ABOUT THIS MANUAL

This provider manual is the property of Common Ground Healthcare Cooperative (CGHC) and CGHC reserves all rights to add to, delete from and otherwise modify this provider manual at 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 your CGHC provider relations representative or our Member Services at 877-514-2442 for further clarification of the terms expressed in this manual.

For your convenience, this manual contains a quick reference guide for reprinting and distribution to multiple locations or departments.

Please note: Material in this manual is subject to change. The most up-to-date version is available online at www.CommonGroundHealthcare.org.

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, either through the Trilogy network (EMPOWER) or directly contracted (ENVISION), must comply with the policies and procedures explained 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.
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Common Ground Healthcare Cooperative 120 Bishop’s Way Suite 150 Brookfield, WI 53005

Website: www.CommonGroundHealthcare.org

MEMBER SERVICE/PROVIDER RELATIONS/ELIGIBILITY 877-514-2442

OTHER IMPORTANT PHONE NUMBERS:
- 414-455-0500 (main)
- 877-450-8497 (toll-free)

PRIOR AUTHORIZATIONS:
- 877-779-7598 (medical)
- 855-577-6545 (OptumRx)

OPTUMRX:
- Fax: 262-754-9690 (MAIN & REFERRALS)
- P/A Fax Number: 877-251-0387
- Referral Email: CGHCReferrals@commongroundhealthcare.org

SUBMIT CLAIMS TO:
For Envision (Aurora/Bellin) Members
Common Ground Healthcare Cooperative
PO Box 1630
Brookfield, WI 53008-1630
EDI: 77170

For Empower (Trilogy) Members
Trilogy
PO Box 1171
Milwaukee, WI 53201
EDI: 62777

CGHC IDENTIFICATION (ID) CARD

Samples of our member health plan ID cards are shown below and also at:
http://www.commongroundhealthcare.org/for-providers/resources/ (click on ID card samples).

Example of Envision Individual ID Card

Example of Empower 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 19 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 bring affordable health insurance to Eastern Wisconsin since 2014. CGHC 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 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.
In 2018, Common Ground Healthcare Cooperative offers Exclusive Provider Organization (EPO) products to individual consumers and Preferred Provider Option (PPO) products to small group purchasers. Individual buyers residing or whose place of business is based within our 19 county service area (Brown, Calumet, Door, Fond du Lac, Kenosha, Kewaunee, Manitowoc, Marinette, Milwaukee, Oconto, Outagamie, Ozaukee, Racine, Shawano, Sheboygan, Walworth, Washington, Waukesha, and Winnebago counties) are eligible to obtain insurance from CGHC. Summary plan information on our insurance products can be found at:

http://www.commongroundhealthcare.org/our-plans/.

Many CGHC members purchase coverage through the Federally Facilitated Marketplace (FFM or Healthcare.gov) in order to take advantage of 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 individual and small group members access to integrated systems of hospitals and healthcare professionals through Aurora Health Care, Bellin Health Partners, Door County Medical Center and pediatric care coordinated through Children’s Hospital of Wisconsin and the Medical College of Wisconsin - Children’s Specialty Group.

In addition to the ENVISION plans, small employer customers of CGHC also have the option to purchase an EMPOWER plan, which offers members the freedom to choose healthcare providers across the broader Trilogy Health Network. With EMPOWER, the member may seek care from a broad panel of doctors and hospitals which best suit a member’s individual needs. Benefit summaries for Small Employer plans may be found at:

http://www.commongroundhealthcare.org/small-businesses/.

IMPORTANT - SPECIAL INSTRUCTIONS FOR OUT-OF-NETWORK REFERRALS

Limitations on Out-of-Network Benefits for Individual Plans
For 2018, all CGHC Individual Plans have moved to an Exclusive Provider Organization (EPO) plans. These EPO plans have NO out-of-network benefits EXCEPT in limited circumstances. These include emergency and out-of-service area urgent care services; when there is no Network provider qualified to treat the member’s condition; and some limited behavioral health service for Wisconsin college students.

If a CGHC Network provider believes that there are no Network providers qualified to treat a member’s condition, the member’s Network provider must submit a referral to CGHC to request approval for non-network care. See the referral form below. This referral will be evaluated to ensure there are no qualified Network providers prior to the referral being approved. If the Member seeks non-Network services prior to the referral being approved, payment for those services will be denied. Once the referral is approved, services are subject to the Prior Authorization provision, if applicable. We will attempt to minimize non-Network balance billing (the amount the non-Network provider charges over what we determine is the Maximum Allowed Amount), however, this will not always be possible.
EPO REFERRAL FORM

To be completed by In-Network Provider Only. Referrals to out-of-network providers will only be approved if there is no in-network provider available to perform the medically necessary service.

Please complete this form fully to prevent delays in review. Referral must be approved by CGHC prior to the member receiving care. An approved referral is not a guarantee of coverage. If Prior Authorization is required, this must be completed separately by calling 877.779.7598.

<table>
<thead>
<tr>
<th>DATE OF REQUEST:</th>
<th>REFERRAL FORM COMPLETED BY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td>Member ID Number:</td>
</tr>
<tr>
<td></td>
<td>Patient Date of Birth:</td>
</tr>
<tr>
<td>Patient Address:</td>
<td></td>
</tr>
<tr>
<td>Patient Email Address:</td>
<td>Patient Phone Number:</td>
</tr>
</tbody>
</table>

REFERRING PHYSICIAN INFORMATION

<table>
<thead>
<tr>
<th>Referring Physician Name</th>
<th>Referring Physician Clinic Name:</th>
<th>Referring Physician Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referring Physician Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office contact person name:</td>
<td>Phone number:</td>
<td>Email:</td>
</tr>
<tr>
<td></td>
<td>Fax number:</td>
<td></td>
</tr>
</tbody>
</table>

REFERRING TO INFORMATION

| Physician Name: | Location where care will be provided: | Specialty: |
|                |                                          |            |
| Office contact person name: | Phone number: | Email: |
|                         | Fax number: | |

CLINICAL INFORMATION

<table>
<thead>
<tr>
<th>Diagnosis Description:</th>
<th>ICD 10 Code(s): Procedure Code(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of care requested:</td>
<td>Dates of service: From__/<strong>/</strong> to__/<strong>/</strong></td>
</tr>
<tr>
<td>Urgent Request: □ Yes □ No</td>
<td></td>
</tr>
</tbody>
</table>

Reason for referral to out-of-network provider:

FOR INTERNAL USE ONLY

□ Approved □ Denied DOS approved: From__/__/__ to__/__/__
Prior Authorization Required: □ Yes □ No Prior Authorization Approved: □ Yes □ No
Notes:

Send encrypted email to CGHCReferrals@CommonGroundHealthcare.org
to 262.754.9690 or mail to: CGHC, Attn Referrals, PO Box 1630, Brookfield, WI 53008-1630
ELIGIBILITY

Common Ground Healthcare Cooperative provides several ways for providers to determine Member eligibility:

- Identification Cards
- During regular business hours by calling CGHC Member Services at 877-514-2442 and press 2
- Smartphone app
- HIPAA-compliant 270/271 real-time transactions via our clearinghouse, Smart Data Solutions (SDS)
MEMBER IDENTIFICATION

Common Ground Healthcare Cooperative mails health plan ID cards to all CGHC members. Each card contains information on the Member’s assigned network which corresponds to either the Envision or Empower network; the Envision network shows Aurora and Bellin logos, whereas Empower has the Trilogy logo. Cards also show the member’s effective date when benefits were first available to the member and the member’s out-of-pocket payment indicators. When checking eligibility, providers should confirm the member’s network assignment at the time of patient registration.

ID Number Definitions

- Beginning with leading zeros (as shown below) – On Exchange Individual Member
- Beginning with I (capital letter i) – Off Exchange Individual Member
- Beginning with S (capital letter s) – Non-SHOP Small Group Member
- Beginning with 1 (number one) – SHOP Small Group Member

CGHC also makes available a convenient mobile ID card app for smartphones. Members who log in with their ID number, date of birth, and zip code can easily access their ID card and email or fax it to their provider or pharmacy.
VERIFYING MEMBER COVERAGE & MEMBERS IN “GRACE PERIODS”

A member is issued a CGHC ID card when she or he enrolls in the plan. Unfortunately, the card does not ensure eligibility at the time of service. You need to contact us by [how to do it] to confirm the member is eligible for benefits at the time of service.

There is a special circumstance under the ACA for a member who purchases health insurance on the Marketplace (Exchange) and receives an Advanced Premium Tax Credit (APTC). These members have a full 90 day grace period. During the first 30 days of this grace period, we must pay their claims as if they paid their premium. During the following 60 days, they remain a member, but we will deny payment for claims with dates of service in this 60 day period. If the full premium is never paid, the claims will remain denied. If the member’s premiums are paid in full before the end of the grace period, the member’s coverage remains in-force for the second and third months of the grace period, and CGHC will subsequently pay the denied claims when the provider resubmits previously denied claims.

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

If you are unable to verify a member’s eligibility at the time of service, please contact CGHC Member Services at 877-514-2442 for assistance.

IF A MEMBER IS HOSPITALIZED WHEN COVERAGE BEGINS

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. Your facility must notify CGHC as soon as possible of the member’s admission. In such cases, providers should submit a split bill for the dates of service which are covered by CGHC.

IF A MEMBER IS HOSPITALIZED WHEN COVERAGE TERMINATES

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. For the most accurate reimbursement, please submit a split bill for the dates of service for which CGHC was in effect.
Please refer to the member’s current Certificate of Coverage for a detailed description of benefits at http://www.commongroundhealthcare.org/certificate/. (Click “2018 Certificate of Coverage”)

Benefits are available only if all of the following are true:

- Health Services which may be covered services are subject to the conditions, exclusions, limitations and provisions of the member’s policy including any attachments or endorsements.
- Covered 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 service and does not guarantee payment. Excluded services are not covered.
- Covered 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 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 in the exclusions and limitations section are not covered services unless specific provisions apply.

Benefits which are limited within any of the covered service categories described in the policy (including limits that may apply to more than one health service category) are stated in the corresponding covered health service category in the schedule of benefits. CGHC will not pay for any services, treatments, items or supplies that exceed these benefit limits.

CGHC’s full exclusions and limitations list can be found at http://www.commongroundhealthcare.org/members/exclusions.
NETWORK PROVIDER PARTICIPATION

Common Ground Healthcare Cooperative is not accepting unsolicited requests for Envision network provider participation in 2018. Providers who have questions about services which may not be available within a CGHC network should contact the Provider Contracting and Relations department.

WHO TO CONTACT: PROVIDER CONTRACTING & RELATIONS

The Provider Contracting and Relations Department is part of your CGHC service team. The department educates and informs our network providers on CGHC’s policies and procedures, explains our processes to facilitate care for our members and intervenes when providers encounter unusual challenges. Please contact us at 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 twenty-one (21) 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 business 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, 7 days per week

**Emergency Care:**
1. Prior authorization is NOT required for emergency services in or out of CGHC network.
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, 7 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.
The purpose of the credentialing program is to support a systematic approach to credentialing within CGHC. CGHC’s credentialing program includes a written credentialing plan documenting compliance with the credentialing plan’s requirements, specific credentialing responsibility assignments to administrative and professional staff and a mechanism for the periodic review and revision of the credentialing plan. The purpose of the credentialing plan is to provide general guidance for the decision-making surrounding acceptance or continued participation of professional staff who wish to participate in the CGHC provider network. Specific objectives of the credentialing plan include:

- The criteria to be used in assessing the qualifications of applicants seeking initial or on-going association with Common Ground Healthcare Cooperative;
- Processes for verification and evaluation of a practitioner’s credentials; and
- Processes for action if a practitioner’s credentials do not meet the established minimum criteria.

Unless there are clear and convincing reasons to depart from these guidelines, CGHC’s Delegation Oversight committee (DOC), Executive Quality Oversight committee (EQOC) and staff are expected to adhere to these guidelines. Nothing contained in the credentialing plan shall limit CGHC’s discretion in accepting, restricting, disciplining, or terminating a practitioner’s association with CGHC. The credentialing plan may be changed at any time at CGHC’s sole discretion. Such changes shall be effective on the date of the change for new applicants and existing practitioners.

**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 medical director 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 RIGHT 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 will notify the practitioner immediately in writing in the event that 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 RIGHT 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 Contracting & 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 Envision 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 Executive Quality Oversight committee (EQOC), 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 (MD/DO) 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 (MD, DO), 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. 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 Executive Quality Oversight Committee (EQOC) 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 Credentialing committee 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 as long as 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 Executive Quality Oversight Committee (EQOC) 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 EQOC 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 in 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 ten areas of
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. To guide you in notifying us of changes, please note the proper notification processes.

**ENVISION (Aurora/Bellin)**

Providers who have a direct contract with CGHC to participate in the ENVISION product, may use the provider information form below. Physicians and clinical professionals who are EMPLOYED by Aurora and facilities or other entities owned by Aurora do not need to contact CGHC--your change information will be submitted directly by Aurora. If you are contracted with CGHC for Envision through Bellin Health Partners (BHP), BHP will notify CGHC of changes and updates.

**EMPOWER (Trilogy)**

Providers who participate in the EMPOWER (Trilogy) network should update their information directly with Trilogy at providerchange@trilogycares.com.

CGHC’s online provider search, including a print-on-demand Provider Directory, for either ENVISION or EMPOWER is available at: [http://www.commongroundhealthcare.org/find-a-doctor](http://www.commongroundhealthcare.org/find-a-doctor) (Click on the desired provider directory)

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

**COMMON GROUND HEALTHCARE COOPERATIVE PROVIDER INFORMATION FORM**

The form below shows the necessary information CGHC needs to maintain correct marketing and payment records. While the form itself is not required for every change and data may be submitted in any format, the information below should be properly submitted. It can be accessed at: [http://www.commongroundhealthcare.org/](http://www.commongroundhealthcare.org/) (Click on provider information form). The addition of any new practitioner should be accompanied by required credentialing materials and a completed W-9 form will be required for any revisions to a provider’s tax identification name and/or number. No practitioner will be considered “in-network” until applicable credentialing has been successfully completed, unless otherwise noted above, at CGHC’s sole discretion. This form is not a credentialing application; if credentialing is required for a practitioner listed below, you will be contacted to initiate the application process.

If you use this form, be sure to:

1. Enter all the locations associated with your practice in Section 4.
2. Enter billing/remittance information for your practice. If multiple billing/remittance addresses, list each address for the corresponding office code.
3. Enter data for every provider in your practice, including any physician assistants or nurse practitioners.
Please return this completed update form via e-mail, fax, or mail to:
  Common Ground Healthcare Cooperative
  Provider Information
  PO Box 1630
  Brookfield, WI 53008-1630
Files and demographic updates can also be faxed to 262-754-9690 or submitted electronically to providerinfo@commongroundhealthcare.org.
Section 1: Organization/Business Practice and Contact Information

<table>
<thead>
<tr>
<th>Organization/Business Legal Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax ID #</td>
<td></td>
</tr>
<tr>
<td>Form Submitted by (name/title):</td>
<td></td>
</tr>
<tr>
<td>Phone Number (with area code):</td>
<td></td>
</tr>
<tr>
<td>Fax Number (with area code):</td>
<td></td>
</tr>
<tr>
<td>E-mail:</td>
<td></td>
</tr>
</tbody>
</table>

Effective Date of Change: ________________________________

Reason(s) for update (Place an “X” next to all that apply).

<table>
<thead>
<tr>
<th>Legal name change (Complete Section 2)</th>
<th>Practitioner change(s) (Complete Sections 3 and 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Federal tax ID # change (Complete Section 2)</td>
<td>Service location change(s) (Complete Section 4)</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Billing/mailing contact change (Complete Section 2)</td>
<td>Practice closed</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Please provide additional information in the following sections as noted above.

Section 2: Organization/Practice Information Updates

| New Legal Name (as indicated on W-9): |  |
|---------------------------------------|  |
| New Tax ID #:                        |  |
| New Remittance Address:              |  |
| New Billing Phone Number (with Area Code): |  |
| New Billing Fax Number (with Area Code): |  |
| New Mailing Address:                 |  |

Effective Date of Change: ________________________________

Check here if you wish to enroll in Electronic Funds Transfer ("EFT") ☐

NOTE: Please attach a current W-9 for all legal name, federal tax ID and billing address changes. Attach forwarding information for practice closures.
Section 3: Practitioner Updates

Please make copies of this page as needed to document all practitioner & changes.

<table>
<thead>
<tr>
<th>NPI:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TIN:</td>
<td></td>
</tr>
<tr>
<td>Provider Name:</td>
<td></td>
</tr>
<tr>
<td>Clinic Name:</td>
<td></td>
</tr>
<tr>
<td>Office Address</td>
<td>(refer to Section 4)</td>
</tr>
</tbody>
</table>

Accept_New?   Yes ☐   No ☐   CG_Directory?   Yes ☐   No ☐

| Provider Type |  |
| Primary Specialty |  |
| Secondary Specialty |  |
| Tertiary Specialty |  |
| Billing_Name |  |
| Billing_Address |  |
| Billing_City |  |
| Billing_State |  |
| Billing_Zip |  |
| Group_NPI |  |
| Primary Language |  |
| Secondary Language |  |

Reason(s) for update: (indicate all that apply)

Practitioner added to staff (list service locations in Section 4)   Effective Date: _____________
Practitioner leaving staff ☐  Effective Date: _____________
Reason: Leave of absence ☐ Expected Date of Return: _____________
Practitioner retired ☐ Practitioner deceased ☐ Relocation (see Sec 4) ☐
Other (Please explain): ____________________________________________

Practitioner demographic data change(s) (indicate all that apply) Effective Date: _____________

Name: ___________________________ Specialty: ___________________________

Section 4: Service Location Updates   Add ☐ Remove ☐ Primary Site?   Yes ☐ No ☐

Please make copies of this section as needed to document all service location changes.

| Location # |  |
| Effective Date: |  |
| Office Address: |  |
| Office City: |  |
| Office ST: |  |
| Office Zip: |  |
| Office Phone (with area code): |  |
| Office County: |  |
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. Continuation of treatment through the current period of active treatment or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.
2. Continuation of care through the postpartum period for members in their second or third 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 Services rendered to a CGHC member.

We encourage our providers to submit claims electronically. Electronic claims submission is fast, accurate and reliable. Electronic claims may be submitted twenty-four (24) hours a day, seven (7) 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.

Claims may be submitted to:

For Envision (Aurora/Bellin) Members
EDI: 77170

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

For Empower (Trilogy) Members
EDI: 62777

Paper:
Trilogy
PO Box 1171
Milwaukee, WI 53201

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 contracted provider participating in the CGHC network, you agree to cooperate with CGHC regarding subrogation and coordination of benefits (COB) and to notify us after you receive information of any member who may have a claim involving subrogation or COB. 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 CGHC rate.

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 process and pay the claim on initial notification, note the COB information in the member’s file and deny any related additional claims.
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. Should you need assistance with your EDI processing, please contact Smart Data Solutions or call 877-514-2442 and ask to speak to Provider Relations.

PAPER CLAIMS

If submitting claims electronically is not a viable alternative for you, 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 in “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); and
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); and
39. Field 76: Attending physician’s name and ID (NPI or QUAL ID)

Providers must bill with current ICD-10 and CPT-IV or HCPCS codes. Codes that have been deleted from CPT-IV or HCPCS will not be recognized. When a miscellaneous procedure code is billed or a code is used for a service not described in CPT-IV or HCPCS, supportive documentation must accompany the claim. Only submit claims after service is rendered. Claims submitted without the above mandatory information will not be accepted and will be returned to the provider.

To allow for more efficient processing of your claims, we ask for your cooperation with the following:

- When a physician or a clinic becomes a participating provider, they agree to accept payment made by CGHC as payment in full. Discounts are not to be billed to the member or the secondary insurance company. Members may be billed for copayments, coinsurance, deductible amounts, and non-covered services.
- CGHC requires the use of the correct and complete member number. Please refer to the ID Card Section for further explanation. Using the correct member number on the claims will help us ensure correct claim payment.
- CGHC requires network providers to file claims in a timely manner. All claims must be submitted in accordance with the claim filing limit stipulated in your provider agreement. Refer to the services/obligations section of your agreement for additional details.
- 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.
- Coordination of Benefit (COB) claims must be received along with the primary payer’s explanation of benefits within the timely filing limit outlined in your agreement.
- Claims for newborns should be split into two claims: one for the mother and one for the newborn.
- Please code preventive services using Modifier 33 as appropriate.
Provider Reimbursement Schedule (PRS) Sources. Unless otherwise agreed by contract, CGHC’s reimbursement policies are aligned with the following methodologies:

a. RBRVS RVU  Wisconsin GCPI’d for the year stated in the PRS
b. J-codes for drugs Medicare ASP updated as of January 1 of each year or as in your PRS
c. DRG  **ENVISION:** CMS updated October 1 of each year;  **EMPOWER**/Trilogy: CMS update as of January 1 of each year.
d. ASA  American Society of Anesthesiology or CMS as defined in your PRS
e. 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

**Prolonged E&M service (Modifier 21)**

No additional payment is allowed for service billed with this modifier.

**Unusual Procedure (Modifier -22)**

Surgeries or other procedures for which services performed are significantly greater than usually required may be billed with Modifier 22. When Modifier 22 is used, the provider is claiming that the surgical or invasive procedure required an unusual amount of time and effort, above and beyond the "difficult" case. Modifier 22 signifies "services performed are significantly greater than usually required,” therefore its use should be exceptionally infrequent. 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. Therefore, CGHC requires the provider to clearly indicate why this case is beyond the usual range of difficulty for procedures reported with the code. The provider should briefly describe, in one or two paragraphs, the difficult nature of the service(s) that justify why the service was unusual and the increased work that was necessary for that member in simple medical terminology so as to be clear to a non-surgeon. Please be advised that submitting the operative report with a Modifier 22 paragraph, Explanation Form or supplemental letter will not guarantee 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. In order 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. Examples of Inappropriate Usage include services provided by a physician other than the physician performing the procedure and/or documentation shows the amount of work performed is consistent with that normally performed with the procedure.

**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 through the use of 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. Please use this modifier as appropriate to assist us in our reporting requirements. We follow the guidelines recommended by the U.S. Preventive Services Task Force. Please refer to this link under the “Members” tab for more information: [http://commongroundhealthcare.org/members/preventivecare/](http://commongroundhealthcare.org/members/preventivecare/).

**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 will pay 150% of the fee schedule amount. This is consistent with current Medicare guidelines. Bi-lateral procedures are subject to the multiple procedure reimbursement logic. If billing with modifiers LT and RT (not recommended), the procedure must be listed on two lines. CGHC will pay the first line at 100% and the second line at 50%.

**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. Reimbursement for multiple procedures may be reduced when performed during a single encounter. 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. 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 79% of the allowable fee, subject to provider contract 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 contract 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 contract 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)**
Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. 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, should modifier 59 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 and -81)**
CGHC will reimburse assistant surgeons at 16% of the contracted rate of the surgery. This reduction is systematically taken based on the modifier (AS, 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 (AS)**
CGHC will pay for assistants-at-surgery 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**
Observation cannot last more than three days or 72 hours as an outpatient claim.

**Clinic Visit/Facility Fees for Professional Office Visit (Revenue code 510-529)**
Facility clinic visits are defined as a preventive, curative, diagnostic, rehabilitative and/or education services provided to an ambulatory patient in an outpatient setting, whether in a free standing or an attached facility center that is either owned, operated, leased or controlled by the facility. CGHC reimburses the professional for both their services and associated overhead. Revenue codes 510-529, or any successor codes, are not reimbursed by CGHC, unless there is a contractual requirement to do so; otherwise, for those facility billed charges, the Member is not liable and is held harmless for these charges.

**Mid-Level Providers**
Mid-level providers are defined by CGHC as nurse practitioners, physician assistants, advance practice nurse, etc. These provider types shall be reimbursed 85% of the physician’s fee.
Anesthesia Billing
CGHC reimburses anesthesia providers using the ASA standards. Providers will be expected to bill the number of units and include the minutes and patient status indicators.

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) 50% of Fee Schedule Allowance

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.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Unusual Procedure (with supporting documentation)</td>
<td>Maximum of 110% of the base code allowable</td>
</tr>
<tr>
<td>24</td>
<td>Unrelated E&amp;M service by the same physician during post-op period</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Preventive service indicator</td>
<td>Pay 100% of the base code allowable</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral procedure</td>
<td>Pay 150% of the base code allowable</td>
</tr>
<tr>
<td>RT/LT</td>
<td>Right/left sides</td>
<td>100% if billed alone, 150% total if billed together</td>
</tr>
<tr>
<td>51</td>
<td>Multiple procedures</td>
<td>100/50/25/stop</td>
</tr>
<tr>
<td>52</td>
<td>Reduced Services</td>
<td>Pay 50% of the base code allowable</td>
</tr>
<tr>
<td>53</td>
<td>Discontinued Procedure</td>
<td>Pay 50% of the base code allowable</td>
</tr>
<tr>
<td>54</td>
<td>Surgical Care Only</td>
<td>79% of the base code allowable</td>
</tr>
<tr>
<td>55</td>
<td>Post-op Management Only</td>
<td>Pay 20% of the base code allowable</td>
</tr>
<tr>
<td>56</td>
<td>Pre-op Management Only</td>
<td>Pay 10% of the base code allowable</td>
</tr>
<tr>
<td>59</td>
<td>Distinct procedural service</td>
<td>No reduction if billed alone</td>
</tr>
<tr>
<td>62</td>
<td>Co-surgeon</td>
<td>62.5% of the base code allowable</td>
</tr>
<tr>
<td>76</td>
<td>Repeat procedure – same physician</td>
<td>Pay 50% of the base code allowable</td>
</tr>
<tr>
<td>77</td>
<td>Repeat procedure – different physician</td>
<td>Pay 100% of the base code allowable</td>
</tr>
<tr>
<td>78</td>
<td>Unplanned return to the OR</td>
<td>Pay 50% of the base code allowable</td>
</tr>
<tr>
<td>79</td>
<td>Unrelated procedure during post op</td>
<td>Pay 100% of the base code allowable</td>
</tr>
<tr>
<td>80, 81, 82, AS**</td>
<td>Assistant surgeon</td>
<td>16% of the base code allowable</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service with medical direction by a physician</td>
<td>Pay 50% of the base code allowable</td>
</tr>
<tr>
<td>QK</td>
<td>Medical supervision of 2, 3 or 4 concurrent anesthesia procedures</td>
<td>Pay 50% of the base code allowable</td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one CRNA by an anesthesiologist</td>
<td>Pay 50% of the base code allowable</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service without medical direction by a physician</td>
<td>Pay 50% of the base code allowable</td>
</tr>
<tr>
<td>GW</td>
<td>Non hospice diagnosis related service</td>
<td>Pay 100% of the base code allowable</td>
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</tbody>
</table>
EXPLANATION OF BENEFITS (EOB)

EXPLANATION OF BENEFITS

THIS IS NOT A BILL.
If you have questions regarding your explanation of benefits,
please call Member Services at 977.534.2442 or
e-mail info@CommonGroundHealthcare.org.

[MEMBER NAME]
[ADDRESS] [ADDRESS 2]
[CITY] [STATE] [ZIP]

Member Name: [Subscriber Name]
Patient Name: [Patient Name]
Plan Name: [Plan Name - this will run onto two lines]
Member ID: [Member ID]
Healthcare Provider: [Provider Name]
Date: [Date]
Claim Number: [Claim Number]

CLAIM SUMMARY

<table>
<thead>
<tr>
<th>Description of Service</th>
<th>Service Dates From</th>
<th>Service Dates To</th>
<th>Procedures</th>
<th>Billed Charges</th>
<th>Allowed Amount</th>
<th>Your CGHC Plan Paid</th>
<th>Not Covered</th>
<th>Remark Code</th>
<th>Amount You Owe Provider</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Totals

Amount Your Plan Saved You

REMARK CODE DESCRIPTIONS

<table>
<thead>
<tr>
<th>Remark Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Learn more about how to read your explanation of benefits at
www.CGCare.org/EOB

The enclosed notice contains details for the CGHC appeals process and for accessing language assistance.

## PLAN SUMMARY

<table>
<thead>
<tr>
<th>Limits</th>
<th>Annual Limit</th>
<th>Year to Date</th>
<th>Remainder</th>
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</thead>
<tbody>
<tr>
<td><strong>INDIVIDUAL</strong></td>
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<tr>
<td>Medical Deductible</td>
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<tr>
<td>Medical Out of Pocket</td>
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<tr>
<td><strong>FAMILY</strong></td>
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<tr>
<td>Medical Deductible</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Medical Out of Pocket</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## ADDITIONAL DETAILS

**TOTAL BILLED CHARGES:** $0.00  
This is the total amount billed by a provider for healthcare services provided to you or a family member.

**ALLOWED AMOUNT:** $0.00  
On behalf of our members, we work with our network providers to lower the amount we pay for healthcare services. If you have received care from an in-network provider, this is the amount your provider and CGHC have agreed upon as reimbursement for the services you received. Out-of-network emergency, urgent or approved care will be paid at our allowed amount based on Medicare and other payer rates. Because we do not have a contract with out-of-network providers, we cannot stop them from billing you for any amount above what we pay.

**AMOUNT NOT COVERED:** $0.00  
This is the amount not covered under your health plan. Whether or not you must pay this amount, depends on whether you stayed in network and whether your provider billed you the balance for these services. See the Remarks section on the previous page(s) for more information.

**WHAT YOUR CGHC PLAN PAID:** $0.00  
The amount CGHC paid to [Subscriber Name or Provider Name]

**WHAT YOU OWE:** $0.00  
This is the amount you owe after we subtract what we pay toward your healthcare, subject to agreed upon discounts with healthcare providers. This may include amounts used to satisfy your deductible, any copays, any percentage of a covered amount (coinsurance), or for services and other care not covered by your plan. Any amount you pay when you received these services (such as a copay) may reduce the amount you owe to the provider.

**AMOUNT CGHC SAVED YOU:** $0.00  
This is the amount you saved off your provider’s total billed charges. This amount is the total of our discount plus what we paid toward your healthcare.
When the status on an EOP indicates “reversal of previous payment,” it acknowledges CGHC’s receipt of a refund or reprocessing of a prior claim paid incorrectly, not a recoupment of a payment.

**ELECTRONIC FUNDS TRANSFER (EFT)**

To enroll in electronic funds transfer (EFT) and electronic remittance advice (ERA) with our banking partner, U.S. Bank, you may contact them at 877-833-6821 or Provider Relations at 414-455-0500 for the enrollment form. The form is also available at: [http://commongroundhealthcare.org/for-providers/resources](http://commongroundhealthcare.org/for-providers/resources). (Click on “Provider EFT Form”)

**APPEAL PROCESS**

If you have questions about this decision or want more information, you can call us at 1-877-514-2442. If you do not agree with any part of the decision we made on your claim, you can file an appeal within 180 days, but not later than 3 years from the date found on this notification. Appeals must be sent to Common Ground Healthcare Cooperative (“CGHC”) Member Appeals and Grievances, P.O. Box 1630, Brookfield, WI 53008-1630. Your complaint will be reviewed by the Common Ground Healthcare Cooperative Grievance Committee and a decision will be issued within 30 days of receipt of your appeal, unless additional time is requested. You have the right to attend the Committee meeting by telephone, in person, or you may send an authorized representative in your place. You should provide all information you want considered with your appeal.

You have the right to pursue an independent external review if the denial of your claim is based on medical judgment (for example, medical necessity, experimental and investigational treatment, and appropriateness of health care setting). In most cases, you must go through CGHC’s internal grievance procedure first and you must file for the review with 4 months after the date you receive the CGHC decision. External reviews are conducted by the federal Department of Health and Human Services (“HHS”) through the MAXIMUS Federal Services process. Requests for review must be made in writing to: HHS Federal Review Request, MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534, or fax to 1-888-866-6190.

You may request an expedited review if you believe the time period for resolving your appeal will result in jeopardizing your health. In urgent situations, the internal review process can be done at the same time as the expedited review process. The expedited process will produce a binding result within 72 hours. To request an expedited review, in addition to the methods listed above, you can also call 1-888-866-6205.

Complete details regarding filing an appeal can be found in your Certificate of Coverage/policy.

You may also contact the Wisconsin Office of the Commissioner of Insurance for questions at 1-608-266-0103/toll free 1-800-236-8517 or send an email to ocicomplaints@wisconsin.gov. Complaints can be mailed to the following address: Office of the Commissioner of Insurance, Complaints Department, P.O. Box 7873, Madison, WI 53707-7873. Complaints may be faxed to 608-264-8155.

If your plan is employer-sponsored and governed by ERISA, you may contact the Employee Benefits Security Administration at 1-866-444-3272 or askebsa.dol.gov. You may file a civil action under section 502(2) of the Employee Retirement Income Security Act (ERISA) once you exhaust the grievance procedure.
PROVIDER APPEALS & RECONSIDERATIONS

Providers who send a written request for any reconsideration should include the following information: provider name, TIN, member name and ID number, date of service and a brief description of the basis for the contestation; for claims disputes, please also include claim number, charge amount and payment amount. In addition, be sure to include any relevant supporting documentation (medical records, copy of invoice, etc.).

CLAIM APPEALS & RECONSIDERATIONS

Upon receipt of the explanation of payment, provider may inquire about the accuracy of the processed claims, including the member’s payment responsibility. Claims may be reprocessed by CGHC due to administrative error in cases where applicable.

If the provider disagrees with the payment determination and wishes to request a reconsideration, the provider may submit an appeal of the determination to CGHC. All provider requests for claims reconsideration must be received by CGHC within 12 months of the date the claim was paid unless state or federal law or any applicable provider agreement between the parties stipulate other requirements. Please refer to the claim reconsideration form at http://www.commongroundhealthcare.org/providers/resources/. (Click on Claims Reconsideration form). Providers may also call CGHC at 877-514-2442 or submit written or electronic documentation to:

CGHC Provider Appeals
120 Bishop’s Way, Suite 150
Brookfield, WI 53005
providerinfo@commongroundhealthcare.org
Fax: 262-754-9690
REFUND & RECOUPMENT POLICY

In the event that a claim is either over- or underpaid by an amount less than $20 (twenty dollars) per claim, CGHC shall adjust the claim accordingly but neither the provider nor CGHC will be obligated to pay the outstanding balance to the other. In cases of systematic errors affecting all claims, either party may notify the other of suspected discrepancies in order to research the root cause of the issue and alternative resolutions.
**PREVENTABLE ADVERSE EVENTS (PAE) POLICY (NEVER EVENTS)**

Should any of the events listed in the grids 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 ten (10) business days.

**PHYSICIAN PREVENTABLE ADVERSE EVENTS (PAE) POLICY**

There are four (4) major surgical PAE or Never Events that should they occur to a member, the provider shall neither bill nor receive payment from any source.

<table>
<thead>
<tr>
<th>PREVENTABLE ADVERSE EVENT (NEVER EVENT)</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery performed on the wrong patient</td>
<td>Any surgery on a patient that is not documented by informed consent for that patient. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
<tr>
<td>Surgery performed on the wrong body part</td>
<td>Any surgery performed on a body part that is not consistent with the signed informed consent of the patient. This excludes emergent situations that occur during the approved procedure or such urgency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
<tr>
<td>Wrong surgical procedure performed on a patient</td>
<td>Any surgery performed on a patient that is not approved by the patient via informed consent. This excludes emergent situations that occur during the approved procedure or such urgency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
<tr>
<td>Retention of a foreign object in a patient after a procedure or surgery.</td>
<td>This excludes any implant intentionally placed as part of the planned procedure or surgery or that were present from a previous procedure and intentionally left.</td>
</tr>
</tbody>
</table>

**FACILITY PREVENTABLE ADVERSE EVENTS (PAE) POLICY**

There are three (3) major surgical PAE or Never Events that, should they occur to a Member, the provider shall neither bill nor receive payment from any source.

<table>
<thead>
<tr>
<th>PREVENTABLE ADVERSE EVENT (NEVER EVENT)</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery performed on the wrong patient</td>
<td>Any surgery on a patient that is not documented by informed consent for that patient. Surgery includes endoscopies and other invasive procedures.</td>
</tr>
</tbody>
</table>
**PREVENTABLE ADVERSE EVENT (NEVER EVENT)**  
| Surgery performed on the wrong body part | Any surgery performed on a body part that is not consistent with the signed informed consent of the patient. This excludes emergent situations that occur during the approved procedure or such urgency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures. |
| Wrong surgical procedure performed on a patient | Any surgery performed on a patient that is not approved by the patient via informed consent. This excludes emergent situations that occur during the approved procedure or such urgency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures. |

**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 should remove all charges related to the HAC prior to billing.
REFERRAL AND AUTHORIZATION FOR SERVICES

REFERRAL (INDIVIDUAL PLAN MEMBERS)

INDIVIDUAL PLAN MEMBER REFERRAL REQUIREMENTS: In 2018, members who buy individual insurance plans have Exclusive Provider Organization (EPO) benefits. In order for benefits to apply for Covered Services, members must seek services ONLY from in-network providers except under very limited circumstances. These limited circumstances include the following:

1. Emergency Health Services performed at a Non-Network facility or by Non-Network providers. Once the Emergency has been stabilized, ongoing hospitalization and any follow up care must be provided by Network Providers.
2. Medically Necessary Urgent Care services at out of Service Area Providers when a Covered Person is traveling or a dependent residing outside of our Service Area. Any follow-up care must be provided by Network Providers.
3. If specific Covered Health Services are not available from a Network Provider or there is not a qualified Network provider, the member may be able to obtain a written referral from a Network provider to see a Non-Network Provider. The written referral must be approved by us before services are rendered. Any Services the Non-Network Provider recommends must comply with all provisions of Policy, including Prior Authorization. If you and the member fail to obtain the written, approved referral prior to treatment, 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 after services are rendered (except in cases of emergency), the penalty listed in the Prior Authorization section will apply.
4. For a Dependent Student Member of your Certificate who attends school outside of the Service Area, we will treat as Covered Health Services, Non-Network Emergency Medical Services or Urgent Care services. Any follow-up care must be provided by Network Providers.
5. For a Dependent Student Member of your Certificate who attends an Institution of Higher Learning outside of the Service Area, but inside the State of Wisconsin, we will treat as Covered Health Services, a clinical assessment by a Non-Network Provider and 5 visits for outpatient behavioral health or addiction treatment. We reserve the right to select the provider of those services. Notify us prior to receiving treatment, or as soon as possible.

It is critical that you understand your role as a Network provider in those rare instances where there are no qualified Network providers and referral to an out-of-network provider is required. To initiate the Referral process, in-network providers must submit a Referral request to CGHC at:

Common Ground Healthcare Cooperative  
Attn: Referrals  
120 Bishop’s Way Suite 150  
Brookfield WI 53005  

OR

CGHCRreferrals@commongroundhealthcare.org

Please keep in mind that all resources within the Envision network for specialty care must be exhausted before a referral is submitted. The Referral form authorization form is available at: http://www.commongroundhealthcare.org/for-providers/resources/. (Click “Provider Referral Form”)
SMALL GROUP PLAN MEMBERS: CGHC still provides benefits for non-Network services under our employer group plans. Please remember that in order for Small Group members to receive the highest level of benefits available under their plan, services must be rendered by any in-network provider.

PRIOR AUTHORIZATION

All CGHC plans have prior authorization requirements for certain services regardless of a provider’s participation with CGHC. The Utilization Management (UM) Program is designed to ensure that health care resources efficiently and effectively provide the best value to our members. 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. Certification or prior authorization does not guarantee any payments — payments are 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, for Covered Services or items required over extended periods, CGHC will not allow a purchase of more than a 30 day supply of authorized supplies, and reimbursement for such services shall only be made on a month-by-month basis.

The Prior Authorization process is distinct from the Referral process. A Referral is necessary whenever an in-network provider believes a member needs treatment outside of the network. A Prior Authorization is necessary based upon the nature of the service being performed. For example, if an in-network provider believes that a member need an office visit consult with a non-Network provider, only a referral is needed because Prior Authorization is not required for office visits. However, if an in-network provider believes a member needs an inpatient surgery at a non-Network facility, both a Referral and a Prior Authorization would be required.

PRIOR AUTHORIZATION IS REQUIRED FOR THE FOLLOWING

Services that require Prior Authorization:

- Ambulance — non-emergency air and ground
- Any procedure that could be considered cosmetic
- Biofeedback
- Botox injections
- Chemotherapy — outpatient and oral
- Routine care associated with Clinical trials
• Cochlear Implants
• Dental care resulting from an accident
• Dental/Anesthesia - Hospital Ambulatory Surgery Services
• Diagnostic testing including, MRI, MRA, PET, CT Scans and Echocardiograms
• Dialysis (outpatient and home dialysis)
• Durable Medical Equipment over $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). Some examples include but are not limited to:
  o Continuous glucose monitoring device
  o CPAP machine for sleep apnea
  o Insulin pump (not for supplies only)
  o Feeding pump
  o Transcutaneous Electronic Nerve Stimulator (TENS)
  o Implantable devices, including but not limited to infusion pumps and neurostimulators
  o Hospital bed(s)
  o Wheelchair(s)
  o Ventilator(s)
• Genetic Testing
• Inpatient Confinement, including Inpatient Hospice (not including observation stay which is less than two (2) midnights)
• Care or confinement levels other than Inpatient: Residential, Partial Hospitalization, Intensive Outpatient services, Skilled Nursing Facility, and Inpatient Rehabilitation Facility.
• Oral surgery
• 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]
• Prosthetics
• Radiation therapy — outpatient and inpatient
• Reconstructive or plastic surgery procedures, including breast reconstruction surgery following mastectomy
• Specialty Medications administered in an office or outpatient setting
• Surgery - Outpatient hospital, free standing surgical center and ambulatory surgery centers (does not include physician office procedures)
• Temporomandibular joint disorder services and procedures, including but not limited to orthognathic procedures
• Transplant evaluations, services, and procedures

Please refer to the covered services and exclusions sections for more detail. Please feel free to call Member Services 877-514-2442 with any questions about which services require prior authorization or visit:
http://www.commongroundhealthcare.org/members/faq/ (Click “What’s not covered?”)
WHERE TO SUBMIT PRIOR AUTHORIZATION REQUESTS

Authorization requests can be made by telephone or via fax.

Prior authorization toll free number: 877-779-7598

Fax Number: 877-251-0387

The Prior authorization form is available at: [http://www.commongroundhealthcare.org/for-providers/resources/](http://www.commongroundhealthcare.org/for-providers/resources/). (Click “Prior Authorization Form”)

### AUTHORIZATION REQUESTS – TYPES AND TIMELINESS

<table>
<thead>
<tr>
<th>Request Type</th>
<th>Priority</th>
<th>Definition</th>
<th>CGHC time for response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective</td>
<td>Urgent</td>
<td>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.</td>
<td>72 hours</td>
</tr>
<tr>
<td>Non-Urgent</td>
<td></td>
<td>The definition of urgent (above) does not apply</td>
<td>15 calendar days</td>
</tr>
<tr>
<td>Retrospective</td>
<td>NA</td>
<td>Review is requested after the services have been provided, or after the patient is discharged from the hospital</td>
<td>30 calendar days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(allow supervisor override for additional 15 days)</td>
<td></td>
</tr>
<tr>
<td>Concurrent Inpatient - Initial</td>
<td>NA</td>
<td>After admission, but prior to discharge, and no days have been certified</td>
<td>72 hours</td>
</tr>
<tr>
<td>Concurrent Inpatient - Continued Stay</td>
<td>&gt;= 24 hours prior</td>
<td>Request received at least 24 hours prior to expiration of the certification</td>
<td>24 hours</td>
</tr>
<tr>
<td></td>
<td>&lt;24 hours prior</td>
<td>The request is received less than 24 hours prior to expiration of certification</td>
<td>72 hours</td>
</tr>
<tr>
<td>Concurrent Outpatient - Initial</td>
<td>NA</td>
<td>Services have already been started, but no certification has been issued yet</td>
<td>72 hours</td>
</tr>
<tr>
<td>Request Type</td>
<td>Priority</td>
<td>Definition</td>
<td>CGHC time for response</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concurrent Outpatient - Extension of Service</td>
<td>Urgent</td>
<td>a) 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 OR request received prior to expiration of the certification.</td>
<td>24 hours</td>
</tr>
<tr>
<td>Non-Urgent</td>
<td>The definition of urgent (above) does not apply, <strong>AND</strong> the request is received after expiration of certification</td>
<td>15 calendar days</td>
<td></td>
</tr>
<tr>
<td>Peer to Peer / Reconsideration</td>
<td></td>
<td>24 hours</td>
<td></td>
</tr>
<tr>
<td>Internal Appeal</td>
<td>Expedited</td>
<td>Refer to definition of urgent above</td>
<td>72 hours</td>
</tr>
<tr>
<td></td>
<td>Standard</td>
<td>The definition of urgent (above) does not apply</td>
<td>30 calendar days</td>
</tr>
</tbody>
</table>
Common Ground Healthcare Cooperative’s goal is to have members receive high quality care that is the most appropriate care, in the most appropriate setting, by the most appropriate provider, in the most cost effective manner. The Utilization Management Program is designed to facilitate that value equation.

**UTILIZATION MANAGEMENT HOURS OF OPERATION**

Providers may contact CGHC’s Utilization Management team at 877-779-7598; staff are available 24 hours a day, seven days a week.

**UTILIZATION MANAGEMENT PROGRAM PURPOSE**

The purpose of the Utilization Management (UM) Program is to ensure that health care resources are used efficiently and effectively to provide the best value to individuals and organizations purchasing health care and services. Common Ground Healthcare Cooperative’s goal is to have members receive high quality care that is the most appropriate care, in the most appropriate setting, by the most appropriate provider, in the most cost effective manner.

**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 calling 877-779-7598. CGHC shall utilize written UM decision-making criteria that are objective and based on sound medical evidence. Approved criteria include the following:

a. **MCG Health© Guidelines:**
   Evidence-based guidelines span the continuum of care, supporting clinical decisions and care planning transitions between care settings, and facilitating conversations between providers and payers.

b. **Behavioral Health Services: Optum/OptumHealth Behavioral Solutions criteria and MCG Care Guidelines**

c. **State and Federal Regulatory Criteria, including:**
   Centers for Medicare and Medicaid Services (CMS), Food and Drug Administration, National Institutes of Health.

d. **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. **IROs**
   - MCMC LLC
   - Prest & Associates
ACCESS TO UTILIZATION MANAGEMENT

1. Administrative and clinical personnel are available to receive inbound calls relative to routine UM issues at least eight (8) hours per day during normal business hours (8:30 a.m. to 5:00 p.m. Central time, Monday through Friday).

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.

7. CGHC has TDD/TTY lines available for members who require this assistance at 711.
QUALITY IMPROVEMENT

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. As described within this document, clinical care and services include physical and behavioral health care, the delivery system, health plan services and 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.

SPECIFIC ELEMENTS OF THE QUALITY IMPROVEMENT PROGRAM INCLUDE BUT 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

Participating practitioners 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 and chief operating officer (COO), 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.
A. The Medical Management Committee is responsible for the selection, approval, review, and updates to the clinical practice guidelines.

B. All guidelines will be selected based on scientific evidence and sponsored by recognized and appropriate clinical sources. Guidelines will be relevant to the entire population or a portion of the population that is at high risk, problem prone or high cost.

C. CGHC ensures that practitioners are using clinical practice guidelines by:
   1. Adopting guidelines for at least two medical conditions and at least two behavioral conditions
   2. Establishing a clinical basis for each guideline
   3. Two of the clinical practice guidelines are the basis for the Disease Management (DM) programs
   4. Guidelines are reviewed/updated every two years
   5. Guidelines are distributed to the appropriate providers
   6. Clinical Practice Guidelines support acute disease treatment protocols, chronic condition management programs or quality performance measurement.

D. CGHC will review Clinical Practice Guidelines no more than every (2) years and update as needed. Reviews will take place more frequently when new scientific evidence or national standards are published before the (2) year review date.

These guidelines serve as the basis of disease management programs. They are used to assist practitioners/providers in maintaining consistency for provisions of acute, chronic and behavioral health care. They are not developed to replace clinical judgment or to be all-inclusive. Each practitioner is primarily responsible to assess the health status of each patient individually, and develop the best plan of action to meet the patient’s health care needs. Guidelines are to be used by the health care practitioners and members collectively to ensure the best outcome for the members.

Visit: http://www.commongroundhealthcare.org/for-providers/resources/clinical-practice-guidelines/ to access CGHC’s Practice Guidelines and Standards.
DISEASE MANAGEMENT

Common Ground Healthcare Cooperative offers disease management programs for eligible members who have been identified as having the following chronic diseases:

- Asthma
- Coronary Artery Disease
- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Diabetes

For 2018, CGHC will continue to place special emphasis on the guidelines listed below for targeted Disease Management:

1. Eye Care of the Patient with Diabetes Mellitus (American Optometric Assn) (NGC #010328)
2. Diagnosis and Management of Asthma (ICSI) (NGC #009282)
3. Screening for Depression in Adults (USPSTF) (NGC # 010889)
4. Screening and Behavioral Counseling Interventions in Primary Care of Reduce Alcohol Misuse (USPSTF) (NGC: 009843)

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

The Disease Management program utilizes practitioners with current knowledge relevant to the information, reviews program information prior to its release, and at least annually thereafter making sure the programs are based upon current clinical principles, processes, and evidence based medicine.

If you have a CGHC Member who is eligible for a program, please call our Quality Improvement staff at 877-779-7598.

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 MemberCare Program toll free line: 877-779-7598
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: [http://www.commongroundhealthcare.org/members/preventivecare/](http://www.commongroundhealthcare.org/members/preventivecare/)

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.  

**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](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](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf) and/or  

Health Resources and Services Administration (HRSA)  
CONFIDENTIALITY/PERSONAL HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1997 (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/](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;
• Advanced 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.);
• Continuity and Coordination of Care:
  a. Discharge summary from any hospitalizations
  b. Reports from any consultant or specialists 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.

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 details of the drug benefit.

In cooperation with its pharmacy benefit management designate, CGHC provides pharmacy information available to practitioners, clinics and facilities in the Formulary section of our Provider web link (http://www.commongroundhealthcare.org/for-providers/resources/). The Drug Formulary is updated on an annual basis with periodic updates as necessary. The Pharmacy Benefit Management 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 contacting 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 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 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 or 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.

Visit: [http://www.commongroundhealthcare.org/for-providers/resources/](http://www.commongroundhealthcare.org/for-providers/resources/) (Click on “Prescription drugs requiring Prior Authorization.”)


### 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 Customer Care at 855-577-6545 for further assistance.

### OTHER HELPFUL PHARMACY INFORMATION

CGHC representatives are available 24 hours a day, 7 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...

**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:
  o Developed with involvement from appropriate prescribers with current knowledge relevant to the criteria.
  o 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 (1) 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 (6) months.

External Communication:
• Within two (2) business days of receiving FDA notification:
  o 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.
  o 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 (3) to five (5) 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 fifteen (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 day 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 (6) 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.

In order for Members to utilize their benefits (or, for small group PPO members, at the highest level), 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 referral has been submitted and approved by CGHC.

MEMBER GRIEVANCE, PROVIDER APPEALS & TIMELY FILING APPEALS

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; PPO subscribers to pay balance remaining for out of network services: EPO subscribers to 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 and website users. This policy explains what types of information is collected by the CGHC: http://www.commongroundhealthcare.org/members/what-you-need-to-know-about-your-coverage/ (Click on “Notice of Privacy Practices”).

WHAT PERSONALLY IDENTIFIABLE INFORMATION IS COLLECTED

CGHC’s members 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’s personal information to provide the member with personalized service; to send e-mail alerts to the member; to answer their requests; to contact members if requested; etc. and do not share any information about members with third parties. Members 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 the member’s 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 of further disclosure. Providers shall grant access to members to their 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.