PROVIDER E-NEWS

Common Ground Healthcare Cooperative (CGHC) Provider Newsletter

Self-Service Tools

At CGHC, we offer self-service tools for your convenience.

Our easy-to-use Provider Portal gives you 24/7 access to information for your CGHC patients. Verify member eligibility (including paid through dates), benefits and out-of-pocket costs, claims status, and completed prior authorization information.

If you are not already registered for the CGHC provider portal, or need a reminder on how to use it, please visit the **Provider Manual** for details or contact us at **ProviderInfo@commongroundhealthcare.org** for further assistance.

IN THIS ISSUE

Refund Submissions

When an overpayment occurs due to a provider billing error, a Federally Facilitated Marketplace change, or claims processing application error, a refund is required. If CGHC discovers that an overpayment has been made, we adjust the impacted claim and request a refund.

Using the correct PO Box to mail in a refund helps ensure that your check is processed appropriately. Please include a copy of the refund request letter with the refund check and mail to:

Common Ground Healthcare Cooperative
P.O. Box 1630
Brookfield, WI 53008-1630

Questions about refunds should be emailed to the CGHC Refunds Department at: **Refunds@commongroundhealthcare.org**.

New Plan Year Reminders

Tips for Submitting Drug Prior Authorization

If you have ever felt confused by the submission process for Prescription Drug Prior Authorizations (Rx PA) or Medical Claim Reconsiderations, you are not alone. To help clear up the confusion, we've created tips to streamline the process for everyone involved.

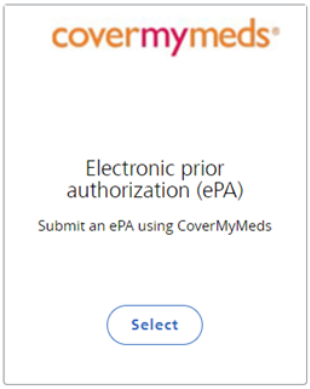
Rx Prior Authorizations

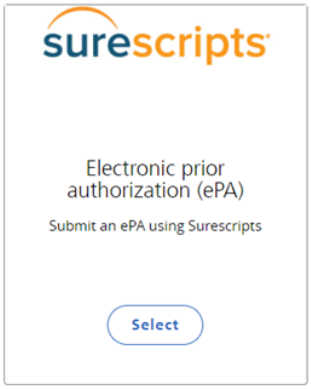
Our Rx PA department follows a set of rules when deciding if a prior authorization request will be approved. They review:

- The CGHC Certificate of Coverage to determine if the drug is a covered benefit, a limited benefit, or an exclusion.
- The CGHC Drug Formulary to see if the drug is covered, and if so, on which Tier.
- Clinical criteria/policies for Medical Necessity and Experimental & Investigational, Step Therapy, etc.
- Evidence-based practice guidelines such as U.S. Preventive Services Task Force (USPSTF) and National Comprehensive Cancer Network® (NCCN®).
- Medical records and clinical evidence to support the Rx PA request.

Tips to avoid denials

1. ***Submit your PA request electronically via covermymeds or surescripts.*** This is the quickest and most accurate way to submit a PA request and receive a decision. Both portals use a decision tree to ask the proper questions and direct you to all the documentation that needs to be submitted with the PA request.





2. ***Submit all required relevant information with the request – a physician statement is not enough to secure approval.*** Attaching all relevant medical records and clinical evidence that make the case for why the person needs the drug will prevent delays in receiving a decision.
3. ***If an Rx PA denial is due to lack of information, and the supporting information is now available, simply re-send the request and supporting documents to CGHC's Rx PA department.*** Note – Two (2) submission attempts are allowed for each prior authorization request. Please do not use the Appeals Department address when re-submitting a PA request; it will only delay the review and decision processes.
4. ***If you receive an initial denial that you disagree with, please request a peer-to-peer discussion with a physician or pharmacist in the Rx PA department.*** Information for requesting the discussion is detailed in the denial letter. Note – the peer-to-peer review must be done within 14 days of the denial.

New Plan Year Reminders, Cont.

Tips for Submitting Medical Claim Reconsiderations

Disagreements about the way a claim was processed can happen. When the amount CGHC paid on the claim doesn't seem right, **submit a Claim Reconsideration request to CGHC's Claims Department**. The claim reconsideration form is available on the CGHC website Provider Forms page.

Mail the completed Claim Reconsideration form to:

Common Ground Healthcare Cooperative
120 Bishop's Way, Suite 150
Brookfield, WI 53005
Attention: Claims Department

Tip to expedite the Claim Reconsideration process and make it a great experience for everyone.

1. ***Use the correct Department Name in the address.*** Many claim reconsideration requests are mistakenly addressed to the Appeals Department.

Questions about benefits and claims can be directed to CGHC Member Services at 877-514-2442.

Provider Updates and Changes
NEW Quarterly Roster Vertification Process

Maintaining timely, accurate information on participating providers is critical for CGHC. Our members and staff need to know anytime a change occurs for In-Network providers. For these reasons we ask you to please be proactive and notify us as soon as possible regarding provider changes. Submit an updated roster or **Provider Change Form** to **providerchanges@commongroundhealthcare.org**.

Regulations included in the Consolidated Appropriations Act, which took effect on January 1, 2022, contain new requirements for provider information. As a result, CGHC will actively reach out to providers on a quarterly basis to ensure the roster information we have on file is accurate. Timely response to our roster verification request is needed. If a response is not received within 14 days, we must remove the practice and its associated providers from CGHC online and print directories. Please ensure your team is aware of this requirement and responds timely to our requests.

Questions? Please contact a CGHC representative at 877-514-2442.

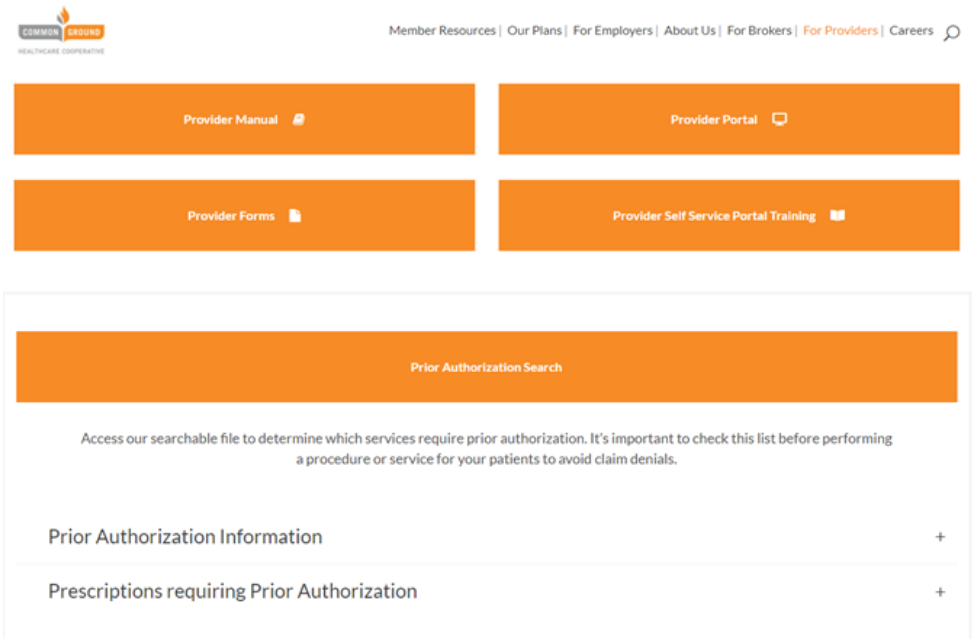
Prior Authorization Code Search Made Easy

Looking for an easy way to verify if a covered health service requires prior authorization with Common Ground Healthcare Cooperative (CGHC)? Our Prior Authorization Search tool is just what you need. Simply go to the Provider Resources and Training page and click the "Prior Authorization Search" button. The Excel spreadsheet that downloads will provide a list of all codes that require prior authorization.

The tool is frequently updated as new services requiring prior authorization are added and others are termed. So please be sure to always visit our website when searching for codes that require prior authorization. This will guarantee you are using the most up-to-date list.

Important – prior authorization must be obtained regardless of whether Common Ground Healthcare Cooperative is the patient's primary or secondary health insurance carrier. Prior authorization does not guarantee coverage and/or payment if a benefit maximum has been reached or coverage has been terminated.

For more resources to help you navigate prior authorizations for CGHC members, use the materials available on the Provider Resources and Training page of the CGHC website.



CGHC follows NCQA guidelines in reviewing prior authorization requests and making determinations. Please submit all Prior Authorizations timely to ensure enough lead time for the member's service(s).

For urgent or emergency admissions, Prior Authorization must be obtained within 48 hours of the admission or the next business day.

Elective inpatient services require approval prior to admission to the facility where the elective services will be received.

NEW - Partial Hospitalizations
When requesting authorization for partial hospitalization through the online portal, the request should be submitted as an outpatient service.

NEW – All T Codes require PA
Beginning 04/01/2022 all temporary codes (T codes) require prior authorization.

Prior Authorization Code Search, Cont.

The **Provider Manual** provides complete details, including CGHC response times for various PA request types based on priority.

(Below) Excerpt from page 41 of 2022 CGHC Provider Manual.

AUTHORIZATION REQUESTS – TYPES AND TIMELINESS

Request Type	Priority	Definition	CGHC time for response
Prospective	**Urgent**	Using the time period for making non-urgent care determinations (a) could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function, or (b) in the opinion of a physician with knowledge of the consumer's medical condition, would subject the consumer to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.	72 hours
	Non-Urgent	The definition of urgent (above) does not apply	15 calendar days
Retrospective	**NA**	Review is requested after the services have been provided, or after the patient is discharged from the hospital	30 calendar days

If you have any questions, please contact us at 877-514-2442.

5 Ways Providers Impact Qualified Health Plan Enrollee Experience Survey (QHPEES) Results

Did you know that Common Ground Healthcare Cooperative (CGHC) members judge our health plan based on the performance of the providers who participate in our networks? Each year, a Qualified Health Plan Enrollee Experience Survey (QHPEES) is sent to a sample of members, asking about their perceptions of CGHC and our network providers. More than half of the questions used for scoring are related to health care providers.

Here are five ways that our network providers can help ensure that CGHC health plans and network receive a world-class member experience rating.

1. Flexibility in Patient Options for Doctor Visits –
   - Can the patient choose in-person, telephone, or video appointments?
2. Timeliness and Ease of Access to Care –
   - Can the patient get an appointment (office visit, screening, test, or treatment) when needed, and were they able to schedule in-person, online and via telephone?
3. Quality and Accuracy of Provider Communications –
   - Does the patient feel the healthcare information shared was adequately explained and their questions were answered?
4. Quality of Provider Interactions with the Patient –
   - Does the patient feel heard, respected, and given adequate time with the provider?
5. Quality of Treatment Outcomes -
   - Does the patient feel that the care received is effective and appropriate?

The QHPEES is an annual reflection of our combined commitment – providers and CGHC – to putting members first.