

PROVIDER E-NEWS

Common Ground Healthcare Cooperative (CGHC) Provider Newsletter



COVID-19 BOOSTER VACCINES

As COVID-19 booster vaccines become available to the public, we want to have clarity around billing these services for claim processing.

If you already billed a COVID-19 booster claim which was denied, we recognize that the code was not previously configured properly in our system. Now that all systems have been updated, we are running an impact report and will proactively adjust any claims that were mistakenly denied for the 3rd booster vaccine.

Please bill the 3rd booster vaccines as follows:

- Moderna: CPT 0013A
- Pfizer: CPT 0003A

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2022 OPEN ENROLLMENT CHANGES

SELF SERVICE TOOLS & PROVIDER PORTALS

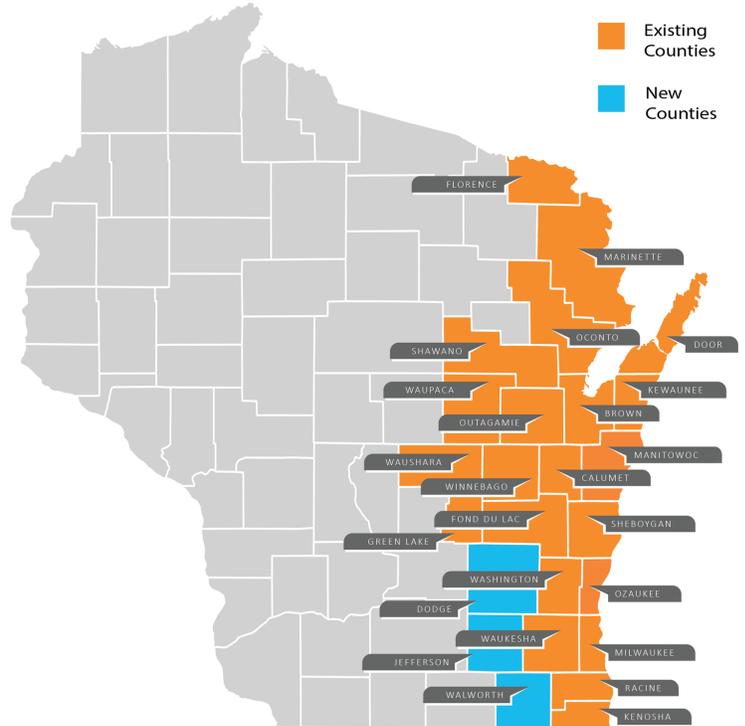
COMING SOON

CORRECTED BILLING REQUIREMENTS

2022 Open Enrollment

CGHC is excited to announce that we are expanding our service area once again with the addition of Dodge, Jefferson, and Walworth counties in 2022. The expansion into Dodge and Jefferson counties is made possible in part by the inclusion of the Watertown Regional Medical Center and its affiliated providers to our Envision network effective November 1, 2021. Advocate Aurora Health Care will serve members in the Walworth county market.

We also wanted to advise our network providers that we have expanded our Individual plan offerings in 2022 to offer buy-up options that include coverage for allergy testing, preventive dental services, and routine vision exams. If you are seeking information on these plan offerings and how to tell if a member's plans includes these optional benefits, we will have more details on our website no later than November 1.



New Enhanced ID Cards

CGHC will be issuing new ID cards to all of our members for their 2022 coverage. The new ID cards contain additional information on the member's benefits including their deductible, copayment, coinsurance, and maximum out-of-pocket amounts. (See sample below.)

Individual ID Cards: Individual Member Card

Family Card



COMMON GROUND

HEALTHCARE COOPERATIVE

Member Services
www.CGcares.org
 877.514.CGHC (2442)
 TTY: 711

Plan: [Metal] EPO
 [+ [Dental /] Vision]
 Network: Envision

Member Name: [First Name] [Last Name]
 Member #: [Member ID]

Effective Date:	01/01/2022	PCP: \$80	
		Specialist: \$120	
		QuickCare/FastCare: \$20	
		Urgent Care: \$200	
		ER: \$400	

Individual		RX BIN: 610011	
Deductible:	\$9,100	Rx PCN: IRX	
Rx Deductible:	\$5,000		
Max Out of Pocket:	\$9,100		

 OPTUMRX RX Group: CGHC



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Member Name: [First Name] [Last Name]
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Effective Date:	01/01/2022	PCP: \$80	[Depend First Name Last Name]
		Specialist: \$120	[Depend First Name Last Name]
		QuickCare/FastCare: \$20	[Depend First Name Last Name]
		Urgent Care: \$200	[Depend First Name Last Name]
		ER: \$400	[Depend First Name Last Name]

Individual		Family	
Deductible:	\$9,100	Deductible: \$17,100	
Rx Deductible:	\$5,000	Rx Deductible: \$10,000	
Max Out of Pocket:	\$9,100	Max Out of Pocket: \$17,100	

 OPTUMRX RX Group: CGHC

Self Service Tools

Due to the extremely high call volumes that occur during Open Enrollment, CGHC strongly encourages providers to utilize the self-service tools we have available to improve efficiencies and eliminate long wait times. Here are several tools that can be utilized to monitor member benefits, eligibility, claims status, and prior authorizations. **Please share this information with any billing service or other vendor contracted to perform these activities on behalf of your practice.**

Verifying a Member's Eligibility

Common Ground Healthcare Cooperative provides several ways for providers to confirm member eligibility:

- Each member is provided an identification card and is encouraged to show this card at each visit.
- CGHC Provider Portal available at <https://portal.commongroundhealthcare.org/Logon.jsp>
- HIPAA-compliant 270/271 real-time transactions via our clearinghouse, Smart Data Solutions (SDS)
- Utilize the CGHC Interactive Voice Response (IVR) system at 877-514-2442, Option 2, then Press 1

Checking Claims Status

Instead of waiting on hold to speak with one of our Member Services representatives:

- CGHC Provider Portal available at <https://portal.commongroundhealthcare.org/Logon.jsp>
- HIPAA-compliant 276/277 real-time transactions via our clearinghouse, Smart Data Solutions (SDS)

Requests for Prior Authorization & Checking Status

Providers can submit prior authorization requests and check status on pending authorizations by:

- Utilizing the Prior Authorization Portal at <https://provider.commongroundhealthcare.org/Account/Login?ReturnUrl=%2F>
- Faxing the appropriate prior authorization request form to 715-221-9749
- Calling our prior authorization toll free number at 877-825-9293

CGHC Portal Access

Don't have portal access today? No problem, the process for gaining portal access is simple. First, determine which of the CGHC portals you need access to based upon your job duties. The **CGHC Provider Portal** provides access to real-time eligibility information (including paid thru date), benefit info, and claims status.

The **Prior Authorization (PA) Portal** allows you to submit authorization requests online and check the status of any pending authorizations. Use of the PA Portal will improve the turnaround time on your requests. **In fact for some services like high-tech imaging (CT, MRI, and PET scans), if your request meets InterQual criteria, it can be auto-approved and the assignment of your authorization number is immediate so you can avoid any delays in scheduling.**

Some important tips for signing up for the CGHC Provider Portal at:

<https://portal.commongroundhealthcare.org/Logon.jsp>

1. If you are with an independent provider organization, you can actually register for the portal directly on our website with your Facility or Clinic Tax ID Number (TIN), as outlined in the Provider Self Service Training Guide.

<https://www.commongroundhealthcare.org/wp-content/uploads/2019/10/Provider-Self-Service-Training-Documents-Final-Updated-2019-10-23.pdf>

2. If, however, you are a part of a health system or larger provider group with multiple Tax ID Numbers, you will need to contact the designated portal administrator within your organization to request access. Once your administrator approves your request, they will forward your information to CGHC to complete the necessary set-up process so that you may access multiple TINs under a single account and username. If you are uncertain about who your organization's portal administrator is, please call Member Services at 877-514-2442.

To gain access to the Prior Authorization Portal:

<https://provider.commongroundhealthcare.org/Account/Login?ReturnUrl=%2F>

Every organization is required to have an assigned Portal Administrator who will be responsible for granting portal access to individuals within their organization. If your practice doesn't already have a designated administrator or if you want to add another individual as a back-up to the assigned administrator, please contact CGHC Provider Relations at **providerinfo@commongroundhealthcare.org**. Once we complete the initial administrator set-up, we will provide you with the quick and easy instructions for adding additional users.

Provider Roster Updates

While we receive regular monthly updates from our major health system providers, the same doesn't hold true for most of the independent practices with which we contract. Last year we instituted proactive roster outreach to all independent practices twice per year. Beginning in 2022, this process will be conducted quarterly instead to comply with new federal legislative requirements outlined in the Consolidated Appropriations Act (aka No Surprises Act).

It is imperative that practices respond to these requests for information from CGHC, even if it's only to inform us that there haven't been any changes to your roster. If providers fail to respond, CGHC is required under the new legislation to remove your practice from our online and print provider directories until your roster information can be validated.

Aside from the quarterly verification process, providers should always notify us of any changes throughout the year, including the addition of new providers and/or service locations, provider terminations, etc. Please use this [Provider Update form](#) to notify CGHC of any changes and email it to us at providerchanges@commongroundhealthcare.org.

Forms

We have noticed that many of you are still utilizing old, outdated forms for submitting information to CGHC. Please take a moment to pull updated forms for use in your office, which can be found [here](#). This will help us to process your requests on a more timely basis.

Coming Soon!

The updated 2002 Provider Manual will be published to our website by October 1, 2021.

- Click [here](#) for access.

There are no major changes to CGHC's prior authorization requirements for 2022; however, we will be updating our list of codes requiring authorization over the next couple of months to include targeted codes that are new and/or revised for 2022.

- The list will be published by December 1, 2021 and can be found [here](#).
- Click on the link inside the blue box at the bottom of this page for a listing of CPT/HCPCS codes requiring authorization.

Due to a recent announcement from CMS regarding delays to some provisions of the Consolidated Appropriations Act, we are currently pausing our work on the Advanced EOB requirements outlined in the legislation. We are awaiting further guidance and will plan to follow-up with our network providers once more information is available.

Corrected Billing Requirements

BILLING A CORRECTED CLAIM SUBMISSION REQUIREMENTS

In an effort to ensure our providers receive appropriate reimbursement and avoid denied claims, CGHC requests you adhere to the following billing requirements outlined in this document when submitting a corrected claim(s).

WHAT IS A CORRECTED CLAIM?

A corrected claim is a replacement of a previously billed claim that requires a revision to coding, service dates, billed amounts or member information.

CORRECTED CLAIM BILLING REQUIREMENTS

When submitting a claim for corrected billing on a CMS-1500, UB04, and/or electronically (EDI) your practice should include the following information to allow for accurate processing of your corrected claim:

CMS-1500 or UB04 Corrected Claim Submission

For CMS-1500 Claim Form

- Stamp "Corrected Claim Billing" on the claim form
- Use billing code "7" in box 22 (Resubmission Code field)
- Payers original claim number should also be included in box 22 under the "Original Ref No." field

20. OUTSIDE LAB?		\$ CHARGES	
<input type="checkbox"/> YES	<input type="checkbox"/> NO		
22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.	
7		180XXXXXXXXX	
23. PRIOR AUTHORIZATION NUMBER			

For UB04 Claim Form

- The fourth digit of the "Type of Bill" (field 4) should be "7"

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
		3b MED. REC. #	017
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM
			THROUGH 7

- Include the original claim number in box 64 (Document Control Number)

64 DOCUMENT CONTROL NUMBER
180XXXXXXXXX

- Corrected claims should include all previously billed line items and not only the lines or data that requires correction

Corrected Billing Requirements Continued

837I/P CORRECTED CLAIM SUBMISSION REQUIREMENTS

Claims submitted electronically should include claim frequency codes that alert the system to know that the claim is a correction to a previously approved or denied claim. Claim frequency codes are as follows:

- 1 - Original Claim
- 7 - Replacement or Corrected Claim
 - Information on this bill indicates a replacement of the original claim
- 8 - Voided or Canceled Claim

Professional Claims - 837P Billing Requirements

Loop 2300

- CLM05-3 = Frequency Type Code "7"
- REF01 = F8 (Original Reference Number)
- REF02 = Original payer's claim number

Institutional Claims - 837I Billing Requirements:

Loop 2300

- CLM05-3 = Frequency Type Code "7" (4th digit of the Type of Bill code)
- REF01 = F8 (Original reference number)
- REF02 = Original payer's claim numberCor

CLM*12345678*500***11:A:7*Y*A*Y*I~

REF*F8*180XXXXXXXXXX"