COMMON GROUND
HEALTHCARE COOPERATIVE

PROVIDERS of HEALTHCARE
EXCLUSIVE PROVIDER ORGANIZATION (EPO)
FREQUENTLY ASKED QUESTIONS

EPO Products

Q. On January 1, 2018 CGHC is moving all individual plans to Exclusive Provider Organization (EPO) plan designs. What is an EPO and what does this change mean for our CGHC patients who have individual insurance?

A. EPO stands for Exclusive Provider Organization. This change means that CGHC individual members will typically only have coverage for care received from in-network providers. If a member sees an out-of-network provider, the services will not be covered except for emergency care, urgent care outside of our service area or when there is no in-network provider that can perform medically necessary covered services (with a written referral from an in-network doctor approved by CGHC prior to services being received).

Q. Is this change for our CGHC patients who are covered by small employer group plans?

A. No, nothing is changing for our small employer groups. They will still have only PPO plans. If your patient has an identification card with a member number that begins with a capital I or the number 0, they are individual members. If your patient has an identification card with a member number that begins with the letter S or a number 1, they are a small employer member.

Q. In an EPO, do the individual members need to select a primary care physician and get a referral to see in-network specialists?

A. No. Members do not have to select a primary care physician nor do they need a referral to see in-network specialists.

Q. Why did CGHC decide to eliminate the PPO plans for individual policyholders and transition to EPO plans?

A. Out-of-network care is costly to cover because we do not hold an agreement with out-of-network providers. Considering that the majority of our members don't utilize out-of-network care and it was increasing costs for everyone, the member-governed Board of Directors decided to end coverage for out-of-network care except in the circumstances outlined below.

Urgent and Emergency Care

Q. Are members covered for urgent care from an out-of-network provider? (ex: **Urgent care is when a member needs non-emergency medical attention and cannot wait to schedule a doctor's visit**)

A. Members are covered for urgent care from an out-of-network provider only if the urgent care service is provided outside of our 19-county service area. In that case, the urgent care visit will apply to the in-network benefits including deductibles and copayments or coinsurance. However, the member may have to make additional payments if the out-of-network provider bills them for the difference between what they charge and our "maximum allowable fee" (also called the "Maximum Allowed Amount" in our policies) for the service. This is called "balance billing." Follow-up care is not covered if received by an out-of-network provider.

Q. How is CGHC's maximum allowable fee determined?

A. Our maximum allowable fee is determined based upon Medicare Reference Based pricing or other third-party payer rates. Any amounts charged by the out-of-network providers that are in excess of the maximum allowable fee do not apply to the members' deductible, coinsurance or maximum out-of-pocket.

Q. Are members covered for emergency care from an out-of-network provider?

A. Yes, just as they are today. A medically necessary emergency care visit will apply to the in-network benefit including deductibles and copayments or coinsurance subject to the maximum allowable fee (see above). Once the member is no longer in need of emergency care, they need to transition to an in-network provider for follow-up care to be covered.

Q. What if an individual member needs to see an out-of-network doctor when traveling?

A. We have a few options to take care of our members while traveling. In an emergency, they should always go to the nearest emergency room. Costs related to medically necessary emergency care will apply to in-network benefits and will be paid by CGHC at the maximum allowable fee. This means they may have additional out-of-pocket costs (balance bill) for using an out-of-network provider. Please understand that once a member is no longer in need of emergency care, they need to transition to an in-network provider for follow-up care for these services to be considered covered health services.

As an EPO, we will also cover medically necessary urgent care services when members are traveling outside of our 19-county service area. These costs will also apply to the in-network benefits and our payment will be based upon our maximum allowable fee. It's important to understand that out-of-network follow-up care is not covered. After the initial urgent care visit, members must receive all follow-up care by an in-network provider in order to have coverage.

Referrals

Q. What is a referral and when is one required?

A. A referral is a CGHC form that an in-network provider must complete prior to the member receiving out-of-network services. The Referral Form must be submitted by an in-network provider to CGHC for review. The member, the in-network referring provider and the out-of-network provider will receive written confirmation of approval or denial of the requested services. (Note: an out-of-network referral will only be approved in situations where the required medical necessary services cannot be performed by an in-network provider.)
Services received without an approved referral will be denied and the payment will be the responsibility of the CGHC member. A referral is not required for urgent or emergency services.

Q. Where can we find the Referral Form?

A. You may obtain the form on our website at www.CommonGroundHealthcare.org/For-Providers/Resources or you may call Member Services at 877.514.2442 and they will email the form to you.

Q. Can the member or the out-of-network provider complete the Referral Form?

A. No, only an in-network provider can complete and submit the Referral Form. If we receive a Referral Form completed by the member or out-of-network provider, we will return the form and send a letter notifying them of the correct process.

Q. Is there a certain type of in-network provider who can complete the Referral Form?

A. The referral should be completed by an in-network MD or DO. It should typically be a primary care physician but it could also be a specialist (i.e. cardiologist).

Q. Who reviews the Referral Form at CGHC?

A. CGHC's Chief Medical Officer reviews the Referral Form and either approves or denies the referral. You may be asked to provide additional information, including medical records, to support the referral. The Chief Medical Officer may also contact you by telephone to discuss the member's condition and proposed treatment.

Q. How long does it take for CGHC to review a Referral Form?

A. It will take up to 7 business days for a non-urgent referral and up to 72 hours for an urgent request. If the request is urgent and a prior authorization is also required for the service, please note that both the referral review and prior authorization review must be completed within the 72 hours.

Q. Where do we submit the Referral Form?

A. You may submit the Referral Form using one of the following secure methods:

- Email to: CGHCReferrals@CommonGroundHealthCare.org. Please encrypt the email to ensure patient information is protected.
- Fax to: 262.754.9690
- Mail to: CGHC, Attn: Referrals, PO Box 1630, Brookfield, WI 53008-1630

Q. What if the out-of-network service also requires Prior Authorization? How will that work?

A. It is important to note that a referral is separate from a prior authorization. A referral provides approval for the member to utilize an out-of-network provider and the prior authorization process reviews the treatment to ensure it is medically necessary. Optum will continue to perform all prior authorization services.

CGHC will need to receive the written Referral Form from the in-network provider and approve it before Optum will begin the prior authorization process. If the Chief Medical Officer approves the referral, the Referral Form will be submitted to Optum with instructions to begin the prior authorization process.

If an out-of-network provider contacts Optum for a prior authorization, Optum will inform the provider that out-of-network services cannot be authorized until a written referral is submitted to CGHC by the in-network provider and then approved by CGHC (excluding emergency and urgent care).

Q. What happens if a member obtains CGHC referral approval but they don't get a prior authorization?

A. The process will be similar to what happens today. The claim will be denied for failure to prior authorize; however, Optum will perform a retrospective review if the required information is submitted post claim. If Optum finds the procedure was medically necessary, CGHC will reprocess the claim applying the prior authorization penalty (50% of the allowable amount up to $1500) to the claim.

Q. What happens if the referral is denied?

A. CGHC will send a letter to the member and both providers notifying them. If the member still undergoes the service, the claim will be denied.

Q. Are there services that will generally not require a referral?

A. Yes. Here is a list of services that will never require a referral:

- Urgent care outside of CGHC's service area
- Emergency care inside or outside of CGHC's service area

Here is a list of services that may not require a referral, however, we recommend that you still obtain one in order to assist your patient with managing costs since the maximum allowable fee will still apply and it is possible, in many cases, for us to minimize additional costs:

- Maternity care for new members in their 3rd trimester of pregnancy
- Transplants
- Dialysis
- Certain durable medical equipment purchases that cannot be delivered/dispensed by an in-network provider
- For full-time students enrolled in Institutes of Higher Learning seeking behavioral health/substance abuse disorder treatment outside of CGHC's service area but within the State of Wisconsin (see Dependent Children section below)

Dependent Children, including full-time students

Q. If a member has a dependent child on their plan living outside of CGHC's 19-county service area, what coverage will they have?

A. Qualified dependents who are currently living away from home are covered for urgent or emergency care that needs immediate attention. Follow-up care and any covered elective procedure must be obtained from in-network providers. Costs related to medically necessary urgent and emergency care will apply to the in-network benefits and will be paid by CGHC at our maximum allowable fee.

Q. What about coverage for full-time student dependents?

A. There is a Wisconsin Law that requires dependent full-time student members that attend an Institute of Higher Learning within the state of Wisconsin, but outside of the CGHC 19-county service area, to have coverage for one clinical assessment by an out-of-network behavioral health/substance abuse provider and a total of five counseling visits for outpatient behavioral health, substance use treatment or any combination of the two. These students will also have the same access to emergency and urgent care as described above.

Q. Does the full-time dependent student have to obtain a written referral for the behavioral health/substance abuse outside of the network care?

A. No, Wisconsin law does not allow us to require a referral and CGHC does not perform prior authorization for outpatient behavioral health/substance abuse. We recommend you contact us under these circumstances since we may be able to minimize costs to your patient.