



HEALTHCARE COOPERATIVE

COMMON GROUND HEALTHCARE COOPERATIVE PROVIDER MANUAL

<https://commongroundhealthcare.org/provider-resources-and-training/>

January 2023

ABOUT THIS MANUAL

This provider manual is the property of Common Ground Healthcare Cooperative (CGHC), and CGHC reserves all rights to modify this provider manual in its sole discretion. Network providers acknowledge this manual and any other materials provided by CGHC in written or electronic form as proprietary and confidential.

In the event there is a conflict with this manual and your provider agreement with CGHC, your agreement supersedes. We encourage you to contact CGHC at 877-514-2442 if you have questions about the content of this manual.

Please note: Material in this manual is subject to change. The most up-to-date version is available online at <https://commongroundhealthcare.org/provider-resources-and-training/>

PROVIDER COMPLIANCE WITH PROVIDER MANUAL TERMS AND PROVISIONS

The information contained in this manual is intended to assist providers in rendering high-quality cost-effective services to CGHC members. Providers who are contracted to participate in CGHC products must comply with the policies and procedures contained in this manual.

USE OF HEADINGS AND SPECIFIC TERMS IN THIS MANUAL

Headings are used to help navigate to sections of this manual more easily. The use of a heading should not be interpreted to alter the information contained within that section. Certain terms used in this manual are otherwise defined in the terms of your agreement with CGHC or in the certificate of coverage.

2023 QUICK REFERENCE GUIDE

CGHC CONTACT INFORMATION

Common Ground Healthcare Cooperative
120 Bishops Way, Suite 150
Brookfield, WI 53005

Website: www.CommonGroundHealthcare.org

QUESTIONS ABOUT BENEFITS, ELIGIBILITY, CLAIMS STATUS, CALL 877-514-2442

OTHER IMPORTANT PHONE NUMBERS: 414-455-0500 (Main) 877-450-8497 (Toll-free)
PRIOR AUTHORIZATIONS: 877-825-9293 (Medical) 800-711-4555 (Pharmacy)

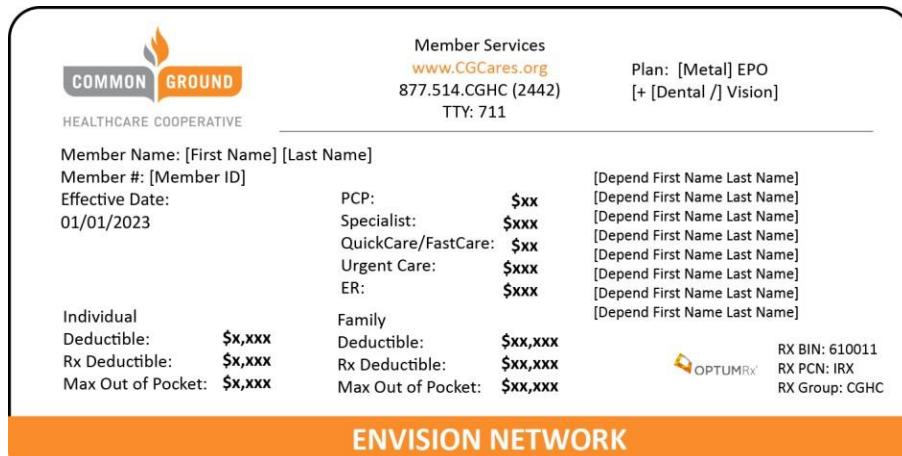
OPTUMRX Prior Authorizations: <https://professionals.optumrx.com>

SUBMIT CLAIMS TO:

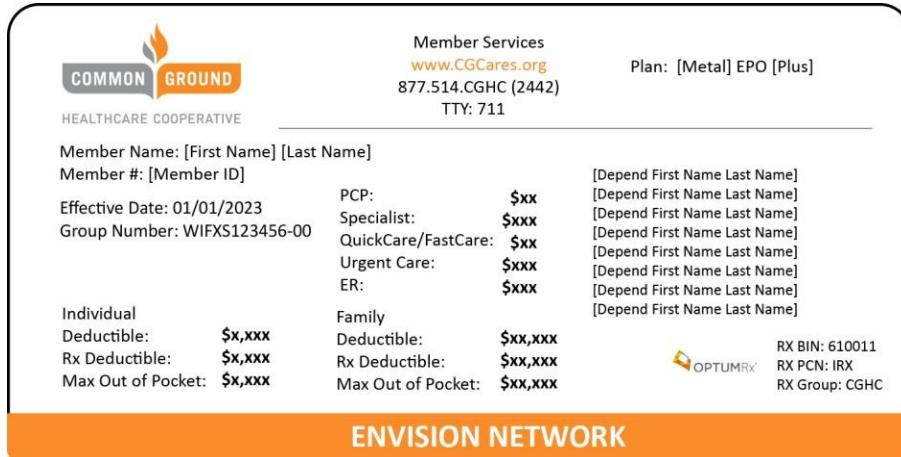
Common Ground Healthcare Cooperative EDI: 77170
PO Box 1630
Brookfield, WI 53008-1630

CGHC IDENTIFICATION (ID) CARD

Members are issued an ID card identifying them as a CGHC enrollee and are asked to show this card at each visit. Samples of our member health plan ID cards can be found below



Envision Small Group ID Card



ABOUT COMMON GROUND HEALTHCARE COOPERATIVE

Common Ground Healthcare Cooperative (CGHC) is the health insurance solution for thousands of small businesses, nonprofits, individuals, and families throughout Eastern Wisconsin. CGHC is a nonprofit cooperative dedicated to delivering quality, comprehensive health insurance. We are changing insurance by delivering a new and better way to experience quality, comprehensive care. Our approach is simple: we value people above profit.

Led by a team of passionate and experienced professionals, CGHC is member-focused and member-governed. That means people come first. It also means members have a voice and a vote. We believe in transparency, because when it comes to healthcare, members should know exactly what they're getting: fair access to quality, integrated care at a competitive rate.

CGHC serves 25 counties throughout Eastern Wisconsin (see service area map). We offer our

benefit plans on and off the Health Insurance Marketplace (also called the Exchange), as well as to employers with 2-50 employees who elect to purchase benefit plans via agents, brokers, or consultants or through the Small Business Health Options Program (SHOP).

WHAT IS A COOPERATIVE?

In 2010, the Patient Protection and Affordable Care Act (commonly referred to as "ACA") created Consumer Operated and Oriented Plans (known as CO-OPs) to foster the creation of new consumer-governed, private, nonprofit health insurers. Each CO-OP expands consumer health insurance choices in select markets by increasing competition among insurers. CGHC was one of the CO-OPs launched from health care reform and has been dedicated to bringing affordable health insurance to Eastern Wisconsin since 2014. CGHC, like all other CO-OPs, must be state-licensed and is subject to the same Wisconsin state insurance laws and regulations as those that apply to all other similarly-situated issuers.

WHO IS COMMON GROUND HEALTHCARE COOPERATIVE (CGHC)?

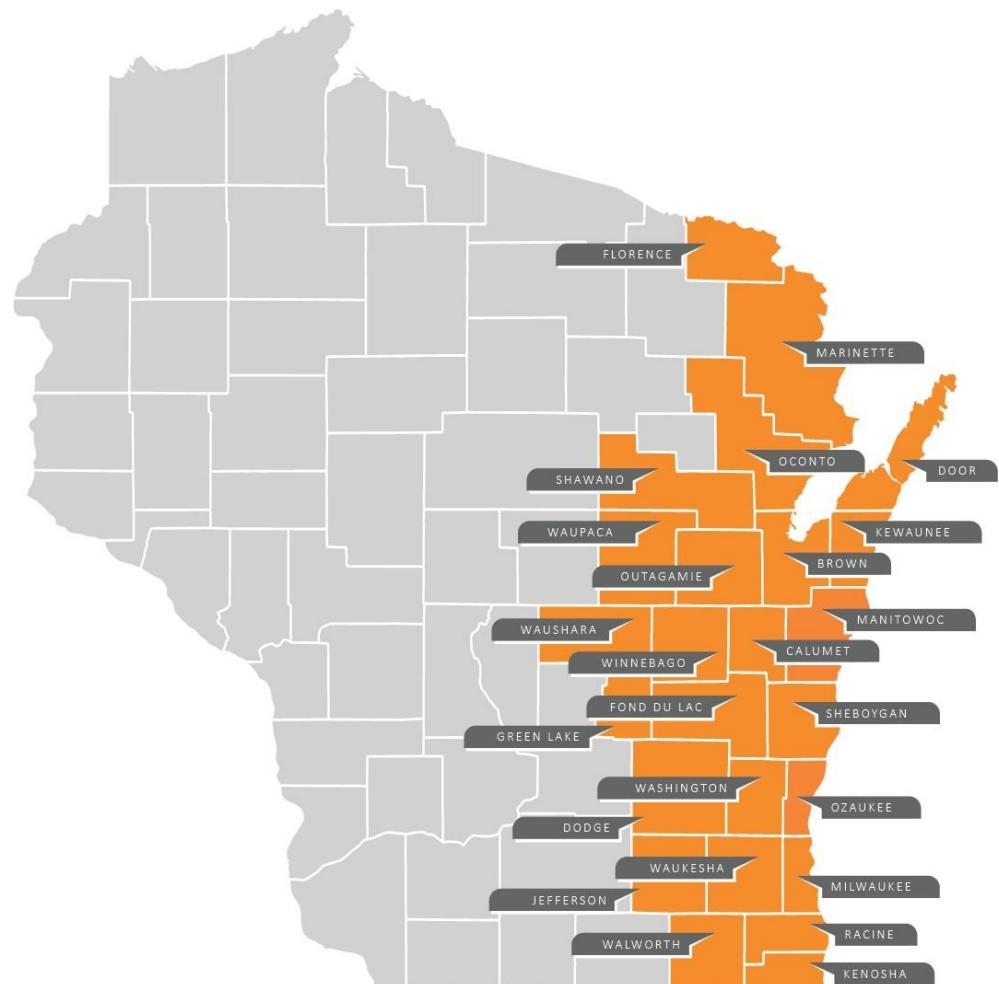
Common Ground Healthcare Cooperative began when a group of like-minded, experienced professionals — who believed in a better health insurance experience — felt inspired to create something different. Born out of Common Ground, a Milwaukee-based, nonpartisan nonprofit, CGHC is a community founded on trust, the voice of its members, and the simple idea of putting people above profit.

As a nonprofit, member-focused cooperative, we deliver on our promise to put people above profit. In fact, any profit made goes directly

back toward lowering premiums and improving benefits — for our members.

Our approach is centered on doing what's best for our members, by providing access to integrated care to our commitment to customer service, and most of all our focus on individuals rather than profit. When someone enrolls in CGHC, they are choosing a health plan that places people first.

COMMON GROUND HEALTHCARE COOPERATIVE SERVICE AREA MAP



COMMON GROUND HEALTHCARE COOPERATIVE NETWORK & SERVICE AREA

Common Ground Healthcare Cooperative offers an Exclusive Provider Organization (EPO) product to individual consumers. Individual buyers residing within our 25-county service area (Brown, Calumet, Dodge, Door, Florence, Fond du Lac, Green Lake, Jefferson, Kenosha, Kewaunee, Manitowoc, Marinette, Milwaukee, Oconto, Outagamie, Ozaukee, Racine, Shawano, Sheboygan, Walworth, Washington, Waukesha, Waupaca, Waushara, and Winnebago counties) are eligible to obtain insurance from CGHC. Summary plan information on our insurance products and our service area map can be found at:

Individual and Family: <https://www.commongroundhealthcare.org/our-plans/individuals-families/>

Small Group: <https://commongroundhealthcare.org/small-employer-plans/>

Most CGHC members purchase coverage through the Federally Facilitated Marketplace (FFM) to access the Advance Premium Tax Credit (APTC) available under the ACA.

Individuals who enroll in CGHC may purchase one of CGHC's **Envision** plans, which give members access to integrated systems of hospitals and healthcare professionals through Aurora Health Care, Bellin Health Partners, ThedaCare, Door County Medical Center, Dickinson County Healthcare System, Watertown Regional Medical Center and pediatric care coordinated through Children's Hospital of Wisconsin and the Medical College of Wisconsin - Children's Specialty Group.

SPECIAL INSTRUCTIONS FOR OUT-OF-NETWORK REFERRALS

CGHC Members have **NO** out-of-network benefits except in LIMITED circumstances. We are required to cover emergency services, out-of-service area urgent care services when a member is travelling, when there is no in-network provider qualified to treat the member's condition, and some limited behavioral health services for college students attending school in Wisconsin.

When care cannot be provided by an in-network provider, a referral is required to permit a member to obtain care from an out-of-network provider. Only in-network providers may initiate an EPO referral, the form can be found [HERE](#). **Note that prior authorization may also be required for services provided under an approved EPO referral.** Prior Authorization and obtaining an approved EPO referral are two separate processes.

Services rendered by an out-of-network provider without an approved EPO referral will not be paid by CGHC unless they were provided in an urgent/emergent situation.

CGHC PROVIDER PORTAL

At CGHC, we strive to promote self-service for our providers' convenience. **Our provider portal is available for all providers to access information on member benefits and out-of-pocket costs, eligibility (including paid thru dates), claims status, and completed prior authorization information.** If you are not already registered for the provider portal, it is important to do so. The portal is available 24/7, is easy to use, and will provide you and your team with easy access to information for your CGHC patients.

Some important tips:

1. If you are with an independent provider organization, you can register with your Facility or Clinic Tax ID Number (TIN), as outlined on the Provider Self Service Training Guide. <https://commongroundhealthcare.org/provider-resources-and-training/> 2. If, however, you are a part of a health system or larger provider group with multiple tax identification 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.



VERIFYING A MEMBER'S ELIGIBILITY

Common Ground Healthcare Cooperative provides several ways for providers to determine 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 Common Ground Interactive Voice Response (IVR) system at 877-514-2442, Option 2, then Press 1

VERIFYING MEMBER COVERAGE & MEMBERS IN "GRACE PERIODS"

Members are issued a CGHC ID card at the time of enrollment. Eligibility for ACA members may change during the year. We recommend that you verify current eligibility, before providing care as possession of a CGHC ID card does not guarantee member eligibility. The most efficient method for doing so is to utilize our Provider Portal, as it contains the most up-to-date information about members.

The ACA contains a provision for Exchange-based members who receive an Advanced Premium Tax Credit (APTC). These members have a full 90-day grace period linked to premium payment:

- During the first 30 days of this grace period, we will pay their claims as if the premium has been paid.
- During the following 60 days, CGHC will pend claims if the premium is unpaid.
- The grace period expires at the end of 90 days, and the member's coverage is terminated. If by the end of the grace period, the member pays their outstanding premium in full, we will process the pended claims. Alternatively, if the member does not pay their outstanding premium during this grace period, the claims after the first 30 days will be denied.

When an APTC member is in a grace period, CGHC can only confirm that member's eligibility and paid-up status as of the time a verification request is made.

HOSPITALIZATION AND NEW OR TERMINATED COVERAGE

- If a member is inpatient at any facility, hospital, skilled nursing facility, hospice, or rehabilitation facility as of the first day their coverage begins, CGHC will only pay for covered health services incurred on that date forward. Services incurred prior to the effective date of the member's policy will not be the responsibility of CGHC. Notify CGHC as soon as possible of the member's admission, but no later than 48 hours after admission.
- If a member is inpatient at any facility, hospital, skilled nursing facility, hospice, or rehabilitation facility and their coverage ends during their period of confinement, CGHC's liability for reimbursement ends as of that date of termination.

NOTE: CGHC understands that there are times where Members may become eligible in the middle of an inpatient stay, and CGHC requires that Providers submit a claim that contains only services on or after the Member becomes effective with CGHC.

COVERED HEALTH SERVICES

The member's current Certificate of Coverage contains a detailed description of benefits under their Plan and may be found at:

<http://www.commongroundhealthcare.org/coverage-details/>

Benefits are available only if all the following are true:

- Health services provided are not excluded by the Certificate of Coverage.
- Covered health services must be medically necessary and not experimental/investigational (except as described in the clinical trial section of the policy). The fact that a provider prescribes or recommends a service, treatment, or supply does not make it medically necessary or a covered health service and does not guarantee payment.
- Covered health services must be received while the member's policy is in effect.
- The person who receives covered health services is a covered person and meets all eligibility requirements specified in the policy.

The policy specifically describes those health services for which benefits are available. The policy's schedule of benefits contains details about:

- The amount a covered person must pay for certain health services (including any annual deductible, copayment, coinsurance, and non-covered services).
- Any limits that may apply to certain covered health services.
- Any limits that apply to the amount members are required to pay in a year (out-of-pocket maximum).
- Any responsibilities members have for obtaining prior authorization or notifying CGHC.

EXCLUSIONS AND LIMITATIONS SUMMARY

Common Ground Healthcare Cooperative will not pay benefits for any services, treatments, items, or supplies described in the exclusions and limitations section of the policy, even if either of the following is true:

- The health service is recommended or prescribed by a physician or clinical provider.
- The health service is the only available treatment for the condition.

The services, treatments, items, or supplies listed in the exclusions and limitations section are not covered health services unless specific provisions apply.

Certain benefits are subject to limitation and CGHC will not pay for any services, treatments, items, or supplies that exceed benefit limitations.

NETWORK PROVIDER PARTICIPATION

Common Ground Healthcare Cooperative is not actively accepting requests for CGHC network provider participation in 2023. However, providers can submit a request by completing the form available at <https://www.commongroundhealthcare.org/providers/become-a-provider/>.

CONTACT PROVIDER RELATIONS

Via Email: ProviderInfo@commongroundhealthcare.org

PROVIDER ACCESS AND AVAILABILITY

Common Ground Healthcare Cooperative regularly monitors the accessibility of healthcare for members. Standards for access to primary, specialty, behavioral health, urgent/emergent, and after-hours care are defined, and network practitioner performance is evaluated against those standards to identify recommendations for improvement.

- A. Access to care is evaluated by the Quality Improvement (QI) Department through monitoring appointment accessibility against established standards.
 - Any practitioner who does not meet the access standard is notified in writing of the CGHC access standards and expectations. The QI Department is responsible for implementing any intervention and for monitoring to ensure that any deficiency has been corrected.
- B. An accessibility of health care analysis and report is done annually and presented to the Executive Quality Oversight Committee (EQOC) for review and recommendations for improvement. The analysis includes, but is not limited to:
 - a. Member Complaints & Appeals
 - b. Member Satisfaction Survey
 - c. Member Services Call Metrics
- C. Any identified provider specific trends/issues related to access to healthcare are included in the credentialing and recredentialing approval process of providers.

Details of Access Requirements:

Primary Care:

1. Routine appointments:
 - a. Annual physical/preventive health visit: 30 calendar days
 - b. Routine, symptomatic, non-urgent (e.g., cold, no fever): 5 calendar days
2. Urgent appointments: within 48 hours

Specialty Care:

1. Consultation appointments: request to appointment time must be consistent with the clinical urgency, but no greater than -30 calendar days.
2. Urgent appointments: within 24 hours of the request. If an appointment cannot be accommodated, the physician, mid-level clinician, or RN must triage and determine the appropriate time frame and place for care.

Behavioral Health Provider:

1. Initial visit for routine appointments: within 10 calendar days

2. Follow-up for routine appointments: within 30 days
3. Urgent appointments: within 48 hours
4. Non-life-threatening emergency: within 6 hours
5. Emergency: immediate, 24 hours per day, seven days per week; or direct the member to an Emergency Department (ED) instead of scheduling for an office visit.

Emergency Care:

1. Prior authorization is NOT required for emergency services whether the provider is in-network or out-of-network; however, should the emergency service result in an inpatient admission, all providers must obtain Prior Authorization within 48 hours after the admission or as soon as medically able to do so. See Prior Authorization section for additional information.
2. CGHC will ensure that there is no clinical delay caused by utilization control measures.
3. Emergency care is defined using the prudent layperson definition.

After Hours Care:

1. All contracted CGHC primary care providers (PCP) are expected to provide member access to physician services, 24 hours a day, seven days a week.

Office Wait Times:

1. Scheduled appointments: wait times should not exceed 30 minutes from appointment time to the time the member is seen by the provider. All providers are to monitor wait times and adhere to this policy.

CREDENTIALING REQUIREMENTS FOR PARTICIPATION

All practitioners who provide care to CGHC members must be appropriately credentialed under CGHC's Credentialing Program. This may require the completion of a credentialing application or may be achieved through delegation of credentialing obligations to a provider organization. CGHC will not pay for services provided by uncredentialed practitioners, and providers are prohibited from billing CGHC members for these charges.

Practitioner Rights During the Credentialing Process

Practitioners have the right to review their credentials file at any time. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received and is available in this manual. The practitioner may exercise this right by notifying the QI Department to request an appointment (up to seven days in advance of the requested time) to review their file. CGHC's Chief Medical Officer and/or other QI staff will attend. The practitioner has the right to review all information in the credentials file except peer references or recommendations which are protected by law from disclosure. The only items in the file that may be copied by the practitioner are documents which the practitioner sent to CGHC or its agent (e.g. the application, the license, and a copy of the DEA certificate). Practitioners may not copy documents that include information that are confidential in nature, such as the practitioner credentialing checklist, the responses from monitoring organizations (i.e. National Practitioner Data Bank, state licensing board), or verification of hospital privileges letters.

Practitioner Rights to Correct Erroneous Information

Practitioners have the right to correct erroneous information in their credentials file. Practitioners are notified of their right in a letter sent to them at the time the initial or recredentialing application is received.

CGHC's QI Department will notify the practitioner immediately in writing if credentialing information obtained from other sources varies substantially from that provided by the practitioner including, for example, actions on a license or malpractice claims history. In such cases, CGHC is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

Notification of credentialing variances will be sent to the practitioner which will detail the information in question and instruct the practitioner how to submit a written response within 10 calendar days of receiving such notification. The practitioner's written response to CGHC should explain the discrepancy, correct any erroneous information, and provide supporting evidence, if available.

Receipt of notification from the practitioner will be documented in the practitioner's credentials file. CGHC will then re-verify the primary source information in dispute. If the primary source information has changed, the practitioner's credentials file will be corrected immediately, and the practitioner will be notified in writing of the correction to their credentials file. If the primary source information remains inconsistent with practitioner's original representation, CGHC will notify the practitioner, who may then provide additional proof of correction by the primary source body to CGHC's QI Department for re-verification. If the practitioner does not respond within 10 calendar days, CGHC will discontinue processing the application and network participation will be denied.

PRACTITIONER RIGHTS TO BE INFORMED OF APPLICATION STATUS

Practitioners have a right, upon request, to be informed of the status of their application. Practitioners are invited to contact the Provider Relations Department during normal business hours to request the status of their application.

The practitioner may be informed of the status of their application by telephone, email, or mail. A response to the request will be sent within two working days. The practitioner may receive the status of their application in the credentialing process as well as any missing information or information not yet verified. Practitioners are prohibited from reviewing references, recommendations, or other information that is peer-review protected.

CRITERIA FOR PARTICIPATION IN THE COMMON GROUND HEALTHCARE COOPERATIVE NETWORK

Although Common Ground Healthcare Cooperative is not accepting unsolicited requests for CGHC network participation, CGHC does have established criteria and verification sources in order to evaluate and select practitioners for CGHC network participation. This policy expressed here defines the criteria that apply to applicants for initial participation, recredentialing, and ongoing network participation. To remain eligible for continued participation, practitioners must satisfy all applicable requirements for participation as stated herein and in all other documentation provided by CGHC. These criteria and the

sources used to verify these criteria are listed below (“Practitioner Criteria and Primary Source Verification”).

CGHC reserves the right to exercise sole discretion in applying any criteria and to exclude practitioners who do not meet the criteria. CGHC may, after considering the recommendations of the Delegation Oversight Committee (DOC) or CGHC’s credentialing delegates, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined that such waiver is necessary to meet the needs of CGHC and the community it serves. The refusal of CGHC to waive any requirement shall not entitle any practitioner to a hearing or any other rights of review. Practitioners must meet the following criteria to be eligible to participate in the CGHC network. If the practitioner fails to provide proof of meeting these criteria, the credentialing application will be deemed incomplete and it will result in an administrative denial or termination from the CGHC network. Practitioners who fail to provide proof of meeting these criteria do not have the right to submit an appeal.

1. Practitioner must practice, or plan to practice within 90 calendar days, within the area served by CGHC.
2. Practitioner must have a current, valid license to practice in their specialty in every state in which they will provide care for CGHC members.
3. Practitioner must have current professional malpractice liability coverage with limits that meet CGHC criteria.
4. If applicable to the specialty, practitioner must have a current and unrestricted federal Drug Enforcement Agency (DEA) certificate and controlled substance certification or registration.
5. Oral surgeons, physicians (MDs, DOs), and podiatrists will only be credentialed in an area of practice in which they have adequate training as outlined below. Therefore, they must confine their practice to their credentialed area of practice when providing service to CGHC members. Adequate training must be demonstrated by one of the following.
 - a. Current board certification by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association in the credentialed area of practice, the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedic and Primary Medicine (ABPOPM), or the American Board of Oral and Maxillofacial Surgery.
 - b. Successful completion of a training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians in Canada (CFPC), or the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must have completed a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA).
 - c. Practitioners (MDs/DOs) who are not board certified as described in section 11a above and have not completed an accredited residency program are only eligible to be considered for participation as a general practitioner in the CGHC network. To be eligible as a general practitioner, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history.

6. At the time of initial application, the practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
7. Practitioner must not be currently excluded, expelled, or suspended from any state or federally funded program including, but not limited to, the Medicare or Medicaid programs.
8. Practitioner must not have been convicted of a felony or pled guilty to a felony for a healthcare related crime including, but not limited to, healthcare fraud, patient abuse, and the unlawful manufacture, distribution or dispensing of a controlled substance.
9. Physician assistants and nurse practitioners who are not licensed to practice independently, but are required to be credentialed as described in the policy above, must have a practice plan with a supervising physician approved by the state licensing agency. The supervising physician must be contracted and credentialed with CGHC.
10. Physicians (MDs, DOs), primary care practitioners, midwives, oral surgeons, podiatrists, and/or those practitioners dictated by state law, must have admitting privileges in their specialty or have a plan for hospital admission by using a hospital inpatient team or having an arrangement with a credentialed CGHC participating practitioner that has the ability to admit CGHC patients to a hospital. Practitioners practicing exclusively on a consultative basis are not required to have admitting hospital privileges. Physicians practicing in dermatology, occupational medicine, pain medicine, physical medicine and rehabilitation, psychiatry, sleep medicine, sports medicine, urgent care, and wound management do not require admitting privileges.
11. Licensed midwives who perform deliveries outside of an acute care hospital must have a formal arrangement in place with an OB/gyn contracted and credentialed with CGHC. This arrangement must include 24-hour coverage and inpatient care for CGHC members in the event of emergent situations. Family practitioners providing obstetric care may provide the back-up in rural areas that do not have an OB/gyn. This back-up physician must be located within 30 minutes from the midwives' practice.
12. Nurse midwives, licensed midwives, oral surgeons, physicians, primary care practitioners, and podiatrists must have a plan for shared call coverage that includes 24-hours a day, seven days per week, and 365 days per year. The covering practitioner(s) must be qualified to assess over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day. Physicians practicing in dermatology, occupational medicine, pain medicine, physical medicine and rehabilitation, sleep medicine, sports medicine, urgent care, and wound management are not required to have 24-hour coverage.
13. CGHC, in its sole discretion, may determine that a practitioner is not eligible to apply for network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by CGHC, who is currently in the fair hearing process, or who is under investigation by CGHC or CGHC's credentialing delegates. CGHC also may, in its sole discretion, determine that a practitioner cannot continue network participation if the practitioner is an employee of a practitioner or an employee of a company owned in whole or in part by a practitioner, who has been denied or terminated from network participation by CGHC. For purposes of this criterion, a

company is owned by a practitioner when the practitioner has a majority financial interest in the company, through shares or other means.

14. Practitioners denied by the CGHC's DOC or CGHC's credentialing delegates are not eligible to reapply until one year after the date of denial by the Credentialing Committee. At the time of reapplication, practitioner must meet all criteria for participation outlined above.
15. Practitioners terminated by the DOC or CGHC's credentialing delegates are not eligible to reapply until five years after the date of termination by the Credentialing Committee. At the time of reapplication, practitioner must meet all criteria for participation as outlined above.
16. Practitioners denied or terminated administratively as described throughout this policy are eligible to reapply for participation anytime if the practitioner meets all criteria for participation above.

PROVISIONAL CREDENTIALING

It can occasionally be in the best interest of members to make practitioners available prior to completion of the entire initial credentialing process. In this case, if allowable by regulatory agency, CGHC has the option of provisional credentialing for practitioners applying to the organization for the first time. A practitioner may only be provisionally credentialed once. Practitioners who had been in the CGHC network via a delegation arrangement are not eligible for provisional credentialing if the delegation arrangement is terminated or if the practitioner is no longer affiliated with the delegate. At a minimum, CGHC requires the following to be completed prior to approval of provisional credentialing:

- Primary-source verification of a current, valid license to practice
- Primary-source verification of the past five years of malpractice claims or settlements from the National Practitioner Data Bank (NPDB) or Healthcare Integrity and Protection Databank (HIPDB) query
- A current attestation within 180 calendar days

Each of these elements must be primary-source verified within 180 calendar days of the provisional credentialing decision. The same process is followed for presenting provisional credentialing files to the CQIC or medical director as the regular credentialing process. Practitioners may not be held in provisional status for more than 60 calendar days.

DELEGATED CREDENTIALING

Common Ground Healthcare Cooperative may delegate credentialing by contract only when a delegated entity's credentialing plan meets or exceeds the minimum criteria in the plan. The processes outlined in this plan define CGHC's credentialing process. A delegated entity's credentialing process must also support the minimum criteria in this plan. CGHC delegates credentialing and recredentialing to provider groups that meet CGHC's requirements for delegation. CGHC's Delegation Oversight Committee (DOC) must approve all delegation and sub-delegation arrangements and retains the right to limit or revoke any and all delegated credentialing activities when a delegate fails to meet CGHC's requirements.

The DOC retains the right to approve new providers and providers' sites and terminate practitioners, providers, and site of care based on requirements in CGHC's credentialing plan.

To be delegated for credentialing, provider groups must:

- Be National Committee for Quality Assurance (NCQA) accredited or certified for credentialing or pass in CGHC's credentialing pre-delegation audit, which is based on NCQA credentialing standards and requirements with a score of at least 90%;
- Correct deficiencies within mutually agreed upon time frames when issues of noncompliance are identified by CGHC at pre-delegation or continued delegation audits;
- Agree to CGHC's contract terms and conditions for credentialing delegates;
- Submit timely and complete reports to CGHC as described in any policy, procedure, or contract; and
- Comply with all applicable federal and state laws.

Please note that any sub-delegation must be approved by CGHC prior to the commencement of any sub-delegation. In the event the IPA or provider group intends to sub-delegate primary source verification to a Credentialing Verification Organization (CVO), the CVO must be NCQA certified in all 10 areas of accreditation. Regardless of the terms of delegation, CGHC reserves the right to approve, suspend, or terminate practitioners or practice sites.

PROVIDER UPDATES/CHANGES

Common Ground Healthcare Cooperative strives to maintain timely, accurate information on its participating providers. In-Network providers should submit an updated roster or a provider update form ([found Here](#)) by sending an email with these items attached to providerchanges@commongroundhealthcare.org.

CGHC actively outreaches to providers every 90 days to ensure the information on file is accurate, however providers should notify as soon as possible of any changes to ensure proper claims processing. Due to regulations included in the Consolidated Appropriations Act (a.k.a. No Surprises Act) that took effect January 1, 2022, if providers fail to respond our roster verification requests, CGHC must remove the practice and its associated providers from our online and print directories, so please respond timely.

If you have any questions, please contact a CGHC representative at 877-514-2442.

CONTINUITY OF CARE

Common Ground Healthcare Cooperative follows the State of Wisconsin statute regarding continuity of care (§609.24), as well as those required by applicable accreditation bodies.

CGHC must notify members affected by the termination of a practitioner or practice group in general or family practice, internal medicine, or pediatrics at least 30 calendar days prior to the effective termination date, and help members select a new practitioner. The “termination date” is the date on which a practitioner’s termination becomes effective. The practitioner must notify CGHC that they will no longer be available at least 30 calendar days before the termination date. This obligation applies either when an individual practitioner terminates their employment with a contracted in-network clinic or group practice or CGHC’s contract with the practitioner or their group practice terminates.

If a practitioner’s contract is discontinued, CGHC allows affected members continued access to the practitioner as follows:

1. For primary care providers (defined as family practice, general practice, internal medicine, pediatrics, geriatrics, OB/GYN, or nurse practitioner or physician assistant practicing in a primary care provider role) through the end of the plan year.
2. For non-primary care providers, continuation of treatment through the current period of active treatment, for up to 90 calendar days, or end of the then current plan year whichever is less, for members undergoing active treatment for a chronic or acute medical condition.
3. Continuation of care through the postpartum period for members in any trimester of pregnancy.

CLAIMS, FILING PROCEDURES AND EXPLANATION OF PAYMENT (EOPS)

CLAIMS SUBMISSION

A claim is the uniform bill form or electronic submission form in the format used by CGHC and submitted for payment by a provider for covered health services rendered to a CGHC member.

Please note the following regarding claims submission:

- Do not submit claims with invalid or deleted codes. Claims containing deleted or invalid codes (CPT/HCPCS/Revenue/ICD-10, etc.) will not be paid.
- Only submit claims after the service has been rendered.
- Claims for newborns should be billed separately from the mother’s services.
- CGHC members are not responsible for claims denied due to incorrect or invalid information.
- When a physician or a clinic becomes an in-network provider, they agree to accept payment made by CGHC as payment in full. Members may only be billed for copayments, coinsurance, deductible amounts, and non-covered services.

- All claims for services related to work-related injuries or illness should be submitted to the worker's compensation carrier. If claims are denied by the worker's compensation carrier, you may submit the claim along with the denial for consideration by CGHC. All referral and/or prior authorization guidelines apply in this situation. You must submit the claim (s) in a timely manner along with the denial as outlined in the timely filing guidelines.
- CGHC requires that all services billed be appropriately documented in the patient's medical record in accordance with CGHC's medical records policy. If the services billed are not documented in the patient's medical record, in accordance with the policy, they will not be considered reimbursable by CGHC. CGHC's medical records policy can be found in the Quality Improvement section of this manual.

We encourage our providers to submit claims electronically. Electronic claims submission is fast, accurate, and reliable. Electronic claims may be submitted 24 hours a day, seven days a week. If complete information is provided, claims will typically be processed seven to 10 days faster than paper claims. Please refer to the electronic claims section of this manual for more information.

SUBMISSION OF ELECTRONIC CLAIMS

Electronic Data Interchange (EDI) allows CGHC's network providers and facilities to submit and receive electronic transactions from their computer systems. EDI is available for most common health care business transactions, such as:

- 837 Health Care Claim Professional
- 837 Health Care Claim Institutional
- 835 Health Care Claim Payment/Remittance Advice

CGHC is HIPAA-compliant and is a strong proponent of EDI transactions because they significantly reduce both parties' administrative and operating costs, improve processing time, and data quality. EDI transactions also secure member identification during transmission and reduce the risks associated with lost or misplaced documents.

CGHC contracts with Smart Data Solutions (SDS) to facilitate EDI claim submission, as well as real time benefits/coverage and claim status inquiries. Registering for an EDI Account with SDS is fast and easy, and can be done at: <https://quickclaim.smart-data-solutions.com/quickclaim/servlet/quickclaim/template/ClearingHouse%2COpenEnrollment.vm/cc/CHGHC>. Should you need assistance with your EDI processing, please contact Smart Data Solutions Provider Support at 855.297.4436 or CGHC Provider Relations department at providerinfo@commongroundhealthcare.org.

Providers should utilize payer ID 77170 to submit claims electronically to CGHC.

SUBMISSION OF PAPER CLAIMS

Claims Mailing Address:

Common Ground Healthcare Cooperative
PO Box 1630
Brookfield, WI 53008-1630

If submitting claims electronically is not possible for your facility, claims must be submitted on a CMS-1500 claim form for professional and other non-facility services and on an UB-04 CMS-1450 claim form for services provided in a facility. To be considered a clean claim, the following information is mandatory, as defined by applicable law, for each claim:

A. The following fields of the CMS-1500 claim form must be completed before a claim can be considered a “clean claim:”

1. Field 1: Type of insurance coverage
2. Field 1a: Insured ID number
3. Field 2: Patient’s name
4. Field 3: Patient’s birth date and sex
5. Field 4: Insured’s name
6. Field 5: Patient’s address
7. Field 6: Patient’s relationship to insured
8. Field 7: Insured’s address (if same as patient address can indicate “same”)
9. Field 8: Patient’s status (required only if patient is a dependent)
10. Field 9 (a-d): Other insurance information (only if 11d is answered “yes”)
11. Field 10 (a-c): Relation of condition to: employment, auto accident, or other accident
12. Field 11: Insured’s policy, group, or FECA number
13. Field 11c: Insurance plan or program name
14. Field 11d: Other insurance indicator
15. Field 12: Information release (“signature on file” is acceptable)
16. Field 13: Assignment of benefits (“signature on file” is acceptable)
17. Field 14: Date of onset of illness or condition
18. Field 17: Name of referring physician (if applicable)
19. Field 21: Diagnosis code
20. Field 23: Prior authorization number (if any)
21. Field 24: A, B, D, E, F, G Details about services provided
22. Field 24 I, J: Non-NPI provider information
23. Field 25: Federal tax ID number
24. Field 28: Total charge
25. Field 31: Signature of provider including degrees or credentials (provider name sufficient)
26. Field 32: Address of facility where services were rendered
27. Field 32a: National Provider Identifier (NPI)
28. Field 32b: Non-NPI (QUAL ID), as applicable
29. Field 33: Provider’s billing information and phone number
30. Field 33a: National Provider Identifier (NPI)
31. Field 33b: Non-NPI (QUAL ID), as applicable

B. The following fields of the UB-04 CMS-1450 claim form must be completed for a claim to be considered a “clean claim:”

1. Field 1: Servicing provider’s name, address, and telephone number
2. Field 3: Patient’s control or medical record number
3. Field 4: Type of bill code
4. Field 5: Provider’s federal tax ID number
5. Field 6: Statement Covers Period From/Through
6. Field 8: Patient’s name
7. Field 9: Patient’s address
8. Field 10: Patient’s birth date
9. Field 11: Patient’s sex
10. Field 12: Date of admission
11. Field 13: Hour of admission
12. Field 14: Type of admission/visit
13. Field 15: Admission source code
14. Field 16: Discharge hour (for maternity only)
15. Field 17: Patient discharge status
16. Fields 31-36: Occurrence information (accidents only)
17. Field 38: Responsible party’s name and address (if same as patient can indicate “same”)
18. Fields 39-41: Value codes and amounts
19. Field 42: Revenue code
20. Field 43: Revenue descriptions
21. Field 44: HCPCS/Rates/HIPPS Rate Codes
22. Field 45: Service/creation date (for outpatient services only)
23. Field 46: Service units
24. Field 47: Total charges
25. Field 50: Payer(s) information
26. Field 52: Information release
27. Field 53: Assignment of benefits
28. Field 56: PI
29. Field 58: Insured’s name
30. Field 59: Relationship of patient to insured
31. Field 60: Insured’s unique ID number
32. Field 62: Insurance group number(s) (only if group coverage)
33. Field 63: Prior authorization or treatment authorization number (if any)
34. Field 65: Employer information (for workers’ compensation claims only)
35. Field 66: ICD Version Indicator
36. Field 67: Principal diagnosis code
37. Field 69: Admitting diagnosis code (inpatient only)
38. Field 74: Principal procedure code and date (when applicable)
39. Field 76: Attending physician’s name and ID (NPI or QUAID)

TIMELY FILING GUIDELINES FOR INITIAL SUBMISSION

The initial submission of a claim is subject to the timely filing guidelines expressed in your agreement with CGHC. If a claim is rejected for improper submission (for example, coding errors or incomplete information), a resubmission must be completed within the filing limit outlined in the provider agreement. Please note that when a claim is not filed by the contractual deadline, your rights to reimbursement from CGHC for that claim are forfeited and you may not pursue payment from the member for those services.

COORDINATION OF BENEFITS/SUBROGATION

As a provider by submitting a claim to CGHC, you agree to cooperate with subrogation and coordination of benefits (COB). Providers must notify us when they receive information for a CGHC member whose claim involves subrogation or COB. In the event provider fails to supply information on subrogation or COB, CGHC may recover funds from provider beyond any applicable contractual terms that may be in place between Provider and CGHC.

As an in-network provider, when CGHC is the primary payer, the combined payments of CGHC, the secondary plan, and the member will not exceed the CGHC rate. When CGHC is secondary to the primary plan, CGHC and the member will pay no more in total than the lesser of the CGHC contracted rate or the remaining members responsibility from the primary plan.

Providers must submit the primary payer's explanation of payment/remittance advice (EOP) along with the claim for proper reimbursement. If COB is suspected, CGHC will request additional information from the member while the claim is pended in our system. Should the member not respond the claim will be denied for lacking information necessary for adjudication.

REIMBURSEMENT STATEMENTS

Provider Reimbursement Schedule (PRS) Sources. Unless otherwise agreed by contract, CGHC's reimbursement policies are aligned with the following methodologies:

- | | |
|--------------------------|---|
| a. RBRVS RVU | Wisconsin GCPCI'd |
| b. Drugs and Biologicals | Medicare ASP updated quarterly |
| c. DRG | CMS updated October 1 of each year |
| d. ASA | RVU's as published by ASA |
| e. DME | CMS DMEPOS Fee Schedule with updates and PEN components |
| f. Laboratory | CMS Clinical Lab Fee Schedule with updates |
| g. Gap Fill | Based on industry-standard third-party determinations |

Coding Edits/Bundling

CGHC will process claims that are accurate and complete utilizing industry standard coding and bundling rules, including, but not limited to, the Centers for Medicare and Medicaid Services (CMS) medical and coding policies including local coverage determinations, Correct Coding Initiative (CCI) guidelines, and in accordance with applicable state and/or federal laws, rules, and regulations. Such claims processing procedures and edits are updated periodically to reflect the most current coding practices and may include, without limitation, automated systems applications which identify, analyze, and compare the amounts claimed for payment with the diagnosis codes, and which analyze the appropriate relationships among the billing codes used to represent the services provided to members. These automated systems may result in an adjustment of your payment for the services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. Modifiers used in the submission of claims do not ensure reimbursement; some modifiers increase or decrease reimbursement, while others are only informational. Providers may request reconsideration of any adjustments produced by these automated systems by submitting a timely claim reconsideration request to CGHC. Examples of claim editing rules that comply with national standards established by commercial and public payers include, but are not limited to:

- National correct coding initiative (NCCI) edits
- Medicare outpatient-code edits (OCE)
- Medically unlikely edits (MUE)
- Frequency edits
- Global Surgical Period edits
- Age-appropriate edits
- Gender appropriate edits
- Other coding guidelines published by industry-recognized resources and/or guidelines accepted and adapted by CGHC

Unusual Procedure (Modifier 22)

Surgeries or other procedures for which services performed are significantly greater than usually required may be billed with Modifier 22. Modifier 22 is only reported with procedure codes that have a global period of 0, 10, or 90 days; other procedures are ineligible for Modifier 22. Supporting documentation is required in order to consider additional reimbursement.

Unrelated E&M Service by the Same Physician During Global Period (Modifier 24)

Reimbursement is considered independent of services in which they are not a component.

Significant, Separately Identifiable Evaluation and Management Service (Modifier 25)

Significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedure or other service require billing with Modifier 25. To report Modifier 25, the patient's condition must require a significant, identifiable E/M service above and beyond the other service provided or services beyond the usual preoperative and postoperative care associated with the procedure that was performed and billed in accordance with the appropriate level of the E/M service.

Professional Component-Outside of Office (Modifier 26)

Claims for clinical laboratory services that do not have an associated professional component will not be reimbursed when reported with modifier -26. According to CMS, it is inappropriate for pathologists to bill for laboratory oversight and supervision with modifier -26. Reimbursement for laboratory oversight and supervision is included in the reimbursement to a hospital or independent laboratory instead.

Preventive Service Indicator (Modifier 33)

Modifier 33 is used to indicate preventive (wellness) services provided to members. When the primary purpose of the service is in accordance with the US Preventive Services Task Force or other preventive services identified in preventive mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

Bi-lateral Procedures (Modifier 50)

Modifier 50 is used to indicate a bi-lateral procedure when reported on a single line on the claim form. CGHC utilizes Medicare Rules and payment indicators to determine appropriate application and payment of this modifier. CGHC will pay 150% of the fee schedule amount for services Medicare deems to be bilateral and where the 50 modifier is appropriate even when indicated by providers utilizing RT or LT modifiers instead. Bi-lateral procedures may be subject to the multiple procedure reimbursement logic. Bilateral status is determined before applying multiple procedure adjustments. When a procedure is billed utilizing Modifier 50 the procedure occupies both the first and second surgical slot, meaning any additional surgical procedures will be considered to have occupied the third and subsequent slots from a multiple procedure reduction perspective and are subject to reduced reimbursement.

Multiple Procedures/Multiple Surgery Reduction (Modifier 51)

In cases where multiple surgical procedures are planned, be sure to obtain all required authorizations for each procedure. CGHC utilizes CMS's published Multiple Procedure Status Indicators to determine when a code is subject to a multiple procedure reduction. Reimbursement for multiple procedures indicated with a 2 or 3 status by CMS will be reduced when performed during a single encounter as follows: CGHC will pay the primary procedure at 100% of the allowable fee, the second procedure at 50%, and the third procedure at 25%. There will be no reimbursement beyond the third procedure. Reimbursement for multiple procedures indicated with a 4 status by CMS will be reduced when performed during a single encounter as follows: When the procedures are billed with a TC modifier, CGHC will pay the primary procedure at 100% of the allowable fee, the second and all subsequent procedures at 50% of the allowable fee. When the procedures are billed with a 26 modifier, CGHC will pay the primary procedure at 100% of the allowable fee, the second and all subsequent procedures at 95% of the allowable fee. Reimbursement for multiple procedures indicated with a 5 status by CMS will be reduced when performed during a single encounter as follows: CGHC will pay the primary procedure at 100% of the allowable fee, the second and all subsequent procedures at 80% of the allowable fee. Reimbursement for multiple procedures indicated with a 6 status by CMS will be reduced when performed during a single encounter as follows: When the procedures are billed with a TC modifier, CGHC will pay the primary procedure at 100% of the allowable fee, the second and all subsequent procedures at 75% of the allowable fee. Reimbursement for multiple procedures indicated with a 7 status by CMS will be reduced when performed during a single encounter as follows: When the procedures are billed with a TC modifier, CGHC will pay the primary procedure at 100% of the allowable

fee, the second and all subsequent procedures at 80% of the allowable fee. Reimbursement for multiple procedures indicated with a 0 or 9 status by CMS will not be reduced when performed during a single encounter. Multiple procedures should be reported using the Modifier 51 on each line.

Reduced Service (Modifier 52)

Reimbursement will be allowed at 50% of the allowable fee, subject to the provider contracted terms.

Discontinued Procedure (Modifier 53)

Reimbursement will be allowed at 50% of the allowable fee, subject to the provider contracted terms.

Surgical Care Only (Modifier 54)

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single global code was reported. Reimbursement will be allowed at seventy (70) percent of the allowable fee, subject to provider contracted terms.

Post-Operative Management Only (Modifier 55)

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single global code was reported. Reimbursement will be allowed at 20% of the allowable fee, subject to provider contracted terms.

Pre-Operative Management Only (Modifier 56) When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single global code was reported. Reimbursement will be allowed at 10% of the allowable fee, subject to provider contracted terms when applied to surgical codes except for (1) codes that have 0 days in the Global period; (2) Evaluation & Management services; or (3) in addition to modifiers 54, 55, 80, 81, 82, or AS.

Distinct Procedural Service (Modifier 59)

Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances modifier 59 should be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

- XE – Separate encounter, a service that is distinct because it occurred during a separate encounter.
- XP - Separate structure, a service that is distinct because it was performed by a different practitioner.
- XS – Separate structure, a service that is distinct because it was performed on a separate

organ/structure.

- XU – Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

Assistant Surgeons (Modifier 80, 81, and 82)

CGHC will reimburse assistant surgeons at 16% of the contracted rate of the procedure. This reduction is systematically taken based on the modifier (80, 81, or 82) on the claim. CGHC uses the American College of Surgeons (ACS) as the primary source to determine which procedures allow an assistant surgeon. For procedures that the ACS lists as “sometimes,” CMS is used as the secondary source.

Assistants-at-Surgery Services Provided “Incident To” a Surgery by Auxiliary Personnel (Modifier AS)

CGHC will pay for assistants-at-surgery at 16% of the contracted rate of the procedure only when the person reporting the service is a physician or the person bears the designation of physician assistant, nurse practitioner, nurse midwife, or clinical nurse specialist, subject to all terms and conditions of the policy including medical necessity. If the person who assists at surgery is a surgical technologist or bears any title other than those listed, the service is not payable by CGHC.

Co-Surgeon (Modifier 62)

Each co-surgeon shall receive 62.5% of the allowable fee. Co-surgeons are defined as two surgeons who work together as primary surgeons performing distinct parts of a surgical procedure. Each surgeon should report his/her distinct, operative work by adding the modifier “62” to the procedure code and any associated add-on code(s) for the procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery only once, using the same procedure code. If additional procedures are performed during the same surgical session, separate code(s) should be reported with the modifier “62” added.

Observation Care

Claims should be billed to CGHC at the appropriate level of care for which the patient meets per clinical criteria. Observation Care which exceeds two days/48 hours requires prior authorization and review for appropriate level of care, failure to obtain authorization will result in denial of the entire claim.

Medical mid-level Providers

Mid-level providers are defined by CGHC as non-MD/DO providers. These provider types shall be reimbursed 85% of the physician’s fee.

Unlisted Codes

All unlisted codes require Prior Authorization by CGHC. When a Facility or Provider bills using an unlisted code, CGHC will require the services be submitted with medical records and indication of a comparable code in order to allow for the service. An unlisted code shall be allowed, when approved through the Prior Authorization process, at the applicable fee schedule rate for the comparable code.

Telehealth Services

CGHC does allow members to receive services via Telehealth, all other limits and plan requirements (ie: Prior Authorizations) apply when applicable. Providers should bill either with place of service “02” or with the applicable place of service and the appropriate modifier (ie: 95, GT). Please note when billing place of service “02” modifiers are not necessary.

Anesthesia Billing

CGHC reimburses anesthesia providers using the ASA standards. Providers will be expected to bill the number of minutes and any applicable patient status indicator(s). Anesthesia services must be submitted with the appropriate anesthesia modifiers. Claims lacking this information will be denied as a billing error.

Medical Supervision by a physician: more than four concurrent anesthesia procedures (Modifier AD)

Services will be reduced to 50% of the Fee Schedule Allowable amount for a bill submitted with this modifier.

Medical Direction of More than One Concurrent Anesthesia Procedures (Modifier QK)

50% of Fee Schedule Allowance. Total reimbursement for CRNA and MD will not exceed the allowed amount otherwise recognized had the service been furnished by the MD alone.

CRNA Service under Medical Direction by an Anesthesiologist (Modifier QX)

50% of Fee Schedule Allowance. Total reimbursement for CRNA and MD will not exceed the Fee Schedule Allowance otherwise recognized had the service been furnished by the MD alone.

Medical Direction of One CRNA by an Anesthesiologist (Modifier QY) 50% of Fee Schedule Allowance

CRNA Service: Without Medical Direction by a Physician (Modifier QZ) 100% of Fee Schedule Allowance

Monitored Anesthesia Care (MAC) services (Modifier QS) 100% of Fee Schedule

Modifier Summary Table

The table below lists commonly billed unique modifiers and the reimbursement applied by CGHC. This table is not an all-inclusive list of modifiers available for use.

Modifier	Description	Application
22	Unusual Procedure (with supporting documentation)	Maximum of 110% of the base code allowable
24	Unrelated E&M service by the same physician during post-op period	Pay 100% of the base code allowable
33	Preventive service indicator	Pay 100% of the base code allowable
50	Bilateral procedure	Pay 150% of the base code allowable for a single unit of service
RT/ LT	Right/left sides	100% if billed alone, 150% total if billed together
51	Multiple procedures	Based on CMS Status Code Indicators, see full description above
52	Reduced Services	Pay 50% of the base code allowable
53	Discontinued Procedure	Pay 50% of the base code allowable
54	Surgical Care Only	Pay 70% of the base code allowable
55	Post-op Management Only	Pay 20% of the base code
56	Pre-op Management Only	Pay 10% of the base code allowable
59	Distinct procedural service	No reduction if billed alone
62	Co-surgeon	62.5% of the base code allowable
76	Repeat procedure – same physician	Pay 50% of the base code allowable
77	Repeat procedure – different physician	Pay 100% of the base code allowable
78	Unplanned return to the OR	Pay 50% of the base code allowable
79	Unrelated procedure during post op	Pay 100% of the base code allowable
80, 81, 82, AS	Assistant surgeon	16% of the base code allowable
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	Pay 50% of the base code allowable
QX	CRNA service with medical direction by a physician	Pay 50% of the base code allowable
QK	Medical supervision of 2, 3, or 4 concurrent anesthesia procedures	Pay 50% of the base code allowable
QS	Monitored Anesthesia Care (MAC) services	Pay 100% of the base code allowable
QY	Medical direction of one CRNA by an anesthesiologist	Pay 50% of the base code allowable
QZ	CRNA service without medical direction by a physician	Pay 100% of the base code allowable
GW	Non hospice diagnosis related service	Pay 100% of the base code allowable

ELECTRONIC FUNDS TRANSFER (EFT)

To enroll in electronic funds transfer (EFT) and electronic remittance advice (ERA) providers must be enrolled with InstaMed. You may contact them at 877-833-6821 or your Provider Relations representative at providerinfo@commongroundhealthcare.org. The form is also available <https://commongroundhealthcare.org/wp-content/uploads/2021/11/Provider-EFT-Form.pdf>

PROVIDER RECONSIDERATIONS

If the provider disagrees with the payment determination and wishes to request a reconsideration, the provider may submit such reconsideration as described below to CGHC. All provider requests for claims reconsideration must be received by CGHC **within 12 months** of the date the claim was originally paid unless state or federal law or any applicable provider agreement between the parties stipulate other requirements. Please refer to the claim reconsideration form [HERE](#). Providers may also call CGHC at 877-514-2442 or submit written or electronic documentation to:

CGHC Provider Reconsiderations
120 Bishop's Way, Suite 150
Brookfield, WI 53005
providerinfo@commongroundhealthcare.org
Fax: 262-754-9690

Providers who send a written request for reconsideration should include the following information: Provider name, TIN, member name and ID number, date of service, claim number, charge amount, initial payment and a brief description of the basis for the reconsideration (ie: coding related issues, incorrect payment, changes in prior reported units or codes, etc.). In addition, be sure to include any relevant supporting documentation (medical records, copy of invoice, etc.).

PREVENTABLE ADVERSE EVENTS (PAE) POLICY (NEVER EVENTS)

Should any of the events listed below occur, the provider will report the PAE to the correct state agency, either the Joint Commission or a patient safety organization ("PSO") certified and listed by the Agency for Healthcare Research and Quality. Providers shall never attempt to collect or accept payment from the member or CGHC for such events. If any payment is received from any source, the provider will refund it within 10 business days.

PHYSICIAN PREVENTABLE ADVERSE EVENTS (PAE) POLICY

There are major PAE or Never Events that, should they occur to a member, the provider shall neither bill nor receive payment from any source, including CGHC and their members.

SURGICAL EVENTS

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure on a patient
- Retention of a foreign object in a patient after surgery or other procedure

- Intraoperative or immediately post-operative death in a normal healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative)

FACILITY PREVENTABLE ADVERSE EVENTS (PAE) POLICY

There are major PAE or Never Events that, should they occur to a member, the provider shall neither bill nor receive payment from any source, including CGHC and their members.

SURGICAL EVENTS

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure on a patient
- Retention of a foreign object in a patient after surgery or other procedure
- Intraoperative or immediately post-operative death in a normal healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative)

PRODUCT OR DEVICE EVENTS

- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
- Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility

PATIENT PROTECTION EVENTS

- Infant discharged to the wrong person
- Patient death or serious disability associated with patient elopement (disappearance) for more than four hours
- Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility

CARE MANAGEMENT EVENTS

- Patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products
- Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
- Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility

- Patient death or serious disability due to spinal manipulative therapy

ENVIRONMENTAL EVENTS

- Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
- Patient death associated with a fall while being cared for in a healthcare facility
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

CRIMINAL EVENTS

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- Abduction of a patient of any age
- Sexual assault on a patient within or on the grounds of a healthcare facility
- Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility

HOSPITAL ACQUIRED CONDITIONS (HACS)

Common Ground Healthcare Cooperative will follow all current and future CMS recognitions of HACs. All inpatient facility claims must be populated with the current and valid POA indicators as defined by CMS. When a HAC occurs, all inpatient facilities shall identify the charges and/or days that are a direct result of the HAC. These charges and/or days shall not be billed to CGHC or the member. The facility shall remove all charges related to the HAC prior to billing.

EPO REFERRALS

REFERRAL REQUIREMENTS

MEMBER REFERRAL REQUIREMENTS: In 2023, all members who buy insurance plans with CGHC have Exclusive Provider Organization (EPO) benefits. In order for services to be considered Covered Health Services, members must seek those services in-network providers ONLY, except under very limited circumstances. These limited circumstances include the following situations:

1. Emergency health services performed at an out-of-network facility or by an out-of-network provider. Once the emergency has been stabilized, ongoing hospitalization and any follow up care must be transitioned to and provided by in-network providers and facilities.
2. Medically necessary urgent care services at out-of-network providers outside CGHC's 25 county service area, such as while traveling. Any follow-up care must be provided by in-network providers and/or facilities.
3. If specific covered health services are not available from an in-network provider or there is not a qualified in-network provider, the member may be able to obtain a written EPO referral from an in-network provider to see an out-of-network provider. The written EPO referral must be approved by CGHC prior to services being rendered. Such EPO referral must be submitted to CGHC on [this form](#). Any services the out-of-network provider recommends must comply with all provisions of the member's policy, including but not limited to the need to obtain prior authorization. If providers and/or members fail to obtain the written, approved EPO referral prior to treatment, NO benefits are available and therefore NO payment will be made for those services. If you fail to get a prior authorization, payment will be denied pending submission of the prior authorization. If the authorization is approved retroactively after services are rendered (except in cases of an emergency), the penalty listed in the Prior Authorization section may apply.
4. For a covered dependent on a member's policy, who attends school outside of CGHC's 25-county service area, only out-of-network emergency medical services and/or out-of-network urgent care services will be covered. Follow-up care or services not considered to be emergent or urgent must be provided by in-network providers and facilities.
5. For a covered dependent on a member's policy, who attends school outside of CGHC's 25-county service area, but inside the State of Wisconsin, a clinical assessment by an out-of-network provider and up to five visits of outpatient behavioral healthcare or addiction treatment will be covered. Members qualifying for this benefit should contact CGHC Member Services at 877-514-2442, prior to receiving such services as CGHC reserves the right to direct the member to a specific provider of our choosing.

As an in-network provider, it is important that if services are not available within the network and therefore a member must be referred to an out-of-network provider, that you complete the EPO Referral Form, found [here](#) and submit to us either by fax to 262-754-9690 or email to CGHCReferrals@commongroundhealthcare.org.

Please keep in mind that CGHC requires all in-network providers options must be exhausted before an EPO referral is considered for approval.

UTILIZATION MANAGEMENT PROGRAM

Common Ground Healthcare Cooperative's goal is to have members receive high quality care that is both cost effective and with an in-network. The Utilization Management Program is designed to facilitate that value equation.

Providers may contact CGHC's Utilization Management team at 877-825-9293; staff are available Monday through Friday from 8AM – 5 PM Central Standard Time.

AFFIRMATIVE STATEMENT - FINANCIAL INCENTIVES AND UTILIZATION MANAGEMENT DECISION MAKING

Guiding Principle:

Our principal role is to work collaboratively with providers to assist in managing health benefit resources. These resources are managed in order to facilitate the provision of effective quality health care to our members covered under our health plan.

Purpose:

Financial incentives can result in inappropriate care. Financial incentives can also negatively impact the provision of health care services, resulting in increase and/or decrease in the level of care including denial of care.

Statement:

CGHC does not have a system for reimbursement, bonuses, or incentives to staff or health care providers based directly on consumer utilization of health care services. CGHC does not reward providers or other individuals for issuing denials of coverage. There are no financial incentives for Utilization Management (UM) decision makers to encourage decisions that result in inappropriate utilization. All UM decisions are based solely on appropriateness of care and service utilizing criteria as established by CGHC.

UTILIZATION MANAGEMENT PROGRAM OBJECTIVES

The Utilization Management Program objectives and goals are summarized below.

- Comply with state and federal regulations, as well as National Committee for Quality Assurance (NCQA) standards;
- Monitor potentially avoidable admissions and develop appropriate mechanism to address identified areas of concern;
- Focus inpatient review activities on problem areas determined by appropriate data sources;
- Trend and monitor data to identify areas of possible over and under-utilization. Areas may include, but are not limited to, procedure utilization, pharmacy utilization (certain medications and classes of medications), ER utilization, inpatient utilization, laboratory utilization, and physician practice utilization;
- Assess provider satisfaction with Utilization Management activities and address areas of provider dissatisfaction, when appropriate

- Assess member satisfaction with Utilization Management activities and address areas of Member dissatisfaction, when appropriate

Integrate Utilization Management with disease and case management as appropriate when identified during UM activities:

- Monitor and analyze variations in the delivery of care in the network for which evidence-based standards of appropriate care exist, and consider opportunities for the Utilization Management programs that will improve quality of care and reduce medical costs
- Implement or maintain policies and procedures in accordance with applicable regulatory and accreditation requirements and standards
- Develop or adopt UM criteria and guidelines that are consistent with generally accepted standards and are based on sound clinical evidence
- Implement and maintain a process to review emerging medical technology and new uses for existing medical technology to determine both safety and effectiveness
- Maintain a process to ensure that relevant information is collected to review medical necessity requests for coverage
- Utilize qualified health professionals to assess the clinical information used to support UM decisions
- Maintain a process in which UM decisions are made in a timely manner and to ensure that members and providers are notified of determinations of coverage in accordance with federal and state requirements and accreditation standards
- Provide access to staff for members and practitioners seeking information about the UM process and the authorization of care and prompt turnaround of decisions by qualified health reviewers
- Implement and maintain mechanisms for objective and systematic monitoring, evaluation, and improvement of UM processes and services
- Implement and maintain mechanisms and policies and procedures that assist in monitoring the quality of utilization management decisions. These mechanisms include but are not limited to: inter-rater reliability and manageability, case audits, and the identification of potential adverse events.

SCOPE OF THE UM PROGRAM

The Utilization Management (UM) Program incorporates the review and evaluation of patient care for medical and behavioral health. To support the UM Program, CGHC maintains processes to ensure: (a) equitable access to care across the network and (b) the most appropriate use of medical services in accordance with benefit coverage.

MAJOR CATEGORIES OF UM

The scope of UM activities includes the following major categories:

- Prospective Review/Prior Authorizations
- Concurrent Review and Evaluation/ Discharge Planning

- Retrospective Review
- Reconsideration and Internal Appeals

The UM program coordinates quality of care monitoring with the Quality Improvement (QI) Program.

UM CLINICAL CRITERIA

The approved clinical criteria are available upon request by contacting your provider relations representative at providerinfo@commongroundhealthcare.org. CGHC shall utilize written UM decision-making criteria that are objective and based on sound medical evidence. Approved criteria include the following:

a. InterQual® Guidelines:

Evidence-based clinical intelligence to support appropriate care and foster optimal utilization of resources.

b. State and Federal Regulatory Criteria, including:

Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration, National Institutes of Health.

c. Other approved evidence-based clinical guidelines, such as:

- Academy/Association relating to specific specialties
- NCCN
- National Cancer Institute
- National Kidney Foundation
- World Federation of Hemophilia Guidelines for the Management of Hemophilia

d. Other Nationally Recognized Criteria:

From time to time, a service is requested that does not have a clear medical necessity criteria in any of the sources mentioned above. In these cases, UM staff may refer to guidelines from national professional organizations.

e. CGHC Internal Medical Policies

f. IROs

- MCMC LLC

ACCESS TO UTILIZATION MANAGEMENT

1. Administrative and clinical personnel are available to receive inbound calls relative to routine UM issues at least eight hours per day during normal business hours Monday through Friday (8AM to 5PM. Central Standard Time,).
2. UM communication services are accessible through a toll-free telephone number 877-779-7598. CGHC clinical personnel are able to receive inbound communication regarding UM issues after normal business hours.
3. Staff identifies themselves by name, title, and organization name when initiating or returning calls regarding UM issues.
4. Outbound communication from staff regarding inquiries about UM is conducted during normal business hours unless otherwise agreed upon.

5. During non-business hours, the CGHC telephone system provides instructions to incoming callers, explaining how to contact the clinical staff directly or to leave a message, which is responded to within one business day after the date on which the call was received.
6. For members who request language services, CGHC will provide service in the requested language through bilingual staff or an interpreter, to help members with UM issues.

PRIOR AUTHORIZATION

Prior Authorization applies to in-network providers, as well as out-of-network providers with an approved EPO Referral. CGHC's Utilization Management (UM) Program is designed to ensure that health care resources are provided in an efficient and effective manner which provides members with the best possible value. The UM Program evaluates requests for covered services on the basis of medical necessity, appropriateness, and efficiency of the health care services under the applicable health benefit plan.

CGHC's prior authorization guidelines are an integral part of CGHC's Utilization Management Program. A description of CGHC's prior authorization process is described below.

Prior authorization is a determination by clinical staff that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness as defined in the health benefit plan. Approved prior authorization does not guarantee payment — payment is subject to plan eligibility and benefit plan provisions in force at the time services are provided.

If prior authorization is not obtained, where required, in advance of the services being provided, services may be denied or penalties applied. As a provider, your failure to secure necessary prior authorizations may jeopardize your reimbursement and/or continued participation in CGHC's network.

In most cases, CGHC will not allow more than a 30 day authorized quantity, and reimbursement for such supplies shall only be made on a month-by-month basis.

PRIOR AUTHORIZATION REQUIREMENTS

Providers should consult our up to date and complete listing of codes requiring prior authorization by visiting CGHC's website and using our interactive tools available [HERE](#).

Additionally, prescription drugs — As noted in the prescription drug formulary, any drug requiring prior authorization for Step Therapy (ST) or for quantity limit (QL) must be approved by OptumRX at 855-577-6545.

WHERE TO SUBMIT PRIOR AUTHORIZATION REQUESTS

Prior authorization requests can be submitted online 24/7 through the use of our Prior Authorization Portal at <https://provider.commongroundhealthcare.org/Account/Login?ReturnUrl=%2F>. In order to gain access to the portal, please consult with your organization's portal administrator. If you are uncertain as to who acts as your portal administrator or if your practice doesn't have an assigned portal administrator, please contact CGHC Provider Relations at providerinfo@commongroundhealthcare.org.

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
Concurrent Inpatient - Initial	NA	After admission, but prior to discharge, and no days have been certified	72 hours
Concurrent Inpatient - Continued Stay	>/= 24 hours prior	Request received at least <u>24 hours prior to</u> expiration of the certification	24 hours
	<24 hours prior	The request is received <u>less than 24 hours prior to</u> expiration of certification	72 hours
Concurrent Outpatient - Initial	NA	Services have already been started, but no certification has been issued yet	72 hours
Concurrent Outpatient - Extension of Service	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	24 hours
		(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 OR request received prior to expiration of the certification.	
	Non-Urgent	The definition of urgent (above) does not apply, AND the request is received <u>after</u> expiration of certification	15 calendar days
Peer to Peer / Reconsideration			24 hours

Internal Appeal	Expedited	Refer to definition of urgent above	72 hours
	Standard	The definition of urgent (above) does not apply	30 calendar days

THE QUALITY IMPROVEMENT PROGRAM (QIP)

The Quality Improvement Program (QIP) is established to provide the structure and key processes that enable the health plan to carry out its commitment to ongoing improvement of care and service, and the health of its members. The QIP provides a formal process by which CGHC and its network providers and practitioners strive to continuously improve the level of care and service rendered to members and customers. The program addresses both medical and behavioral health care, and the degree to which they are coordinated. It defines the systematic approach used to identify, prioritize, and pursue opportunities to improve services, and to resolve identified problems. The QIP is reviewed, updated, and approved by the EQOC and forwarded to the Board of Directors at least annually. It is distributed to applicable regulatory bodies and other stakeholders, as requested.

SCOPE OF PROGRAM

The scope of the CGHC Quality Improvement Program is to monitor care and identify opportunities for improvement of care and services to both our members and practitioners. Clinical care includes the delivery and plan services for both physical and behavioral health care. Our Quality Improvement programs are accomplished by assisting with the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative service. The scope of service includes, but is not limited to, services provided in institutional settings, ambulatory care, home care, behavioral health, and pharmacy. Contracted provider groups, primary care and specialty practitioners, and ancillary providers may render these services. CGHC is committed to comprehensive behavioral health care management. To meet this purpose, our focus is not only on behavioral health issues, but on the integration of medical and behavioral health care throughout the healthcare continuum. CGHC works in partnership with members and practitioners to promote a seamless delivery of health care and services. Elements of the QI program include, but are not limited to:

- Practitioner accessibility and availability for both medical and behavioral healthcare services
- Member satisfaction/complaints/grievances
- Member safety
- Continuity and coordination of care
- Clinical measurement and improvement monitoring
- Credentialing and re-credentialing
- Peer review
- Clinical practice guidelines
- Under and over utilization
- Adverse outcomes/sentinel events
- Practitioner satisfaction
- Timeliness of handling claims

- Regulatory requirements and reporting
- Pharmacy services and medication management
- Disease management
- Complex case management

QI PROGRAM

In-network providers are contractually obligated to comply with the CGHC QI Program and are expected to cooperate with and assist CGHC, other participating providers, and members in adhering to all applicable laws, regulations, and accreditation standards.

The key components of the QI Program with which participating providers are required to comply include (but are not limited to):

- Ensuring that care is appropriately coordinated and managed
- Cooperation with on-site audits and requests
- Cooperation with the member grievance process (e.g. supplying information necessary to assess and respond to a grievance)
- Responding to inquiries by CGHC Quality Improvement staff
- Allow CGHC to use practitioner/provider performance data

ORGANIZATIONAL STRUCTURE SUPPORTING QUALITY IMPROVEMENT - ACCOUNTABILITY: BOARD OF DIRECTORS

The CGHC Board of Directors has ultimate authority and responsibility for the quality of care and service delivered by CGHC. The Board of Directors is responsible for the direction and oversight of the Quality Improvement Program and delegates authority to the Executive Quality Oversight Committee (EQOC) under the leadership of the Chief Medical Officer (CMO), unless otherwise specified. The Board of Directors reviews regular plan reports and recommendations made by the EQOC as well as any significant actions taken by the EQOC or any other related committee.

EXECUTIVE QUALITY OVERSIGHT COMMITTEE (EQOC)

The EQOC is responsible for the implementation and ongoing monitoring of the Quality Improvement Program. Through the quality sub-committees, the EQOC recommends policy decisions, analyzes and evaluates the progress and outcomes of all quality improvement activities, institutes needed action, and ensures follow-up. The EQOC sets the strategic direction for all quality activities at CGHC. The EQOC receives reports from all sub committees, advises and directs the committees on the focus and implementation of the QI Program and work plan. The EQOC reviews data from QI activities to ensure that performance meets standards and makes recommendations for improvements to be carried out by sub-committees or by specific departments.

The EQOC confirms and reports to the Board that plan activities comply with all state, federal, regulatory and NCQA standards. The EQOC reports to the Board any variance from quality performance goals and the plan to correct these variances. The EQOC develops and presents an annual Quality Improvement Program description, work plan, and prior year evaluation, as well as quarterly summaries of activities to the Board.

The EQOC is chaired by the CGHC's chief medical officer and is composed of the management of key health plan functional areas.

DISEASE MANAGEMENT

The objectives of the Diabetes Disease Management (DM) program is to improve patient compliance through increased knowledge of the disease process and self-management skills through education and promotion of a healthier lifestyle.

The DM program utilizes practitioners and pharmacists with current knowledge to ensure the programs is based upon current clinical principles, processes, and evidence-based medicine.

If you have a CGHC member who is eligible for the Diabetes DM program, please contact a CGHC representative at 877-514-2442.

CASE MANAGEMENT

CGHC identifies members eligible for case management using a variety of clinical care processes and data sources. CGHC utilizes a rules engine that identifies members that are appropriate candidates for Complex Case Management (CCM) through systems-based rules that consider certain medical conditions, utilization, claims, and pharmacy and laboratory data. CGHC utilizes the following data sources to analyze the health status of members: claims data, encounter data, hospital admission/discharge data, pharmacy data obtained from Pharmacy Benefit Management (PBM) organization and/or state, data collected through the Utilization Management (UM) process, laboratory results, reinsurance reports, emergency department use reports, and/or predictive modeling software programs/reports. CGHC also utilizes appraisal/assessment data and reports. Members that could benefit from Complex Case Management can directly access or be referred by the provider to case management.

CGHC members have access to case management at any time, through CGHC's MemberCare Program. The member can self-refer or receive referral by a practitioner to the program (s) by calling CGHC's Member Services Department at 1-877-514-2442.

PREVENTIVE HEALTH

To encourage the appropriate delivery and use of preventive services at appropriate intervals, CGHC has adopted and implemented preventive health guidelines for prevention and early detection of illnesses. Preventive health guidelines are an essential component of the goals of managed care. Preventive care services can reduce the incidence of illness, disease, and accidents. Early detection of potentially serious illnesses may reduce the impact of illness on the member and associated health care costs. Additionally, use of preventive health guidelines has the potential to reduce unwanted variation in health care outcomes.

For the convenience of both members and providers, these guidelines are provided [on our website](#).

CGHC will annually measure compliance to these guidelines and associated outcomes.

CGHC recommends the following preventive health guidelines to help practitioners and members make decisions regarding appropriate preventive services and related care.

Preventive Health Services for Adults: Agency for Healthcare Research and Quality and the U.S. Preventive Services Task Force's Recommendations.

<http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

Preventive Health Services/Immunizations for Adults & Children 0-18 yrs: Department of Health and Human Services Centers for Disease Control and Prevention. **CDC Immunization Schedule(s):** <http://www.cdc.gov/vaccines/schedules/easy-to-read/index.html>

Preventive Health Services for Children: Bright Futures and American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care.

https://www.aap.org/en-us/Documents/periodicity_schedule.pdf and/or

<https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx>

Health Resources and Services Administration (HRSA)

<http://www.hrsa.gov/womensguidelines/>

MEDICAL RECORD DOCUMENTATION

CONFIDENTIALITY/PERSONAL HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has many provisions affecting the health care industry, including transaction code sets, privacy, and security provisions. HIPAA impacts what is referred to as covered entities, specifically, providers, health plans, and health care clearinghouses that transmit health care information electronically. HIPAA has established national standards addressing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All network providers are required to adhere to HIPAA regulations under the terms of their provider agreement with CGHC and as a matter of law. For more information about these standards, please visit <http://www.hhs.gov/ocr/hipaa/>. In accordance with HIPAA guidelines, network providers may not interview members about medical or financial issues within hearing range of other patients.

PROVIDER MAINTENANCE OF MEDICAL INFORMATION

Providers are responsible for maintaining a medical record for each individual member. Records are expected to be current, detailed, and organized to allow for effective and confidential patient care by all providers. They should also have the following characteristics:

- Patient collaboration
- Contains patient's health history
- Contains information from all healthcare providers
- Accessible at any time
- Private and secure
- Transparent (traceable access and editing)

Confidentiality

Medical records, both electronic and paper, should be securely maintained yet easily retrievable. Only authorized personal may have access to patient medical records.

Providers must implement confidentiality procedures to guard member health information, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy standards, applicable federal and state regulations, and the policies set forth by CGHC. Providers should make sure that both clinical and administrative staff receive periodic training regarding the confidentiality of member information.

Documentation Standards

The provider's documentation in the medical record shall include the following content, as applicable:

- Patient name or identifier is on every page
- All entries are signed and dated
- All entries are legible
- Personal and biographical data are included in the record
- Allergies and adverse reactions are prominently noted or noted as "none" or "NKA"

- Complete medication list with dosage, strength, and the start/stop dates
- An updated problem list is maintained (if in every progress note, then compliant)
- Complete medical, social, family, and birth (if applicable) history for patients seen more than two times
- Chief medical complaint or purpose of the service(s)
- Clinical assessment and findings
- Diagnosis and plan of care
- Follow up instructions and time frame for follow up or the next visit are recorded as appropriate
- Unresolved problems from previous visits are addressed in subsequent visits
- Tests ordered, such as laboratory or x-ray studies, reflect practitioner review
- Therapies or other treatments administered reflect practitioner review
- An immunization record is present
- Advance directives are housed within the medical record or a discussion or education on advance directives is noted (NA for <18 years of age)
- Age-appropriate routine preventive services/risk screenings are consistently noted (i.e. mammograms, pap tests, immunizations, etc.); and
- Continuity and coordination of care:
 - a. Discharge summary from any hospitalizations
 - b. Reports from any consultant or specialist referrals
 - c. Follow-up and education regarding inappropriate emergency room visits
 - d. Practitioner review of any therapy, behavioral health care/treatment, home health, etc.

Compliance with Medical Record Requests

Common Ground Healthcare Cooperative, in order to comply with reporting requirements under the Affordable Care Act and other legal commitments, support claim processing and/or fulfill quality initiatives, may, from time to time, request medical records or access to member's health information. Providers shall facilitate access to such information and cooperate with CGHC in fulfilling these requests, failure to do so may result in delay or denial of payment.

HEDIS & RISK ADJUSTMENT REPORTING

HEDIS (Healthcare Effectiveness Data and Information Set) is a standardized set of performance measures that assess plans' performance on a number of elements, including such things as financial stability, access, and quality of care. CGHC annually collects data and reports on performance measures.

CGHC uses HEDIS information to assess the quality of care delivered by network providers and identify improvement projects and studies.

In addition to HEDIS, CGHC is also required to submit data to regulatory authorities for purposes of risk adjustment and data validation. This data is dependent upon the accurate and complete coding of member diagnoses submitted by practitioners, and CGHC's submission period has strict guidelines for compliance.

All network providers are expected to cooperate with CGHC in the accurate and prompt collection of data, including medical record review and reporting. CGHC will collect data according to HEDIS and/or

risk adjustment specifications and will notify practitioners and providers of any additional information requirements.

PHARMACY

CGHC PHARMACY BENEFITS MANAGEMENT & FORMULARY INFORMATION

Common Ground Healthcare Cooperative provides a comprehensive drug benefit for our members. The member's identification card will assist you in identifying pharmacy related plan information.

In cooperation with its Pharmacy Benefit Manager (PBM), CGHC provides pharmacy information available to practitioners, clinics and facilities in the formulary section of our website located [HERE](#). The drug formulary is updated on an annual basis with periodic updates, as necessary. The PBM Customer Service Department may be contacted at 855-577-6545 about specific prescription drug products and for information on how prescription drug products can be obtained.

DRUG PRIOR AUTHORIZATION PROCESS

In accordance with state and federal regulations, accreditation standards, and client contractual stipulations, CGHC will utilize industry-standard methods and best practices in its review and processing of benefit-related prior authorization requests in order to promote high quality, cost-effective care. The review and processing of all requests will be conducted by highly-trained personnel, including pharmacy technicians and licensed healthcare professionals; CGHC does not have an automated review process. The prior authorization request starts when the member's/patient's healthcare professional or dispensing pharmacy contacts CGHC for appropriate information, including required forms and processes for completion, submission, review, and notification of the outcome.

1. Certain specified drugs designated by CGHC require prior authorization by CGHC's PBM prior to the dispensing of such prescriptions. Prescribers, pharmacies, and members are responsible for requesting and obtaining prior authorization for a prescribed drug which the plan identifies as requiring a prior authorization. If a drug is subject to prior authorization, the dispensing pharmacy will receive a rejected claim with a message prompting the pharmacy to contact CGHC for further information.
2. The prescriber, pharmacy, and/or member may contact CGHC's PBM to initiate a prior authorization request. For plans that permit prior authorization to be initiated orally, a pharmacy technician will review the prior authorization guidelines with the prescriber (or designated representative), pharmacy and/or member via phone. In some circumstances, prior authorizations may be initiated via the web on specified products/medications. Otherwise, the pharmacy technician faxes the prescriber, pharmacy, and/or member CGHC's Prior Authorization Form and asks the requestor to complete the form and return it to CGHC via fax. Pharmacy technicians log that the Prior Authorization Form or plan-specific form was faxed to the prescriber, pharmacy, or member.
3. CGHC collects only the information necessary to authorize the prescription. For example, CGHC requires only the sections of the medical record necessary in a specific case to certify medical necessity

or appropriateness of the prescription. Typically, the following types of information may be submitted as part of the prior authorization process in order for CGHC to render a prior authorization decision:

- a. Diagnosis with ICD-10 code
 - b. Documented medical rationale
 - c. Supporting documentation, e.g. progress notes and labs if applicable
 - d. Previous therapies
 - e. Additional clinically relevant information as appropriate
4. All UM decisions and benefit determinations are based on appropriateness and cost effectiveness of care and existence of coverage.
5. There are no financial incentives or specific rewards for UM decisions that could result in denial of services or inappropriate utilization.
6. Upon receipt of a returned Prior Authorization Form or plan-specific form from the prescriber, pharmacy, and/or member, the pharmacy technician documents receipt of the form in the Claims Processing System and the UM System, as necessary, and reviews the prior authorization request by applying the prior authorization criteria to the claim and considering clinical information available to the prescriber and the company at the time the prior authorization request was submitted. In addition, pharmacists may consult supporting documentation from FDA and other government agencies, medical associations, national commissions, primary medical literature and peer-reviewed journals, and nationally recognized compendia to assist them in conducting prior authorization review. The compendia may include, but are not limited to:
- i. Thomson Micromedex DrugDex
 - ii. Clinical Pharmacology
 - iii. AHFS Drug Information
 - iv. National Comprehensive Cancer Network (NCCN)
7. Any decision regarding hiring, compensation, termination, promotion, or similar matters with respect to an individual (such as a claims adjudicator or a medical expert) will not be based upon the likelihood that the individual will support the denial of benefits.

CGHC's PBM has online tools available for submitting pharmacy prior authorizations, which can be found [HERE](#).

EXCLUDED OR NONFORMULARY DRUG POLICY

Common Ground Healthcare Cooperative utilizes a closed formulary. Should a pharmaceutical that you require not be on the formulary, contact CGHC's PBM Customer Support at 855-577-6545 for further assistance.

OTHER HELPFUL PHARMACY INFORMATION

CGHC's PBM representatives are available 24 hours a day, seven days a week to speak with members, prescribers, and pharmacists regarding details of urgent Utilization Management issues. All other Utilization Management issues will be discussed during normal business hours. For access to pharmacy information, call our PBM at 855-577-6545. Prescribers may also register at <https://campaign.optum.com/landing/rx/pharmacycareservices.html?v=pbm>.

Pharmacy Criteria Development:

CGHC develops utilization criteria after a thorough review of clinical literature and claims data. All decision-making criteria are objective and based on:

- a. Clinical evidence
- b. Individual needs
- c. Assessment of the local delivery system
- d. Involvement of appropriate practitioners

Inter-reliability testing is completed annually to ensure consistency in using the clinical criteria. Criteria are developed of criteria using nationally recognized references and guidelines:

- a. Clinical Pharmacology
- b. Thomson Micromedex DrugDex
- c. American Hospital Formulary Service-Drug Information (AHFS-DI)
- d. National Cancer Comprehensive Network (NCCN) Drugs and Biologics Compendia
- e. Facts and Comparison
- f. National Guidelines Clearinghouse
- g. Food and Drug Administration
- h. Center for Drug Evaluation and Research (CDER)
- i. CDER New Prescription Drug Approvals
- j. CDER Prescription Drug Information
- k. CDER Major, Consumer, and Over the Counter Drug Information
- l. CDER Drug Safety and Side Effects
- m. CDER Public Health Alerts and Warning Letters
- n. Pharmacist's Letter
- o. Center for Medicare and Medicaid Services
- p. Professional Organizations (e.g. American Diabetes Association)

A review of clinical criteria is completed annually and made available to practitioners, upon request.

Pharmacy and Therapeutics Committee:

The Pharmacy and Therapeutics Committee along with the UM and Formulary Departments provide CGHC with clinical criteria that are based on clinical information that includes:

- Assessing peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, and outcome research data.
- Published practice guidelines, developed by an acceptable evidence-based process.
- Comparison of the efficacy as well as the type and frequency of the side effects and potential drug interactions among alternative drug products.
- Assessing the likely impact of drug product on patient compliance when compared to alternative products.
- Basing formulary system decisions on a thorough evaluation of the benefits, risks, and potential outcomes for consumers.
- Explicit clinical review criteria that are:
 - Developed with involvement from appropriate prescribers with current knowledge relevant to the criteria.
 - Based on current clinical principles and processes.
- Evaluated at least annually and updated, if necessary, by the company and appropriate, actively practicing physicians and pharmacists, with current knowledge relevant to the criteria that are approved by the Pharmacy and Therapeutics Committee.
- Prior to Pharmacy and Therapeutics Committee review, new drugs are added to the formulary at a default status of non-preferred brand, so the consumers have access to drugs when they become available.

CLASS I RECALL PROCESS:

When Drug Intelligence Services becomes aware of a Class I recall, the following steps are taken.

Internal Communication/Report Request:

- Within one business day of receiving FDA notification, Drug Intelligence Services sends an email notification to internal business units containing details of the recall and submits a request to the Analytics Department to identify recall-impacted clients, members, and prescribers based on claims data. The default look-back period is six months.

External Communication:

- Within two business days of receiving FDA notification:
 - Drug Intelligence Services creates and distributes the RxBulletin to all company clients who have elected to receive recall notifications. The email communication contains details of the recall and copies of the member and prescriber notification templates applicable to Class I recalls.
 - Provider relations posts, delivers by fax, or emails to the provider network information regarding the recall or safety-related market withdrawal promptly following FDA notification, or as contract stipulations dictate.

Completed Reports:

- Within three to five business days of submitting a report request, or as contract(s) stipulations dictate, the Analytics Department returns completed Client & Member and Prescriber Impact Reports to Drug Intelligence Services.
- Upon receipt, Drug Intelligence Services sends notification to internal business units, including, but not limited to, clinical consultants and the Account Management Team, that Client & Member and Prescriber Impact Reports are available.

Notification Fulfillment:

- Standard template letters to members and prescribers are postmarked in an expedited manner, not to exceed 15 business days (postmarked) of CGHC's receipt of the FDA notification.
- Based on contract stipulations, Account Management/Clinical Consultants, or a designee determines the client-specific needs for notification fulfillment and coordinates the fulfillment process.

System Changes:

- Drug Intelligence Services works with appropriate departments, including, but not limited to, Clinical Program Operations, Benefit Administration, Formulary Management Services, Utilization Management Services, and Prior Authorization, to determine if changes are necessary to processing of claims, including hard rejects for the Class I recalled product(s), to update UM criteria, and to make formulary changes. All changes receive priority attention.

CLASS II RECALLS (NOT LOT-SPECIFIC) AND SAFETY-RELATED MARKET WITHDRAWALS PROCESS

When a Class II recall or safety-related market withdrawal is identified, an evaluation of the following determines if further communications are required:

- Class II recall or market withdrawal is not lot-specific; AND
- Class II recall or market withdrawal is safety-related; AND
- Extent of Class II recall or market withdrawal is to the patient level.

If the Class II recall (not lot-specific) or safety-related market withdrawal meets the above criteria, the following steps are taken. The time frames noted may vary depending on unique circumstances and availability of information, volume, or size of each Class II product recall (not lot-specific) or safety-related market withdrawal.

Internal Communication/Report Request:

- Within ten (10) business days of receiving FDA notification, Drug Intelligence Services sends an email notification to internal business units containing details of the recall or safety-related market withdrawal and submits a request to the Analytics Department to identify recall or market withdrawal-impacted clients, members, and prescribers based on claims data. The default look-back period is six months.

External Communication:

- Within ten (10) business days of receiving FDA notification, Drug Intelligence Services creates and distributes the RxBulletin to all company clients who have elected to receive recall notifications. The email communication contains details of the recall or safety-related market withdrawal, as well as copies of member and prescriber notification templates applicable to Class II recalls (not lot-specific) and safety-related market withdrawals.

- Provider relations promptly posts, delivers by fax, or emails information to the provider network regarding the recall or safety-related market withdrawal, or as contract stipulations dictate.

Completed Reports:

- Within five (5) business days of submitting report request or as contract stipulations dictate, the Analytics Department returns the completed Client & Member and Prescriber Impact Reports to Drug Intelligence Services.
- Upon receipt, Drug Intelligence Services sends notification to internal business units, including, but not limited to, clinical consultants and Account Management, that Client and Member and Prescriber Impact Reports are available.

Notification Fulfillment:

- Based on contract stipulations, Account Management/Clinical Consultants, or designee determines client-specific needs for notification fulfillment and coordinates the fulfillment process. Letters to members and prescribers are postmarked within thirty (30) days of FDA notification.
- If mail-order or specialty pharmacy services dispensed the recalled product, the dispensing entity will notify impacted members according to their policies.
 - See site-specific Site of Pharmacy: Drug and Product Recall Policy – Specialty
 - See site-specific Site of Pharmacy: Drug Recall Policy – Mail

System Changes:

- Drug Intelligence Services works with appropriate departments, including, but not limited to, Clinical Program Operations, Benefit Administration, Formulary Management Services, Utilization Management Services, and Prior Authorization, to determine if changes are necessary to processing of claims, including hard rejects for the Class II recalled or safety-related market withdrawal product(s), and to make formulary changes. All changes receive priority attention.

Exception/Override Process

- For an exception to the formulary to request an override to allow a brand name medication in place of a generic, please call 855-577-6545.

PATIENT-PROVIDER RELATIONSHIP

Provider shall not be prohibited from discussing fully with a member any issues related to the member's health including recommended treatments, treatment alternatives, treatment risks, and the consequences of any benefit coverage or payment decisions made by plan or any other party. Provider may, subject to the limitations of their contract with CGHC, disclose to the member the general methodology by which provider is compensated under the terms of their agreement. Plan shall not refuse to allow or to continue the participation of any otherwise eligible provider or refuse to compensate provider in connection with services rendered, solely because provider has in good faith communicated with one or more of his/her/its current, former or prospective patients regarding the provisions, terms or requirements of a health benefit plan as they relate to the health needs of such patient.

For members to best utilize their benefits, CGHC providers MUST take all reasonable steps to refer to CGHC in-network providers. Providers may NOT refer CGHC EPO members to out-of-network

providers UNLESS all in-network options have been exhausted and out-of-network EPO referral has been submitted and approved by CGHC.

MEMBER GRIEVANCE AND APPEALS PROCESS

In accordance with governing laws and various regulatory and accrediting agencies, CGHC has developed a policy to ensure all member complaints and grievances are handled as required and in a fair and timely manner.

This policy is applicable to all CGHC members.

The purpose of this policy and procedure is to address the identification, review, and resolution of any complaint or grievance received from a CGHC member.

The process for member appeals differs from the processing of a complaint or grievance issue because member appeals are subject to external review.

POLICY

Common Ground Healthcare Cooperative maintains an internal process for the timely investigation and resolution of complaints, grievances, and appeals. Members may file a complaint, grievance or appeal regarding any aspect of care or service provided to them by CGHC and/or their contracted providers. The internal complaint/grievance/appeal process includes steps to ensure careful and complete consideration is given to each complaint/grievance/appeal while attempting to be as expeditious as possible.

MEMBER RIGHTS & RESPONSIBILITIES

Members have the Right to:

- Receive information about CGHC, its services, its practitioners and providers, and member rights and responsibilities.
- Be treated with respect and dignity by CGHC employees, contracted providers, vendors, and health care professionals.
- Privacy and confidentiality regarding their health and their care.
- Participate with practitioners in making decisions about their health care.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Voice complaints or concerns about CGHC or any of its network providers.
- Appeal any decision made by CGHC and to receive a response within a reasonable amount of time.
- Make recommendations regarding CGHC's member rights and responsibilities policy.
- Choose an advance directive to designate the kind of care they wish to receive should they become unable to express their wishes.
- Have a safe, secure, clean, and accessible health care environment.

- Have access to emergency health care services in cases where a “prudent layperson” acting reasonably would believe that an emergency existed.

Members have the Responsibility to:

- Pay their premiums.
- Comply with all provisions of the policy outlined in the Certificate of Coverage, including prior authorization requirements.
- Know and confirm their benefits before receiving treatment.
- Show their ID card before receiving health care services.
- Follow agreed upon instructions and guidelines for care.
- Understand their health problems and develop mutually agreed upon treatment goals, to the degree possible.
- Provide accurate information, to the extent possible, that CGHC and their practitioner require to care for them, or to make an informed coverage determination.
- Use practitioners and providers affiliated with their health plan for health care benefits and services, except where services are authorized or allowed by their health plan, or in the event of emergencies.
- Pay appropriate co-payments, coinsurance, and deductibles to participating practitioners and providers when services are received.
- Pay charges incurred for non-covered services
- Pay full charges for out-of-network services.

CGHC distributes these Member Rights and Responsibilities to:

- New members when they enroll
- Existing members at least annually
- New practitioners when they join our network
- Existing practitioners at least annually

CGHC'S PROVIDER/MEMBER PRIVACY POLICY

Common Ground Healthcare Cooperative places a high priority on protecting your privacy. This privacy policy was created in order to demonstrate the CGHC's firm commitment to the privacy of our members, providers, and other website users. This policy explains what types of information is collected by CGHC and is available [HERE](#).

WHAT PERSONALLY IDENTIFIABLE INFORMATION IS COLLECTED

CGHC's providers who register for www.CommonGroundHealthcare.org and individuals who sign up to receive CGHC's e-communications voluntarily provide us with contact information (such as name and e-mail address). We may use this information for specific, limited purposes. The member may always "opt out," either now or at any time in the future if they do not wish to receive our messages.

HOW YOUR INFORMATION MAY BE USED

We use a member or provider's personal information to provide personalized service, to send e-mail alerts, to answer requests, to contact providers if requested, etc. and do not share any information about members or providers with third parties. Providers may choose to opt out at any time, which will cease all communications from us.

EMAIL PRIVACY

CGHC does not provide, sell, or rent email addresses to anyone outside the organization.

MODIFICATIONS

We may amend this privacy policy from time to time; please review it periodically. We maintain the option to modify this privacy at any time by electronic notice posted on our website. Continued use of our website after the date that such notices are posted will be deemed to be agreement to the changed terms.

PROVIDER RESPONSIBILITIES

Providers are subject to the privacy guidelines and shall ensure that all member information is protected via safeguards that protect the information from inappropriate use or further disclosure. Providers shall grant access to members to their Personal Health Information (PHI) during regular business hours. Providers shall also inform CGHC if a security breach has occurred and inappropriate use or disclosure of PHI has taken place.