supportive Supervision and Community Behavioral Health Support

Emergency room and post stabilization services do not require prior authorization. Providers should notify Coordinated Care of post stabilization services including, but not limited to, the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery, within one (1) business day of the service initiation.

Inpatient Admissions: **Notification for Medical Admissions is currently automatically received by the Health Plan for most admissions.** The web portal should not be used to notify the Health Plan of an Inpatient Admission.

Providers must fax admission notifications under the following circumstances:

- Neonatal admissions
- Extended Nursery stay (after mother is discharged)
- If the facility does not participate in the Admission, Discharge, Transfer data exchange through Point Click Care
- For all members admitted prior to retrospective enrollment occurs
- Non-participating provider observation admissions
- Behavioral Health/SUD admissions
- When Coordinated Care is not the primary payer

Providers should **notify Coordinated Care of all inpatient admissions within one (1) business day** of the admission for medical necessity review and ongoing concurrent review and discharge planning.

Medical Admissions require the following clinical information:

- History and Physical
- Doctor's Orders / Medical Progress Notes (physician orders for observation to inpatient)
- MAR / IV Fluid Rates
- Lab / Radiology Results
- Plan of Care
- Level of Care (Acute, Intermediate, ICU)
- PT/OT/ST Progress notes
- Patient Education
- Discharge planning notes
- Discharge planner name and contact information

Behavioral Health Admissions require the following clinical information:

- Current medical records or clinical information,
- Relevant court documents for involuntary hold,
- Initial or ongoing assessments for psychiatric or substance use disorders,
- List of current medications,
- Safety plan for suicide risk and/or harm to self,
- Up-to-date treatment plan

Maternity admissions require notification within one (1) business day of admission and information on the delivery outcome (including the Apgar score, birth weight, gestational age, and birth method) is also required. Apple Health Expansion member delivery notification should be sent to FFS/HCA. Clinical information is required for ongoing authorization of the service beyond 48 hours for a vaginal delivery and 96 hours for a C-section delivery. Providers should notify Coordinated Care of any newborn who is admitted to a level of care higher than newborn nursery within one (1) business day by faxing notification to our NICU team at 1-833-247-1270.

Prior authorization is required for all elective inpatient admissions and providers must still notify Coordinated Care within one (1) business day of the admission. Failure to obtain a prior authorization may result in a denial, even with timely notification of admission.

Exceptions to timely admission notifications will be made under the following circumstances:

- A catastrophic event substantially interfered with normal business operations of the provider or damage or destruction of the provider's business office or records due to a natural disaster.
- A pending or retroactive eligibility issue exists, and the provider is able to provide documentation of the earliest date that Plan eligibility was identified following the start date of service.
- Member qualified for earlier enrollment and HCA has retroactively assigned Coordinated Care eligibility at the beginning of that month. Provider must notify the Plan of admission within one (1) business day of identification of eligibility.
- Provider was unaware that the member was eligible for services at the time services were rendered. PA is granted in this situation only if one of the following conditions are met:

- Provider's records document that the member refused or was physically unable to provide the ID number, name with correct spelling, or date of birth. If two identifiers are given, then the provider should be able to find coverage in ProviderOne for Apple Health (Medicaid) members. These situations include:
 - Member unable to provide coverage information as in:
 - Trauma or unresponsive patient
 - Psychiatric patient admitted through ED
 - Child unattended by parent
 - Non-English speaking patients unable to obtain interpreter services
 - Patient indicated they were self-pay and had no medical coverage at time of treatment

All Durable Medical Equipment (DME) requires an appropriate provider signature. Non-covered DME/Supplies require medical necessity review. ETR no longer applies to non-covered DME and non-durables. WAC 182-543-2000 and WAC 182-543-0500.

The PCP or appropriate ordering provider should request authorizations via fax to 1-877-212-6669 or on the secure provider portal at www.CoordinatedCareHealth.com with appropriate supporting clinical information to request an authorization.

Questions about existing authorizations can be made by calling 1-877-644-4613 (TTY: 711)
Phone: 1-877-644-4613 (TTY: 711).

Failure to obtain authorization may result in administrative claim denials. Providers are prohibited from holding any Coordinated Care member financially liable for any service administratively denied by Coordinated Care for the failure of the provider to obtain timely authorization.

Notice of Adverse Determination: When Coordinated Care determines that a service or authorization request does not meet criteria and will therefore not be authorized, Coordinated Care will submit an adverse determination (or denial) notification to the providers rendering the service(s) and to the member. The notification will include the following information/instructions:

- The reason(s) for the proposed determination in clearly understandable language.
- A reference to the criteria, guideline, benefit provision, or protocol used in the decision, communicated in an easy-to-understand summary.
- A statement that the criteria, guideline, benefit provision, or protocol will be provided upon request.
- Information on how the provider may contact the Peer Reviewer to discuss decisions and proposed determinations.
- Instructions for requesting an appeal including the right to submit written comments or documents with the appeal request; the member's right to appoint a representative to assist them with the appeal, and the timeframe for making the appeal decision.
- Instructions for requesting an expedited appeal.
- The right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

You can find detailed information for how to request re-review of a denied service/authorization in the provider resources page of CoordinatedCareHealth.com under Provider Resources/Reconsideration Resources Grid. [Medicaid Provider Reconsiderations, Disputes and Complaints](#)

Peer Clinical Review Process: If the requested inpatient or outpatient service is denied due to an apparent lack of medical necessity, the treating provider (physician, nurse practitioner, pharmacist, or psychologist) can request a Peer-to-Peer telephonic conversation to discuss the reason for the denial. This is an opportunity to provide additional information to one of Coordinated Care's Peer Review Physicians or designees, to augment the information already received by the Plan for review. As a result of the Peer-to-Peer conversation, Coordinated Care's Peer Reviewer Physician or designee makes a decision to approve the service or allow the denial to stand.

A Peer-to-Peer Review is not available when the facility or treating physician has not previously provided clinical information for the Plan to review and the denial is based on a lack of information. Or when the service is an excluded benefit. A Prior Authorization (Pre-service) Peer-to-Peer Review must be requested within 5 business days of the date the denial letter was issued, or 60 days for retail pharmacy requests an Inpatient Concurrent Peer-to-Peer request must be requested within 10 business days of the date the denial letter was issued.

To request a Peer-to-Peer conversation, please call our scheduler at 833-661-0642 (TTY: 711), leave a voicemail at 253-442-1505, or email request to McaidP2P@centene.com. To request a Pharmacy or Medical Pharmacy Peer-to-Peer, call Centene Pharmacy Services at 1-866-399-0928.

Peer to peer will be scheduled as soon as there is an available timeframe; cases where the member is still admitted or of clinical urgency will be scheduled as soon as the same day of the request if the provider is available. Peer to peer can be held with the ordering or requesting provider as long they maintain independent licensure. When the peer to peer is scheduled the Plan's Medical Director or a Clinical Pharmacist will contact the provider at the pre-arranged phone number. If the Plan cannot reach the provider at the primary and backup number provided the Plan will allow for a Peer to Peer to be rescheduled if there were extenuating circumstances.

Eligibility: Establishing member eligibility for benefits and obtaining an authorization before treatment is essential for the claims payment process. It is the responsibility of the Network Provider to monitor the member's ongoing eligibility during the course of treatment.

Network Providers should use either of the following methodologies to verify member eligibility:

- Contact Coordinated Care Customer Service at 1-877-644-4613, (TTY: 711).
- Access the Provider web portal at www.CoordinatedCareHealth.com

Utilization Determination Timeframes: Authorization decisions are made as expeditiously as possible and in accordance with our member's needs. Our UM decisions are made within the following timeframes:

Type	Timeframe
Urgent Pre-Service	<p>Electronically submitted requests will be processed in 1 calendar day; If more information is needed it will be requested within 1 calendar day. The provider has 2 days to respond to request for more information. A decision will be made within 2 days of receiving the information. A possible extension up to 10 calendar days can be made with notification to member and provider.</p> <p>Non-electronically submitted requests will be processed in 2 calendar days; If more information is needed it will be requested within 1 calendar day. The provider has 2 days to respond to request for more information. A decision will be made within 2 days of receiving the information. A possible extension up to 10 calendar days can be made with notification to member and provider.</p>
Standard Pre-Service	<p>Electronically submitted requests will be processed in 3 calendar days if more information is needed it will be requested within 1 calendar day. The provider has 5 days to respond to request for more information. A decision will be made within 4 days of receiving the information up to maximum of 14 days. A possible extension up to 28 calendar days with notification to member and provider.</p> <p>Non-electronically submitted requests will be processed in 5 calendar days; if more information is needed it will be requested within 5 calendar days. The provider has 5 days to respond to request for more information. A decision will be made within 4 days of receiving the information up to a maximum of 14 calendar days. Possible extension up to 28 calendar days with notification to member and provider.</p>
Concurrent/Urgent	Lesser of 1 business day or 3 calendar days; up to 3 business days for initial request if more clinical information is needed
Retrospective	30 calendar days
Pharmacy and Medical Pharmacy (Covered outpatient drugs, over-the-counter drugs, or physician administered drugs)	<p>24 hours of the original receipt of the request.</p> <p>For electronic standard requests, If additional information is required and requested, the provider is given five (5) calendar days to submit the information. Decision to approve or deny the request within four (4) calendar days of the receipt of the additional information. If the provider does</p>

	<p>not respond to the request for additional information within five (5) calendar days of the request, a decision must be made to either approve or deny. Possible extension of up to fourteen (14) additional calendar days with notification to member and provider.</p> <p>For non-electronic standard requests, If additional information is required and requested, the provider is given five (5) calendar days to submit the information. Decision to approve or deny the request within four (4) calendar days of the receipt of the additional information. Possible extension of up to fourteen (14) additional calendar days with notification to member and provider.</p> <p>For electronic expedited authorizations, If additional information is required and requested, the provider is given two (2) calendar days to submit the information. Decision to approve or deny the request within two (2) calendar days of the receipt of the additional information. Possible extension of up to ten (10) additional calendar days.</p> <p>For non-electronic expedited authorizations, If additional information is required and requested, the provider is given two (2) calendar days to submit the information. Decision to approve or deny the request within two (2) calendar days of the receipt of the additional information. Possible extension of up to ten (10) additional calendar days.</p>
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11.4 Post Acute Care (PAC) Facility Services

Coordinated Care is responsible for medically necessary Skilled Nursing Facility (SNF), Inpatient Rehabilitative (IPR), and Long-Term Acute Care Hospital (LTACH) stays when Coordinated Care determines that long-term acute care, skilled nursing or inpatient rehabilitative care is more appropriate than acute hospital care. Coordinated Care will coordinate with hospital or other acute care facility discharge planners and post-acute facility care managers or social workers to ensure a smooth transition of the member to or from a PAC facility. Coordinated Care will coordinate with the SNF PAC facility to provide care coordination and transitional care and will ensure coverage of all medically necessary services, prescriptions and equipment not included in the negotiated PAC facility daily rate. This includes prescription medications, durable medical equipment not available at the PAC facility, and intravenous medications or products not readily available at the PAC facility.

If Coordinated Care, in coordination with the SNF, anticipates the member will be in the facility for additional days after a member no longer meets criteria for medically necessary skilled nursing or rehabilitative care, Coordinated Care will coordinate with the Aging and Long-Term Services Administration (AL TSA) Home and Community Services (HCS) to:

- Determine functional, financial and institutional eligibility, if necessary
- Assist the member to explore all options available for care, including whether the member will be discharged to his or her home or a community residential setting, or remain in the Nursing Facility (NF) for long-term services and supports (LTSS)

If the member remains in the NF, the member remains enrolled in Apple Health (Medicaid) and ALTSA is responsible for payment of NF room and board beginning on the date the member is determined not to meet or no longer meets criteria for the rehabilitative or skilled benefit. Coordinated Care continues to be responsible for all medically necessary services, prescriptions, and equipment not included in the ALTSA nursing facility rate until the member is no longer eligible with Coordinated Care. The care during this period of time is still subject to any required medical necessity determinations and service authorizations.

Coordinated Care will provide written notice to the facility and the member if the member:

- Does not meet rehabilitative or skilled nursing criteria; or
- If a previously authorized stay is being reduced.

If a Coordinated Care member is in a PAC facility at the time of termination of enrollment and the member was enrolled with Coordinated Care on the date of admission, Coordinated Care will be responsible for payment of all covered facility and professional services from the date of admission until one of the following occurs:

- The member is discharged from a facility to home or a community residential setting.
- The member's eligibility to receive Apple Health (Medicaid) services ends. Coordinated Care's obligation for payment ends at the end of the month the member's Medicaid eligibility ends.
- The member no longer meets the Coordinated Care's rehabilitative or skilled criteria. Coordinated Care uses InterQual® criteria by McKesson to determine the medical necessity of services. LOC may change during the stay as a result of member's progress/need. Evaluations will be conducted weekly as directed by Coordinated Care utilization management.
- "Custodial Care" may be approved for a limited number of days when there is a delay in discharge by Coordinated Care or as part of discharge planning.
- Inpatient Per Diem includes all Skilled and Rehabilitation Services provided by PAC facility. Excluded from the Per Diem is Specialty DME (not available at the PAC facility), Pharmacy, Infusion, and Vent/Trach services provided by contracted Vendors.
- PAC facility must use Coordinated Care contracted Providers for Specialty DME, Pharmacy, Infusion Services, and Vent/Trach Services. Authorization may be required for some of the services. Non-contracted Providers may be used by Coordinated Care with the use of Single Case Agreements (SCA) when contracted providers are not available.
- For readmissions, contact the Utilization Management department to determine requirement of new authorization.
- When required, PAC facility must initiate prior authorization requests for Pharmacy and Infusion Services.
- When required, DME Provider shall initiate their own request for prior authorization after request from PAC facility for their specific service.

11.5 Administrative Days

Inpatient days when the member no longer meets inpatient medical necessity criteria are covered in accordance with WAC 182-550-4550. Please refer to Coordinated Care's policy for Administrative Days. All policies (Clinical and Payment) can be found on the website <https://www.coordinatedcarehealth.com/providers/resources/clinical-payment-policies.html>

11.6 Concurrent Review Discharge Planning

Concurrent Review Clinicians perform ongoing concurrent review for inpatient admissions through onsite, fax, EMR access or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and when necessary, with the member's attending physician. The clinician will review the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Ongoing concurrent reviews are made within 1 (one) calendar day of the next scheduled review date. Written or electronic notification may include the number of days of service approved, and the next review date.

While a member is in an inpatient facility receiving acute care services, Coordinated Care's Utilization Managers, Complex Discharge Planners, Intensive Case Managers, and Care Coordinators work with the facility's treatment team to develop a discharge plan for continued care with outpatient practitioners. Every effort is made to collaborate with the outpatient practitioners to assist with transition back to the community and a less restrictive environment as soon as the member is stable. Discharge planning should be initiated on admission. For members with complex discharge needs, Coordinated Care assigns dedicated Discharge Planners to assist facilities with coordination of the discharge plan, including assistance with authorizations for home health, behavioral health services, durable medical equipment, SNF/LTAC/IPR services, etc. Prior to discharge from an inpatient setting, an ambulatory follow-up appointment must be scheduled within seven (7) calendar days after discharge. Coordinated Care Intensive Case Management and/or Care Coordination staff follow up with an appointment reminder to the member. If a member does not keep the outpatient appointment after discharge, Intensive Case Management and/or Care Coordination staff will follow up with the member and assist with rescheduling the appointment and provide resources as needed to ensure appointment compliance.

In accordance with HB1860, a psychiatric hospital should make every effort to inform Coordinated Care of the individuals anticipated discharge no later than 24 hours prior to the known discharge date. HB1860 is intended to increase care coordination and prevent homelessness among individuals discharging from inpatient behavioral health settings. Notification of anticipated discharge is key to ensuring appropriate collaboration and coordination of treatment and social needs for each individual.

Follow up after hospitalization is one of the most important markers monitored by Coordinated Care to help members remain stable and to maintain treatment compliance after discharge. Follow up after discharge is monitored closely by the National Committee for Quality Assurance (NCQA), which has developed and maintains the Healthcare Effectiveness Data and Information Set (HEDIS). Even more important, increased compliance with this measure has been proven to decrease readmissions and helps minimize no-shows in outpatient treatment.

14-Day Potentially Preventable Readmissions

Coordinated Care reviews all 14-day readmissions in accordance with WAC-182-550-2950. Please refer to Coordinated Care's policy around Provider Preventable Readmissions. All policies (Clinical and Payment) can be found on the website

<https://www.coordinatedcarehealth.com/providers/resources/clinical-payment-policies.html> or by following this link: [Payment Policy: Provider Preventable Readmission](#)

11.7 Radiology and Diagnostic Imaging and Interventional Pain Management Services

As part of a continued commitment to further improve the quality of advanced imaging and radiology services and interventional pain management services, Coordinated Care is using Evolent to provide prior authorization services and utilization. Prior authorization is required for the following outpatient procedures:

- CT/CTA
- MRI/MRA
- PET
- Cardiac Imaging
- Epidural, Facet Joint and Sacroiliac Joint Injections

KEY PROVISIONS:

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- It is the responsibility of the **ordering** physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

To reach Evolent and obtain authorization, please call 1-877-644-4613 (TTY: 711) and follow the prompt for radiology authorizations. Evolent also provides an interactive website, which may be used to obtain on-line authorizations. Please visit www.RadMD.com for more information or call our Provider Services department.

11.8 Interventional Pain Management

Evolent manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

- Spinal Epidural Injections
- Paravertebral Facet Joint Injections or Blocks
- Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
- Sacroiliac Joint Injections
- Spinal Cord Stimulators

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through Evolent for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission is still required through New Hampshire Healthy Families. To obtain authorization through Evolent, visit RadMD.com

11.9 Musculoskeletal Care Management (MSK) and Ortho Spinal Procedures

In keeping with our commitment of promoting continuous quality improvement for services provided to Coordinated Care members, Coordinated Care has partnered with Evolent to implement a Musculoskeletal Care Management (MSK) program. This program includes prior authorization for non-emergent MSK procedures for Coordinated Care members. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

How the Program Works

MSK Surgeries: Prior authorization will be required for the following non-emergent inpatient and outpatient hip, knee, shoulder, lumbar and cervical surgeries:

Hip

- Revision/Conversion Hip Arthroplasty
- Total Hip Arthroplasty/Resurfacing
- Femoroacetabular Impingement (FAI) Hip Surgery (includes CAM/pincher & labral repair)
- Hip Surgery – Other (includes synovectomy, loose body removal, debridement, diagnostic hip arthroscopy, and extra-articular arthroscopy knee)

Knee

- Revision Knee Arthroplasty
- Total Knee Arthroplasty (TKA)
- Partial-Unicompartmental Knee Arthroplasty (UKA)
- Knee Manipulation under Anesthesia (MUA)
- Knee Ligament Reconstruction/Repair
- Knee Meniscectomy/Meniscal Repair/Meniscal Transplant
- Knee Surgery – Other (includes synovectomy, loose body removal, diagnostic knee arthroscopy, debridement with or without chondroplasty, lateral release/patellar realignment, articular cartilage restoration)

Shoulder

- Revision Shoulder Arthroplasty
- Total/Reverse Shoulder Arthroplasty or Resurfacing
- Partial Shoulder Arthroplasty/Hemiarthroplasty
- Shoulder Rotator Cuff Repair
- Shoulder Labral Repair
- Frozen Shoulder /Adhesive Capsulitis Repair

- Shoulder Surgery – Other (includes debridement, manipulation, decompression, tenotomy, tenodesis, synovectomy, claviclectomy, diagnostic shoulder arthroscopy)

Cervical

- Cervical Anterior Decompression with Fusion –Single & Multiple Levels
- Cervical Posterior Decompression with Fusion –Single & Multiple Levels
- Cervical Posterior Decompression (without fusion)
- Cervical Artificial Disc Replacement – Single & Two Levels
- Cervical Anterior Decompression (without fusion)

Lumbar

- Lumbar Microdiscectomy
- Lumbar Decompression (Laminotomy, Laminectomy, Facetectomy & Foraminotomy)
- Lumbar Spine Fusion (Arthrodesis) With or Without Decompression – Single & Multiple Levels
- Lumbar Artificial Disc – Single & Multiple Levels

Sacroiliac

- Sacroiliac Joint Fusion

As a part of the Evolent clinical review process, actively practicing, orthopedic surgeon specialists (hip, knee, and shoulder) or neurosurgeons (spine) will conduct the medical necessity reviews and determinations of musculoskeletal surgery cases.

Please refer to the “Solutions” tab on the Evolent home page (<https://www.RadMD.com>) for additional information on the MSK program. Checklists and tip sheets are available there to help providers ensure surgical procedures are delivered according to national clinical guidelines.

Should you have questions, please contact Evolent

11.10 Physical/Occupational/Speech Therapy

Coordinated Care requires prior authorization for Network Providers as indicated below:

Providers should submit an authorization request for therapy services which would be anticipated to exceed the limits noted below. Coordinated Care will use internal prior authorization processes to manage medical necessity review of therapy services for Apple Health (Medicaid) members.

Prior authorization will be required as noted below, for members 20 and under, for a 6-month span (after initial visit completed):

Physical Therapy	Occupational Therapy	Speech Therapy
Initial PAR provider: After 12 visits	Initial PAR provider: After 12 visits	Initial PAR provider: After 6 visits
Initial Non-PAR provider: After eval plus two visits	Initial Non-PAR provider: After eval plus two visits	Initial Non-PAR provider: After eval plus two visits

Physical Therapy	Occupational Therapy	Speech Therapy
Subsequent PAR provider visits: Requires review, able to approve up to 48 visits with a 180-day (6-month) span	Subsequent PAR provider visits: Requires review, able to approve up to 48 visits with a 180-day (6-month) span	Subsequent PAR provider visits: Requires review, able to approve up to 48 visits with a 180-day (6-month) span
Subsequent Non-PAR provider visits: Requires review, able to approve up to 48 visits with a 180-day (6-month) span	Subsequent Non-PAR provider visits: Requires review, able to approve up to 48 visits with a 180-day (6-month) span	Subsequent Non-PAR provider visits: Requires review, able to approve up to 48 visits with a 180-day (6-month) span

Prior authorization will be required as noted below, for members 21 and older for a 6-month span (after initial visit completed):

Physical Therapy	Occupational Therapy	Speech Therapy
Initial PAR provider: After 12 visits	Initial PAR provider: After 12 visits	Initial PAR provider: After 6 visits
Initial Non-PAR provider: After Eval plus 2 visits	Initial Non-PAR provider: After Eval plus 2 visits	Initial Non-PAR provider: After Eval plus 2 visits
Subsequent PAR provider visits: Requires review, able to approve up to 12 visits with a min 45 days date span up to max of 180 days	Subsequent PAR provider visits: Requires review, able to approve up to 12 visits with a min 45 days date span up to max of 180 days	Subsequent PAR provider visits: Requires review, able to approve up to 12 visits with a min 45 days date span up to max of 180 days
Subsequent Non-PAR provider visits: Requires review, able to approve up to 12 visits with a min 45 days date span up to max of 180 days	Subsequent Non-PAR provider visits: Requires review, able to approve up to 12 visits with a min 45 days date span up to max of 180 days	Subsequent Non-PAR provider visits: Requires review, able to approve up to 12 visits with a min 45 days date span up to max of 180 days

Please use the normal Coordinated Care processes to submit prior authorization requests. The authorization forms can be found in the Provider Resources section of www.CoordinatedCareHealth.com, faxed to 1-877-212-6669, or can be submitted electronically via the Secure Portal.

Neurodevelopmental Centers of Excellence are still exempt from any therapy authorizations aligning with HCA's regulations. No changes will be made to NDC's exemption policy. Authorization is still not required from any state awarded NDC.

11.11 Second Opinion

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the Coordinated Care network. If there is

not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the member.

11.12 Secondary Payer Requirements

For services that require prior authorization, Coordinated Care requires providers to obtain a prior authorization only if an authorization was not already obtained from the primary payer. Claims that have been denied by the primary payer due to lack of authorization will also be denied by Coordinated Care.

11.13 Clinical Information Needed for Prior Authorization Requests

Authorization requests may be submitted by fax, phone or secure web portal. Authorization determinations may be communicated to the provider by fax, phone, secure email, or secure web portal. Adverse determinations will be followed up in writing. A clinician may request additional information and/or complete the medical necessity screening telephonically. For most services on the prior authorization list, documentation supporting medical necessity will be required.

Coordinated Care clinical staff request clinical information minimally necessary for clinical decision-making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Coordinated Care is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, without the authorization of the member.

Information necessary for authorization of covered services may include but is not limited to:

- Member's Name, date of birth and Coordinated Care or Apple Health (Medicaid) ID number
- Provider's name and telephone number
- Facility name if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g., primary and secondary diagnosis, planned surgical procedures, surgery date, behavioral health symptoms)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed and any recent psychiatric evaluation and/or substance use assessment)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans

If additional clinical information is required, a clinician or medical service representative will notify the requester via phone or fax of the specific information needed to complete the authorization process. Coordinated Care has specific Prior Authorization/Notification forms available on the website under Provider page to help guide the clinical information needed to complete authorizations for the following services:

- Electroconvulsive Therapy
- Residential Treatment
- Transcranial Magnetic Stimulation

- Applied Behavioral Analysis
- WISe/PACT
- Outpatient/Inpatient Behavioral Health (which includes the following)
 - Residential Treatment for Mental Health and Substance Use
 - Inpatient Acute Psychiatry (Involuntary and Voluntary)
 - Intensive Outpatient
 - Day Treatment/Partial Hospitalization Program
- Pharmacy and Medical Pharmacy (which include covered outpatient drugs, over-the-counter drugs, or physician administered drugs)

11.14 Clinical Decisions

The Coordinated Care Utilization Management team is comprised of qualified clinicians appropriate to the type of service under review. Coordinated Care's utilization review decisions are made in accordance with industry standard healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Medical Necessity Criteria are used for the review and approval of treatment. Requests that do not meet Medical Necessity guidelines are referred to the appropriately licensed physician, psychiatrist, or psychologist for review and peer-to-peer discussion.

Coordinated Care affirms that utilization management decision making is based on appropriateness of care and services and the existence of coverage. Coordinated Care does not reward practitioners or other individuals for issuing denials of service or care.

Delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the Coordinated Care Medical Director, or designee, are responsible for making utilization management (UM) decisions in accordance with the member's plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

11.15 Pharmacy Services

Coordinated Care is committed to providing appropriate, high-quality, and cost-effective drug therapy to all Coordinated Care members. Coordinated Care adheres to the Health Care Authority's guidance to determine medications that are covered under the Coordinated Care pharmacy benefit.

Pharmaceutical management procedures are a crucial part of the pharmacy program. These procedures promote and ensure the utilization of clinically appropriate drugs to improve the health and well-being of our members.

Coordinated Care covers prescription medications and certain over the counter (OTC) medications when ordered by a Washington Apple Health (Medicaid) enrolled, Coordinated Care practitioner. The pharmacy program does not cover all medications. Some medications require prior authorization (PA) or have limitations on age, dosage, and maximum quantities.

The Coordinated Care Apple Health Medicaid Preferred Drug List (PDL) and Apple Health Expansion PDL are the list of covered drugs members can receive at retail, mail order, and specialty pharmacies. The Washington State Health Care Authority P&T Committee and Drug Utilization Review Board continually evaluate the PDL to promote the appropriate and cost-effective use of medications.

Coordinated Care's PDLs include information about preferences and restrictions. To find out if any restrictions apply to a drug your patients take or want to take, check the Preferred Drug List at CoordinatedCareHealth.com/providers.html or call Provider Services at 1-877-644-4613.

Coordinated Care may limit how much medication a member can get at one time. If you feel that the member has a medical reason for getting a larger amount, then you can submit a PA. If Coordinated Care does not grant a PA, Coordinated Care will notify you and the member and provide information regarding the appeal process.

Some medications listed on the Coordinated Care PDLs may require specific medications to be tried first before the member can receive a non-preferred medication or medication with PA requirements. We may require information including clinical records and/or a history of previous drug tried and failed before we can authorize PA. If we do not grant a PA, then Coordinated Care will notify you and the member and provide information regarding the appeal process.

For more information about the Coordinated Care PDLs, prior authorization, generic substitution, therapeutic interchange, step-therapy protocols, limits, and quotas, please refer to the Pharmacy section of the Coordinated Care website at: CoordinatedCareHealth.com/providers.html.

In addition to drugs available from a retail pharmacy, Coordinated Care covers specialty injectable drugs or pharmaceuticals that can be administered in a physician's office or member's home. While most drugs are covered through a member's prescription drug benefit, some drugs may be covered through medical benefit. Providers may search for prior authorization requirements for drugs processed through a member's medical benefits by using the Pre-Auth Check tool on the Coordinated Care website.

Both pharmacy and medical pharmacy PA requests are reviewed by Centene Pharmacy Services. Visit Coordinated Care website, Pharmacy section for information on the prior authorization process, forms, contact phone and fax number based on the type of request.

11.16 Medical Necessity

Medical necessity is defined in the Washington Apple Health (Medicaid) contract as, "a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate

or prevent worsening of conditions in the member that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the member requesting the service. For the purpose of this section, 'course of treatment' may include mere observation or, where appropriate, no medical treatment at all." WAC 182-500-0070

For Coordinated Care members, this means that our members will receive healthcare services, supplies or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury
- In accordance with the standards of good medical practice consistent with evidence based and clinical practice guidelines
- Not primarily for the personal comfort or convenience of the member, family, or provider
- The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member
- Furnished in a setting appropriate to the patient's medical need and condition and, when supplied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient service
- Not experimental or investigational or for research or education

11.17 Utilization Review Criteria

Coordinated Care has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual® appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual® criteria cover medical, behavioral and surgical admissions, outpatient procedures, and ancillary services for both adult and pediatric populations. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual® is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determinations and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Coordinated Care utilizes the American Society of Addiction Medicine Patient Placement Criteria (ASAM) for substance use disorder Medical Necessity Criteria. ASAM and the McKesson InterQual® criteria sets are proprietary and cannot be distributed in full; however, a copy of the specific criteria relevant to any individual need for authorization is available upon request. ASAM and InterQual® criteria are reviewed on an annual basis by the Coordinated Care Clinical Policy Committee and Population Health and Clinical Operations Subcommittee, which includes Network Providers as well as Coordinated Care clinical staff.

Coordinated Care is committed to the delivery of appropriate service and coverage, and offers no organizational incentives, including compensation, to any employed or contracted UM staff

based on the quantity or type of utilization decisions rendered. Review decisions are based only on appropriateness of care and service criteria, and UM staff is encouraged to bring inappropriate care or service decisions to the attention of the Medical Director.

Providers or members may obtain the criteria used to make a specific adverse determination by contacting the health plan at 1-877-644-4613 (TTY: 711). Our Medical policies are available on our website at CoordinatedCareHealth.com and some InterQual® criteria are available on our Web Portal; our license to use InterQual® criteria will not permit distribution of all criteria to all providers. Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. Please call the number on the denial notice to set up a 'peer to peer' discussion.

Members or healthcare professionals with the member's written consent may request an appeal related to a medical necessity decision made during the authorization or concurrent review process verbally or in writing. Appeals should be directed to:

Coordinated Care
Clinical Appeals Coordinator
1145 Broadway, Suite 700
Tacoma, WA 98402
Phone: 1-877-644-4613 (TTY: 711)
Fax: 1-866-270-4489

11.18 Benefit Determination: New Technology

Coordinated Care evaluates the value of using new technologies for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Population Health and Clinical Operations staff may identify relevant topics for review pertinent to the Coordinated Care population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

HCA also has a New Technology program that is used by the Apple Health (Medicaid) Plans. "Health Technology Assessment (HTA)" means a program that determines if health services used by Washington State government are safe and effective. The program examines scientific evidence for new technologies, which is then reviewed by a committee of practicing clinicians. The purpose of the program is to ensure medical treatments and services paid for with state health care dollars are safe and proven to work. HTA contracts for scientific, evidence-based reports about whether certain medical devices, procedures and tests are safe and work as promoted. Coordinated Care acts in accordance with findings of the Health Technology Assessment (HTA) program promulgated by HCA (Chapter 182-55 WAC).

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Population Health and Clinical Operations department at 1-877-644-4613 (TTY: 711).

11.19 Retrospective Review

Retrospective review is an initial review of services after services have been provided to a member. This may occur when authorization or timely notification to Coordinated Care was not obtained due to extenuating circumstances (i.e., member was unconscious at presentation, services authorized by another payer who subsequently determined member was not eligible at the time of service, or member had been granted retroactive Apple Health (Medicaid) enrollment). Requests for retrospective review must be submitted within one (1) business day of discovering the member has Coordinated Care coverage. A coverage decision will be made within thirty (30) calendar days following receipt of the request. For inpatient notifications that occur after discharge but where notification to the Health Plan was timely, the coverage decision will be made within thirty (30) calendar days after the receipt of a request as these services are also retrospective determinations.

11.20 Incarceration and Institutional Guidance

Jails, Prison, Juvenile Rehabilitation, Juvenile Detention Centers, and State Psychiatric Hospitals (Correctional facilities)

In accordance with State Senate Bill (SSB) 6430 (Laws of 2016, chapter 154), Members who transition into a “correctional facility”, including city and county jails, Department of Corrections (DOC) facilities, Juvenile Rehabilitation facilities, Eastern State Hospital, and Western State Hospital, will go into a suspended Apple Health (Medicaid) status. At release, the State will re-enroll the member with the MCO he or she was enrolled in prior to incarceration.

Correctional Facilities

- **Inpatient Stay in First Month of Incarceration:** If a member is enrolled with an MCO and becomes an inmate at a city/county jail, the MCO pays for inpatient stays that occur within the first month of incarceration. If the inpatient stay occurs after the first month of incarceration, the member’s MCO Apple Health (Medicaid) coverage is suspended, and Fee for Service (FFS) Medicaid covers the inpatient stay.
- **Same-Day Enrollment:** “Early” or same-day enrollment rules apply. For example, if a member enrolls with an MCO 1/10, is incarcerated 1/11, and is admitted inpatient on 1/12, they will be enrolled with the MCO effective 1/1 and the MCO is required to pay for the inpatient stay (assuming the inpatient stay occurred within the first month of incarceration).
- **Continuous Health Events:** Continuous health event rules apply; MCOs are required to cover medically necessary services associated with an inpatient stay that occurred during the first month of incarceration until discharge even after the member dis-enrolls with the plan. Coordinated Care’s obligation for payment ends at the end of the month the member’s Apple Health (Medicaid) eligibility ends.
- **Prior Auth/ Medical Necessity:** Medical necessity rules apply. To facilitate payment, facilities should check MCO PA requirements to understand which services require PA. If inpatient services were provided without PA, claims will be reviewed retrospectively for medical necessity. Services that meet medical necessity will be paid. To prevent claims issues, inpatient facilities are encouraged to notify HCA when an incarcerated member is admitted for an inpatient stay. To notify HCA, providers may email to

Mark.Westenhaver@HCA.WA.gov. Both HCA and Coordinated Care are committed to ensuring medically necessary claims are paid.

Coordinated Care staff may send a note to the Coordinated Care Compliance inbox to request information from HCA on:

- Whether HCA has been notified of the member's incarceration
- Check enrollment/suspension status
- Information on what type of institution (prison vs. jail)

Compliance will forward the request to HCA for research.

Post-Payment Claim Recovery: If HCA does not receive notification that A) a member is incarcerated OR B) a member has been released from jail, enrollment may not be appropriately reflected in ProviderOne at the time a claim is billed. When enrollment is later corrected and the member is retro-disenrolled from either FFS or the MCO, HCA or the MCO will recoup payment and the facility will need to bill the claim to the other party.

Washington Reentry Initiative: The Reentry Initiative creates an exception to the Medicaid Inmate Exclusion Rule and allows reimbursement for a limited scope of reentry services within 90-days pre-release. This is in addition to the existing inpatient hospitalization benefit. A facility participating in the Reentry Initiative may bill for reentry services for eligible individuals 90-days prior to release. Beginning July 2025, pre-release services may include:

- Reentry Targeted Case Management (rTCM)
- Medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD)
- 30-day supply of medications and medical supplies at release
- Medications during the prerelease period
- Lab and radiology
- Services by community health workers with lived experience
- Physical and behavioral clinical consultations

In alignment with state guidance, Coordinated Care will not require PA due to network status from participating Reentry Initiative embedded correctional facility providers for services that do not typically require a PA for one year after the correction facility's implementation date. Additionally, Coordinated Care will pay for Covered Services without regard to network status for providers whose NPI is registered with HCA for one year past the facility's implementation date of the MTP 2.0 reentry demonstration initiative. This does not apply to pharmacy point of sale.

Consolidated Appropriations Act of 2023: Beginning July 2025, the Consolidated Appropriations Act of 2023 (CAA) specifies additional Apple Health benefits for incarcerated juveniles who are Apple Health eligible and: age 20 or younger; or age 18 and up to 26 who aged out of foster care on or after their 18th birthday. The CAA requirement applies to all carceral facilities in the state, regardless of their participation in the Reentry Initiative.

The CAA specifies a different set of benefits when eligible juveniles are post-adjudication or pre-adjudication. CAA-eligible members who are pre-adjudication are eligible for full Apple Health benefits. CAA-eligible members who are post-adjudication and thirty (30) calendar days

pre-release are eligible for reentry CAA Benefits. Reentry CAA benefits post-adjudication includes the following:

- Clinical assessment and evaluation (assessment, evaluation, and diagnosis of physical and behavioral health needs) provided 30 days pre-release or no later than seven calendar days post-release or as soon as practicable after release, and
- Reentry Targeted Case Management (rTCM) 30-days pre-release and available at least 30 days post-release and longer when medically necessary.

Coordinated Care will collaborate with HCA's contracted Third Party Administrator (TPA) to provide education to providers and correctional facilities about CAA requirements, health care available to members who are incarcerated, the MTP 2.0 reentry demonstration initiative, and payment mechanisms for embedded correctional facility providers.

For additional billing and policy details related to the Washington Reentry Initiative and the Consolidated Appropriations Act of 2023, see HCA's Reentry Targeted Case Management (rTCM) [Billing Guide](#), [Reentry Initiative Covered Procedure Code List](#), and [Reentry Initiative Policy and Operations Guide](#).

11.21 Patient Review and Coordination (PRC) Program and PCPs

Patient Review and Coordination (PRC) is a program designed to protect the health and safety of members who may be using controlled substances and/or medical services inappropriately. The PRC program restricts identified members to one primary care provider, one pharmacy, and one controlled substance prescriber for a minimum of 24 months.

The PRC Program is directed by WAC 182-501-0135

<http://app.leg.wa.gov/WAC>

Under the PRC Program:

- **Patient review and coordination (PRC)** is a health and safety program that coordinates care and ensures members enrolled in PRC use services appropriately and in accordance with agency rules and policies.
 - PRC applies to medical assistance fee-for-service and managed care members.
 - PRC is authorized under federal Medicaid law 42 U.S.C. 1396n(a)(2) and 42 C.F.R. 431.54(e).

Program Requirements: Lock-In members must seek care from their assigned PCP, Facility, and Pharmacy. This information should be verified in ProviderOne as RESTRICTED and can be identified on our [secure provider portal](#). Hospital services are allowed at the non-designated hospital **only for emergency services without authorization**. The member's assigned PCP is required as the Referring Physician on claims unless the rendering is the assigned provider.

"Assigned provider." An agency-enrolled health care provider or one participating with an agency-contracted managed care organization (MCO) who agrees to be assigned as a primary provider and coordinator of services for a fee-for-service or managed care member in the PRC program. Assigned providers can include a primary care provider (PCP), a pharmacy, a prescriber of controlled substances, and a hospital for nonemergency services.

"Primary Care Provider" or "PCP." A person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), or

a physician assistant (PA) who supervises, coordinates, and provides health care services to a member, initiates referrals for specialty and ancillary care, and maintains the member's continuity of care.

Member financial responsibility. A member placed in the PRC program may be billed by a provider and held financially responsible for health care services when the member obtains nonemergency services and the provider who renders the services is not assigned or referred under the PRC program.

Initial placement in the PRC program. When a member is initially placed in the program:

- The agency or MCO places the member for no less than twenty-four (24) months with one or more of the following types of health care providers:
 - Primary care provider (PCP)
 - Pharmacy for all prescriptions
 - Prescriber of controlled substances
 - Hospital for nonemergency services unless referred by the assigned PCP or a specialist. A member may receive covered emergency services from any hospital; or
 - Another qualified provider type, as determined by agency or MCO program staff on a case-by-case basis.
- The managed care member will remain in the same MCO for no less than twelve (12) months unless:
 - The member moves to a residence outside the MCO's service area and the MCO is not available in the new location; or

The PCP:

- Supervises and coordinates health care services for the member, including continuity of care and referrals to specialists when necessary.
- Provides the plan of care for members that have documented use of the emergency department for a reason that is not deemed to be an emergency medical condition.
- Files the plan of care with each emergency department that the member is using or with the emergency department information exchange.
- Makes referrals to substance use disorder treatment for members who are using the emergency department for substance use disorder issues; and
- Makes referrals to mental health treatment for members who are using the emergency department for mental health treatment issues.

When a member is enrolled in PRC, the following care management services are provided:

- Individual is assigned care manager for 24 months
- Care plans are shared with PCP
- Continual monitoring and motivational interviewing are provided as well as medication education
- Individuals are reviewed in PRC committee led by Medical Director Bi-weekly

All questions concerning PRC Program may be directed to the PRC Team by calling 833-236-4818 or via e-mail WA_MM_PRC@coordinatedcarehealth.com. After hour messages can be left at 833-236-4818 and will be addressed the next business day. For immediate after hour assistance call our TFN 1-877-644-4613

11.22 Clinical Practice Guidelines

Coordinated Care has adopted many of the preventive, physical and behavioral health clinical practice guidelines known to be effective in improving health outcomes. These guidelines are adopted in consultation with contracted health care professionals; and published by the American Psychiatric Association, Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Academy of Child and Adolescent Psychiatry as well as evidence-based practices for a variety of services.

Whenever possible, Coordinated Care adopts clinical practice guidelines that are published by nationally recognized organizations or government institutions based on current scientific evidence, medical literature, and national accrediting bodies, as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field. Coordinated Care providers are expected to follow these guidelines.

Practice guidelines are both clinical and preventative in nature, are based on valid and reliable clinical evidence and consider the needs of the members. They are reviewed and approved at least annually, more often if national guidelines change during that time, by our Quality Assurance Improvement Committee.

Behavioral healthcare guidelines: Because behavioral healthcare clinical practice guidelines often address primary, secondary or tertiary prevention as part of the management of acute or chronic conditions, Coordinated Care may adopt preventive and/or non-preventive behavioral health clinical practice guidelines.

Practice guidelines include, but are not limited to treatment of serious mental illness and chronic substance use disorders such as

- Schizophrenia or Major Depressive Disorder,
- Medication Management for Mental Health Disorders, and
- Opioid Risk and Prescription.

Clinical Practice Guidelines may be accessed through our website, www.CoordinatedCareHealth.com, or you may request a paper copy of the guidelines by contacting your network representative or by calling 1-877-644-4613 (TTY: 711). Copies of our evidence-based practices can be obtained in the same manner. Clinical Practice Guidelines are posted on our website within sixty (60) calendar days of adoption or revision, identifying which specific guidelines are newly adopted or revised. Compliance with Clinical Practice Guidelines is assessed annually as part of the quality process.

12 CLINICAL PRACTICE GUIDELINES

Coordinated Care clinical and quality programs are based on evidence-based preventive and clinical practice guidelines. Whenever possible, Coordinated Care adopts physical and

behavioral health practice guidelines known to be effective in improving health outcomes. These guidelines are published by nationally recognized organizations or government institutions as well as statewide collaborative and/or a consensus of healthcare professionals in the applicable field. Practice guidelines must be valid and reliable clinical scientific evidence. In the absence of scientific evidence, must be based on professional standards; or in the absence of scientific evidence and professional standards, a consensus of Health Care Professionals in the particular field. Coordinated Care providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. Following is a *sample* of the clinical practice guidelines adopted by Coordinated Care:

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: [Standards of Medical Care in Diabetes](#)
- [Center for Disease Control and Prevention \(CDC\)](#): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- [U.S. Preventive Services Task Force Recommendations](#) for Adult Preventive Health

Coordinated Care develops guidelines based on the United States Preventive Services Task Force (USPSTF) as the primary source. For links to the most current version of the guidelines adopted by Coordinated Care, visit our website at www.CoordinatedCareHealth.com.

13 CARE MANAGEMENT PROGRAM

The Care Management program is designed to help members obtain needed services, whether those services are covered within the Coordinated Care array of services, from community resources, or from other non-covered venues. Our Care Management program is designed to improve healthcare practice and assist members and their support system to become engaged in a collaborative recovery process that encompasses management of medical, social, mental health, and substance use conditions more effectively. The goal of Care Management is to achieve an optimal level of wellness and improve coordination of care.

The program is based upon an integrated care model that uses a multi-disciplinary case management team of licensed and non-licensed clinicians. The goal of case management is to monitor and manage the care of Medicaid beneficiaries in an effort to increase access to care and reduce inappropriate ED and other high-cost care usage. We engage in a collaborative behavioral and physical health whole-person approach that facilitates in providing resources, engagement, health education, and care planning to ensure the appropriate care is provided to the member. Members are engaged through an outbound call and mailing service using techniques of behavior modification, motivational interviewing, self-monitoring, problem solving, and trauma informed care. All members receive a welcome/screening call and multiple subsequent follow-up calls from a team member.

The program consists of a systematic approach for early identification of eligible members, needs assessment, and development and implementation of an individualized care plan that includes:

- Member/family education
- Actively links the member to providers and support services
- Outcome monitoring and reporting back to the PCP

Our Care Management team will integrate covered and non-covered services and provide a holistic approach to a member's medical, social, behavioral health, and substance use conditions. We will coordinate access to services not included in the core benefit package, such as transportation and dental services. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver support, impaired cognitive abilities and transportation needs.

A Care Management team is available to help all providers manage access to services for their patients who are Coordinated Care members. Listed below are programs and components of services that are available and can be accessed through the case management team. We look forward to hearing from you about any Coordinated Care members who could benefit from the addition of care management.

Included in our Care Management program are the following (some programs do not apply to Apple Health Expansion members):

- Opioid Use Disorder/Substance Use Disorder Management
- Medication Adherence
- Transitions of Care
- Diabetes Management
- Depression Management
- Choose Tomorrow suicide support
- Zero Overdose
- Care Coordination
- Health Coaching
- Cardiac Management
- Asthma Management
- Children and Individuals with Special Healthcare Needs
- ED Super Utilizers
- Post Hospital Follow-up Readmissions
- Pre-Discharge Planning
- Social Determinants of Health
- Acquiring ABA services
- Blood Lead Level reduction

Referrals for care management can be made through the secure provider portal, or providers may contact a care manager for referral or more information on any of our programs:

Coordinated Care (Medicaid) Care Management Department
1-877-644-4613 (TTY: 711).

Send a secure email to caremanagement@coordinatedcarehealth.com

Apple Health Core Connections Health Care Coordination (Foster Care)
1-844-354-9876

Send a secure email to AHCCTeam@coordinatedcarehealth.com

13.1 Chronic Care/Disease Management Programs

Chronic Care/Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition through ongoing integrative care. Chronic care management supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

Disease management programs promote a coordinated, proactive, disease-specific approach to management that will improve members' self-management of their conditions, improve clinical outcomes, and control high costs associated with chronic medical conditions. Coordinated Care programs include but are not limited to asthma, diabetes, smoking cessation, depression and congestive heart failure.

It is worth noting that diagnosis of a certain condition, such as diabetes, does not mean automatic enrollment in a chronic care/disease management program. Members with selected disease states will be stratified into risk groups that will determine the need and level of intervention most appropriate for each case. High-risk members with co-morbid or complex conditions will be referred for case management program evaluation.

To refer a member for chronic care management call:

Coordinated Care Management

1-877-644-4613

Send a secure email to caremanagement@coordinatedcarehealth.com

Smoking Cessation - As part of disease management, Coordinated Care and Apple Health Core Connections (Foster Care) offer smoking and tobacco cessation programs with health coaches who can assist members who are ready to quit tobacco use.

Members may refer themselves or providers can refer members to these programs by calling the numbers below:

Washington Apple Health (Medicaid)

1-866-274-5791, Ext. #6

Apple Health Core Connections (Foster Care)

1-844-882-3827, Ext. #4

Tobacco cessation medications are outlined within the Preferred Drug List (PDL) located on the website under Pharmacy. A prior authorization is required for some of these medications.

13.2 Integrated Care Teams (ICTs)

Coordinated Care provides Care Management services through Integrated Care Teams (ICTs). ICTs consist of Care Managers, Program Specialists, Health Coaches, Program Coordinators, Community Health Workers, Medical Directors, Pharmacy Directors, and other key individuals involved in Member Services and care coordination activities on the member's behalf. ICTs will be led by clinical licensed nurses or behavioral health clinicians with either adult or pediatric expertise as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the

population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. The Coordinated Care ICT will manage care for members whose needs are primarily functional as well as those with such complex conditions as hemophilia, breast/cervical cancer, trauma, organ transplants, and renal dialysis. Foster care members and children with special health care needs are at special risk and are also eligible for enrollment in Care Management that may result in the formation of an ICT to address the member's complex needs.

Our integrated care management program strives to improve health outcomes while monitoring healthcare costs. Integrated care management is a collaborative process of assessing, care planning, and advocating for options and services that meet a member's healthcare needs. Care managers assist with transitions of care, care planning, and provide healthcare education. They also direct members to the right services, information, and programs to help avoid unnecessary hospital stays and duplicative services.

Through integrated care management, members:

- Learn about their chronic co-morbid conditions
- Become empowered to take an active role in their healthcare
- Provide wrap around support with their family and caregivers in the management of their chronic conditions
- Decrease health care costs through fewer inpatient admissions and emergency room visits
- Engage their whole person by integrating their behavioral and physical health care

13.3 Patient Centered Medical Home Qualification Standards

In order for the Medical Home program to be successfully implemented, each participating PCP must first meet specific standard of care criteria. Additionally, each PCP or PCP provider group must have a minimum number of assigned members to ensure statistically sound measurement of their performance in any given year. The criteria listed below depict the minimum qualification requirements for providers wishing to participate in our Medical Home program:

- Applicant must be a credentialed, participating (contracted) health plan provider with a Primary Care Provider (PCP) designation
- Applicant must have extended office hours to include evenings, weekends, same-day and urgent care
- Applicant must have provisions for patients to receive service beyond office visits (i.e., phone, email, online)
- Applicant must have services specifically designed for patients with chronic conditions (outreach/educational programs, extended care staff)
- Applicant must have an efficient system of communication with hospital and ER personnel to ensure timely communication of patient ER use and discharge notices
- Applicant must be willing to work in a team-oriented care delivery system
- Applicant must be willing to provide or have provided to patients (by an agreed upon third party) education programs for his/her patients that are documented, tracked and trended

Health Home Services: The Health Home program is a service available to eligible Washington Apple Health (Medicaid) members with chronic conditions (does not apply to the Apple Health Expansion population).

The program was created under the Affordable Care Act (ACA) to provide care coordination and services to high-risk Medicaid members. These services specifically assist members with serious chronic conditions like diabetes, asthma, heart disease, etc.

Health Home services include:

- Care management
- Care coordination and health education
- Transitional care
- Individual and family support services
- Referrals to community and social support services

Is your patient eligible for Health Home Services?

Contact Coordinated Care's Health Home team at 1-877-644-4613 (TTY: 711) to find out. Apple Health Expansion members are not eligible for the Health Home program. If your patient is not eligible, you can learn why by visiting the Washington Healthcare Authority's Health Home Resource Page and using the Clinical Eligibility Tool available under Forms.

Contracted providers are also able to become qualified Health Home Care Coordination Organizations. Providers interested in participating in our Health Home program should contact the Health Home team at CCWHealthHomes@centene.com.

13.4 Partnership Access Line (PAL)

The Partnership Access Line (PAL) is Washington's telephone-based child mental health consultation system funded by the state legislature. PAL employs child psychiatrists, child psychologists, and social workers affiliated with Seattle Children's Hospital to deliver its consultation services. The PAL team is available to any primary care provider throughout Washington.

PCPs may call 1-866-599-7257 between the hours of 8:00 a.m. and 5:00 p.m. for any type of child mental health issue that arises with any child, not just Coordinated Care members. Network prescribers can bill HCA for their time spent engaging in a Second Opinion Network review by submitting a claim using procedure code 99441. Additional information regarding the PAL may be found at: <http://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/>.

Mental Health Referral Service for Children and Teens (MHRS)

Washington's MHRS connects patients and families with evidence-supported outpatient mental health services in their community. MHRS is a telephone-based referral service that is funded through HCA, operated by Seattle Children's Hospital, and free to families. Health care providers do not access MHRS. Rather, they are routed to PAL for consultation. Facilitation activities include assessing the level of services needed by the child within one to two weeks of receiving a call from a parent or guardian, and identifying mental health professionals who are in network with the child's health plan and accepting new patients. This service coordinates

contact between the family and mental health provider and provides post-referral reviews to determine if the child still has unmet needs. The PAL Family Referral Line is (833) 303-5437.

Perinatal Psychiatry Consult Line for Providers (PPCL)

The University of Washington (UW) Perinatal Psychiatry Consult Line for providers is a free telephone consultation service for health care providers on any mental health-related questions for patients who are pregnant, in the first year postpartum, or who have pregnancy-related complications (e.g., pregnancy loss, infertility). PPCL is staffed to respond to calls between 1:00 p.m. and 5:00 p.m. on weekdays. PPCL for Moms line is (203) 685-2924.

Additional information at: <http://providerresource.uwmedicine.org/videos/partnership-access-line-pal-for-moms1>

14 MEDICAL RECORDS

14.1 Medical Records Management and Records Retention

Coordinated Care providers must keep accurate and complete patient medical records, financial and other records pertinent to Coordinated Care members. Such records will enable providers to render the highest quality healthcare service to members. They will also enable Coordinated Care to review the quality and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location.

Coordinated Care requires providers to maintain all records for members for at least ten (10) years; however, when an audit, litigation or other action involving records is initiated prior to the end of such period, records shall be maintained for a minimum of ten (10) years following resolution of such action (42 CFR 438.3(h)). See the Member Rights section of this provider manual for policies on member access to medical records.

14.2 Required Information

To be considered a complete and comprehensive medical record, the member's medical record (file) should include, at a minimum, provider notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (i.e., x-rays, laboratory tests). Medical records should be accessible at the site of the member's participating primary care physician or provider. All medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, should be documented and prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.

- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members, or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Coordinated Care and HCA practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use history via evidence-based screening tools.
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records protected.
- Evidence that an Advance Directive has been offered to adults 18 years of age and older.

14.3 Medical Records Release

All members' medical records shall be confidential. Under 42 CFR Part 2, information related to substance use disorders should not be released without the written authorization of the member or their parent/legal guardian. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

14.4 Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Coordinated Care members. If the member or member's parent/legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

14.5 Medical Records Audits

Coordinated Care will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of services, as well as the outcome of such services, is also subject to review and assessment during a medical record audit. Coordinated Care will provide written notice prior to conducting a medical record review.

14.6 HCA Medical Record Requirements

The Clinical Data Repository (CDR) web portal

The CDR web portal is available for viewing by all licensed professionals. This includes physical and behavioral health providers and their delegates. Data contributed by the provider community and Sponsors, as part of data collection initiatives, provides a longitudinal record of patient care and claims information.

- All organizations viewing CDR data must be a HIPAA covered entity and have a HIE participation agreement with OneHealthPort.
- Only staff with a need to view individual client-level data may access the CDR. (As determined by their manager and configured by their internal IT access staff.) This is similar to how your organization grants electronic health records access.
- Users can complete training in one hour or less. Organizations using the CDR will not incur training costs from OneHealthPort or HCA. Reference materials are available on OneHealthPort's website: <https://www.onehealthport.com/clinical-portal>

CDR Participation Requirements and Options

"The MCO shall require that when their subcontracted provider organizations with certified EHRs see an Apple Health (Medicaid) Managed Care members they send a care summary (CCDA) from the provider's EHR to the Clinical Data Repository..."

If your organization meets the following three criteria then you are required to participate in the CDR:

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

For assistance with CDR registration, the OneHealthPort help desk is available 24 hours a day, seven days a week by calling 1-800-973-4797.

15 FRAUD, WASTE, AND ABUSE

Coordinated Care takes the detection, investigation, and prosecution of fraud, waste and abuse (FWA) very seriously, and has a FWA program that complies with the State of Washington and federal laws. Coordinated Care, in conjunction with its parent company, Centene, operates a FWA Special Investigations Unit (SIU). Coordinated Care routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims section of this provider manual. SIU performs retrospective and prospective audits which, in some cases, may result in taking actions against providers who commit waste, abuse, and/or fraud. Coordinated Care is required to recoup all identified overpayments after review of claims and medical records.

These actions may include but are not limited to:

- Remedial education and training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Referral of potential fraud to the Medicaid Fraud Control Division of the state Attorney General's office
- Any other remedies available to rectify

Some of the most common FWA practices include:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes
- Excessive use or misrepresentation of quantity of units
- Misuse of Benefits
- Claims for services not rendered or failure to adequately document services
- Services provided by non-credentialed providers without documentation indicating supervised services

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. Coordinated Care and Centene take all reports of potential waste, abuse or fraud very seriously and investigate all reported issues. Suspected FWA may also be reported directly to the Health Care Authority at 1-800-562-6906.

15.1 Understanding Important FWA Laws

False Claims Act: The False Claims Act is a federal law (31 United States Code §3729-3733) that prohibits:

- Presenting a false claim for payment or approval;
- Making or using a false record or statement in support of a false claim;

- Conspiring to violate the False Claims Act;
- Falsely certifying the type/amount of property to be used by the Government;
- Certifying receipt of property without knowing if it's true;
- Buying property from an unauthorized Government officer; and
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

Penalties and damages for violating the False Claims Act include fines and imprisonment. Damages may be tripled, and monetary penalties range from \$5,000 to \$10,000 for each false claim. If convicted, an individual will be fined, imprisoned, or both. If the violations resulted in death, the individual may be imprisoned for any term of years or for life, or both (18 United States Code §1347). The False Claims Act's 'qui tam' provision allows an individual with knowledge of past or present fraud committed against the government to bring a lawsuit on behalf of the government. Qui tam provides whistleblower protections for good faith reports and affords the individual the right to receive all or part of a penalty imposed.

Anti-Kickback Statute: The Anti-Kickback Statute (42 United States Code §1320a-7b(b)) prohibits knowingly and willfully soliciting, receiving, offering or paying remuneration, including any kickback, bribe, or rebate, for referrals for services that are paid in whole or in part under a federal health care program. The penalty for violations of the Anti-Kickback Statute includes fines of up to \$25,000, imprisonment up to five (5) years, or both fine and imprisonment.

The Stark Statute: The Stark Statute or Physician Self-Referral Law (42 United States Code §1395nn) prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply). Claims tainted by an arrangement that does not comply with Stark are not payable. Penalties range from up to a \$15,000 fine for each service provided and up to a \$100,000 fine for entering into an arrangement or scheme.

The Social Security Act and Federal Exclusions: Under the Social Security Act (42 U.S.C. §1395(e)(1)) and the federal laws that govern program integrity for federal and state health care programs (42 C.F.R. §1001.1901), no federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General (OIG) or another agency of the federal government. Excluded providers shall be terminated from Coordinated Care's network.

15.2 FWA Program Compliance Authority and Responsibility

The Coordinated Care Vice President of Compliance has overall responsibility and authority for carrying out the provisions of the compliance program. Coordinated Care is committed to identifying, and investigating suspected fraud, waste, and abuse. All cases of potential fraud are referred to the Washington State Medicaid Fraud Control Division of the state Attorney General's office.

The Coordinated Care provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury

proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

16 GRIEVANCES AND APPEALS PROCESS

16.1 Member Grievances

A member grievance is defined as any member's expression of dissatisfaction about any matter other than an "adverse determination." Grievance topics include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

A grievance may be requested in writing or verbally. The member, the member's authorized representative or a provider acting on behalf of the member (with the member's written consent) may file a grievance. Coordinated Care will assist members in completing forms or other procedural steps to file a grievance. This includes, but is not limited to, auxiliary aids and services, such as providing interpreter services and toll-free numbers that have adequate TTY and interpreter capability. Any individual who resolves a grievance will not be involved in any previous level of review or decision-making nor will they be a subordinate or direct report of any such individual. In any case where the reason for the grievance involves clinical issues, Coordinated Care shall ensure that the decision makers are healthcare professionals with the appropriate clinical expertise in treating the member's condition or disease. Coordinated Care values its providers and will not take punitive action, including termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member's behalf. There is no time limit on when the member or member's authorized representative can file a grievance. Coordinated Care will assist both members and providers with filing a grievance and may be contacted at:

Coordinated Care
Attention: Grievance Department
1145 Broadway, Suite 700
Tacoma, WA 98402
Phone: 1-877-644-4613 (TTY: 711).

16.2 Acknowledgement

For informal grievances, defined as those received verbally and resolved immediately to the satisfaction of the member, representative or provider, the staff will verbally provide resolution and document the resolution details. For grievances that could not be resolved verbally, the staff will acknowledge the grievance within two (2) business days. Acknowledgement may be either in writing or verbally and will include the substance of the grievance.

16.3 Grievance Resolution Time Frame

Grievance resolution will occur as expeditiously as possible, not to exceed 45 calendar days from the date of the initial receipt of the grievance. Member notification of grievance resolution shall be made within five business days of determination, but not more than 45 days after receipt. The resolution notification may be verbal or in writing for grievances not involving clinical issues. Notices of disposition for clinical grievances must be in writing. Grievances will

be resolved by the Grievance Coordinator, with direction from other Coordinated Care staff as needed. If the health plan extends the timeframe for resolution, it shall, for any extension not requested by the member, give the member written notice within 2 calendar days of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.

16.4 Notice of Resolution

The Grievance Coordinator will provide written resolution to the member, representative or provider within the timeframes noted above for any grievances not resolved verbally at the time of call. The grievance response shall include, but not be limited to, the decision reached by Coordinated Care, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the members. A copy of verbal complaints logs and records of disposition of written grievances shall be retained for ten (10) years.

16.5 Appeals

An appeal is the request for review of an adverse benefit determination. An adverse benefit determination is the denial or limited authorization of a requested service, including:

- The type or level of service,
- Requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit,
- The reduction, suspension or termination of a previously authorized service,
- The denial, in whole or in part, of payment for a service; the determination of whether the member has “good cause” not to cooperate with third-party liability procedures when this will result in denial of payment,
- The failure to provide services or act in a timely manner as required herein, including failure to issue an authorization or denial within required timeframes,
- Failure of Coordinated Care to act within the timeframes for disposition, resolution, and notification of appeals and grievances,
- The denial of member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities,
- For a rural area resident with only one Managed Care Organization (MCO) available, the denial of the member’s request under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside the Coordinated Care network; or,
- For a plan’s denial of coverage by an out-of-network provider when the in-network providers do not have the needed training, experience, and specialization, or do not provide the service the member seeks, when receiving all care in-network would subject the member to unnecessary risk, or when other circumstances warrant out-of-network treatment. (42 C.F.R. § 438.400(b)).

The appeal may be requested in writing or verbally. The member, the member’s authorized representative or a provider acting on behalf of the member (with the member’s written consent) may file an appeal. Appeals can be mailed, called in or faxed to:

Coordinated Care of Washington
Appeals Department

1145 Broadway, Suite 700
Tacoma, WA 98402
Phone: 1-877-644-4613 (TTY: 711)
Fax: 1-866-270-4489

Coordinated Care will help members complete forms and other procedural steps to file an appeal. This includes, but is not limited to, auxiliary aids and services, such as providing interpreter services and toll-free numbers that have adequate TTY and interpreter capability.

Appeals must be made within 60 calendar days from the date on Coordinated Care's notice of determination. For appeals for termination, suspension, or reduction of previously authorized services when the member requests continuation of such services, the member must file an appeal within ten calendar days of the date on the Coordinated Care's notice of determination.

16.6 Acknowledgement

Coordinated Care shall acknowledge receipt of each standard appeal in writing within five calendar days after receiving an appeal. Expedited appeals will be acknowledged either in writing or verbally within 72 hours of receipt.

16.7 Expedited Appeals

An appeal may be expedited when either Coordinated Care or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. Certain authorization denials will automatically qualify for expedited review. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal will be transferred to the timeframe for standard resolution of appeals and Coordinated Care will make reasonable attempts to give the member verbal notification of the denial and follow up with a written notice within two (2) calendar days. The member has a right to file a grievance regarding Coordinated Care's denial of a request for expedited resolution. Coordinated Care will inform the member of their right to file a grievance in the notice of denial of expedited status.

Resolutions of expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours after initial receipt of the appeal. Coordinated Care may extend the appeal timeframe for an additional 14 days if it is in the member's best interest.

16.8 Resolution

Coordinated Care shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 14 calendar days from the date Coordinated Care receives a non-expedited appeal. Coordinated Care may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Coordinated Care demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Coordinated Care shall make reasonable efforts to provide verbal notice of the delay and follow up within

two calendar days with written notice to the member of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision. In all circumstances, the appeal determination must not be extended beyond 28 calendar days.

Written notice will include the following information:

- The decision reached by Coordinated Care,
- The date of decision,
- A written statement of the clinical rationale for the decision including how the requesting provider or member may obtain the Utilization Management clinical criteria or decision-making criteria,
- For appeals not resolved wholly in favor of the member, the right to request a State administrative hearing and information as to how to do so, and
- The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the Coordinated Care decision.

16.9 Administrative Hearing Process

An appeal that is not resolved wholly in favor of the member by Coordinated Care may be appealed to the Office of Administrative Hearings (OAH) by the member or the member's authorized representative. A provider may not request a hearing on behalf of a member. Coordinated Care will provide to HCA and the member, upon request, and within three business days, and for expedited appeals, within one business day, all Coordinated Care documentation related to the appeal including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities.

The member or their authorized representative (with the member's written consent) may request a hearing from the Office of Administrative Hearings by contacting:

Office of Administrative Hearings
PO Box 42489
Olympia, Washington 98504-2489
Phone: 1-800-583-8271

16.10 Independent Review

After exhausting both the Coordinated Care and the Administrative Hearing Process, a member has the right to independent review by an Independent Review Organization (IRO) in accordance with RCW 48.43.535. The member may request an independent review within 21 calendar days of the hearing decision, or they may skip directly to HCA's Board of Appeals Judge Decision.

If a member, Coordinated Care or HCA disagrees with the results of the administrative hearing or independent review, any party may appeal the decision to HCA's Board of Appeals in accordance with Chapter 182-526 WAC.

16.11 HCA Board of Appeals Judge Decision

If a member does not agree with the IRO's decision, a member has the right to ask for a final review of the case by HCA Review Judge. A request for this review must be made within 21 calendar days of the date of mailing of the IRO decision. The decision of HCA's Review Judge is final. To ask for this review, please contact:

HCA Board of Appeals
PO Box 42700
Olympia, WA 98504
Toll Free: 1-844-728-5212
Phone: 360-725-0910
Fax: 360-507-9018

16.12 Continuation of Services

Coordinated Care shall continue the member's services if all the following apply:

- An appeal, hearing, or independent review is requested on or before the later of the following:
 - Within ten calendar days of Coordinated Care mailing the notice of adverse benefit determination, which for adverse benefit determinations involving services previously authorized
 - The intended effective date of Coordinated Care's proposed adverse benefit determination
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider
- The original period covered by the original authorization has not expired
- The member requests an extension of the service(s)

If, at the member's request, Coordinated Care continues or reinstates the member's services while the appeal, hearing, independent review or HCA Board of Appeals is pending, the services shall be continued until one of the following occurs:

- The member withdraws the appeal, hearing, or independent review request
- Ten (10) calendar days pass after Coordinated Care mails the notice of resolution of the appeal and the member has not requested a hearing (with continuation of services until the hearing decision is reached) within the ten (10) calendar days
- Ten (10) calendar days pass after HCA mails the initial hearing decision and the member has not requested an independent review (with continuation of services until the independent review decision is reached) within the ten (10) calendar days
- Ten (10) calendar days pass after Coordinated Care mails the notice of the resolution of the independent review and the member has not requested an HCA Board of Appeals (with continuation of services until HCA Board of Appeals decision is reached) within ten (10) calendar days
- The time period of service limits of a previously authorized service has been met.
- When the Office of Administrative Hearings (OAH) issues a decision adverse to the member.

If the final resolution of the appeal upholds Coordinated Care's determination, Coordinated Care may recover from the member the amount paid for the services provided to the member for the first 60 calendar days during which the appeal was pending, to the extent they were provided solely because of the requirement for continuation of services.

16.13 Reversed Appeal Resolution

In accordance with 42 CFR §438.424(a), if Coordinated Care, the State Office of Administrative Hearings (OAH), independent review organization (IRO), or HCA's Review Board reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, Coordinated Care shall authorize or provide the disputed services promptly and as expeditiously as the member's health requires, but no later than 72 hours from the date Coordinated Care receives notice reversing the determination.

If Coordinated Care, OAH, IRO or the Board of Appeals reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, Coordinated Care shall pay for those services (42 CFR §438.424(b)).

16.14 Availability of Behavioral Health Advocates

The Office of Behavioral Health Advocacy (OBHA) is an independent body that represents members engaged in behavioral health services and supports members by providing consulting, resources, advocacy, and mediation for complaints against behavioral health services by individual providers and facilities. The role of the Office of Behavioral Health Advocates (OBHA) is to support and advocate for individuals who are receiving or applied for Medicaid. Behavioral Health Advocates are also available to assist members in filing a grievance or appeal with Coordinated Care. Providers can obtain contact information for regional behavioral health advocates on the OBHA website: <https://www.obhadvocacy.org/>.

17. Behavioral Health Supplemental Transaction (BHST)

17.1 BHST Requirements

BHST means non-encounter data submissions as defined in the Behavioral Health Supplemental Transaction Data Guide, published by the Health Care Authority. The data includes additional demographic and social determinant data, as well as service episode and outcome data necessary for federal Substance Abuse and Mental Services Administration (SAMHSA) block grant reporting and other state reporting needs.

Behavioral Health agencies providing mental health and substance use disorder treatment to members must comply with all reporting requirements outlined in the latest BHST Data Guide, and implement any updates to the [BHST Data Guide](#) within 120 calendar days of the publication date. Behavioral Health agencies must submit BHST data to the vendor selected by Coordinated Care, Beacon, via the ProviderConnect system and cooperate with all data validation audits. To sign up for ProviderConnect, send a request via email to wabhds@beaconhealthoptions.com. Behavioral Health agencies must submit corrections to BHST data within 14 calendars of notification from Beacon or Coordinated Care.

18 QUALITY IMPROVEMENT PROGRAM

18.1 Overview

Coordinated Care culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program uses a systematic approach to quality improvement initiatives using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions.

Coordinated Care analyzes and evaluates the results of QI activities including annual review of the results of performance measures, utilization data, and performance improvement, and institute actions to address performance deficiencies, including policy recommendations with appropriate follow-up.

Coordinated Care recognizes its legal and ethical obligation to provide members with a level of care and access to services that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, Coordinated Care will provide for the delivery of quality care with the primary goal of improving the health status of its members. Where the member's condition is not amenable to improvement, Coordinated Care implements measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This includes the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Coordinated Care QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

18.2 QAPI Program Structure

The Coordinated Care Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BOD oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness of—and continuously enhance and improve the quality of—care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring: the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the QI, UM, and Credentialing and Re-credentialing programs.

The following subcommittees report directly to the QIC:

- Health Equity Improvement Committee (HEIC)
- Population Health and Clinical Operations (PHCOC)
 - WISe Sub-Committee
 - Utilization Management
- Performance Improvement Workgroups (ad Hoc)
- Clinical Policy Committee (CPC)
- Community Advisory Committee (CAC)

18.3 Practitioner Involvement

Coordinated Care recognizes the integral role practitioner involvement plays in the success of its QAPI Program. Practitioner involvement at various levels of the process is highly encouraged through provider representation. Coordinated Care encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentialing Committee, and select ad-hoc committees.

18.4 Quality Assessment and Performance Improvement

Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to Coordinated Care members. The Coordinated Care QAPI Program incorporates all demographic groups and ages, lines of business, benefit packages, care settings, providers and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, long-term care (depending on the product), ancillary services, and operations.

Coordinated Care's primary QAPI Program goal is to improve the health status of members through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

To that end, the Coordinated Care QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulations
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department entity oversight
- Department performance and service
- Employee and provider cultural awareness & responsiveness
- Fraud and abuse detection and prevention
- Oversight of the quality activities of the plan to ensure compliance with contractual requirements, federal and state statutes and regulations, and requirements of accrediting bodies such as the National Committee for Quality Assurance (NCQA)
- Information management

- Assessment of health equity, including identification of health disparities
- Marketing practices
- Member enrollment and disenrollment
- Member Grievance and Appeals System
- Member Satisfaction
- Member Services
- Network Performance
- Organizational Structure
- Patient safety (including hospitals, ambulatory care centers and office-based surgery sites to endorse and adopt procedures for verifying correct patient, the correct procedure, and the correct surgical site that meets or exceeds those set forth in the Universal Protocol™ developed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
- Performance Improvement Projects (PIPs)
- Pharmacy Services & Benefits
- Primary Care Provider changes
- Provider and Plan accessibility
- Provider Availability
- Provider Complaint System
- Provider Network Adequacy and Capacity
- Provider Satisfaction
- Provider Services
- Adoption of preventive health, behavioral and physical practice guidelines known to be effective in improving health outcomes to promote appropriate and standardized quality of care
- Quality Management
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization Management, including under- and over-utilization

18.5 Patient Safety and Quality of Care

Patient Safety is a key focus of the Coordinated Care QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member. Coordinated Care employees (including Population Health and Clinical Operations staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting and analyses.

Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential quality of care issues

received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Per WAC 182-502-0022, Coordinated Care will deny or recover payments to healthcare professionals and inpatient hospitals for care related only to the treatment of the consequences of Healthcare Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC), also known as Serious Adverse Events. In accordance with 42 C.F.R § 434.6(a)(12) and Washington State regulations, Coordinated Care require all its providers to report Provider Preventable Conditions associated with claims for payment or members treatments for which payment would otherwise be made.

18.6 Performance Improvement Process

The Coordinated Care QIC reviews and adopts an annual QAPI Program and Work Plan based on Medicaid (and, where appropriate, Medicare) managed care appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to identify problems, issues, and trends with the objective of developing improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Coordinated Care to monitor increased and sustained improvement over time regarding the health outcomes of the member. Certain performance improvement projects are specified by HCA, with ongoing monitoring and outcomes reported regularly to HCA.

Annually, Coordinated Care develops a QAPI Work Plan for the upcoming year, with quarterly updates throughout the year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QIC activities, reporting and studies from all areas of the organization (clinical and service) and includes:

- Goals and objectives for the year, including objectives for patient safety, serving a culturally and linguistically diverse membership, individuals with special health care needs, health equity, and health care utilization
- Timelines for completion each activity and reporting to the QIC as well as requirements for external reporting
- Identification of a responsible person for each activity
- Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs as defined in HCA's Quality Strategy
- Studies and other performance measurement activities and metrics to be tracked over time are scheduled in the QAPI Work Plan

Coordinated Care communicates activities and outcomes of its QAPI Program to both members and providers through avenues such as the member newsletter, provider newsletter and the Coordinated Care web portal at www.CoordinatedCareHealth.com.

At any time, Coordinated Care providers may request additional information on the health plan programs including a description of the QAPI Program and a report on Coordinated Care progress in meeting the QAPI Program goals by contacting the Quality Improvement department.

18.7 Quality Improvement (QI) Activities

Coordinated Care requires providers and practitioners to cooperate with all Coordinated Care Quality Improvement activities to improve the quality of care, services and member experience and allow the plan to use provider and/or practitioner performance data, to ensure the success of the Quality Improvement Program. If you are interested in learning more about our programs, please contact Coordinated Care at 1-877-644-4613 (TTY: 711) and ask to speak to the Quality Improvement Department.

18.8 Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans nationally. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.

HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Washington State Apple Health (Medicaid) contract between HCA and Coordinated Care.

As both the State of Washington and the Federal government move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider. HCA uses the aggregated HEDIS rates to evaluate the effectiveness of an MCO's ability to demonstrate an improvement in preventive health outreach to its beneficiaries. Physician-specific scores are used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs, such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on scoring of such quality indicators as HEDIS.

HEDIS Rate Calculations

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-10 and HCPCS codes can reduce the necessity of medical record reviews (see Coordinated Care website and HEDIS brochure for more information on reducing HEDIS medical record reviews). HEDIS Measures typically requiring medical record review include: childhood immunizations; diabetic HbA1c, LDL, eye exam and; controlling high-blood pressure; cervical cancer screening; and prenatal care and postpartum care.

Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-10 and HCPCS codes can reduce the necessity of medical record reviews.

Who conducts Medical Record Reviews (MRR) for HEDIS?

Coordinated Care conducts HEDIS MRR reviews in house and contracts with an independent national MRR vendor to support our internal efforts. Medical record review audits for HEDIS are conducted February through May each year. At that time, if any of your patient's medical records are selected for review, you will receive a call from a medical record review representative. Your prompt cooperation with the representative is greatly needed and appreciated.

Access to Records and Audits by Coordinated Care

Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit Coordinated Care or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, or remote access of such records, in order to audit, inspect, review, perform chart reviews, and duplicate such Records. If performed on site, access to records for the purpose of an audit shall be scheduled at mutually agreed upon times, with at least thirty (30) calendar days prior written notice by Coordinated Care or its designated representative, but not more than sixty (60) days following such written notice.

EMR Access

Whenever possible, the provider will grant Coordinated Care access to Provider's Electronic Medical Record (EMR) system in order to effectively case manage Members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the Coordinated Care for this access.

As a reminder, protected health information (PHI) may be used or disclosed for purposes of treatment, payment or healthcare operations in accordance with HIPAA Privacy Rules (45 CFR 164.506) and generally does not require consent or authorization from the member. Providers subject to 42 CFR Part 2 regarding substance use disorder-related information, must obtain written authorization from members prior to disclosure of such information to the extent required by that law. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Coordinated Care, which allows them to collect PHI on our behalf.

How can providers improve their HEDIS scores?

- **Understand the specifications** established for each HEDIS measure.
- **Submit claims and encounter data for each and every service rendered.** All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Coordinated Care. Claims and encounter data is the most clean and efficient way to report HEDIS.
- **Submit claims and encounter data correctly, accurately, and on time.** If services rendered are not filed or billed accurately, then they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- **Ensure chart documentation reflects all services provided.**
- **Submit claims and encounter data using CPT codes related to HEDIS** measures such as diabetes, retinal eye exam and controlling blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact us at 1-877-644-4613 (TTY: 711) and ask for the Quality Improvement department.

18.9 Provider Satisfaction Survey

Coordinated Care conducts an annual provider satisfaction survey, which includes questions to evaluate provider satisfaction with our services such as claims, communications, and utilization management. Behavioral health providers receive a provider survey specific to the provision of behavioral health services in the Coordinated Care network. These surveys are conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Coordinated Care, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

18.10 Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA-certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well we are meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

18.11 Collaboration with Developmental Disabilities Administration (DDA)

Coordinated Care participates in quarterly comprehensive reviews to assess the overall quality of care and services for individuals with developmental disabilities living in the community, in accordance with the Allen et al. vs. Western State Hospital settlement agreement. Members chosen for review are enrolled with DDA and have recently been involved in behavioral health inpatient or outpatient services, including but not limited to hospitalization at Eastern State or Western State hospitals.

18.12 Provider Performance Monitoring and Incentive Programs

Over the past several years, pay-for-performance (P4P) programs, which include provider profiling, have been nationally recognized as a promising strategy to improve the quality and cost-effectiveness of care. In Washington, Coordinated Care will manage a provider performance monitoring program to capture data relating to healthcare access, costs, and quality of care that Coordinated Care members receive.

The P4P program promotes efforts that are consistent with the Institute of Medicine's aims for advancing quality (safe, beneficial, timely, patient-centered, efficient and equitable) as well as recommendations from other national agencies such as the CMS-AMA Physician Consortium, NCQA, and NQF. Additionally, Coordinated Care will provide an opportunity for financial reward to PCPs and specialists using an incentive payment program that encourages accurate and timely submission of preventive health and disease monitoring services in accordance with evidence-based clinical practice guidelines.

The goals of Coordinated Care's P4P program are:

- Increase provider awareness of their performance in key, measurable areas
- Motivate providers to establish measurable performance improvement processes relevant to Coordinated Care member populations in their practices
- Use peer performance data and other established benchmarks to identify outlier provider practices that reflect best practices or less than optimal performance, to share this data (as appropriate) to educate and for future performance improvement opportunities
- Increase opportunities for Coordinated Care to partner with providers to achieve measurable improvement in health outcomes by developing and implementing nationally recognized, practice-based performance improvement initiatives

Coordinated Care will accomplish these goals by:

- Producing and distributing provider-specific reports containing meaningful, reliable, and valid data for evaluation by Coordinated Care and the provider.
- Creating incentives for provider implementation of practice-based performance improvement initiatives that are pertinent to Coordinated Care member populations linked with adopted evidence-based clinical practice guidelines and that yield measurable outcomes.
- Establishing and maintaining an open dialogue with providers related to performance improvement objectives.

Physicians, meeting a minimum panel threshold, may receive a quarterly profile report with an individual score for each measure. Scores will be benchmarked per individual measure and compared to the Coordinated Care network average and, as applicable, to the current NCQA Quality Compass Medicaid mean. Provider profile indicator data is not risk-adjusted, and scoring is based on provider performance within the service area range.

PCPs who meet or exceed established performance goals and who demonstrate continued excellence or significant improvement over time may be recognized by Coordinated Care in publications such as newsletters, bulletins, press releases, and recognition in our provider

directories as well as being eligible for applicable financial incentive programs. Additionally, Coordinated Care offers several financial incentive programs such as claim based incentive programs. More information on our incentive programs can be found on the provider web portal or by contacting Coordinated Care Contracting and/or Provider Relations departments.

18.13 Physician Incentive Programs

On an annual basis and in accordance with Federal Regulations, Coordinated Care must disclose to the Centers for Medicare and Medicaid Services (CMS) and HCA any Performance Incentive Programs that could potentially influence a physician's care decisions. The information that must be disclosed includes the following:

- Effective date of the Physician Incentive Program
- Type of Incentive Arrangement
- Amount and type of stop loss protection
- Patient panel size
- Description of the pooling method, if applicable
- For capitation arrangements, the amount of the capitation payment that is broken down by percentage for primary care, referral, and other services
- The calculation of significant financial risk (SFR)
- Whether Coordinated Care does not have a Physician Incentive Program
- The name, address, and other contact information of the person at Coordinated Care who may be contacted with questions regarding Physician Incentive Programs

Physician Incentive Programs may not include any direct or indirect payments to providers/provider groups that create inducements to limit or reduce the provision of necessary services. In addition, Physician Incentive Programs that place providers/provider groups at SFR may not operate unless there is adequate stop loss protection, member satisfaction surveys, and fulfillment of disclosure requirements satisfying the Physician Incentive Program regulations.

Significant Financial Risk occurs when the incentive arrangement places the provider/provider group at risk beyond the risk threshold, which is the maximum risk if the risk is based upon the use or cost of referral services. The risk threshold is set at 25% and does not include amounts based solely on factors other than a provider/provider group's referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

If you have questions regarding the Physician Incentive Program Regulations, please contact your Provider Engagement Administrator.

19 BILLING AND CLAIMS SUBMISSION

Coordinated Care processes claims in accordance with applicable prompt pay and timely claims payment standards specified for Medicaid fee-for-service in Section 1902(a) (37) (A) of the Social Security Act, 42 CFR 447.46 and specified for health carriers in WAC 284-170-431. **Per Section 1902(a)(25)(C) of the Social Security Act, providers are prohibited from directly billing Apple Health (Medicaid) beneficiaries.** Coordinated Care agrees to comply with these timely claims payment standards and will adjudicate and require our subcontracted vendors that process claims to adjudicate clean claims as follows:

- 95% of clean claims within thirty (30) calendar days of receipt
- 99% of clean claims within ninety (90) calendar days of receipt

The date of receipt is the date Coordinated Care receives the claim as indicated by its date stamp on the claim.

19.1 Clean Claim Definition

To eliminate confusion among providers and further ensure compliance, Coordinated Care has adopted HCA's definition of a Clean Claim: A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. The following exceptions apply to this definition: (a) a claim for which fraud is suspected; and (b) a claim for which a Third-Party Resource should be responsible.

19.2 Non-Clean Claim Definition

A non-clean claim is defined as a submitted claim that requires further investigation or development beyond the information contained in the claim. The errors or omissions in the claim may result in:

- A request for additional information from the provider or other external sources to resolve or correct data omitted from the claim
- A need for review of additional medical records
- A need for other information necessary to resolve discrepancies.

In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within timely filing standards.

Coordinated Care is required by State and Federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary rejections and/or denials.

Claims will be rejected or denied if not submitted correctly. In general, Coordinated Care follows the CMS billing requirements for paper, EDI, and web submitted claims. For questions regarding billing requirements not addressed in this manual, contact a Coordinated Care Provider Services Representative at 1-877-644-4613.

When required data elements are missing or are invalid, claims will be rejected or denied by Coordinated Care. Rejections must be corrected and re-submitted as a first-time claim. Denials must be re-submitted as a corrected claim, or if the provider disagrees with the outcome, they may follow the Reconsideration and Dispute process.

- For EDI claims, rejections happen through one of our EDI clearinghouses if the appropriate information is not contained on the claim.
- For paper claims, rejections happen prior to the claims being received in the claims adjudication system and will be sent to the provider with a letter detailing the reason(s) for the rejection.

- Denials happen once the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP) or Electronic Remittance Advice (ERA).

Claims for billable services provided to Coordinated Care members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

All claims filed with Coordinated Care are subject to verification procedures that include but are not limited to the following:

- All claims will be subject to 5010 validation procedures based on CMS and Washington State Healthcare Authority requirements.
- All required fields are completed on the current industry standard paper CMS 1500 Claim Form (HCFA), CMS 1450 Claim Form (UB-04), EDI electronic claim format, or claims submitted individually or batch on our Secure Provider Portal.
 - **Please note that *no copied or handwritten claim forms are accepted; these claims will be rejected and sent back to the provider.***
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for:
 - The date of service
 - Provider type/specialty billing
 - Bill type
 - Age/sex of the patient
- All Diagnosis Codes are to the highest number of digits available (4th or 5th digit).
- Principal Diagnosis billed reflects an allowed Principal Diagnosis as defined in the current ICD-10 CM for the date of service billed.
 - For a CMS 1500 claim form, this criteria looks at all procedure codes billed and the diagnosis to which they are pointing. If a procedure points to the diagnosis as primary and that code is not valid as a primary diagnosis code, that service line will deny.
 - All inpatient facilities are required to submit a Present on Admission (POA) indicator on all claims. Claims will be denied (or rejected) if the POA indicator is missing. Please reference the CMS billing guidelines regarding POA for more information and for excluded facility types.
- The Member identification number is located in Box 1A of the paper CMS 1500 claim form and Loop ID 2010 BA Segment NM109 of the 837p.
- A Member is eligible for services under Coordinated Care during the time period in which services were provided.
- Appropriate authorizations must be obtained for the services performed.
- Third party coverage has been clearly identified, and appropriate COB information has been included with the claim submission.

19.3 Rejections vs. Denials

REJECTION: A rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located on the website at www.CoordinatedCareHealth.com. Rejections will not enter our claims adjudication system, so

there will be no Explanation of Payment (EOP) for these claims. The provider will receive a letter for paper claims or a rejection report if the claim was submitted electronically. A rejected claim is not considered a clean claim, and the date of rejection does not qualify as the claim's received date for determining timely filing.

DENIAL: A denial is defined as a claim that has passed edits and entered the system but has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason.

19.4 Corrected Claims, Reconsiderations, and Claim Disputes

Except in the case of fraud or being related to coordination of benefits with another carrier, all requests for corrected claims, reconsiderations, or claim disputes must be received within 24 months of the date of service. Prior processing will be upheld for corrected claims or provider claims requests for reconsideration or disputes received outside of the 24-month timeframe. For coordination of benefits with another carrier, requests must be received within 30 months.

Relevant Claim Definitions

- **Corrected claim** – A provider is *changing* the original claim.
- **Request for reconsideration** – A provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
- **Claim dispute** – A provider disagrees with the claim outcome and is submitting medical records or other documentation to support the disagreement.

Corrected Claims

Corrected claims must clearly indicate they are corrected in one of the following ways:

- Submit a corrected claim via the Secure Provider Portal. Follow the instructions on the portal for submitting a correction.
- Submit a corrected claim electronically via a clearinghouse.
 - Institutional Claims (UB): Field CLM05-3=7 and REF*8 = **Original Claim Number**
 - Professional Claims (CMS): Field CLM05-3=7 and REF*8 = **Original Claim Number**
- Submit a corrected paper claim to:

Coordinated Care
Attn: Corrected Claims
PO Box 4030
Farmington, MO 63640-4197

- Upon submission of a corrected paper claim, the original claim number must be **typed** in field 22 (CMS 1500) and in field 64 CMS 1450 (UB-04) with the corresponding frequency codes in field 22 of the CMS 1500 and in field 4 of the CMS 1450 (UB-04) form.
- Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will be rejected upfront.

Request for Reconsideration

- A request for reconsideration is a communication from the provider about a disagreement with the manner in which a claim was processed. Requests for reconsideration do not require submission of supporting or additional information. An example of this is when a provider believes a particular service should be reimbursed at a particular rate, but the payment amount did not reflect that particular rate. Providers may elect to call Provider Services at 1-877-644-4613 to explain the request.
- Providers may send a written letter that includes a detailed description of the reason for the request. To ensure timely processing, the letter must include sufficient identifying information, which includes, at a minimum, the member name, member ID number, date of service, total charges, provider name, original EOP, and/or the original claim number. **It is not necessary to attach a copy of the submitted claim.**

Requests for reconsideration can be submitted in one of the following ways:

- Call Provider Services at 1-877-644-4613 to explain the request
- Mail requests for reconsideration and any applicable attachments to:

Coordinated Care
Attn: Request for Reconsideration
PO Box 4030
Farmington, MO 63640-4197

- Submit a reconsideration via the Secure Provider Portal. Follow the instructions on the portal for submitting a reconsideration.

The outcome of the Request for Reconsideration is communicated to the provider. An overturned request will result in a reprocessed claim with a new reason code. A written or verbal communication is shared with the provider when reconsideration requests result in upholding the original decision.

Claim Dispute

A claim dispute should be submitted when a provider believes additional information will result in a different outcome. Oftentimes, additional information is contained within medical records. Claim disputes can be submitted via mail or the Provider Portal. Disputes must include an explanation outlining why the original decision is incorrect, along with specific medical records supporting the suggested outcome.

A claim dispute must be submitted on a Claim Reconsideration and Dispute form found on our website under Manuals, Forms and Resources / Reconsideration Resources if the dispute is submitted via mail. The claim dispute form must be completed in its entirety. **DO NOT** include a copy of the original claim form with your dispute. Please submit one claim per dispute form.

Mail completed claim dispute forms and additional information to be considered to:

Coordinated Care
Attn: Claim Dispute
PO Box 4030
Farmington, MO 63640-4197

A Claim Reconsideration and Dispute form is not required for requests submitted via the Provider Portal.

A claim dispute will be resolved within 30 calendar days. If the original decision is upheld, a written letter will be sent that includes the rationale for upholding the decision. If the original decision is overturned the claim will be reprocessed with a new reason code.

Indian Health Care Providers have the ability to submit complaints to HCA for resolution and for the HCA to facilitate resolution directly with Coordinated Care.

19.5 Coding of Claims/Billing Codes

Coordinated Care requires claims to be submitted using codes from the current version of ICD-10, ASA, DRG, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary.

Below are some code related reasons a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of service
- Code inappropriate for the age or sex of the member
- Diagnosis code missing the 4th or 5th digit as appropriate
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on same date of service

19.6 Code Auditing and Editing

Coordinated Care uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment and reporting, as well as meeting HIPAA compliance regulations. The software will detect, correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifier, and place of service codes. Claims billed in a manner that does not adhere to the standards of the code editing software will be denied.

NOTE: A Reconsideration/Dispute with medical records is required for review of code-auditing software denials.

The code editing software contains a comprehensive set of rules addressing coding inaccuracies such as unbundling, fragmentation, up-coding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

- American Medical Association (AMA) – the software utilizes the CPT Manuals, CPT Assistant, CPT Insider's View, the AMA web site, and other sources.
- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) which includes column 1/column 2, mutually exclusive and outpatient code editor (OCE edits). In addition to using the AMA's CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Public-domain specialty society guidance (e.g., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario. In addition to nationally recognized coding

guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

The following provides conditions where the software will make a change on submitted codes:

Unbundling of Services – Identifies Services That Have Been Unbundled

Example: Unbundling lab panels. If component lab codes are billed on a claim along with a more comprehensive lab panel code that more accurately represents the service performed, the software will review for denial of unbundled codes or flag for post payment review.

Code	Description	Status
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, automated, and automated differential WBC	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Allow

Explanation: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes should be corrected to only the comprehensive lab panel code.

Bilateral Surgery – Identical Procedures Performed on Bilateral Anatomical Sites During Same Operative Session

Example:

Code	Description	Status
69436	Tympanostomy	Disallow
69436 50	Tympanostomy billed with modifier 50 (bilateral procedure)	Allow

Explanation: Identifies the same code being billed twice, when reimbursement guidelines require the procedure to be billed once with a bilateral modifier. These should be billed on one line along with modifier 50 (bilateral procedure). **Note:** *Modifiers RT (right), or LT (left) should not be billed for bilateral procedures*

Duplicate Services – Submission of Same Procedure More than Once on Same Date of Service That Cannot Be or Are Normally Not Performed More Than Once on Same Day

Example: Excluding a Duplicate CPT

Code	Description	Status
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Allow
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Disallow

Explanation: Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx. It is clinically unlikely that this procedure would be performed twice on the same date of service.

Evaluation and Management Services (E/M) – Submission of E/M Service Either Within a Global Surgery Period or on the Same Date of Service as another E/M Service

Global Surgery

Procedures that are assigned a 90-day global surgery period are designated as *major* surgical procedures; those assigned a 10-day or 0-day global surgery period are designated as *minor* surgical procedures.

- Evaluation and management services, submitted with major surgical procedures (90-day) and minor surgical procedures (10-day), are not recommended for separate reporting because they are part of the global service.
- Evaluation and management services, submitted with minor surgical procedures (0-day), are not recommended for separate reporting or reimbursement because these services are part of the global service unless the service is listed on the Missouri Fee Schedule with an asterisk.

Example: Global Surgery Period

Code	Description	Status
27447 - DOS 5/20/22	Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).	Allow
99213 - DOS 6/2/22	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling & coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 minutes face-to-face w/patient &/or family.	Disallow

Explanation:

- Procedure code 27447 has a global surgery period of ninety (90) days.
- Procedure code 99213 is submitted with a date of service that is within the 90-day global period.

When a substantial diagnostic or therapeutic procedure is performed, the evaluation and **management service is included in the global surgical period.**

Example: E/M with Minor Surgical Procedures

Code	Description	Status
11000	Debridement of extensive eczematous or infected skin; up to 10% of body surface.	Allow
99213	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 minutes face-to-face with patient and/or family.	Disallow

Explanation:

- Procedure 11000 (0-day global surgery period) is identified as a minor procedure.

- Procedure 99213 is submitted with the same date of service.
- When a minor procedure is performed, the evaluation and management service is considered part of the global service.

Same Date of Service

One evaluation and management service are recommended for reporting on a single date of service.

Example: Same Date of Service

Code	Description	Status
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Usually, problem(s) are moderate/high severity. Physicians spend 40 minutes face-to-face with patient and/or family.	Allow
99242	Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling/coordination of care with other providers or agencies is provided consistent with nature of problem(s) and patient's/family's needs. Presenting problem(s) are low severity. Physicians spend 30 minutes face-to-face with patient/family.	Disallow

Explanation:

- Procedure 99215 is used to report an evaluation and management service provided to an established patient during a visit.
- Procedure 99242 is used to report an office consultation for a new or established patient.
- Separate reporting of an evaluation and management service with an office consultation by a single provider indicates a duplicate submission of services. Interventions provided during an evaluation and management service typically include the components of an office consultation.

19.7 Modifiers

Modifiers – Codes Added to the Main Procedure Code to Indicate the Service Has Been Altered by a Specific Circumstance

- Modifier 24 is used to report an unrelated evaluation and management service by the same physician during a post-operative period.
- Modifier 25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.
- Modifier 79 is used to report an unrelated procedure or service by the same physician during the post-operative period.
- When modifiers 24 and 25 are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician,

the evaluation and management service is questioned, and a review of additional information is recommended.

- When modifier 79 is submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, separate reporting of the evaluation and management service is recommended.
- Modifier PO is used to report services, procedures and/or surgeries provided at off-campus provider-based outpatient departments.
- Modifier XE is used to report a separate encounter, a service that is distinct because it occurred during a separate encounter.
- Modifier XP is used to report a separate practitioner, a service that is distinct because it was performed by a different practitioner.
- Modifier XS is used to report a separate structure, a service that is distinct because it was performed on a separate organ/structure.
- Modifier XU is used to report a separate unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

Modifier 26 (professional component)

Definition: Modifier 26 identifies the professional component of a test or study.

- If modifier 26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.
- When a claim line is submitted without the modifier 26 in a facility setting (for example, POS 21, 22, 23, 24), the rule will replace the service line with a new line with the same procedure code and the modifier 26 appended.

Example: Inpatient POS

Code	Description	Status
78278	Acute gastrointestinal blood loss imaging	Disallow
78278 26	Acute gastrointestinal blood loss imaging	Allow

Explanation:

- Procedure code 78278 is valid with modifier -26.
- Modifier 26 will be added to procedure code 78278 when submitted without modifier 26.

Modifier 80, 81, 82, and AS (assistant surgeon)

Definition: This edit identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically does not require an assistant surgeon.

Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, and assisting with wound closure and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

Example:

Code	Description	Status
42820 81	Tonsillectomy and adenoidectomy; under age 12	Disallow

Explanation: Procedure code 42820 is not recommended for Assistant Surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance of this procedure.

19.8 CPT® Category II Codes

CPT Category II Codes are supplemental tracking codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service and may reduce the need for retrospective medical record review.

Uses of these codes are optional and are not required for correct coding. They may not be used as a substitute for Category I codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

19.9 Code Editing Assistant

A web-based code auditing reference tool is available for participating providers via the secure provider portal. This allows Coordinated Care to share some claim auditing rules and clinical rationale we use to pay claims. You can access the tool in the Claims Module by clicking “Claim Auditing Tool.”

- Prospectively access the appropriate coding and supporting clinical edit clarifications for services
- Proactively determine the appropriate code/code combination representing the service

The Code Editing Assistant tool should only be used as a guide and does not guarantee payment. It is meant to apply coding logic only. The tool does not take into consideration historical claims information or other potential variables during processing. The tool assumes all CPT codes are billed on a single claim. The tool will not take into consideration individual fee schedule reimbursement, authorization requirements, or other coverage.

19.10 Timely Filing

Providers will make their best effort to submit claims within one hundred eighty (180) calendar days from the date of service or the primary plan’s EOP. When Coordinated Care is the secondary payer, providers will make their best effort to submit claims one hundred eighty (180) calendar days from the date of service or ninety (90) calendar days of the final determination of the primary payer (whichever is later). Coordinated Care will honor original claims and encounters within three hundred sixty-five (365) calendar days from date of service and secondary claims within three hundred sixty-five (365) calendar days from primary date of payment.

NOTE: A rejected claim is not considered a clean claim, and the date of rejection does not qualify as the claim’s received date for determining timely filing. A claim’s received date for establishing timely filling is the date we receive a clean claim into our system and assign a claim number.

Coordinated Care shall pay for medically necessary services submitted beyond the three hundred sixty-five (365) calendar day standard claims payment time frame in this circumstance:

- When HCA program integrity activities result in recoupment of an improperly paid claim by HCA that should have been paid by Coordinated Care. Providers must submit any claims to Coordinated Care within one hundred twenty (120) calendar days from HCA's notification of improper payment. Providers can submit the first time claim to include HCA notification, or they can receive the timely filing denial for the first time claim to then submit a reconsideration including HCA notification.

Tribal providers will be effectively treated as PAR regardless of contracting status. Tribal providers will have a 365-day timely filing limit for their claims, regardless of PAR status or product.

Except in the case of fraud or being related to coordination of benefits with another carrier, all requests for corrected claims, reconsiderations, or claim disputes must be received within 24 months from the date of service. Prior processing will be upheld for corrected claims or provider claims requests for reconsideration or disputes/appeals received outside of the 24-month timeframe. For coordination of benefits with another carrier, requests must be received within 30 months.

- All corrected claims, requests for reconsideration or claim disputes must be received within twenty-four (24) months from the date of service. Timely filing requirements may be evaluated in the event of one of the following qualifying circumstances: Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster.
- Mechanical or administrative delays or errors by Coordinated Care or the Washington Department of Health and Human Services.
- The member was eligible; however, the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
 - The provider's records document that the member refused or was physically unable to provide their ID card or information.
 - The provider can substantiate that he continually pursued reimbursement from the patient until eligibility was discovered.
 - The provider can substantiate that a claim was filed within three hundred sixty-five (365) calendar days of discovering Plan eligibility.
 - The provider has not filed a claim for this member prior to the filing of the claim under review.

19.11 Who Can File Claims?

All providers (in-network or out-of-network) who have rendered services for Coordinated Care members can file claims. It is important that providers ensure Coordinated Care has accurate billing information on file. Please confirm with the Provider Services department or your dedicated Provider Engagement Administrator that the following information is current in our files:

- Provider Name (as noted on current W-9 form)
- National Provider Identifier (NPI)

- Tax Identification Number (TIN)
- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

We recommend that providers notify Coordinated Care as soon as possible, but no later than thirty (30) calendar days in advance of changes pertaining to billing information. Please submit this information on a Demographic Change form along with a W-9 (provided on the Coordinated Care website). Changes to a Provider's TIN and/or address are NOT acceptable when conveyed via a claim form. Updates can be sent directly to our contracting email box at contracting@coordinatedcarehealth.com or faxed to 1-877-644-4602 attention: Contracting

19.12 How to File a Claim

Coordinated Care will accept claims from our providers in multiple HIPAA compliant methods. We support all HIPAA EDI (Electronic Data Interchange) transaction formats, including HIPAA 837 Institutional and Professional transactions and HIPAA compliant NCPDP format for pharmacies. Providers may submit EDI using over 60 clearinghouses or submit HIPAA 837 claims to us directly via our secure web-based Provider Portal. Providers may enter claims directly online in HIPAA Direct Data Entry (DDE) compliant fashion via our online claims entry feature – another secure component of our Provider Portal. Finally, providers may also mail CMS 1500 or UB-04 standard paper claims to us (see *Paper Claim Form Requirements* section of the manual).

19.13 Taxonomy Code Billing Requirement

Taxonomy numbers are required for all claims. Claims submitted without taxonomy numbers will be upfront rejected with an EDI Reject Code of 91 (Invalid or Missing Taxonomy Code). If the claim was submitted on paper, a rejection letter will be returned indicating that the taxonomy code was missing.

Below are three scenarios involving the Taxonomy Code Billing Requirement:

Scenario One: Rendering NPI is different than the Billing NPI CMS 1500 Form

Required Data	Paper CMS 1500	Electronic Submission	
		Loop ID	Segment/Data Element
Rendering NPI	<u>Unshaded</u> portion of box	2310B	NM109
		2420A	NM109
Taxonomy Qualifier ZZ for paper	<u>Shaded</u> portion of box 24 I	2310B	PRV02 REF01
		2420A	PRV02 REF01
Rendering Provider Taxonomy Number	Shaded portion of box 24J	2310B	PRV03 REF02
		2420A	PRV03 REF02
Group NPI	Box 33a	2010AA	NM109
Billing Provider Group		2000A	PRV03

Taxonomy utilizing the ZZ Qualifier for paper (for the 2000A PROV02 = qualifier "PXC") e.g., box 33b ZZ208D00000X EDI PRV*PE*PXC*208D00000X Billing Provider Group FTIN(EI)/SSN(SY)	Box 33b		
		2010AA	REF01 REF02

Scenario Two: Rendering NPI and Billing NPI are the same CMS 1500 Form

It is NOT necessary to submit the Rendering NPI and Rendering Taxonomy in this Scenario; however, if box 24 I and 24 J are populated, then all data MUST be populated.

Required Data	Paper CMS 1500	Electronic Submission	
Applicable NPI	Box 33a	2010AA	NM109
Applicable Taxonomy utilizing the ZZ Qualifier for paper (for the 2000A PROV02 = qualifier "PXC")	Box 33b	2000A	PRV03
Billing Provider Group FTIN(EI)/SSN(SY) e.g. REF*EI*999999999		2010AA	REF01 REF02

Below is an example of the fields relevant to Scenario One and Scenario Two above.

The diagram shows a portion of the CMS 1500 form with the following callouts:

- ZZ Qualifier:** Points to the 'ZZ' column in the '24. RENDERING PROVIDER ID #' section.
- Rendering Taxonomy:** Points to the 'I' column in the '24. RENDERING PROVIDER ID #' section.
- Rendering NPI:** Points to the 'NPI' column in the '24. RENDERING PROVIDER ID #' section.
- Group NPI:** Points to the 'NPI' field in the '33. BILLING PROVIDER INFO & PH #' section.
- Group Taxonomy with ZZ Qualifier:** Points to the 'ZZ' field in the '33. BILLING PROVIDER INFO & PH #' section.

The form includes sections for: 24. RENDERING PROVIDER ID #, 25. FEDERAL TAX ID. NUMBER, 26. PATIENT'S ACCOUNT NO., 27. ACCEPT ASSIGNMENT?, 28. TOTAL CHARGE, 29. AMOUNT PAID, 30. Paid for NUCC Use, 31. SIGNATURE OF PHYSICIAN OR SUPPLIER, 32. SERVICE FACILITY LOCATION INFORMATION, and 33. BILLING PROVIDER INFO & PH #.

Scenario Three: Taxonomy Requirement for UB 04 Forms

Required Data	Paper UB 04	Electronic Submission
Taxonom y Qualifier Code with B3	Box 81 CC	Billing Level 2000A Loop and PRVR segment

Below is an example of the UB 04 form:

Below is an example of the UB 04 form

The diagram illustrates the location of the B3 Qualifier and Taxonomy on the UB-92 CMS-1480 form. The B3 Qualifier is located in the 'REMARKS' section, and the Taxonomy is located in the 'PATIENT' section.

19.14 CLIA (lab) Services

Effective January 6, 2014, providers billing lab services to Coordinated Care must include a valid and appropriate CLIA number (i.e., either a CLIA Certification Number or CLIA Certificate of Waiver number, as applicable) with the claim, as follows:

- **Paper claims** - a valid and appropriate CLIA number must be included in Box 23 of the CMS-1500 form.
- **EDI claims** - *if a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in:* X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4. If a claim is submitted with both laboratory services for which CLIA certification or waiver is required and non-CLIA covered laboratory test, in the 2400 loop for the appropriate line report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4. For additional information regarding submission of paper claims or EDI claims, please see the enclosed document. You can also refer to the HIPAA 837P Transaction Companion Guide found on our website at: www.CoordinatedCareHealth.com.

If a valid and appropriate CLIA number is not included with the claim as provided above, the entire claim will not be considered a clean claim and will be rejected as incomplete. This process is consistent with the procedure followed by CMS and is applicable to all products offered by Coordinated Care.

Please note that, to be considered for reimbursement, **all claims must be submitted as clean claims within the initial claim timely filing period as stated in the Provider Manual.**

If you have any questions regarding this information, please feel free to contact Provider Services at **1-877-644-4613** (TTY: 711).

*For a list of CLIA Waived services, Provider Performed Microscopy Procedures, tests subject to CLIA edits and tests excluded from CLIA edits, please see the following link:

http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Categorization_of_Tests.html

19.15 Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Coordinated Care partners with PaySpan to provide Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers. EFT and ERA services help providers reduce costs, speed secondary billings, and improve cash flow by enabling online access of remittance information, and straightforward reconciliation of payments. As a Provider, you can gain the following benefits from using EFT and ERA:

- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
- Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information on our EFT and ERA services, please visit our website at www.CoordinatedCareHealth.com, contact Provider Services at 1-877-644-4613 or contact PaySpan directly at 1-877-331-7154 or www.PaySpanhealth.com or ProviderSupport@payspanhealth.com.

19.16 Refunds and Overpayments

Coordinated Care routinely audits all claims for payment errors. Claims identified to have been underpaid or overpaid will be reprocessed appropriately. Providers have the responsibility to report overpayments or improper payments to Coordinated Care. Providers have thirty (30) calendar days from the date of notification to refund overpayments before claims are reprocessed. Providers have the right to submit a Request for Reconsideration or Claim Dispute.

Providers have the option to mail refunds and overpayments along with supporting documentation (copy of the remittance advice identifying affected claims and reason for refund or check return) to the following address:

Coordinated Care of Washington, Inc.
PO Box 952909
St. Louis, MO 63195-2909

19.17 Third Party Liability

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.

As an Apple Health (Medicaid) managed care plan, Coordinated Care is always the payer of last resort. The one exception is the Indian Health Service, including Indian Health Care Providers, Coordinated Care providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Coordinated Care members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third-party resources, the provider shall inform Coordinated Care that efforts have been unsuccessful. Coordinated Care will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, Coordinated Care will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

Specifically related to Washington Apple Health (Medicaid):

- Benefits available through Coordinated Care will be secondary to any other medical coverage
- Coordinated Care and providers will not refuse or reduce services provided through Coordinated Care solely due to the existence of similar benefits provided under any other health care contracts except in accordance with applicable coordination of benefits rules
- Coordinated Care shall attempt to recover any third-party resources made available to members and Coordinated Care and providers will make all records pertaining to coordination of benefits collections for members available for audit and review by HCA
- Coordinated Care will pay claims for preventive pediatric care and then seek reimbursement from third parties
 - Exception: Apple Health Expansion members claims require the primary EOB for coordination of benefits prior to claims payment and fall under cost avoidance rather than pay and chase.
- Coordinated Care will pay claims for contracted services when probable third-party liability has not been established or the third-party benefits are not available to pay a claim at the time it is filed

19.18 Procedure for Electronic Claim Submissions

Electronic Data Interchange (EDI) allows faster more efficient, and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the healthcare industry's efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs:
 - Eliminates the need for paper claim submission
 - Reduces claim re-work (adjustments)
- Receipt of clearinghouse reports as proof of claim receipt
- Faster transaction time for claims submitted electronically
- Validation of data elements on the claim format

All the same requirements for paper claim filing apply to electronic claim filing. Claims not submitted correctly or not containing the required field data will be rejected and/or denied.

We encourage all providers to submit claims and encounter data electronically. Coordinated Care can receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, we can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP) and deliver it securely to providers electronically or in paper format, dependent on provider preference. For more information on electronic claims and encounter data filing, contact:

Coordinated Care
Centene EDI Department

1-800-225-2573, extension 6075525
Or by e-mail at: EDIBA@centene.com

Providers that bill electronically are responsible for filing claims within the same timely filing requirements as providers filing paper claims. Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounter information.

Coordinated Care Payer ID is 68069 and we work with the following clearinghouses:

- ALLSCRIPTS/PAYERPATH
- AVAILITY
- CAPARIO/CHANGE HEALTHCARE
- CLAIM MD
- CLAIM REMEDI
- CLAIMSOURCE/EFFICIENTC
- CPSI
- DEKALB
- EDL360
- ELIGIBILITY
- ELIGIBILITY INC
- EMDEON
- ENCODA
- EXPERIAN
- FIRST HEALTH CARE
- GATEWAY
- GHNONLINE
- GREAT EXPECTATIONS
- IGI
- INMEDIATA
- MD ON-LINE/ABILITY
- MEDASSETS/XACTIMED
- OFFICE ALLY
- PHYSICIANS CC
- PRACTICE INSIGHT
- RELAY /MCKESSON
- SMART DATA SOLUTIONS
- SSI
- TRIZETTO PROVIDER SOLUTIONS

- VIATRACK
- ZIRMED

Envolve Vision Payer ID is 56190. Claims can be submitted directly through the secure website at: www.visionbenefits.envolvehealth.com. Providers will need a login and password to utilize the secure website. For assistance, providers can call the Customer Solutions Department at: 1-800-531-2818 from 9:00 a.m. to 6:00 p.m. Eastern time. For IHCPs, Envolve Vision claims can be submitted directly to Coordinated Care.

IMPORTANT STEPS TO A SUCCESSFUL SUBMISSION OF EDI CLAIMS

1. Select clearinghouse to utilize or Coordinated Care's website.
2. Contact the clearinghouse to inform them you wish to submit electronic claims to Coordinated Care.
3. Inquire with the clearinghouse what data records are required.
4. Verify with Provider Services at Coordinated Care that the provider is set up in the Coordinated Care system before submitting EDI claims.
5. You will receive two reports from the clearinghouse. **ALWAYS** review these reports daily.
 - a. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to Coordinated Care and those claims not meeting the clearinghouse requirements.
 - b. The second report will be a claim status report showing claims accepted and rejected by Coordinated Care. If rejections are noted, correct and resubmit.
6. **MOST** importantly, all claims must be submitted with provider identifying numbers. See the companion guide on the Coordinated Care website for claim form instructions and claim forms for details. **NOTE: Provider identification number validation is not performed at the clearinghouse level. The clearinghouse will reject claims for provider information only if the fields are empty.**

19.19 Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified in the Companion Guide. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements. The Companion Guide is located on Coordinated Care's website at www.CoordinatedCareHealth.com.

19.20 Electronic Claim Flow Description & Important General Information

To send claims electronically to Coordinated Care, all EDI claims must first be forwarded to one of Coordinated Care's clearinghouses. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and Plan specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is very important to review this error report daily to identify any claims that were not transmitted to Coordinated Care. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Coordinated Care, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Coordinated Care by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important to review this report daily. The report shows rejected claims, and these claims must be reviewed and corrected in a timely manner. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

19.21 Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Coordinated Care must first pass the clearinghouse proprietary edits and Plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Coordinated Care. In these cases, the claim must be corrected and re-submitted within the required filing deadline of three hundred sixty-five (365) calendar days from the date of service. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI BA Support at 1-800-225-2573 ext. 25525 or via e-mail at EDIBA@centene.com. If you are prompted to leave a voice mail, you will receive a return call within 24 business hours.

Exclusions: The following inpatient and outpatient claim types are excluded from EDI submission options and must be filed on paper or through the secure Provider Portal:

- Claim records requiring supportive documentation or attachments, e.g., consent forms. (Note: COB claims can be filed electronically)
- Medical records to support billing miscellaneous codes
- Claims for services that are reimbursed based on purchase price, e.g., custom DME, prosthetics. Provider is required to submit the invoice with the claim.
- Claims for services requiring clinical review, e.g., complicated or unusual procedure. Provider is required to submit medical records with the claim.
- Claims for services requiring documentation and a Certificate of Medical Necessity, e.g., oxygen, motorized wheelchairs.

19.22 Electronic Secondary Claims

Coordinated Care has the ability to receive coordination of benefits (COB or Secondary) claims electronically. The field requirements for successful electronic COB submission are below (5010 Format):

COB Field Name The below should come from the primary payer's Explanation of Payment (EOP)	837I - Institutional EDI Segment and Loop	837P - Professional EDI Segment and Loop
COB Paid Amount	If 2320/AMT01= D , MAP AMT02 or 2430/SVD02	If 2320/AMT01= D , MAP AMT02 or 2430/SVD02
COB Total Non-Covered Amount	If 2320/AMT01= A8 , map AMT02	If 2320/AMT01= A8 , map AMT02
COB Remaining Patient Liability	If 2300/CAS01 = PR, map CAS03 Note: Segment can have 6 occurrences. Loop2320/AMT01= EAF , map AMT02 which is the sum of all of CAS03 with CAS01 segments presented with a PR	If 2320/AMT01= EAF , map AMT02
COB Patient Paid Amount		If 2320/AMT01 = F5 , map AMT02
COB Patient Paid Amount Estimated	If 2300/AMT01= F3 , map AMT02	
Total Claim Before Taxes Amount	If 2400/AMT01 = N8 , map AMT02	If 2320/AMT01 = T , map AMT02
COB Claim Adjudication Date	IF 2330B/DTP01 = 573, map DTP03	IF 2330B/DTP01 = 573, map DTP03
COB Claim Adjustment Indicator	IF 2330B/REF01 = T4, map REF02	IF 2330B/REF01 = T4, map REF02 with a Y

19.23 Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
Coordinated Care Payer ID	68069 4665-Relay Health NOTE: Please reference the vendor provider manuals at: www.CoordinatedCareHealth.com for their individual payer IDs.
Claim Transmission Questions & General EDI Questions	Contact EDI Support at 1-800-225-2573 Ext. 6075525 or 314-505-6525 or via e-mail at EDIBA@centene.com
Claims Transmission Report Questions	Contact your clearinghouse technical support area.
Remittance Advice Questions	Contact Coordinated Care Provider Services at 1-877-644-4613 or the secure Provider Portal at www.CoordinatedCareHealth.com .

Provider Payee, UPIN, Tax ID, Payment, Address Changes	Notify Provider Services in writing at: Coordinated Care Attn: Provider Services PO Box 4030 Farmington, MO 63640-4197
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19.24 Procedures for Online Claim Submission

For providers who have internet access and choose not to submit claims via EDI or paper, Coordinated Care has made it easy and convenient to submit claims directly to us on our secure provider portal.

You must request access to our secure site by registering for a username and password and you must select the Claims Role Access module. To register, please go directly to www.CoordinatedCareHealth.com. If you have technical support questions, please contact Provider Services at 1-877-644-4613.

Once you have access to the secure portal, you may file first time claims individually or submit first time batch claims. You will also have the capability to find, view, and correct any previously processed claims.

- Please note for best results when utilizing the web portal, use Internet Explorer 8 (IE8) or higher.
- Reference the Instruction Manual, Terms & Conditions, and Privacy Policy at the bottom of the main Viewing Dashboard.

19.25 Paper Claim Form Requirements

Coordinated Care only accepts the CMS 1500 (02/12) and CMS UB-04 original red paper claim forms. Copies, handwritten claims, and other claim form types will be rejected.

- Effective April 1, 2013, any UB-04 and CMS-1500 forms received that do not meet the CMS printing requirements will be rejected back to the provider or facility upon receipt.
- The only acceptable claim forms are those printed in Flint OCR Red, J6983, or exact match ink. Although a copy of the CMS-1500 form can be downloaded, copies of the form cannot be used for submission of claims, since your copy may not accurately replicate the scale and OCR color of the form. The majority of paper claims sent to carriers and DMERCs are scanned using Optical Character Recognition (OCR) technology. This scanning technology allows for the data contents contained on the form to be read while the actual form fields, headings, and lines remain invisible to the scanner. Photocopies cannot be scanned and therefore are not accepted by all carriers and DMERCs.

The National Uniform Billing Committee (NUBC) is responsible for the design of the form, and award of the contract for printing of the form. CMS does not supply the form to providers for

claim submission. Blank copies of the form may also be available through office supply stores in your geographic area.

Submit first time claims to Coordinated Care at the following address:

Coordinated Care
Claim Processing Department
P. O. Box 4030
Farmington, MO 63640-4197

Coordinated Care cannot receive claims at our Tacoma, Washington address and will return them to the provider.

Coordinated Care encourages all providers to submit claims securely on the web portal or electronically. Paper submissions are subject to the same edits as electronic and web submissions. Refer to our Companion Guides at www.CoordinatedCareHealth.com.

19.26 Completing a CMS 1500 Form

Coordinated Care will only accept the 02/12 version of the CMS 1500 (HCFA). Approved forms will say “Approved OMB-0938-1197 FORM 1500 (02-12)” on the bottom right-hand corner. Refer to the NUCC website for further detailed instructions. Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation, or the service provided. **Note: Claims with missing or invalid Required (R) field information will be rejected or denied.**



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S ID NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)										7. INSURED'S ADDRESS (No., Street)									
CITY										CITY									
STATE										STATE									
ZIP CODE										ZIP CODE									
TELEPHONE (Include Area Code)										TELEPHONE (Include Area Code)									
8. RESERVED FOR NUCC USE										11. INSURED'S POLICY GROUP OR FECA NUMBER									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										12. INSURED'S DATE OF BIRTH MM DD YY									
10. IS PATIENT'S CONDITION RELATED TO:										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
a. EMPLOYMENT? (Current or Previous)										14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY									
b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>										15. OTHER DATE MM DD YY									
c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
10d. CLAIM CODES (Designated by NUCC)										17. NAME OF REFERRING PROVIDER OR OTHER SOURCE									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY										20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/>									
15. OTHER DATE MM DD YY										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to C to service line below (24E))									
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY										22. RESUBMISSION CODE ORIGINAL REF. NO.									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										23. PRIOR AUTHORIZATION NUMBER									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										B. PLACE OF SERVICE									
20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/>										C. EMG									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to C to service line below (24E))										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)									
22. RESUBMISSION CODE ORIGINAL REF. NO.										E. DIAGNOSIS POINTER									
23. PRIOR AUTHORIZATION NUMBER										F. \$ CHARGES									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										G. DAYS ON UNITS									
B. PLACE OF SERVICE										H. SPGC Family Plan									
C. EMG										I. ID. QUAL.									
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										J. RENDERING PROVIDER ID. #									
E. DIAGNOSIS POINTER																			
F. \$ CHARGES																			
G. DAYS ON UNITS																			
H. SPGC Family Plan																			
I. ID. QUAL.																			
J. RENDERING PROVIDER ID. #																			
25. FEDERAL TAX ID. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.									
26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$									
28. TOTAL CHARGE \$										29. AMOUNT PAID \$									
29. AMOUNT PAID \$										30. Revd for NUCC Use									
30. Revd for NUCC Use										31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION									
32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()									
33. BILLING PROVIDER INFO & PH # ()																			
SIGNED DATE										a. NPI b. NPI									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Field	Field Description	Instruction or Comments	Required or Conditional
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. Enter "X" in the box noted "Other"	R
1a	INSURED'S ID NUMBER	The 11-digit Apple Health (Medicaid) ID number on the member's Coordinated Care ID card.	R
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Coordinated Care ID card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE/SEX	Enter the patient's 8-digit date of birth (MMDDYYYY). Mark the appropriate box to indicate if the patient is male (M) or female (F).	R
4	INSURED'S NAME	Enter the patient subscriber's name.	C
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	C
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C
7	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space	C

		as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	OTHER INSURED'S BIRTH DATE/SEX	REQUIRED if field 9 is completed. Enter the 8-digit date of birth (MMDDYYYY) and mark the appropriate box to indicate the sex/gender for the person listed in field 9. M = male F = female	C
9c	EMPLOYER'S NAME OR SCHOOL NAME	Enter the name of employer or school for the person listed in field 9. Note: Employer's Name or School Name does not exist in the electronic 837 Professional 4010A1.	C
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (person listed in field 9) insurance plan or program name.	C
10a,b,c	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line.	R
10d	RESERVED FOR LOCAL USE	Always mark to indicate self.	Not Required
11	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C
11a	INSURED'S DATE OF BIRTH / SEX	Same as field 3.	C
11b	EMPLOYER'S NAME OR SCHOOL NAME	REQUIRED if Employment is marked Yes in field 10a.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete field's 9a-d and 11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of	C

		information necessary to process and/or adjudicate the claim.	
13	PATIENT'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MMDDYY) or 8-digit (MMDDYYYY) onset for the: Present illness Injury LMP (last menstrual period) if pregnant	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	If applicable, enter the date in the following format: MMDDYYYY. Do not include hyphens, dashes, etc.	Not Required
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	If applicable, enter the date in the following format: MMDDYYYY. Do not include hyphens, dashes, etc.	Not Required
17a,b	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials). REQUIRED for PRC Lock-In members. Field a – ID Number: Use ZZ qualifier for Taxonomy code. Field b – NPI Number REQUIRED for PRC Lock-In members.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	REQUIRED for professional services related to a continuous inpatient stay. If applicable, enter the date in the following format: MMDDYYYY. Do not include hyphens, dashes, etc.	C
19	ADDITIONAL CLAIM INFORMATION	Enter any notes that would help in processing a claim for payment.	Not Required
20	OUTSIDE LAB / CHARGES	If applicable, check the appropriate box and enter charges.	Not Required
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the diagnosis or condition of the patient using the appropriate release/update of ICD-9/ICD-10 CM Volume 1 for the date of service. Diagnosis codes submitted must be valid ICD-9/ICD-10 codes for the date of service and carried out to its highest digit – 4 th or 5 th . 'E' codes are NOT acceptable as a primary diagnosis.	R

		New form requires ICD indicator: 9 – ICD-9-CM 0 – ICD-10-CM	
22	RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the DCN (Document Control Number) of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	PRIOR AUTHORIZATION NUMBER	Enter the authorization number if a prior auth was acquired.	C
24a-g Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC Anesthesia start/stop time & duration Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions. HIBCC or GTIN number/code. For detailed instructions and qualifiers, refer to the Billing Tips and Reminders section of this guide.	C
24d Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPCS code and 2- character modifier, if applicable. Only one CPT or HCPCS and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R
24e Unshaded	DIAGNOSIS CODE	Enter the numeric single digit diagnosis pointer (1, 2, 3, and 4) from field 21. List the primary diagnosis for the service provided or performed first followed by any additional or related diagnosis listed in field 21 (using the single digit diagnosis pointer, not the diagnosis code.) Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service, or the claim will be rejected/denied.	R
24f Unshaded	CHARGES	Enter the charge amount for the claim line-item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99).	R

		Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	
24g Unshaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.	R
24h Shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral.	C
24h Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24i Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy Use or 1D qualifier for ID, if an Atypical Provider.	R
24j Shaded	NON-NPI PROVIDER ID#	<u>Typical Providers:</u> Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24i shaded. Use ZZ qualifier for Taxonomy Code. <u>Atypical Providers:</u> Enter the Provider ID number.	R
24j Unshaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, etc.).	R
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN.	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number.	C
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Coordinated Care recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments.	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24f. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Coordinated Care. Coordinated Care is always the payer of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed	C

		(i.e., 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	
30	BALANCE DUE	<p>REQUIRED when field 29 is completed.</p> <p>Enter the balance due (total charges minus the amount of payment received from the primary payer).</p> <p>Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.</p>	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	<p>If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form.</p> <p>If the signature is missing or invalid, the claim will be returned unprocessed.</p> <p>Note: Does not exist in the electronic 837P.</p>	R
32	SERVICE FACILITY LOCATION INFORMATION	<p>REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <p>Enter the name and physical location. (P.O. Box numbers are not acceptable here.)</p> <p>First line – Enter the business/facility/practice name.</p> <p>Second line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).</p> <p>Third line – In the designated block, enter the city and state.</p> <p>Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.</p>	C
32a	NPI – SERVICES RENDERED	<p>Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <p>Enter the 10-character NPI ID of the clinic/facility where services were rendered.</p>	C
32b	OTHER PROVIDER ID	<p>REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <p><u>Typical Providers:</u> Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces).</p>	C

		<u>Atypical Providers:</u> Enter the 2-character qualifier 1D (no spaces).	
33	BILLING PROVIDER INFO & PH#	<p>Enter the billing provider's complete name, address (include the zip + 4 code), and phone number.</p> <p>First line -Enter the business/facility/practice name.</p> <p>Second line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).</p> <p>Third line -In the designated block, enter the city and state.</p> <p>Fourth line- Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414).</p> <p>NOTE: The 9-digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission.</p>	R
33a	GROUP BILLING NPI	Enter the 10-character NPI ID.	R
33b	GROUP BILLING OTHERS ID	<p><u>Typical Providers:</u> Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces).</p> <p><u>Atypical Providers:</u> Enter the 2-character qualifier 1D (no spaces).</p>	R

19.27 Completing a CMS UB-04 Claim Form

This is the only acceptable claim form for submitting inpatient/outpatient hospital, Comprehensive Outpatient Rehabilitation Facilities (CORF), home health agencies, nursing home admissions, inpatient Hospice, and dialysis services. The correct form will say "Approved OMB No. 0938-0997" on the bottom left-hand corner. For additional support, please refer to the NUBC Data Specifications Manual. Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation, or the service provided. **Note: Claims with missing or invalid Required (R) field information will be rejected or denied.**

- Professional fees must be billed on a CMS 1500 claim form
- Include the appropriate CPT code next to each revenue code
 - Refer to the HCA Revenue Code Grid for rev codes that do not require a CPT 4 code

UB-04 Claim Form Example

1										2										3a PRV CONT # 3b PRV REC #										4 TYPE OF BILL									
5 PATIENT NAME										6 PATIENT ADDRESS										7										8 STATEMENT COVERED PERIOD FROM THROUGH									
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Field	Field Description	Instructions or Comments	Required or Conditional
1	BILLING PROVIDER NAME	Line 1: Complete Provider Name Line 2: Street Address or Post Office Box Line 3: City, State, and Zip Code plus 4 code (include hyphen). Line 4: Area code and phone number (& Fax)	R
2	PAY-TO NAME AND ADDRESS	Report only if different from Field 1.	C
3a	PATIENT CONTROL NO.	Enter the facility patient account/control number.	Not Required
3b	MEDICAL RECORD NO.	Enter the facility patient medical or health record number.	R
4	TYPE OF BILL	Enter the appropriate 3-digit type of bill (TOB) code (as specified by the NUBC Uniform Billing Manual) minus the leading "0" (zero). Digits should reflect as follows: 1 st digit – Type of facility 2 nd digit – Type of care 3 rd digit – Billing sequence	R
5	FEDERAL TAX NO.	Enter the 9-digit tax identification number (TIN) assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD	Enter begin and end or admission and discharge dates for the services billed. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	UNLABELED FIELD	Not Used	Not Required
8a	PATIENT NAME	Enter the patient's last name, first name, and middle initial as it appears on the Coordinated Care ID card. Use a comma to separate the last and first names. Titles (Mr., Mrs., etc.) should not be reported. Prefix: No space after the prefix of a name (e.g., McKendrick, <u>H</u>) Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: A space should separate a last name and suffix.	R
8b	PATIENT IDENTIFIER	The 11-digit Apple Health (Medicaid) ID number on the member's Coordinated Care ID card.	R
9a-d	PATIENT ADDRESS	Line a – Street Address Line b – City Line c – State Line d – Zip Code	R

10	BIRTHDATE	Patient's 8-digit date of birth (MMDDYYYY) - If billing baby on mom's ID, enter the baby's birth date instead.	R
11	SEX	Indicate if the patient is male (M) or female (F) – If billing baby on mom's ID, enter the baby's sex.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims or date of service for outpatient claims.	R
13	ADMISSION HOUR	<p>Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.</p> <p>Code Time AM</p> <p>00 12:00-12:59</p> <p>01 01:00-01:59</p> <p>02 02:00-02:59</p> <p>03 03:00-03:59</p> <p>04 04:00-04:59</p> <p>05 05:00-05:59</p> <p>06 06:00-06:59</p> <p>07 07:00-07:59</p> <p>08 08:00-08:59</p> <p>09 09:00-09:59</p> <p>10 10:00-10:59</p> <p>11 11:00-11:59</p> <p>Code Time PM</p> <p>12 12:00-12:59</p> <p>13 01:00-01:59</p> <p>14 02:00-02:59</p> <p>15 03:00-03:59</p> <p>16 04:00-04:59</p> <p>17 05:00-05:59</p> <p>18 06:00-06:59</p> <p>19 07:00-07:59</p> <p>20 08:00-08:59</p> <p>21 09:00-09:59</p> <p>22 10:00-10:59</p> <p>23 11:00-11:59</p>	R
14	ADMISSION TYPE	<p>Required for inpatient admissions. Enter the 1-digit code indicating the priority of the admission:</p> <p>1 – Emergency</p> <p>2 – Urgent</p> <p>3 – Elective</p> <p>4 – Newborn</p> <p>5 – Trauma</p>	C

15	ADMISSION SOURCE	<p>Enter the 1-digit code to indicate the source of referral for admission or visit.</p> <p>For Type of Admission 1,2,3 or 5:</p> <ul style="list-style-type: none"> 1 – Physician 2 – Clinic 3 – Health Maintenance (HMO) 4 – Transfer from hospital 5 – Transfer from Skilled Nursing Facility (SNF) 6 – Transfer from another health care facility 7 – Emergency Room 8 – Court Law Enforcement 9 – Information not available <p>For Type of Admission 4:</p> <ul style="list-style-type: none"> 1 – Normal Delivery 2 – Premature Delivery 3 – Sick Baby 4 – Extramural Birth 5 – Information not available 	C
16	DISCHARGE HOUR	<p>Enter the time using 2-digit military time (00-23) for the time of inpatient or outpatient discharge.</p> <p>Code Time AM</p> <ul style="list-style-type: none"> 00 12:00-12:59 01 01:00-01:59 02 02:00-02:59 03 03:00-03:59 04 04:00-04:59 05 05:00-05:59 06 06:00-06:59 07 07:00-07:59 08 08:00-08:59 09 09:00-09:59 10 10:00-10:59 11 11:00-11:59 <p>Code Time PM</p> <ul style="list-style-type: none"> 12 12:00-12:59 13 01:00-01:59 14 02:00-02:59 15 03:00-03:59 16 04:00-04:59 17 05:00-05:59 18 06:00-06:59 19 07:00-07:59 20 08:00-08:59 21 09:00-09:59 22 10:00-10:59 23 11:00-11:59 	C

17	PATIENT STATUS	<p>Required for inpatient claims. Enter the 2-digit disposition of the patient as of the “through” date for the billing period listed in field 6 using one of the following codes:</p> <p>01 – Routine Discharge 02 – Discharged to another short-term general hospital 03 – Discharged to a Skilled Nursing Facility (SNF) 04 – Discharged to an Intermediate Care Facility (ICF) 05 – Discharged to another type of institution 06 – Discharged to care of home health organization 07 – Left against medical advice 08 – Discharged/Transferred to home under care of a Home IV provider 09 – Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 – Expired or did not recover 30 – Still patient (to be used only when the member has been in the facility for 30 consecutive days if payment is based on DRG) 40 – Expired at home (hospice only) 41 – Expired in a medical facility (hospice only) 42 – Expired at place unknown (hospice only) 43 – Discharged/Transferred to a federal hospital (such as a Veteran’s Administration [VA] hospital) 50 – Hospice at home 51 – Hospice at medical facility 61 – Discharged/Transferred within this institution to a hospital-based Medicare approved swing bed 62 – Discharged/Transferred to an inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 – Discharged/Transferred to a Medicare certified long-term care hospital (LTCH) 64 – Discharged/Transferred to a nursing facility certified under Apple Health (Medicaid) but not certified under Medicare 65 – Discharged/Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 – Discharged/Transferred to a critical access hospital (CAH)</p>	C
18-28	CONDITION CODES	<p>Used to identify conditions relating to the bill that may affect payer processing.</p> <p>Each field allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions, refer to the NUBC Uniform Billing Manual.</p>	C
29	ACCIDENT STATE	If applicable, enter the state in which the accident occurred (example: OR, CA, etc.).	Not Required

31-34	OCCURRENCE CODE AND DATES	<p>Used to identify events relating to the bill that may affect payer processing.</p> <p>Each field allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions, refer to the NUBC Uniform Billing Manual.</p> <p>Occurrence Date (MMDDYYYY): use when applicable or when a corresponding Occurrence Code is present on the same line.</p>	C
35-36	OCCURRENCE SPAN CODE AND DATE	<p>Occurrence Span Code: use to identify events relating to the bill that may affect payer processing.</p> <p>Each field allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions, refer to the NUBC Uniform Billing Manual.</p> <p>Occurrence Span Date (MMDDYYYY): use when applicable or when corresponding Occurrence Span Code is present on the same line.</p>	C
37	RESUBMISSIONS OR ADJUSTMENTS	REQUIRED when the TOB (field 4) 3 rd digit (billing sequence) is a 7.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS	Enter the information for the claim addressee.	Not Required
39-41	VALUE CODES AND AMOUNTS	<p>Used to identify events relating to the bill that may affect payer processing.</p> <p>Each field allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields.</p> <p>Value Code 54: REQUIRED for newborns. Enter this code in the code field with the newborn birth weight in grams in the amount field (no decimals). Right justify the weight in grams to the left of the dollars/cents delimiter.</p> <p>For a list of codes and additional instructions, refer to the NUBC Uniform Billing Manual.</p> <p>Amount: use when applicable or when a Value Code is entered. Enter the dollar amount for the associated Value Code. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e., 199,999.99). Do NOT enter a dollar sign</p>	C

		(\$) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e., 10.00) enter 00 in the area to the right of the vertical line.	
42	REVENUE CODE	<p>Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient.</p> <p>Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions.</p> <p>Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.</p> <p>Line 23 – Enter 0001 for total charges</p>	R
43	DESCRIPTION	<p>Enter a brief description that corresponds to the rev code entered in field 42.</p> <p>When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug for the specified detail line.</p> <p>Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.</p> <p>Line 23 - Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted enter a "1" in both fields (i.e., PAGE "1" OF "1").</p>	R
44	HCPCS/CPT/RATES	<p>REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPCS and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use spaces, commas, or dashes.</p> <p>Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions.</p> <p>Please refer to your current provider contract with HSHP or to the Department of Health and Hospitals Medicaid Provider Procedures Manual.</p>	C
45	SERVICE DATE	<p>REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY) Multiple dates of service may not be combined for outpatient claims.</p> <p>Line 23 (REQUIRED) - Enter the date the bill was created or prepared for submission on all pages submitted. (MMDDYY)</p>	C

46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47	TOTAL CHARGES	Enter the total charge for each service line. Line 23 - Enter the total charges for all service lines.	R
48	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts. Line 23 - Enter the total non-covered charges for all service lines.	C
49	UNLABELED FIELD	Not Used	Not Required
50	PAYER	Enter the name for each Payer from which reimbursement is being sought in the order of the Payer liability. Line a – Primary payer Line b – Secondary payer Line c – Tertiary payer	R
51	HEALTH PLAN IDENTIFICATION NUMBER	For Apple Health (Medicaid), leave blank. Enter the health plan identification number (if known) in 51 a, b, c depending on whether the insurance is primary, secondary, or tertiary.	Not Required
52	RELEASE OF INFORMATION CERTIFICATION INDICATOR	Indicate whether the patient or patient's legal representative has signed a statement permitting the provider to release data to other organizations. The Release of Information is limited to the information carried on the claim. Enter "Y" (yes) or "N" (no) in fields a-c. Providers are expected to have the necessary release information on file. It is expected that all released invoices contain "Y".	R
53	ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR	Enter "Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Medicaid/Coordinated Care is listed as secondary or tertiary. Line a – Primary payment Line b – Secondary payment Line c – Tertiary payment	C
55	ESTIMATED AMOUNT DUE	The amount estimated by the provider to be due from the indicated payer (estimated responsibility fewer prior payments).	Not Required

56	NATIONAL PROVIDER IDENTIFIER	Enter the NPI for the billing provider.	R
57	OTHER PROVIDER ID	Enter the numeric provider Medicaid identification number assigned by the Medicaid program. Enter the TPI number (non-NPI number) of the billing provider.	R
58	INSURED'S NAME	For each line (a, b, c) completed in field 50, enter the name of the person who carries the insurance for the patient (last name, first name, middle initial). In most cases this will be the patient's name.	R
59	PATIENT RELATIONSHIP TO INSURED	Enter 18 when the subscriber is the same person as the patient. If the subscriber is not the same person as the patient, do not use this field.	Not Required
60	INSURED'S UNIQUE ID	Enter all of the insured's unique identification numbers assigned by any payer organization. Enter the patient's Insurance/Medicaid ID exactly as it appears on the patient's ID card. Enter the Insurance/Medicaid ID in the order of liability listed in field 50.	R
61	GROUP NAME	Refer to the NUBC manual for more information.	Not Required
62	INSURANCE GROUP NO.	Refer to the NUBC manual for more information.	Not Required
63	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or Referral number when services require pre-certification.	C
64	DOCUMENT CONTROL NUMBER	REQUIRED for claim submitted with a Type of Bill (field 4) Frequency of "7" (Replacement of Prior Claim) or Type of Bill Frequency of "8" (Void/Cancel of Prior Claim). Enter the 12-character Document Control Number (DCN) of the original claim when submitting a replacement or void on the corresponding a, b, c line reflecting Coordinated Care from field 50.	C
65	EMPLOYER NAME	Enter the employer's name of the insured.	Not Required
66	DIAGNOSIS AND PROCEDURE CODE QUALIFIER	Enter the qualifier that identifies the version of the International Classification of Diseases (ICD) reported: 9 – Ninth Revision 0 – Tenth Revision	R
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition. Lines a-q: Other Diagnosis Codes Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received.	R

		<p>Refer to the appropriate release/update of ICD-9/10-CM Volume 1 & 3 for the date of service.</p> <p>The diagnosis code submitted must be a valid ICD-9/10 code for the date of service and carried out to its highest level of specificity – 4th or 5th digit.</p> <p>"E" and most "V" codes are NOT acceptable as a primary diagnosis.</p>	
68	PRESENT ON ADMISSION INDICATOR	<p>Enter indicator with corresponding diagnosis on inpatient facility claims.</p> <p>Y – Yes N – No U – Unknown W – Clinically Undetermined Unreported/Not used – Exempt from POA reporting</p>	C
69	ADMITTING DIAGNOSIS CODE	<p>Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1 & 3 for the date of service.</p> <p>Diagnosis codes submitted must be a valid ICD-9/10 codes for the date of service and carried out to its highest level of specificity – 4th or 5th digit.</p> <p>"E" and most "V" codes are NOT acceptable as a primary diagnosis.</p>	R
70	PATIENT REASON FOR VISIT	<p>Enter the ICD-9/10-CM code that reflects the patient's reason for visit at the time of outpatient registration.</p> <p>Line is REQUIRED, lines b-c are conditional.</p> <p>Diagnosis codes submitted must be valid ICD-9/10 codes for the date of service and carried out to its highest level of specificity – 4th or 5th digit.</p> <p>"E" and most "V" codes are NOT acceptable as a primary diagnosis.</p>	R
71	PPS/DRG CODE		Not Required
72	EXTERNAL CAUSE OF INJURY	Refer to the NUBC manual for more information.	Not Required
73	UNLABELED FIELD	Not Used	Not Required
74	PRINCIPAL PROCEDURE CODE/DATE	<p>Inpatient (REQUIRED): Enter the code identifying the principal ICD surgical or obstetrical procedure and the date on which either was performed. Enter the date in MMDDYY format.</p> <p>Lines a-e: Other Procedure Codes</p> <p>Inpatient (REQUIRED): Enter the codes identifying all other significant procedures performed during the billing period covered by the claim and the dates on</p>	C

		<p>which the procedures were performed. Do not use decimal points.</p> <p>Up to 5 procedure codes may be entered.</p>	
75	UNLABELED FIELD	Not Used	Not Required
76	ATTENDING PROVIDER NAME AND IDENTIFIERS	<p>Enter the NPI number for the attending physician (the physician primarily responsible for the care of the patient) or the resident physician. The NPI number of the Advanced Registered Nurse Practitioners (ARNPs) may also be reported in this form locator if they were primarily responsible for services in the hospital setting. Report in this Form Locator the NPI number of the physician ordering lab tests or X-ray services.</p> <p>NPI: Enter the attending physician 10-character NPI ID.</p> <p>Taxonomy Code: Enter valid taxonomy code</p> <p>Qualifier: Enter one of the following qualifiers and ID number: 0B – State License # 1G – Provider UPIN G2 – Provider Commercial # ZZ – Taxonomy Code</p> <p>LAST: Enter the attending physician's last name FIRST: Enter the attending physician's first name.</p>	R
77	OPERATING PHYSICIAN NAME AND IDENTIFIERS	<p>Enter the NPI number for the operating physician when a surgical procedure code is listed on the claim.</p> <p>NPI: Enter the operating physician 10-character NPI ID.</p> <p>Taxonomy Code: Enter valid taxonomy code</p> <p>Qualifier: Enter one of the following qualifiers and ID number: 0B – State License # 1G – Provider UPIN G2 – Provider Commercial # ZZ – Taxonomy Code</p> <p>LAST: Enter the operating physician's last name FIRST: Enter the operating physician's first name.</p>	C
78-79	OTHER PROVIDER (INDIVIDUAL) NAME AND IDENTIFIERS	<p>Enter the NPI number of other treating providers or the referring provider (REQUIRED for PRC Lock In members). Enter the NPI number for a Primary Care Case Management (PCCM), or Skilled Nursing Facility (SNF).</p> <p>NPI: Enter the other physician's 10-character NPI ID.</p> <p>Qualifier: Enter one of the following provider type qualifiers: DN – Referring Provider</p>	C

		ZZ – Other Operating MD 82 – Rendering Provider Or enter one of the following qualifier and ID Number: 0B – State License # 1G – Provider UPIN G2 – Provider Commercial # LAST: Enter the other physician’s last name. (REQUIRED for PRC Lock In members) FIRST: Enter the other physician’s first name. (REQUIRED for PRC Lock In members)	
80	REMARKS	Enter any notes that would help in processing a claim for payment.	C
81	CODE-CODE	Taxonomy of billing provider. Use ZZ qualifier	C

20 BILLING TIPS AND REMINDERS

20.1 Supplemental Information

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12) form field 24A-G:

- Anesthesia duration
- Narrative description of unspecified/miscellaneous/unlisted codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number–Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council–Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products

The following qualifiers are to be used when reporting these services:

Qualifier	Description
7	Anesthesia information
N4	National Drug Codes (NDC)
F2	Unit Qualifier - International Unit
GR	Unit Qualifier - Gram
ML	Unit Qualifier - Milliliter
UN	Unit Qualifier - Unit
ZZ	Narrative description of unspecified/miscellaneous/unlisted codes
OZ	Product Number Health Care Uniform Code Council - Global Trade Item Number (GTIN)
VP	Vendor Product Number - Health Industry Business Communications Council (HIBCC) Labeling Standard

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the supplemental information.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

More than one supplemental item can be reported in a single shaded claim line *if* the information is related to the un-shaded claim line item it is entered on. When entering more than one supplemental item, enter the first qualifier at the start of 24A followed by the number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the HIBCC, or GTIN number/code. After the entry of the first supplemental item, enter three blank spaces and then the next qualifier and number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the HIBCC or GTIN number/code.

Examples:

Anesthesia

24. A.	DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
	From	To			PLACE OF		(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS	EPST	ID	RENDERING
MM	DD	YY	MM	DD	SERVICE	EMS	CPT/HCPCS	MODIFIER	POINTER		OR	Family	QUAL	PROVIDER ID. #
7	Begin	1315	End	1445	Time	90	minutes							

Unlisted, Non-specific, or Miscellaneous CPT or HCPC Code

24. A.	DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
	From	To			PLACE OF		(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS	EPST	ID	RENDERING
MM	DD	YY	MM	DD	SERVICE	EMS	CPT/HCPCS	MODIFIER	POINTER		OR	Family	QUAL	PROVIDER ID. #
ZZ	Laparoscopic	Ventral	Hernia	Repair	Op	Note	Attached							

Vendor Product Number- HIBCC

24. A.	DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
	From	To			PLACE OF		(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS	EPST	ID	RENDERING
MM	DD	YY	MM	DD	SERVICE	EMS	CPT/HCPCS	MODIFIER	POINTER		OR	Family	QUAL	PROVIDER ID. #
VPA	123	ABC	709	E1F										

Product Number Health Care Uniform Code Council – GTIN

24. A.	DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
	From	To			PLACE OF		(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS	EPST	ID	RENDERING
MM	DD	YY	MM	DD	SERVICE	EMS	CPT/HCPCS	MODIFIER	POINTER		OR	Family	QUAL	PROVIDER ID. #
OZ0	123	456	789	112										

National Drug Codes (NDC)

24. A.	DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.
	From	To			PLACE OF		(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS	EPST	ID	RENDERING
MM	DD	YY	MM	DD	SERVICE	EMS	CPT/HCPCS	MODIFIER	POINTER		OR	Family	QUAL	PROVIDER ID. #
N400517260225ML2														
09	06	13	09	06	13	11		J3475	13	12	00	2		1891785838

20.2 Ambulatory Surgery Center (ASC)

- Ambulatory surgery centers must be billed on a CMS 1500
- Must be billed in place of service 24
- ASC modifier SG is required

20.3 Anesthesia

- Bill total number of minutes in Field 24G of the CMS 1500 form
- Anesthesiologist must bill modifiers listed below for ASA codes:
 - AA – Anesthesia service performed personally by an anesthesiologist

- QX – CRNA/AA service with medical direction by a physician
- QK – Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
- CRNA's must bill with one of the modifiers listed below for all ASA codes:
 - QX – CRNA service with medical direction by a physician should be used when under the supervision of a physician
 - QY – CRNA and anesthesiologist are involved in a single procedure and the physician is performing the medical direction
 - QZ – CRNA service without medical direction by a physician

20.4 DME/Supplies/Prosthetics and Orthotics

- Purchase only services must be billed with modifier NU
 - Please refer to the state DME manuals for appropriate billing of modifiers
- When billing for a weekly or monthly rental, a date span can be billed. Future dates cannot be billed.

20.5 Mom/Newborn Billing

- Coordinated Care recommends holding claims until the newborn receives their own individual ID#
- When billing a newborn claim under the mother's Medicaid ID#, enter the newborn's name, birthdate, and gender in the fields instead of the mom's information
 - Please place an "A" prior to the mother's Medicaid ID# - If twins, place an "A" for the first twin and "B" for the second twin
- Due to the ERIN Act, all newborns are billable under the mom's insurance for the first 21 days or the completion of the birth episode of care, whichever is greater.

20.6 EPSDT/HCY

- Populate 24h with appropriate indicator "Y" for screenings
- Bill modifier TJ for Foster Care member screenings

20.7 Home Health Agency

- Must be billed on a UB 04
- Bill type must be 3XX
- Acceptable modifiers GN, GO, GP

20.8 Patient Review and Coordination (PRC) Claims

- PRC claims require a referral from the member's assigned PCP entered in fields 17a, b of a HCFA or fields 78 & 79 of a UB form.
- Refer to the *PRC Program and PCPs* section of the manual for full information and corresponding WAC.

20.9 OB Care

- Notification of Pregnancy:
 - Use HCPCS code 0500F along with the appropriate billing code on the first prenatal visit.

- Global Maternity:
 - Providers should bill using the complete OB global care if he/she is providing all the maternity care (routine antepartum, delivery, and postpartum).
 - Global codes 59400, 59510, 59610, or 59618
 - If it is necessary to unbundle the OB package for prenatal care only:
 - Antepartum codes 59426, 59425, or E/M (99211-99215 TH, 1-3 visits)
 - If it is necessary to unbundle the OB package for delivery only:
 - Delivery codes 59409, 59514, 59612, or 59620
 - If the provider performs the delivery and provides postpartum care:
 - Delivery with postpartum codes 59410, 59515, 59614, or 59622
 - If it is necessary to unbundle the OB package for postpartum care only:
 - Postpartum code 59430
 - Exception: Effective 1/1/18, RHCs billing under the encounter methodology unbundle global services per HCA policy

20.10 Multi Page Claims

- The page leading up to the last page of a multi-page claim should contain the word “continued” or “cont.” Totaling each page will result in separate claims that may reimburse incorrectly.
- When reporting line-item services on multiple page claims, only the diagnosis code(s) on the first page may be used and must be repeated on subsequent pages. If more than 12 diagnoses are required to report the lines’ services, the claim must be split, and the services related to the additional diagnoses must be billed as a separate claim.

20.11 POA Indicator

- Present on Admission (POA) Indicator is required on all inpatient facility claims. Failure to include the POA may result in a claim denial/rejection.

20.12 Skilled Nursing Facility Services

- Inpatient Level of Care (LOC) must be billed using the following revenue codes:
 - 0190 – Custodial Care (only allowed as part of discharge)
 - 0191 – Skilled Nursing Level I
 - 0192 – Skilled Nursing Level II
 - 0193 – Skilled Nursing Level III
 - 0194 – Skilled Nursing Level IV
- LOC may change during the inpatient stay and must be billed to match the services authorized during the stay.
- Inpatient per diem is all inclusive, except as noted below:
 - Services included in the Per Diem must be itemized
 - DME not available in the SNF/NF shall be provided and billed by DME supplier
 - Pharmacy shall be provided and billed by Pharmacy vendor
 - Infusion shall be provided and billed by Infusion vendor
 - Vent/Trach Respiratory Therapy (RT) shall be provided and billed by Vent/Trach RT vendor
 - For readmissions, contact the Care Manager

20.13 Administrative Days

- Must be billed on a separate claim from the inpatient stay
- Inpatient stay should be billed with a discharge status of 30 indicating still a patient
- Bill using revenue codes 191 or 169

20.14 Immunizations

If an immunization is the only service provided, bill only for the administration of the vaccine and the vaccine itself (if appropriate). Do not bill an E/M code unless a significant and separately identifiable condition exists and is reflected by the diagnosis. In this case, bill the E/M code with modifier 25. If the E/M code is billed without modifier 25 on the same date of service as a vaccine administration, the agency will deny the E/M code. **Exception:** The E/M code 99211 cannot be billed with a vaccine or the vaccine administration code.

You must bill for the administration of the vaccine and for the cost of the vaccine itself as explained below:

- Members 18 years of age and younger – “Free from DOH”/” Vaccine for Children (VFC) Program”
 - Bill for the procedure code for the vaccine with modifier SL.
 - Bill for the administration using CPT Codes 90471-90474
 - DO NOT bill CPT codes 90460/90461 for the administration of VFC vaccines.
- Members 19 years of age and older – All Vaccines
 - Bill for the cost of the vaccine itself by reporting the procedure code for the vaccine given.
 - DO NOT use modifier SL
 - Bill for the administration using CPT codes 90460/90471/90473 (one vacc) and 90461/90472/90474 (each additional vacc).
 - 90460/90461/90471 - 90474 must be billed on the same claim as the procedure code for the vaccine(s).

20.15 Residential Billing Guidelines

While residential claims are preferred to be billed on a professional claim (837p/HCFA), either professional or institutional, (837i/UB) claims will be accepted. If billed institutional, bill with the required revenue/HCPCs code combinations, as defined in the IMC Service Encounter Reporting Instructions (SERI), with the bill type 86X. Revenue codes are not required/accepted for professional billing.

20.16 RHC Billing Guidelines

For RHC opt in providers, Coordinated Care will pay the RHC encounter rate following the below guidelines.

- An encounter eligible service is required when billing T1015 to be eligible for reimbursement up to the RHC encounter rate.
- The T1015 must be billed following the encounter eligible and bundled services.

Correct Billing

T1015 FOLLOWING ENCOUNTER SERVICES

Service Line	Procedure	Encounter Eligible Service	Bundled with Encounter
0100	99214	X	
0200	90686		X
0300	90471		X
0400	T1015		

Incorrect Billing

T1015 FOLLOWING ENCOUNTER SERVICES			
Service Line	Procedure	Encounter Eligible Service	Bundled with Encounter
0100	T1015		
0200	90686		X
0300	90471		X
0400	99214	X	

- Separately reimbursable services can be paid in addition to the encounter rate when billed in one of the following ways:
 - On a separate claim, not including the encounter eligible service and T1015.

Claim# 1: SEPARATELY REIMBURSABLE SERVICE BILLED ALONE			
Service Line	Procedure	Encounter Eligible Service	Separately Reimbursable
0100	81002		X
Claim# 2: ENCOUNTER CLAIM			
Service Line	Procedure	Encounter Eligible Service	Separately Reimbursable
0100	99213	X	
0200	T1015		

- On the encounter claim, following T1015.

SEPARATELY REIMBURSABLE SERVICE BILLED WITH ENCOUNTER			
Service Line	Procedure	Encounter Eligible Service	Separately Reimbursable
0100	99214	X	
0200	90686	X	
0300	90471	X	
0400	T1015		
0500	83036		X

When fee for service amounts is greater than the encounter rate, Coordinated Care is unable to apply a negative amount to T1015. For these claims, payment will be capped at the encounter rate and zero payment will be applied to T1015.

For additional details on RHC billing and which services qualify as an encounter, please reference HCA's Rural Health Clinics Provider Billing Guide (<https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules>).

NOTE: RHC/FQHC Encounter Payments are not reimbursed for Apple Health Expansion members.

21 FILING ENCOUNTER CLAIMS

21.1 Claims versus Encounter Data

A claim is a bill for services, a line item of services, or all services for one member within a bill which may be submitted either electronically or by paper for any medical service rendered. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation of payment or denial (EOP). For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP.

An *encounter* is a claim (usually for well-care, immunizations, and other preventive care services involving EPSDT or HEDIS) that is processed and paid at zero dollars because the provider has been pre-paid for these services. If you are the designated PCP or Behavioral Health Provider for a Coordinated Care member and receive a monthly capitation payment, you must file an encounter claim (also referred to as a proxy claim or encounter data) on a CMS 1500 form for each service provided *even though you have already been paid for providing these services*. **It is mandatory for all services to be submitted for encounter data.** Each month, Coordinated Care generates an encounter report to evaluate all aspects of provider compliance, quality and utilization management related to encounter data submission. Both the state and federal governments have strict requirements regarding the timely and accurate submission of encounter data. If you are unsure of these requirements or unsure of your ability to comply with these requirements, please contact the Coordinated Care Provider Services department at 1-877-644-4613 (TTY: 711) for further assistance.

Providers are required to submit a claim for each service that is rendered to a Coordinated Care enrollee regardless of the provider's claims reimbursement

21.2 Procedures for Filing Claims and Encounter Data

Although we accept claims and encounter data submitted on paper, Coordinated Care encourages all providers to file claims and encounter data electronically. See the Electronic Claims Submission section for more information on how to submit electronic claims and encounters.

22 PROHIBITION AGAINST BILLING THE MEMBER

Providers may not bill Medicaid members for any covered benefits. Under WAC 182-502-0160, HCA places the responsibility for verifying eligibility and obtaining approval for those services that require prior authorization from the provider. These requirements are also terms of the contract between participating providers and Coordinated Care.

Coordinated Care maintains a Payment Liability Log to monitor and trend when members are receiving a bill from their provider. Provider Relations will contact any providers with excessive trends to resolve any ongoing issues to avoid any future member billing.

In accordance with WAC 182-502-0160, 42 CFR 438.106, SSA 1932(b)(6), and SSA 1128B(d)(1), a provider may only bill a Coordinated Care member for non-covered services if the member and the provider both sign an agreement (HCA form 13-879) to pay prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

- The specific service(s) to be provided, which must be no later than ninety (90) calendar days from the date of the signed agreement;
- A statement that the service is not covered by Coordinated Care;
- List treatment alternatives that may have been covered by Coordinated Care;
- Specify the total amount the member must pay for the service;
- Specify what items or services are included in this amount;
- A statement that the member has been fully informed of all available medically appropriate treatment and the member chooses to receive and pay for the specific service;
- Specify that the member may request an exception to rule (ETR), an appeal, or an administrative hearing when HCA or Coordinated Care denies a request for a non-covered service;
- The member is not obligated to pay for the service if it is later found that the service was covered by Coordinated Care at the time it was provided, even if Coordinated Care did not pay the provider for the services because they did not satisfy Coordinated Care's billing or authorization requirements;
- Be completed only after the provider and the member have exhausted all applicable HCA and Coordinated Care processes necessary to obtain authorization of the requested service; and
- Specify the reason(s) the service is not covered.

An example of a member agreement to pay for healthcare service form can be found at https://www.hca.wa.gov/assets/billers-and-providers/13_879.pdf.

For Members who are Limited English Proficient (LEP), the agreement must be translated or interpreted into the Member's primary language to be valid and enforceable.

Providers are required to submit a copy of all signed agreements to bill a Coordinated Care member prior to the service being performed. The signed agreements can be faxed or mailed to the Coordinated Care Provider Services Department. The agreement will be reviewed. If it is

determined that it is not appropriate for the member to be responsible for the services, Provider Services will advise your office of this.

23 PROVIDER MANUAL UPDATES

REVISION DATE	PROVIDER MANUAL SECTION	REVISION DESCRIPTIONS
July 2025	Provider Manual Update	Coordinated Care's Provider Manual was updated and republished (effective 7/1/2025).

