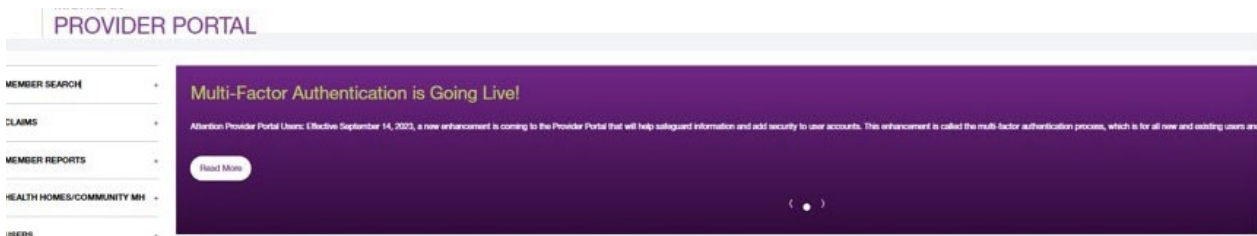




COMMON GROUND HEALTH CARE COOPERATIVE (CGHC) PROVIDER PORTAL

The [CGHC Provider Portal](#) is a secure, encrypted online tool available for any provider serving our members. Providers will need to be registered on the CGHC Provider Portal to use this self-service tool.



PROVIDER FEEDBACK

We closely monitor provider satisfaction with the portal and have implemented a feedback loop to convert that feedback into key enhancement themes. We then build a thoughtful enhancement roadmap that delivers new features that our providers find useful. The enhancements are released iteratively throughout the year and target highly requested items.

Satisfaction surveys are placed directly on the portal to capture provider feedback about overall experience with completing daily tasks.

MEMBER ELIGIBILITY

The portal enables quick access to member information such as eligibility and enrollment, a member's primary language and any other special communication needs.

Go to **Member Search > Member Eligibility**, to check for member eligibility using one of the search options, or search for multiple members at a time. Providers can easily export and print member data as needed. Providers can also access a member's case management plan and submit a request to update case management information.

Member Eligibility

CareSource Id Medicaid Id Member Info Case Number Multiple CareSource Ids Multiple Medicaid Ids

CareSource ID Member is eligible for service on the specified date

Date of Service

Search

Member Information

Member Name:	<input type="text"/>	Address:	<input type="text"/>
CareSource Id:	<input type="text"/>	County of Residence:	<input type="text"/>
Medicaid Id:	<input type="text"/>	County of Eligibility:	<input type="text"/>
Case Number:	<input type="text"/>	Phone:	<input type="text"/>
Gender:	<input type="text"/>	Date of Birth:	<input type="text"/>
Member Profile:	Not Available for this Member Member Profile Report Definitions		Relationship to Subscriber:
Original Effective Date:	<input type="text"/>	Program Details:	Not a coordinated services member
Program:	<input type="text"/>	Member Eligibility Date	<input type="text"/>
Member Alerts:	1. No ambulatory or preventive care visits recorded.		
Member Eligibility Date	Span Last Updated: <input type="text"/>		
Primary Care Provider (PCP):		Phone:	
<input type="text"/>		<input type="text"/>	
NPI #:		Case Manager Phone	
<input type="text"/>		<input type="text"/>	
Case Manager:		Member	
<input type="text"/>		<input type="text"/>	
Member Aid Category:			
Working Disabled, >150% FPL			
Language Preference:			
English			
Alternate Communication Format Needed:			
Large Print			

Subscriber Information

Member Covered Benefits Summary

Member Dental & Vision Services History

MEMBER PROFILE

The Member Profile supports coordinated care between the member’s primary care provider (PCP) and other care coordinators by providing access to comprehensive patient medical information in one convenient location. Member Profile data can be used to coordinate and streamline care for patients.

- Patient demographics
- PCP information
- Prior prescribing information
- Historical diagnoses

Patient-specific quality metrics (such as mammography screening, A1C value, and more)

- Prior hospital admissions
- Emergency room visits
- Specialist visits
- Case management activity

Member Eligibility

CareSource ID Medicaid Id Member Info Case Number Multiple CareSource Ids Multiple Medicaid Ids

CareSource ID Member is eligible for service on the specified date

Date of Service

Search

Member Information

Member Name: Address:

CareSource Id: County of Residence:

County of Eligibility:

Medicaid Id: Phone:

Case Number: Date of Birth:

Gender: Relationship to Subscriber:

Member Profile: [Click To View](#) [Member Profile Report Definitions](#)

Program Details:

Original Effective Date: Member Eligibility Date Span Last Updated:

Program: Alternate Communicat:

Language Preference:

Special Communication Needs:

Member Aid Category:

Primary Care Provider (PCP): Phone:

NPI #:

Case Manager: Case Manager Phone Number:

PROVIDER MEMBERSHIP LIST

Providers can view the members currently assigned to the Providers acting as PCPs and who are related to their Affiliation Number through the Provider Membership List. The list can be sorted by a specific provider related to a group or the entire group's member list. Sort membership lists by clicking on a column heading and/or export in either plain text or comma delimited formats. Access the **Provider Membership List** from the **Member Reports** left-hand menu.

Alerts that display on the Provider Membership List remain for 90 days from the triggering event. Events include:

- **New Assessment:** The member has a new health risk assessment available for review.
- **New Care Treatment Plan:** The member has a new care treatment plan that can be reviewed/acknowledged.
- **Updated Care Treatment Plan:** The member has an updated care treatment plan that can be reviewed/acknowledged.

CLINICAL PRACTICE REGISTRY

The CGHC Clinical Practice Registry (CPR) is an online tool available to health partners to identify and prioritize necessary health care services, screening, and tests for CGHC members. The CPR tool is easy to access via the secure CGHC Provider Portal on the Member Reports tab.

- **Identify gaps in care:** View preventive service history and easily identify Healthcare Effectiveness Data and Information Set (HEDIS®) gaps in care to discuss during appointments.
- **Holistically address patient care:** Receive alerts when CGHC members need tests or screenings, review member appointment histories and view their prescriptions.
- **Improve clinical outcomes:** Easily sort CGHC members into actionable groups for population management.
- **Attributed as PCP via Claims:** Indicates the member is attributed to a provider based on claims data. This type of attribution generally means the member has attributable claims history and is engaged with this provider or provider group.
- **Attributed as PCP via Self-Selection:** Indicates the member has selected a PCP for assignment and is attributed to their self-selected provider. This type of attribution generally means the member has no attributable claims history.
- **Assigned as PCP:** Indicates the member is attributed to their geographically assigned provider. This type of attribution generally means the member has no attributable claims history.

The screenshot shows a web application interface for reviewing claims. At the top, there are six filter dropdown menus: 'Select State' (Ohio), 'Select Plans' (Marketplace, Medicaid), 'Select Measures' (All, Adult Access, Asthma Control), 'Select Criteria' (All, Red, Yellow), 'Select Patient Status' (All, Established, New), and 'Select Enrollment Status' (All, Continuous, Recent). Below the filters is a table with columns for Member Name, Member ID, DOB, Sex, State, Plan, LOS, ADA Access, Action Detail, Date Modifier, Street Contact, Contact Contact, Claims/PA, Eye Exam, ASC, Kidney Function, ER, Lead, # of Visits, DOS, and Mail Case. The table contains several rows of data with colored cells (red, yellow, green) indicating different claim statuses or dates.

CLAIMS STATUS/CLAIM DETAIL

The **Claim Information** feature allows providers to review necessary claim details including payment information with check number, process, and adjustment reason of how the claim was reviewed, and more.

Claim status is updated daily on the CGHC Provider Portal. Providers can check claims that were submitted for the previous 36 months. Search options include Member ID number, member name and date of birth or claim number, patient number, check number and external reference number, or a custom date range. Claim information can be found on **the Claims > Claim Information and Attachments** page.

Highlights of the **Claim Details** include:

- **Process Reason** – Claim clinical edits
- **Adjustment Reason**
- **Remittance Reason**
- **Authorization Number** – The related authorization, if applicable
- **Disallowed Amount** – The disallowed amounts on the claim and line items
- **Rendering Provider Name** – The rendering provider on the claim

Claim Detail

General Information			
Claim #:		Date Received:	
Adjusted From Claim #:		Total Amount Charged:	
Adjusted To Claim #:		Total Patient Responsibility:	
Original Claim #:		Total Amount Paid:	
Patient Account #:		Processed Date:	
		Check Number:	
		Adjustment Amount:	
		Remaining Balance Due:	

Claim Detail

[List View](#)
[Table View](#)
[Dispute](#)
[Post Service Appeal](#)
[Related Documents](#)
[Recovery Request](#)

Line Number: 1			
Status:	Processed	Date of Service:	3/21/2022
Amount Charged:	\$77.00		
Process Reason:	z11 - This claim line is being disallowed because the procedure code has been deleted. - Procedure Code 99201 has been deleted as of 12/31/2020.		
Adjustment Reason:	181 - Procedure code was invalid on the date of service.		
Remittance Reason:	N56 - Procedure code billed is not correct/valid for the services billed or the date of service billed.		
Procedure:	99201 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused exam	Patient Responsibility:	\$0.00
Diagnosis:	S1290XS - Fracture of neck, unspecified, sequela	Amount Paid:	\$0.00
Place of Service:	On Campus - Outpatient Hospital	Recovery Amount:	\$0.00

CLAIMS SUBMISSION

The option to submit a claim via the CGHC Provider Portal will be for date of service Jan. 1, 2025 or later. This can be found on the **Claims > Online Claim Submission** page.

Member Search / Member File Upload

MEMBER SEARCH + **Online Claims Submission**

CLAIMS -

- Online Claim Submission
- Claim Information and Attachments
- Rejected Claims
- Real Time Claims
- Payment History
- Recovery Request
- Disputes
- Post Service Appeals

Online Claims Submission

Member Search

Search by ID MemberID

Start Date of Service

DISPUTES AND APPEALS

Providers can easily submit Disputes or Post Service Claim Appeals while viewing a claim on the Portal on the **Claims** tab. As part of the submission process, additional information or documentation can be submitted up to 100 MB. Using the reference number that is provided upon submissions, providers can check the appeal status and review acknowledgement, and decision letters associated to the appeal.

The image displays two screenshots of a web portal interface for submitting appeals and disputes. The left screenshot shows the 'Post Service Appeals' form, which includes a sidebar with navigation options like 'MEMBER SEARCH' and 'CLAIMS'. The main content area has a title 'Post Service Appeals' and a sub-header 'Payment information for overturned appeals will be displayed on the EOP following appeal decision.' Below this, there are fields for 'Claim ID' (19020248739), 'Appeal Type' (Authorization Denial (Medical)), and 'Authorization Number'. There are also radio buttons for 'Do you have a completed Member Consent form?' (Yes/No) and an 'Attachments' section with a 'Choose File' button and a note 'File sizes must be limited to 100 MB.'. The right screenshot shows the 'Disputes' form, which has a title 'Disputes' and a sub-header 'You file a claim payment dispute for a claim underpayment, a partially or fully denied claim or for an adverse claim payment decision.' Below this, there are fields for 'Claim ID' (19020248739), 'Dispute Type' (Please Select), 'Issue Category' (Claim Dispute Medical), and 'Provider Contact Name'. There is also a 'Notes' field and an 'Attachments' section with a 'Choose File' button and a note 'File sizes must be limited to 100 MB.'. Both forms have 'Cancel' and 'Submit' buttons at the bottom.

PRE-SERVICE APPEALS

Providers can submit pre-service appeals while viewing a denied authorization on the portal. As part of the submission process, additional information or documentation can be submitted up to 100 MB. Using the reference number that is provided on authorization submissions, providers can check the appeal status and review acknowledgement, and decision letters associated with the appeal.

Pre Service Authorization Appeals

Impersonate Provider ID:

Receipt Method:

Received Date:

Received Time:

Appeal Type:

Do you have a completed Member Consent form? Yes No

Reference #:

Reference #: 048349724

Description: Inpatient Elective

Place Of Service: 21 Inpatient Hospital

Submitting Provider: [REDACTED] Medical Center

Requesting/Ordering Provider: [REDACTED] Hospital/Acute Care F

Servicing/Rendering Provider: [REDACTED]

Facility: [REDACTED] Hospital/Acute Care F

Member Information

Member Name: [REDACTED]

CareSource Id: [REDACTED]

Birth Date: [REDACTED]

Gender: Male

Admission Event

Diagnosis Code: F13.129 Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified; M22 Disorder of patella

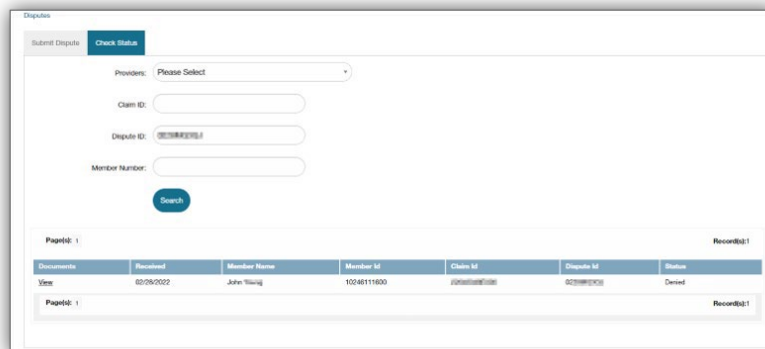
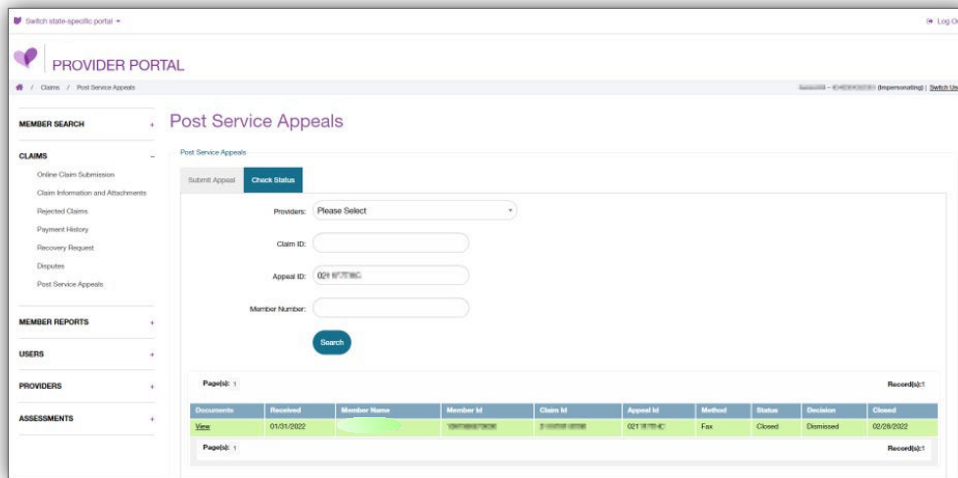
Procedure: 97120 Tx,1 Area,30 Min,Ea;iontophoresis; 99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed

Line #1	Requested Received Date:	Requested Days:	Authorized Days:	Status:
	4/13/2022 10:00:00 AM	1	0	Denied
	Start Date of Service: 4/13/2022			
	End Date of Service: 4/14/2022			

DISPUTE AND APPEAL LETTERS

Providers can easily access Disputes or Post Service Claim Appeal acknowledgement and decision letters on the CGHC Provider Portal three ways:

- While checking the status of the dispute or appeal
- While viewing the associated claim
- From the Provider Documents page



PRIOR AUTHORIZATION SUBMISSION

The CGHC Provider Portal allows providers to submit an inpatient or outpatient prior authorization request and receive an automatic approval for over 200 procedure codes. Through the **Providers > Prior Authorizations and Notifications** page, providers can enter clinical details and receive a decision on the authorization within seconds in addition to an authorization reference number.

Cite Auto Authorization matches the entered procedure and diagnosis information to the integrated clinical criteria and policies to display for the provider to complete that is required for the authorization to be processed. A determination is then made within seconds and given to the provider based on the selected clinical criteria. If a submitted authorization is pending and requires additional clinical information, providers may use the CGHC Provider Portal to update the authorization and attach documentation.

Prior Authorization and Notifications

Medical (Inpatient & Outpatient) | Newborn Delivery Notification | BOT | Observation | Status

[Edit](#)

An authorization or notification is not a guarantee of payment, but is based on medical necessity, appropriate coding and benefits. Benefits may be subject to limitation and / or qualifications and will be determined when the claim is received for processing.

For Physician Administered Pharmacy Codes, please [click here](#) to complete your Prior Authorization

CareSource Id | Medicaid Id | Member Info

Provider ID:

[Impersonate](#)

CareSource ID

Start Date of Service

[Search](#)

Authorization Request

Select Care Setting: Inpatient Outpatient

Select Category:

Select Type of Prior Authorization Request:

Will service be performed in a Facility? Yes No

Requesting/Ordering Provider Information

Search: * Required

Servicing/Rendering Provider Information

Same As Requesting/Ordering

If unable to locate the physician please use the facility.

Search: * Required

PRIOR AUTHORIZATION STATUS

Check the status of a prior authorization, make updates to an existing prior authorization, and view related letters.

Recent Prior Authorizations ▲

Page(s): 1 2 Record(s): 11

Details	Authorization Number	Member ID	Description	Service Start Date	Status
View Details Update			Inpatient Elective		Pending Decision
View Details Update			Outpatient Elective		Fully Approved
View Details Update			Outpatient Elective		Fully Approved
View Details Update			Inpatient Elective		Fully Approved
View Details Update			Inpatient Elective		Pending Decision
View Details Update			Inpatient Emergency		Pending Decision
View Details Update			Inpatient Emergency		Pending Decision
View Details			Outpatient Elective		Pending Decision
View Details			Outpatient Elective		Pending Decision
View Details			Outpatient Elective		Pending Decision

Page(s): 1 2 Record(s): 11

Prior Authorization and Notifications

Medical (Inpatient & Outpatient) | Newborn Delivery Notification | BOT | Observation | **Status**

Eds

Marketplace and Medicaid lines of business only. To check the status of a previously submitted Physician Administered Pharmacy Prior Authorization, [click here](#)

Member Id | Medicaid Id | Member Info | Authorization Number | **Facility**

Select the facility: In State Hospital - 2222222222

Start Date: 10/1/2021

End Date: 10/18/2021

[Search](#)

Authorization(s) found

Page(s): 1 Record(s): 30

Details	Authorization Number	Member ID	Member First Name	Member Last Name	Gender	DOB Data	Description	Service Start Date	Service End Date	Actual Discharge Date	Status
View Details Update Letters		1180000000	Jordan	Walt	F	10/1/1988	Inpatient Elective	10/16/2021	10/19/2021		Pending Decision
View Details Update Letters		1001000000	Davis	Hubert	M	10/1/1988	Inpatient Elective	10/18/2021	10/19/2021		Pending Decision
View Details Update Letters		1100000000	Wise	Valley	F	2/23/2000	Inpatient Elective	10/17/2021	10/18/2021		Pending Decision
View Details Update Letters		1100000000	Cuellar	Reginald	F	6/13/2002	Inpatient Elective	10/16/2021	10/17/2021		Pending Decision
View Details Update Letters		1000000000	Thomas	Wesley	M	10/18/1987	Inpatient Elective	10/15/2021	10/16/2021		Pending Decision
View Details Update Letters		1180000000	Blawie	Heidi	F	10/10/1988	Inpatient Elective	10/14/2021	10/15/2021		Pending Decision

WI-EXC-P-3175581