Cooperative Advantage (HMO D-SNP) offered by Group Health Cooperative of Eau Claire (the Cooperative)

Provider Manual

2026

Administered by:
Group Health Cooperative of Eau Claire
PO Box 3217 | Eau Claire, WI 54702-3217
800.461.4641
group-health.com

CAGHC25095

(Rev. 12/22/2025)

Purpose Statement:

"Optimize the health of our members through the Cooperative's pooling of health-related resources."

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DEPARTMENT CONTACTS

Call our Provider Services Department for: • Member Benefits, Coverage, or Eligibility • Member Concerns • Claims Status • Billing & Payment Procedures • Medicare Enrollment, Membership, Eligibility • Electronic Billing • Provider Portal Assistance • Quality Improvement Information (HEDIS; Quality Reviews) • Utilization Management (Prior Auth, etc.)	PROVIDER SERVICES DEPARTMENT (715) 552-4333 or (866) 563-3020 Fax Number: (715) 836-7683
Call our Provider Relations Department for: • Information on joining our network • Contractual Arrangements such as fee schedule or reimbursement • Changes to your Tax ID, address, additional locations	PROVIDER RELATIONS DEPARTMENT (715) 852-5706 Fax Number: (715) 598-7534
Call our Credentialing Department for: • Clinician information updates • Delegated credentialing updates	CREDENTIALING DEPARTMENT (715) 852-2093 Fax Number: (715) 598-7534

SECTION 1 – ONLINE PROVIDER PORTAL

The Cooperative has an online provider portal. The provider portal allows you to view authorization status, claims status, claims submission, member eligibility, and secure messaging. The provider portal can be accessed at ghcprovider.healthtrioconnect.com.

When signing into the provider portal for the first time, all providers will be guided through a simple account creation process. To begin the registration process, simply have your Tax ID and check the number from a recent payment on hand.

SECTION 2 - RIGHTS & RESPONSIBILITIES

The Member Rights & Responsibilities are located on our website:

Member Rights & Responsibilities

Provider Responsibilities

The Cooperative expects contracted providers to:

- Understand that the Cooperative does not deny patient care but makes payment decisions based on the member's coverage;
- Act in the best interest of members;
- Address a diverse patient population in a culturally competent manner;
- Communicate thoroughly with members regarding their illness, as well as diagnostic treatment options, medication treatments, and therapeutic options available to them regardless of benefit coverage;
- Allow members to participate in their health care decisions;
- Comply with all state and federal regulations with respect to our member's rights;
- Effectively address and overcome any barriers concerning a member's compliance with prescribed treatments and regimes;
- Provide continuity of care for members by ensuring that there is an appropriate confidential exchange of medical information between all providers involved;
- Refer members for specialty care or second opinions within the Cooperative's in-network providers, and obtain written approval from Utilization Management when care is necessary outside of the Cooperative's network;
- Assist Cooperative Advantage members in obtaining Prior Authorization, as necessary, to facilitate claim payment;
- Participate in the Cooperative's utilization management and quality improvement initiatives, including allowing the Cooperative's members reasonable access to medical records at no cost;
- Recognize that there are multiple, well-accepted means of diagnosis and treatment for many given conditions;
- Inform the Medical Director when the Cooperative's procedures or actions are perceived as threatening the health or well-being of the member;
- Communicate with members and the Cooperative in a way that assumes that all parties are acting in good faith with the goal being good care for the member;
- Recognize that the Cooperative is obligated to develop policies and procedures on benefit administration and to administer these fairly and consistently, even though this occasionally results in denial of payment for individual members;
- Understand that the Cooperative's goal is to improve access and quality of health care;
- Complete a successful credentialing program before contact with Cooperative Advantage members;
- Request the member's ID card before services are provided and verify that all

demographic and insurance information is correct to ensure correct registration, billing, and reporting processes;

- Ensure that interpreter services are available for members with hearing impairments or who speak a different language than the provider;
- Provide accessibility for individuals with disabilities as defined by the Americans with Disabilities Act (ADA), the Civil Rights Act, and any state or federal requirements to meet special and cultural needs;
- Contact the Provider Services Department anytime verification of eligibility or verification of Primary Care Physician designation is necessary;
- Contact the Provider Services Department anytime the practitioner or designee becomes aware of incorrect member information;
- Respond to, and within the requested timeframe, various attestation and education requirements that the Cooperative may request as part of regulatory or policy updates.

The Cooperative's Responsibilities

Providers can expect the Cooperative to:

- Assist the provider in meeting the expectations of the Cooperative participation;
- Pay claims fairly and efficiently;
- Provide a due process to the provider when complaints or grievances are lodged against them;
- Support the provider in practice by identifying opportunities to improve care when information is available on a practice basis or an individual member basis;
- Maintain an appeals process that can respond quickly and appropriately to members and providers;
- Educate and encourage members to be seen for appropriate preventive services;
- Inform providers of quality or other initiatives that may affect them or the members; and
- Work in all our operational areas to improve service to providers and members.

Sales Restrictions

The Cooperative has assembled a sales team who are specifically trained and licensed for sales activities within the Cooperative. The Cooperative does not allow providers to act in a manner where they might be viewed as sales agents. Reasons why providers should not act as sales agents are listed below:

1. The Cooperative retains all authority for marketing and sales.
2. All materials shared with a member, including newspaper or other articles that reference the Cooperative, require prior approval by CMS.
3. Providers may not be the best source of membership information for their patients.
4. CMS strictly regulates sales activities for the Cooperative. Discussion of certain

topics, including presenting or discussing premiums or benefits, may require state licensure as an insurance agent.

5. Providers can distribute materials for several plans.

SECTION 3 – CLAIMS INFORMATION

Electronic Claim Submission

To expedite payment to providers, the Cooperative encourages electronic billing whenever possible. Our payer ID is 95192.

Electronic claims can be submitted through an 837 submission, utilizing our quick Claims portal, or utilizing one of our electronic data partners:

ElectronicClaimsSub837
QuickClaimUserManual
Electronic-Data-Partner

Electronic Claim Submission - QuickClaim

The Cooperative has made an online claim submission software program available to contracted providers. QuickClaim is a claims submission program powered by Smart Data Solutions (SDS). If you have questions regarding the functionality of the QuickClaim system, please contact SDS at 855-297-4436 between 8 a.m.-5 p.m., Monday through Friday. If you have any questions regarding logging into the QuickClaim system, please call our Provider Services team at (715) 552-4333 or (866) 563-3020 between 8 a.m.-6 p.m., Monday through Friday. This program combines direct online data entry and automation, allowing providers to submit HIPAA compliant claims directly to the Cooperative at no cost to the provider. This solution eliminates paper claims, reduces costs, and shortens claims processing turnaround time.

QuickClaim can be accessed at group-health.com/QuickClaim.

Paper Claim Submission

To expedite payment to you, the Cooperative encourages electronic billing whenever possible. However, claims being submitted via mail or via fax can be mailed or faxed as follows:

Submit all claims via mail or fax to:

Group Health Cooperative of Eau Claire
PO Box 3217
Eau Claire, WI 54702-3217
Fax: (715) 598-7525

Questions regarding the processing of your claims may be directed to the Provider Services department at the Cooperative. You can reach Provider Services directly at (715) 552-4333 or (866) 563-3020. Staff is available Monday-Friday, 8 a.m. to 6 p.m., to answer questions regarding how your claims are processed.

We do not issue Providers a special identification number for billing purposes. However, each member has a unique member identification number.

Claims submitted after one year from the date of services will be denied unless otherwise stated in the Provider Services Agreement.

Electronic Payment and Remittances

Group Health Cooperative of Eau Claire has partnered with ECHO Health, Inc. to provide electronic payment and remittance advice methods. Providers who enroll for EFT payments will continue to receive the associated ERAs from ECHO with the Payer ID. Our payer ID is 95192. Many of our providers already work with ECHO Health, Inc. today. All generated ERAs will be accessible to download from the ECHO provider portal at www.providerpayments.com. Changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Health Enrollment team at 440-835-3511.

ECHO Health Provider Enrollment Guide
ECHO Health FAQ

If you have not already, please make sure that your Practice Management System is updated to accept Payer ID: 95192.

Example Of Provider Remittance Advice

Group Health Cooperative of Eau Claire
P.O. Box 3217
Eau Claire, WI 54702-3217

<<PROVIDER NAME>>
<<ADDRESS 1>>
<<ADDRESS 2>>
<<ADDRESS 3>>

Your name,<<**PROVIDER NAME**>>, and Tax ID have been verified by the IRS.

For questions on claims, please call 866-563-3020, or fax 715-836-7683, or send a message through the secure provider portal located on our website: https://group-health.com/providers

Tax ID: XXXX *EPC Draft #:* XX *Payment Week:* XX *Payment Date:* XX/XX/XXXX Page 1 of 2

Service Date	Proc/Rev Code (Modifiers)	Units	Explanation Code(s)	Total Charge	Allowed Amount	Contractual Adjustment	Other Coverage	Other Adjustment	Patient Obligation				Net Payment Amount
									Co-Ins	Co-Pay	Deductible	Non-Cov	
Claim Number: XXXXXXXXXXXXX **Provider:** <<PROVIDER NAME>>					**Group ID:** XXXXXX **Patient Name:** XXXXXX **Patient Acct #:** XXXXXX				**Payment Reference Number:** XXXX **Subscriber Name:** XXXX **Patient ID:** XXXXXXX				
XXXXXXX	XXXXXXX	1	96, N448	$100.00	$0.00	$0.00	$0.00	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00
XXXXXXX	XXXXXXX	1	96, N448	$100.00	$0.00	$0.00	$0.00	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Claim Total:			$200.00	$0.00	$0.00	$0.00	$200.00	$0.00	$0.00	$0.00	$0.00	$0.00

Statement Summary	Total Charge	Allowed Amount	Contractual Adjustment	Other Coverage	Other Adjustment	Patient Obligation				Net Payment Amount
Administered By						Co -Ins	Co -Pay	Deductible	Non-Cov	
Group Health Cooperative of Eau Claire	$200.00	$0.00	$0.00	$0.00	$200.00	$0.00	$0.00	$0.00	$0.00	$0.00

Explanation Code(s)

Code	Description
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.

Code values and definitions included here come from https://x12.org/codes

Switch to EFT today and enjoy many benefits including ease of use and reliable, timely receipt of payments! Enroll today at:
https://enrollments.echohealthinc.com/efteradirect/enroll

RIGHT TO REVIEW AND APPEAL: If you have questions or if you are dissatisfied with the payment/denial reflected on this Explanation of Benefits, you may request an informal review of payment within 60 days from the initial payment/denial determination notice. To do this, please contact Provider Services at (866) 563-3020.

If your concern is not settled to your satisfaction, you may also appeal in writing within 60 days from the initial payment/denial determination notice. The appeal must contain the member's name, member identification number (Badger Care Plus ID, Medicaid SSI ID number, Medicare Advantage, or other as applicable), the provider's name, date of service, date of billing, date of rejection, and reason for reconsideration.

If your appeal is medical in nature (i.e. emergency, medical necessity and/or prior authorization related) you must submit medical records with your appeal. All appeals should be mailed to:

Group Health Cooperative of Eau Claire
ATTENTION: PROVIDER APPEALS
P.O. Box 3217
Eau Claire, WI 54702-3217

All appeals will be resolved, and resolution sent in writing, within 45 days of receipt by Group Health Cooperative of Eau Claire.

BADGER CARE PLUS AND MEDICAID SSI ONLY: All Badger Care Plus and Medicaid SSI providers must appeal first to the HMO.

If the health plan fails to respond to your appeal within 45 days or if you are not satisfied with the response to your appeal, you may appeal to the Department of Health Services in writing within 60 days of the final decision or in the case of no response, within 60 days from the 45 day timeline allotted to the HMO to respond.

Providers must appeal the decision to the Department of Health Services through the Provider Appeals portal at https://wi-appeals.entellitrak.com/. Providers are required to submit appeals with legible copies of all supporting documentation as outlined in the Appeals to BadgerCare Plus HMOs and Medicaid SSI HMOs (#384) and Appeals to ForwardHealth (#385) topics of the ForwardHealth Online Handbook. The decision to overturn an HMO's/PIHP's denial must be clearly supported by the documentation the provider submits. Submitting incomplete or insufficient documentation may lead to ForwardHealth upholding the HMO's/PIHP's denial.

MEDICARE ADVANTAGE ONLY: If you are a non-contracted provider appealing a post-service claim denial for a Medicare Advantage plan, complete the Waiver of Liability form as required by section 50.1.1 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. This can be found at Cooperative-Advantage.com.

Corrected Claims

Corrected claims can be submitted on the appropriate claim form with "*correction/resubmission*" identified in box 4 on the UB-04. The fourth digit of the type of bill code should be used to indicate a corrected claim. For CMS-1500 claims only, Box 19 should be used.

Claims that are corrected and/or resubmitted to the Cooperative must be submitted within 180 days of the original claim payment/denial date unless otherwise stated in the Provider Services Agreement. A "resubmission of a claim" or "reconsideration of a claim" is not considered a formal appeal.

To expedite payment to you, the Cooperative encourages electronic billing whenever possible. Our Payer ID is 95192. However, claims being submitted via mail or via fax can be mailed or faxed as follows:

Mail or fax paper claims to:
Group Health Cooperative of Eau Claire
P.O. Box 3217
Eau Claire, WI 54702-3217
Fax: (715) 598-7525

Claim Appeal Process

If you have questions about a claim or if you are dissatisfied with the payment or denial reason reflected on your Provider Remittance Advice, you may request an informal review of payment within 60 days from the initial payment/denial determination notice. To do this, please contact the Cooperative's Provider Services Department.

If your concern is not settled to your satisfaction, you may also appeal in writing within 60 days from the initial payment/denial determination notice, or as outlined in the Provider Services Agreement. A Provider Appeal form can be found online at ghc-ec.com/ProviderAppealForm. The appeal must contain the member's name, member identification number, the provider's name, date of service, date of billing, date of rejection, and reason for reconsideration. If your appeal is medical in nature (i.e. emergency, medical necessity and/or prior authorization related), you must submit medical records with your appeal.

Your appeal can be faxed to the attention of Provider Appeals at 715-598-7538 or sent via regular mail to:

Email: appeals@group-health.com, or
Attention: Provider Appeals
Group Health Cooperative of Eau Claire
PO Box 3217
Eau Claire, WI 54702-3217

All appeals will be reviewed by the Cooperative and a decision provided in writing within 45 days of receipt. The Cooperative's response to the provider on the appeal is final.

Non-Contracted Providers

In addition to the appeal process outlined above, non-contracted provider claim appeals must be submitted with a completed waiver of liability form (WOL), within 60 days of receipt of remittance.

If the Cooperative renders a partial or fully adverse decision, and the non-contracted provider disputes payment, the provider may request an appeal in writing for an Independent Review

Entity (IRE) review within 180 calendar days of the remittance advice. The IRE will review the appeal within 60 calendar days to make sure the correct decision was made. You will receive correspondence by mail regarding their decision.

If the IRE renders a favorable decision for you, the Cooperative must comply with the IRE's decision. A new Remittance Advice will be sent to reflect the IRE's decision.

Adverse Events

Providers must comply with all CMS guidance regarding coding, claims submission, and reimbursement rules. Medicare participating providers must report Serious Adverse Events by populating Present on Admission (POA) indicators on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims, where applicable. In the instance that the "Never Event" has not been reported, the Cooperative will attempt to determine if any charges filed meet the criteria, as outlined by the National Quality Forum (NCF) and adopted by CMS as a Serious Reportable Adverse Event. If a provider fails to comply with these requirements, the claim(s) will be denied as provider responsibility, and the member cannot be billed for the charges.

The Cooperative will not cover a surgical procedure or other invasive procedure when the practitioner mistakenly performs: 1) the wrong procedure, 2) the correct procedure but on the wrong body part, or 3) the correct procedure, but on the wrong patient.

In addition, the Cooperative will not cover hospitalizations and other services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and, therefore, not covered. All providers in the operating room when the Adverse Event occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. However, related services do not include the performance of the correct procedure. Services must be billed appropriately when the following preventable Adverse Events occur, including but not limited to wrong procedure; the correct procedure but on the wrong body part; correct procedure but on the wrong patient; and hospital acquired condition.

- Adverse Event outpatient claims: must be billed with the surgical procedure code and modifier that indicates the type of Adverse Event: modifier PA (wrong body part), PB (wrong patient) or PC (wrong surgery) AND/OR diagnosis code Y65.51 (wrong surgery), Y65.52 (wrong patient) or Y65.53 (wrong body part) must be present as one of the diagnoses codes on the claim.
- Adverse Event inpatient claims: must be billed with a type of bill 110.

If there are covered services or procedures provided during the same stay as the Adverse Event service, then the facility must submit two claims; one claim with covered services unrelated to the Adverse Event and the other claim for all services related to the Adverse Event. Cooperative Advantage members shall not be responsible for payment and must not be billed for any service related to an Adverse Event.

The Cooperative is obligated to disclose to CMS and other regulatory agencies, quality, and performance indicators for benefits under the Cooperative regarding disenrollment, member satisfaction, and health outcomes. Providers may be asked to assist the Cooperative's staff in meeting these requirements.

In addition to sanctions and complaints, the Cooperative will perform semi-annual reviews on Adverse Events found through claims data as required by NCQA.

CMS-1500 FORM INFORMATION

The Cooperative's claims processing system is designed to process standard health insurance claim forms (CMS-1500) using CPT Procedure Codes or Healthcare Common Procedure Coding System (HCPCS) with appropriate modifiers and ICD-10 Diagnosis Codes.

Required information must be filled in completely, accurately, and legibly. If the information is inaccurate or incomplete, your claim cannot be processed and will not be considered a "clean claim". A clean claim has all the necessary data elements, on industry standard paper forms or in an electronic format, with no defect or impropriety. A submission which does not include all the necessary information, or for which the Cooperative must request additional information (for example, medical records, other coverage information, or subrogation information) is not a clean claim until the Cooperative receives the needed information.

Please utilize the appropriate claim form and follow standard Centers for Medicare and Medicaid Services (CMS) submission guidelines for your industry and/or provider type.

BILLING AND REIMBURSEMENT OF PROFESSIONAL SURGICAL SERVICES

Surgical services must be covered under Original Medicare and follow Medicare billing guidelines in order to be considered for reimbursement under the DSNP plan. Services not covered by Medicare but covered by Medicaid may be reimbursable under the Medicaid plan and must follow Medicaid billing requirements. Reimbursement will never be in excess of the maximum daily reimbursement rate.

All surgical procedure codes must be submitted on a CMS-1500 claim form with appropriate modifiers when applicable.

The procedure may also require prior authorization by the Cooperative. Please see the Prior Authorization guidelines on the Cooperative's website at group-health.com/providers/prior-auth-guidelines.

All surgical services are subject to the Cooperative code review and may require submission and review of medical records for payment to occur. If medical records are not submitted with the claim and they are needed for a code review, the claim will be denied. Please review your contractual requirements for resubmission of claims to ensure resubmitted claims are filed timely.

The Cooperative follows Medicare regulations, Current Procedural Terminology (CPT) standards, and the professional association guidelines for covered procedures and services.

Surgical Procedures
Surgical procedures performed by the same physician, for the same member, on the same date of service (DOS) must be submitted on the same claim form. Surgeries that are billed on separate claim forms will be denied.

Co-Surgeons
The Cooperative reimburses each surgeon according to Original Medicare guidelines. If a service is not covered under Medicare, it may be covered under Medicaid. In such cases, Medicaid billing guidelines must be followed. Attach supporting clinical documentation (such as an operative report) clearly marked "co-surgeon" to demonstrate medical necessity. Use modifier "62" on each surgeon's procedures.

Surgical Assistants
The Cooperative reimburses services performed by surgical assistants according to Original Medicare guidelines. If a service is not covered under Medicare, it may be covered under Medicaid. In such cases, Medicaid billing guidelines must be followed. To receive reimbursement for surgical assistants under Medicaid, indicate the surgery procedure code with modifier "80" (assistant surgeon) on the claim. The Cooperative reimburses surgical assistants only for those surgeries that are listed in the physician services fee schedule with modifier "80."

Bilateral Surgeries
Bilateral surgical procedures are reimbursed according to Original Medicare guidelines. If a service is not covered under Medicare, it may be covered under Medicaid. In such cases, Medicaid billing guidelines must be followed.

Multiple Surgeries
Multiple surgical procedures performed by the same physician for the same member during the same surgical session are reimbursed according to Original Medicare guidelines. If a service is not covered under Medicare, it may be covered under Medicaid. In such cases, Medicaid billing guidelines must be followed.

If multiple procedures are performed during the same operative session by the same physician, the procedure ranked highest on the Medicare Physician Fee Schedule will be reimbursed as the primary procedure. The Cooperative permits full payments for surgeries that are performed on the same DOS but at different surgical sessions.

To obtain full reimbursement, submit a claim for all the surgeries performed on the same DOS that are being billed for the member. Then submit additional supporting documentation and modifiers if applicable clarifying that the surgeries were performed in separate surgical sessions.

Robotic Assist
Surgical techniques that involve a robotic surgical system are not a separately reimbursed service and the robotic assisted technique will be considered included as part of the primary surgical procedure.

Computer-assisted navigation using fluoroscopic images or CT/MRI images for surgical procedures is not separately reimbursable.

Three-Dimensional (3D) Rendering of Imaging Studies
The Cooperative considers 3D rendering of imaging studies included in the reimbursement for the imaging study performed. 3D rendering can be applied to Computed Tomography (CT), Magnetic Resonance Imaging (MRI), ultrasound or other tomographic modality. 3D rendering is considered a normal technological advancement and is not separately reimbursable. Add-on CPT Codes 76376 and 76377 are not eligible for separate or additional reimbursement even if billed as a separate and distinct service (modifier 59).

Disposable surgical instruments are not separately reimbursable.

Synthetic conduits and nerve allografts are considered investigational for the repair or closure of nerve gaps. In addition, nerve wraps and conduits would not be separately reimbursable.

Preoperative and Postoperative Care
Reimbursement for certain surgical procedures includes the preoperative and postoperative care days associated with that procedure. Preoperative and postoperative surgical care includes the preoperative evaluation or consultation, postsurgical E&M services (i.e., hospital visits, office visits), suture, and cast removal.

All primary surgeons, surgical assistants, and co-surgeons are subject to the same preoperative and postoperative care limitations for each procedure. For surgical services in which a preoperative period applies, the preoperative period is typically three days. Claims for services which fall within the range of established pre-care and post-care days for the procedure(s) being performed are denied unless they indicate a circumstance or diagnosis code unrelated to the surgical procedure.

UB-04 INFORMATION

UB-04 claim completion is required for inpatient and outpatient services billed by hospitals, skilled nursing facilities, home health agencies and other institutional providers. The data elements are listed as fields on the claim form.

Required information must be filled in completely, accurately, and legibly. If the information is inaccurate or incomplete, your claim cannot be processed and will not be considered a "clean claim". A clean claim has all the necessary data elements, such as timely filing on industry standard paper forms, UB-04 or by electronic format, with no defect or impropriety.

A submission which does not include all the necessary information, or for which the Cooperative must request additional information (for example, medical records, other coverage information, or subrogation information) is not a clean claim until the Cooperative receives the needed information.

Please utilize the appropriate claim form and follow standard Centers for Medicare and Medicaid Services (CMS) submission guidelines for your industry and/or provider type.

Balance Billing / Copayment Information

Providers may not bill, charge, collect a deposit from, seek remuneration from, or have any recourse against a Cooperative Advantage member for covered benefits.

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions, termination of Medicare certification, and/or be fined, imprisoned or both.

A member may request a non-covered service, a covered service for which authorization was denied or a service that is not covered under the member's plan. The charge for these services may be collected from the member if the following conditions are met prior to the delivery of that service:

- The member accepts responsibility for payment in writing.
- The provider and member make payment arrangements for the service.

SECTION 4 – COORDINATION OF BENEFITS

Coordination of Benefit Rules for Medicare: Who Pays First?

- If the member is age 65 or older and has coverage under an employer group health plan with 20 or more employees, either through their current employment or the employment of a spouse, that coverage pays before the Cooperative
- If the member is age 65 or older and has coverage under an employer group health plan with less than 20 employees either through their own current employment or the employment of a spouse, such coverage pays after the Cooperative.
- If the member is under age 65 and entitled to Cooperative Advantage (HMO D-SNP) plan due to a disability (other than end-stage renal disease) and has group health coverage under an employer with two to 99 employees, either through their own employment or the employment of a family member, the Cooperative would be the primary payer. The employee group health coverage will be primary if the employer has 100 or more employees.
- If automobile medical or no-fault liability insurance is available to the member, then benefits under that plan would be primary.

- If the member is eligible for a Cooperative Advantage (HMO D-SNP) plan solely based on end-stage renal disease and is covered under an employer group health plan, the Cooperative pays secondary for the first 30 months, with the employer plan paying primary.
- The Cooperative may exercise the same rights to recover from a primary plan, entity, or individual that the U.S. Secretary of Department of Health and Human Services exercises under the Medicare Secondary Payer regulations as they apply to Medicare Advantage plans.
- If the primary payment is related to a subrogation issue, please reference the section titled *Subrogation and Recoupment*. If the Cooperative discovers primary insurance after charges have been processed, the Cooperative will reverse its original payment. The adjustment will be reflected on the Provider's Remittance Advice (RA).
- If the primary insurance denies a claim because of lack of information, the Cooperative will also deny it. In the event the denial was due to the member's lack of compliance in responding to the primary insurance request for additional information, the Cooperative will reconsider the denial based on the following process: the provider must make, and document, three attempts (verbal or written) to the member indicating they must become compliant in providing the missing information for the primary insurance to process. Each attempt must be at least one week apart. The provider must submit documentation of these outreach efforts with the claim, documenting in box 19 of the CMS-1500 "non-compliant". In the case where the claim is submitted on a UB, notation of "non-compliant" can be documented anywhere on the claim form.

For any questions regarding Coordination of Benefits, call the Provider Services Department.

Coordination of Benefit Rules for Medicaid:

- Medicaid is always the payer of last resort.

Subrogation and Recoupment

The Cooperative maintains subrogation recovery rights when claims have been paid for which a third party is liable, e.g., accidents on private property, motor vehicle accidents, worker's compensation and nonwork-related injuries. The Cooperative will request information from members to determine if third-party liability exists. Providers are required to confirm if primary coverage exists before submission of claims to the Cooperative.

- Providers are required to identify primary payers and bill them for accident or worker's compensation claims prior to billing the Cooperative.
- If the primary carrier pays in part or denies an accident, personal injury or worker's compensation claim for any reason, providers will be required to submit a copy of the primary carrier's original documentation to the Cooperative with the claim submission(s).

- Under 42 CFR §489.20, providers must identify all known primary payers when submitting claims to the Cooperative.
- If the determination of medical payment, no-fault or worker's compensation coverage is unresolved, the Cooperative may make conditional payment on claims.
- If conditional payments are made and a provider later receives payment from a carrier primary to the Cooperative, reimbursement of the Cooperative's payment should be made within 60 days.
- If a member is involved in an auto, personal injury or worker's compensation related incident, the Cooperative will deny claims for coordination of benefits until the primary coverage is exhausted or denied. For medical payment and no-fault coverage, the Cooperative will require an itemized listing of payments made from the primary carrier to consider claims. If medical payment or no-fault coverage has been issued to a member directly and the payment from the primary carrier is itemized and/or attributable to specific claims, the Cooperative will deny payment of those claims. Providers may be expected to seek recovery directly from the Medicare member, for an amount no greater than that paid by the carrier.
- The Cooperative will follow all guidelines and requirements set forth in federal and state law and outlines by CMS in the Medicare Secondary Payer Manual.
- The Cooperative does not withhold payment pending third-party liability payment.

SECTION 5-NON-COVERED SERVICE NOTIFICATION

The Cooperative is obligated to follow Medicare policies. If the service is not covered by Medicare Fee-For-Service, it will not be covered by the Cooperative. If the Cooperative covers a service that Fee-For-Service does not, it will be specifically listed in the member's Evidence of Coverage (EOC), which is available on the Member page at group-health.com/medicare-advantage-dsnp/members All providers (medical staff and suppliers) must obtain prior authorization for services. Claims submitted without the appropriate modifiers attached will be denied as provider responsibility, regardless if the provider obtained the notice or documented in the medical record.

As a contracted provider with the Cooperative, you are required to complete the Notice of Denial of Medical Coverage (NDMC) prior to providing a non-covered service to a member. CMS requirements indicate that the member or the beneficiary must be held harmless for plan-directed care. If you provide a non-covered service or referral to our member, you must discuss this with the member prior to the service being rendered and document the discussion in the patient's medical record for you to be able to bill the member.

CMS does not allow Medicare Advantage contracted providers to use the CMS Advance Beneficiary Notice of Noncoverage (ABN) forms for non-covered services.
You should not submit a claim to the Cooperative for services that are always non-

covered (unless the beneficiary requests a claim to be filed). If a service is typically non-covered but could be covered under certain conditions, then a claim is required to be filed with the appropriate modifier indicating that you have provided the member the NDMC and have a copy on file. Claims submitted without the appropriate modifiers attached will be denied as provider responsibility, regardless of if you obtained the notice or documented in the medical record.

Consequently, when a contracted provider furnishes a service or refers a member for a service that a member reasonably believes is a plan-covered service, the member cannot be financially liable for more than the applicable cost-sharing for that service. If a contracted provider believes an item or service may not be covered for a member, or could be covered only under specific conditions, the appropriate process is for the member or provider to request a pre-service organization determination from the plan.

If a contracted provider refers a member to a non-contracted provider for a service that is covered by the plan upon referral, the member is financially liable only for the applicable cost-sharing for that service. Contracted providers are expected to coordinate care or work with plans prior to referring a member to a non-contracted provider to ensure, to the extent possible, that members are receiving medically necessary services covered by their plan. Furthermore, plans are expected to work with their contracted providers to ensure that clear processes are in place and providers are educated about those processes, including appropriate documentation, to substantiate that a referral has been made.

A member or a provider acting on behalf of the member, always has the right to request a pre-service organization determination if there is a question as to whether an item or service will be covered by the plan. If the plan denies a member's (or his/her treating provider's) request for coverage as part of the organization determination process, the plan must provide the member (and provider, as appropriate) with the standardized denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS-10003). For the requirements related to organization determinations and issuance of the standardized denial notice (CMS-10003) and guidance on completing the form, refer to NDMCP Notice of Denial of Medical Coverage or Pay (cms.gov). As a contracted provider, you are required to use a Notice that CMS has approved for the Cooperative.

If a service is never covered by the plan and the plan's EOC provided to the member is clear that the service or item is never covered, the plan is not required to hold the member harmless from the full cost of the service or item.

For a service or item that is typically not covered but could be covered under specific conditions (e.g., dental care that is necessary to treat an illness or injury), the EOC, in and of itself, is not adequate notice of non-coverage for purposes of determining member liability. In such instances, the appropriate process is for the member or the provider acting on behalf of

the member to request a pre-service organization determination. If the plan denies the service, the plan must issue the standardized denial notice with appeal rights. The member has the right to appeal any denial of a service or item. Plans also must educate their contracted providers about the limits of plan coverage and the need to correctly advise members when providing referrals for covered services. This will prevent confusion related to plan coverage and member financial liability as well as ensure coordination of the care furnished.

When the provider or the plan acting on behalf of the provider, can show that a member was notified (via a clear exclusion in the EOC or the standardized denial notice) prior to receipt of the item or service that the item or service is not covered by the plan; or that coverage is available only if the member is referred for the service by a contracted provider, but the member nonetheless receives that item or service in the absence of a referral, the regulation at §422.105(a) does not require the MA plan to hold the member harmless from the full cost of the service or item charged by the provider.

Do not use the Medicare Advanced Beneficiary Notices (ABNs), or ABN-like notices
No ABNs and ABN-like notices shall be utilized with the Cooperative Advantage (HMO D-SNP) members. An ABN or ABN-like notice is not a valid notice for Cooperative Advantage members. ABNs can only be utilized with Fee-For-Service Medicare beneficiaries. Use of these forms means your claim may be denied for provider liability. You are required to use the NDMC form.

How do providers bill to show appropriate notice of non-coverage was provided?
When billing for non-covered services, providers can demonstrate that they issued an appropriate Notice of Medical Coverage, Form CMS 10003-NDMCP by utilizing one of the following modifiers:

- GY modifier: In the event you file a claim for items or services that are "clearly" always excluded, use the GY modifier to show that the service or item was "clearly" excluded under the member's Cooperative Advantage EOC. If the member appeals any claim associated with a GY modifier and either there is no exclusion in the member's EOC or the exclusion is "not clear," the claim will be reversed and denied as provider liability. You can also utilize the GY modifier if the member refuses to wait to receive an organization determination in favor of having the service completed immediately. You are required to place documentation in the medical record that the member refused to obtain an organization determination and elected to obtain the service or item immediately.
- GA modifier: For items or services that are not always "clearly" excluded from coverage, use the GA modifier to show that appropriate notice of non-coverage (CMS-10003-NDMCP) was provided to the member. If the member appeals a claim associated with a GA modifier and there is no proof that the provider issued the appropriate notice of non-coverage, the claim will be reversed to provider liability, and you will not be able to bill the member for any portion of the denied claim.

Practitioner/Provider Verification of Member Eligibility

- The practitioner or provider shall request the member's ID card before services are provided and verify that all demographic and insurance information is correct to ensure correct registration and reduce the possibility of confusion in the billing and reporting processes.
- The practitioner, provider, or designee shall contact the Cooperative's Provider Services Department any time verification of eligibility or verification of Primary Care Physician designation is necessary.
- The Practitioner's office shall contact the Cooperative's Provider Services Department any time the practitioner, provider, or designee becomes aware of incorrect member information.

Prohibition of Interference

The Cooperative advocates and upholds the patient/practitioner relationship and does not prohibit or otherwise restrict a health care professional, acting within their lawful scope of practice, from providing advice to an individual who is a patient and enrolled in the Cooperative Advantage plan. Specifically, the Cooperative will not interfere with the communications between the provider and patient regarding:

- The patient's health status, medical care, or treatment options (including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options, including no treatment as an option or any alternative treatment that may be self-administered);
- The risks, benefits, and consequences of treatment or non-treatment; or,
- The opportunity for an individual to refuse treatment and to express preferences about future treatment decisions.

The Cooperative shall not penalize a provider because the provider, in good faith, reports to the state or federal authorities any act or practice by the Cooperative that, in the opinion of the provider, jeopardizes patient health or welfare.

SECTION 6 – CREDENTIALING

The Cooperative is proud of the professionals and facilities that make up the in-network contingent of healthcare providers. Providers and facilities must meet rigorous credentialing standards to be included in the provider network. The Cooperative is a member of the Council for Affordable Quality Healthcare (CAQH). CAQH is an online single entry national database that eliminates the need for providers to complete and submit multiple credentialing applications.

The Cooperative's providers and facilities are reviewed against the standards set by the National Committee for Quality Assurance (NCQA), including a current valid license, clinical

privileges, valid DEA certification, educational background, board certification, work history, malpractice history, malpractice insurance, and accreditation status. Site visits may be required for clinics and other service providers. The purpose of the site visit is to ensure that the facility meets basic quality expectations and that clinical processes are in place to provide our members with quality care. This process allows the contracted provider and the Cooperative to develop a relationship to best meet our members' needs. The Cooperative seeks to be a collaborative partner in the provision of health services. Questions or requests for information should be directed to the Credentialing Department.

The Cooperative also welcomes providers to consider an agreement for delegated credentialing. Please contact the Provider Relations Department for information and consideration.

Credentialing Guidelines:

- The Cooperative does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient's insurance coverage in which the practitioner specializes.

- The Cooperative will not pay claims to a provider who is not fully credentialed at the time services are provided to Cooperative Advantage (HMO D-SNP) members. The Cooperative expects that you will not bill the members who are seen prior to credentialing and approved affiliation.
- Credentialing applications must contain complete and accurate information before submission. Physicians and other healthcare providers who are members of CAQH are able to submit an initial credentialing application on the CAQH portal or provide the required information at recredentialing rather than completing several different credentialing applications for each payer. CAQH performs primary source verification of initial and recredentialing applications and delivers the complete credentialing file to the Cooperative for review. Additional information is available by contacting the Cooperative's Credentialing Department.
- Providers requesting affiliation should have their completed application to the Cooperative prior to scheduling Cooperative Advantage (HMO D-SNP) members as patients. The Cooperative needs adequate time to process the application and complete all the required primary source verification.

The Cooperative currently credentials:

- Audiologist
- Behavior Analyst
- Certified nurse midwife
- Certified Registered nurse anesthetist
- Certified substance abuse counselor
- Chiropractor
- Clinical social worker
- Dentist
- Doctor of Medicine
- Doctor of Osteopathy
- Licensed professional counselor
- Licensed marriage and family therapist
- Nurse practitioner
- Occupational therapist
- Optometrist
- Oral surgeon
- Physical therapist
- Podiatrist
- Psychiatrist
- Psychologist
- Speech therapist

- Any other practitioner who is licensed, certified, or registered by the state to practice independently (without direction or supervision) will also be credentialed.
- Any provider who disaffiliates from the Cooperative's network (whether voluntarily or through termination) is subject to credentialing if they apply to re-affiliate.
- The Credentialing Committee meets monthly to help expedite provider credentialing and affiliation. Providers will be notified within 30 days of the Credentialing Committee decision and effective date. The credentialing process will be completed within 90 days of receipt of all necessary documents from provider.
- The Cooperative will re-credential providers every 36 months. Any provider not credentialed within 36 months from previous credentialing approval date will no longer be considered part of in-network.
- Providers have a right to inquire about the status of their application.
- Providers have a right to review the information that was collected from outside sources for credentialing, not including references, recommendations, or peer review protected information.
- Providers have a right to correct erroneous information on their credentialing application within 30 days of initial application by sending corrected information through CAQH.

- Providers can appeal a credentialing decision within 30 days of receiving a denial. Provider must send the appeal in writing to: ProviderRelations@group-health.com. A determination will be made by the Cooperative within 45 days of receipt of the appeal.
- Providers can appeal a termination decision based on failure to meet quality standards within 30 days of receiving the termination notice. Provider must send the appeal in writing to: ProviderRelations@group-health.com. A determination will be made by the Cooperative within 45 days of receipt of the appeal.

SECTION 7 – QUALITY IMPROVEMENT (QI) PROGRAM

Scope

The QI Program is a comprehensive program that addresses the quality and safety of clinical care and the quality of services our members receive. The Cooperative's culture, processes, and systems are structured to ensure our members receive high-quality care and services. By monitoring member satisfaction, access and availability standards, quality of care concerns, and national quality metric results, care improvement opportunities are identified and implemented.

Goal

Our QI Program goal is to improve the quality of health care for our members by implementing QI activities to improve quality of care and services delivered across all care settings.

Provider Participation in QI Initiatives

To ensure the success of the QI Program, the Cooperative requires providers and practitioners to cooperate with all QI initiatives and allow the use of provider and/or practitioner performance data for QI initiatives. QI initiatives include but are not limited to access and after-hours care surveys, collection, evaluation, and submission of data, satisfaction surveys, and participation in QI meetings, QI programs, and partnerships. Provider participation in these activities allows the Cooperative to continuously improve the quality and safety of clinical care, the quality of services, and member experience. Information from QI activities is actively shared with our providers and staff.

We encourage feedback on our QI Program and activities and are available as a resource for QI activities with our in-network providers. Questions or requests for information should be directed to the Cooperative's Provider Services Department.

Screening Tools

Screening tools are used to quickly assess the presence or risk of a condition and are valuable for identifying individuals who might benefit from further evaluation or intervention. The Cooperative has identified various screening tool resources and recommends providers use these tools when appropriate. A list of screening tools is available on our website at group-health.com/providers/health-and-wellness-programs.

Cultural Competency Plan

The Cooperative is committed to establishing multicultural principles and practices throughout the organization to ensure health care and services meet the diverse needs of our members in accordance with the National Standards of Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. These needs include cultural, ethnic, and religious beliefs, language and communication preferences, and health literacy.

Culturally competent training is available to our in-network providers, and we work to ensure they understand the different cultural and linguistic needs of our members. To learn more about CLAS information and training, visit group-health.com/providers/clas-education-and-training.

Healthcare Effectiveness Data and Information Set (HEDIS)
Developed and maintained by the National Committee for Quality and Assurance (NCQA), the Healthcare Effectiveness Data and Information Set (HEDIS) is used as a set of performance measures to evaluate the Cooperative's performance. HEDIS includes measures related to five domains:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Relative Resource Use
- Health Plan Descriptive Information

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
CAHPS surveys help the Cooperative identify strengths and weaknesses, determine where improvements are needed, and track progress over time. This tool is especially useful in evaluating and improving the quality of our provider network. These surveys ask members about their experiences with the health plan and their providers. Members rate their primary care provider, their specialist provider, and the healthcare they receive from their providers.

Providers are also rated on the following variables:
- How well they explain things?
- How well did they listen?
- Did they show respect?
- Did they spend enough time?
- Did they coordinate care?

A member's experience with timely access to care is evaluated by the following questions:
- Did you get care as soon as needed when care was needed right away?
- Did you get a check-up/routine appointment as soon as needed?
- What was the ease of getting care, tests, or treatments?
- Were you able to get an appointment with a specialist as soon as needed?

Access and Appointment Wait Time Standards
All members have the right to receive timely access to medically necessary health care services. Providers must provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities. The Cooperative has established access standards and requires in-network providers to follow the access standards as outlined below. Access standards are reviewed annually. In-network providers are surveyed annually to evaluate compliance with the access standards.

Appointment Wait Time Standards
All providers are required to follow the Cooperative's appointment wait time standards.

Members should be seen within 30 minutes of their scheduled appointment time. When care is unavoidably delayed, members must be notified of the delay and allowed to reschedule their appointment. In-network providers shall offer hours of operation that are no less than the hours of operation offered to Commercial members or Medicaid Fee for Service.

Primary Care Provider Access Standards

Service	Access Standard
Life-threatening emergencies	Immediate access
Urgent Care	Within 48 hours
Routine preventive exam	Within 15 business days

Behavioral Health Care Provider Access Standards

Service	Access Standard
Life-threatening emergencies	Immediate access
Non-life-threatening emergencies	Within 6 hours
Urgent Care	Within 48 hours
Initial routine care visit	Within 10 business days
Follow-up routine care	Within 10 business days

Provider After-Hours Coverage for Members

Primary care providers and behavioral health providers must have a process for ensuring after-hours accessibility and for informing members how to access after-hours care. After-hours patient telephone calls should be returned within one hour from the time placed by the member.

Provider Right to Practice

The Cooperative will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

a. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
b. Any information the member needs to decide among all relevant treatment options.
c. The risks, benefits, and consequences of treatment or non-treatment.
d. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Shared Decision-Making (SDM)
The Cooperative understands the importance of shared decision-making aids in providing information about treatment options and outcomes to members. SDM aids facilitate member and provider discussions on treatment decisions. Please visit our website at group-health.com/providers/quality-care-and-patient-safety for a list of evidence based shared decision-making resources and aids.

Quality Resources for Providers
The Cooperative supports providers to achieve our population health management goals by providing comparative quality information. To learn more, visit our website at group-health.com/providers/quality-care-and-patient-safety.

Population Health Management Programs
The Cooperative offers comprehensive population health management programs for members which include complex case management and disease management. A list of programs and how to enroll can be found on the Cooperative's website at group-health.com/members/tools-and-resources/health-and-wellness-programs.

Transfer/Continuity of Member Care
The Cooperative's goal is to improve continuity and coordination of care for its members to reduce the risk of problems when members see multiple providers in different health care settings. We collaborate with our providers to identify and implement opportunities. We facilitate continuity and coordination of care, and ensure mechanisms are in place for timely and confidential exchange of health information between behavioral health providers and primary care providers, specialists, and health care delivery systems.

Online toolkits are available to our providers for improving continuity, coordination of care and communication between providers on our website at group-health.com/providers/quality-care-and-patient-safety.

- In the event of a change in practice status, practitioners are required to assist the Cooperative with transition of member care.
- It is the contracted facility or practitioner's responsibility to assure effective communication with members regarding the transfer of the member's care to another practitioner.
- Activities associated with transition of member care include:
    - Identify and communicate with the practitioner who will be designated as the member's Primary Care Physician. Accepting practitioner must meet criteria for a Primary Care Physician status as previously outlined.
    - Effective date of anticipated transfer of care.
    - Identification of members in high-risk categories (chronic disease states, members utilizing care management services).
    - Assist members in transferring medical record and treatment plan information to accepting practitioner.

In the event the practitioner cannot assist in the transfer of care, the Cooperative is required to identify a suitable practitioner for members who have not indicated a preference.

- The Cooperative, through review of its panel of in-network practitioners, will assist members in transition of their care to an appropriate practitioner.
- The Cooperative will be responsible for notifying members and other parties regarding any practitioner status changes.
- If you require assistance with this process, please contact the Provider Services Department.

SECTION 8 – ELIGIBILITY AND ENROLLMENT

Eligibility for the Cooperative Advantage (HMO D-SNP) plan is based on a Medicare beneficiary's entitlement to:

- Medicare Part A and Medicare Part B, and
- If they live in the Cooperative's geographic service area, and
    - Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- Are a United States citizen or are lawfully present in the United States, and receive Medicaid benefits.

Eligible individuals may enroll only during specific election periods, as specified by CMS. The Cooperative's service area map is defined here and can be found at group-health.com/providers/service-areas.

Effective Date

The Cooperative will notify the member in writing of their effective date of coverage. If a membership application is rejected by CMS or the Cooperative, the member will be notified in writing of the reason for rejection.

Disenrollment

A member may discontinue coverage from the Cooperative only during specific election periods, as specified by CMS. Disenrollment requests must be submitted in writing or may be received directly from CMS. The member must continue to receive all services from the Cooperative participating providers until the disenrollment date.

Coverage Termination

The Cooperative must terminate a member's coverage under the following circumstances if a member:

- No longer has Medicare Part A and Part B;
- Is no longer eligible for Medicaid, as Cooperative Advantage (HMO D-SNP) is for people who are eligible for both Medicare and Medicaid;
- Moves out of the Cooperative's service area;

- Is away from the Cooperative's service area for more than six months. (If a member is moving or taking a long trip, Member Services should be contacted);
- Becomes incarcerated (goes to prison);
- Is no longer a United States citizen or lawfully present in the United States;
- Lied or withheld information about other insurance that provides prescription drug coverage;
- Intentionally provide incorrect information when enrolling in our plan and that information affects eligibility for the Cooperative. (We cannot make the member leave the Cooperative for this reason unless permission is received from Medicare first.);
- Continuously behaves in a way that is disruptive and makes it difficult for the Cooperative to provide medical care to them or other members of our plan. (The Cooperative cannot make the member leave the plan for this reason unless permission is received from Medicare first.);
- Let someone else use their membership card to get medical care. (The Cooperative cannot make the member leave the plan for this reason unless permission is received from Medicare first.)
    - If membership ends because of this reason, Medicare may have the member's case investigated by the Inspector General.
- Is required to pay the extra Part D amount because of income and if they do not pay it, Medicare will disenroll the member from the Cooperative Advantage plan.

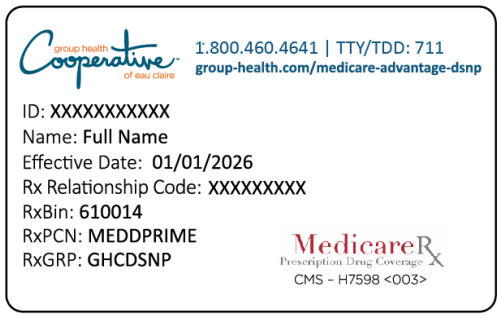
The Cooperative <u>may</u> terminate a member's coverage under the following circumstances:

- If premiums are not paid on a timely basis.
- If the member engages in disruptive behavior.
- If the member provides fraudulent information on an election form or if the member permits abuse of an enrollment card in our plan.

Should coverage be terminated for any of the reasons above, a member will receive advanced notice from the Cooperative. Members have recourse through the Cooperative's grievance program and/or CMS if they are terminated and disagree with the Cooperative's position.

The Cooperative Advantage (HMO D-SNP) Member Identification Card

Upon receipt of CMS approval, a member will receive their member identification card, which they must use instead of their traditional Medicare card when obtaining medical services and receiving prescriptions when applicable.



SECTION 9 – MEMBER GRIEVANCE AND APPEAL PROCESS

Grievances

The Cooperative Advantage (HMO D-SNP) members have grievance rights available to them as specified in this section. A grievance means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of the Cooperative or its provider's operations, activities, or behavior, regardless of whether remedial action is requested. A grievance may also include a complaint that a plan refused to expedite a coverage determination, reconsideration, or redetermination. Other examples include but are not limited to complaints regarding:

- Timeliness
- Appropriateness
- Access to and/or setting of a provided health service
- Covered health service procedure or item during a course of treatment did not meet accepted standards of delivery of health care
- Involuntary disenrollment issues
- Physician demeanor or behavior
- Quality of service issues

Appeals

Members are entitled to a reconsideration of a denied claim or service. If the reconsideration outcome does not meet the member's desired result(s) in whole or part, the matter is turned over to a Medicare contracted independent review entity (IRE). Part C plan adverse reconsiderations will be auto forwarded by the Cooperative to MAXIMUS Federal Services. Part D plan adverse redeterminations will be reviewed by C2C per member request.

Important Note: If a Cooperative Advantage (HMO D-SNP) member gives any indication of finding the provider's assessment unsatisfactory or unacceptable, they can call a Cooperative

Appeals Specialist as soon as possible, preferably that same day, to advise of the potential appealable issue. If the Cooperative issues a Notice of Denial of Coverage letter to the member, it will include the appropriate appeal rights as defined by CMS. CMS considers this letter (or corresponding claims denial) an "organizational determination."

Please remember that an indication of "no-need" or any other direct or indirect denial of need for a requested medical service, implied or stated, constitutes an "organizational determination" regarding the Cooperative's coverage to members, subject to appeal rights.

For questions or concerns regarding this process,
please contact the Appeals Specialist in the Member Appeals department.

SECTION 10 – UTILIZATION MANAGEMENT PROGRAM

Utilization Management Services

The Utilization Management program is designed to facilitate the appropriate, efficient, and cost-effective management of our members' healthcare. While cost and other resource issues are considered as part of a responsible decision-making process, our Utilization Management staff, including the clinicians who make utilization management-related decisions and those who supervise them, make decisions based on the clinical appropriateness of the care or service. Ongoing analysis of under and over utilization of services is performed.

Medical necessity review is the process whereby covered services are reviewed to determine if they meet criteria for medical necessity and clinical appropriateness. As part of this review, national recognized, evidence-based standards and decision support tools/criteria sets and clinical practice guidelines are used to maintain quality of care, eliminate unnecessary care, and improve patient safety. These guidelines serve as a foundation and guide for ensuring the member's needs are being met according to evidence-based guidelines and that medical necessity determinations are being made consistently according to national evidence-based practice standards. A medical necessity review also considers the member's circumstances.

Overview of Utilization Management

Utilization Management performs the following services:

- Review Hospital Admissions
- Concurrent Hospital Review
- Discharge Planning
- Retrospective Review
- Care Management
- Utilization Review
- Referrals
- Prior Authorizations

Admission Notification

- Prior authorization is required for all pre-planned inpatient hospital admissions Notification with submission of clinical documentation is required within one business day of admission to review for medical necessity. Questions related to coverage or benefits should be directed to the Cooperative's Provider Services Department.
- An Advanced Written Notice of Hospital Discharge Appeal Rights (OMB #0938) (CMS-R-193) will be issued to Cooperative hospital inpatients. The hospital must deliver this notice at or shortly after admission but no later than two calendar days following the member's admission to the hospital.

Medical necessity determinations are made using CMS National Coverage Determinations and Local Coverage Determinations. When there is no National or Local Coverage Determination for a service, the following nationally recognized evidence-based clinical practice guidelines are used:

- InterQual medical necessity criteria sets and length of stay data. These protocols are used to review procedures, DME, medical and behavioral health hospital admissions, AODA admissions, and subacute and rehabilitation admissions.
- Hayes Technologies for services that are experimental/investigational.
- Other national evidence-based practice guidelines that are used include but are not limited to the National Comprehensive Cancer Network, American College of Radiology Criteria sets, United States Preventive Services Task Force, JNC 8, NHLBI, ACA-AHA guidelines, ADA guidelines, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and American Academy of Family Practice.
- The Cooperative's policies and procedures are referenced when there is no InterQual criteria set or Hayes Technologies recommendation, for a service that is a covered benefit and there needs to be a medical necessity determination. These internal policies are developed based on nationally recognized evidence-based clinical practice guidelines.

The Cooperative expressly reserves the right to revise our coverage policies as clinical information changes, and welcome further relevant information. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are exclusions or other benefit limitations applicable to approved services or supplies. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e. will be paid for) for a particular member. The member's benefit plan determines the extent and limitations of coverage. In addition, coverage may be defined by applicable legal requirements of the State of Wisconsin, the Federal Government or CMS. This is in no way to imply that providers cannot advocate for member resources.

Care Management

The care manager manages member's health care benefit to ensure the best quality of care and optimize insurance benefits. The care manager is responsible for the following:

- Identifying appropriate alternatives to hospitalization yet achieving cost-effective quality of care.
- Discharge planning of hospitalized patients begins upon receipt of information of the impending admission or upon the initial review of the patient's hospital record.
- The acquisition of needed medical supplies and equipment, as well as home health services (skilled nursing care, physical therapy, speech therapy and occupational therapy), is directed through contracted providers (whenever possible) and negotiates discounts with non-contracted providers.
- Coordinating with reinsurance carrier care manager when applicable.
- Managing prior authorization requests for medical appropriateness and benefit applicability. Requests may include but are not limited to surgical procedures, diagnostic testing, and durable medical equipment.
- Managing concurrent reviews of admissions in and out of network, referrals to out of network facilities for mental health and substance use disorder services, transitional care, and other medical and surgical procedures. Works directly with discharge planners to facilitate transfers to lesser level of care as appropriate.
- Managing prior authorization and continued stay review of home health treatment plans, and skilled nursing facility (SNF) stays in accordance with the Cooperative's policies.
- Upon initiation of home health services ordered by the attending practitioner, maintaining communication with the home health nurse. The care manager will coordinate care with the home health agency as needed until the patient is discharged from care and resumes care from the attending practitioner.
- Identifying and reporting of quality-of-care issues to Medical Directors.

SECTION 11 – PRIOR AUTHORIZATION

Prior Authorization Guidelines

A complete list of services that require prior authorization and prior authorization guidelines and processes can be found on the Cooperative's website at group-health.com/providers/prior-auth-guidelines.

Medicare Outpatient Observation Notice (MOON)

The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires hospitals and Critical Access Hospitals (CAH) to provide notification to Cooperative Advantage members receiving observation services as outpatients for more than 24 hours explaining the status of the individual as an outpatient, not an inpatient, and the implications

of such status regarding cost sharing and coverage for post-hospitalization skilled nursing facility (SNF) services. Hospitals and CAHs are required to furnish the Medicare Outpatient Observation Notice (MOON) to a member who has been receiving observation services as an outpatient. Under CMS's final NOTICE Act regulation, published August 2, 2016, hospitals and CAHs may deliver the MOON to members receiving observation services as an outpatient before such member has received more than 24 hours of observation services. The notice must be provided no later than 36 hours after observation services are initiated or, if sooner, upon release. An oral explanation of the MOON must be provided, ideally in conjunction with the delivery of the paper notice, and a signature must be obtained from the member or a person acting on such member's behalf to acknowledge receipt. In cases where such member or person refuses to sign the MOON, the staff member of the hospital or CAH providing the notice must sign the notice to certify that notification was presented.

Elective (Non-Emergent or Non-Urgently Needed) Admissions Out-of-Network

All elective (nonemergency or non-urgently needed) hospital admissions out of the Cooperative's network require prior authorization before hospital admission to ensure that inpatient criteria have been met. This allows for the identification of potential utilization or coverage issues and suggestions of alternative treatment settings, if appropriate.

Supplier Instructions for Wheelchair Rentals and Purchases

The Cooperative has a defined process for obtaining authorizations for wheelchair rentals and purchases. Detailed instructions can be viewed at group-health.com/cooperative-advantage. To comply with federal regulations of consistency when applying benefits for all members, a Functional Mobility Assessment (FMA) is required for all wheelchair purchases along with a physician's order. Upon written order for the purchase of a wheelchair, the patient should be directed to a physical or occupational therapist for the assessment. An FMA form must be completed. The assessment will enable the Cooperative to ensure that the most appropriate equipment is requested to meet the member's current medical needs.

Part D Medication Prior Authorization Process

A Part D medication prior authorization request may be started by members, providers, or designated representatives by fax, telephone, or mail. We will accept requests from members or their authorized representatives but recommend having the health care practitioner complete the requests as the medical history required to make a timely decision can be more adequately provided.

The Cooperative strongly recommends that you, the health care provider, initiate the prior authorization request process on behalf of your patient. This is because you will be able to include the medical history necessary for a timely decision to be made based on all the relevant information. When a prior authorization request is submitted, there are two types of requests:

1. *Standard*: for a standard request, use the Medicare Part D Coverage Determination Request Form and submit online or via fax. The Cooperative makes decisions on standard requests within 72 hours. For formulary exceptions, step therapy exceptions, quantity limit exceptions, and tiering exceptions, a prescriber's supporting statement (PSS)* is required. If a PSS is not provided with the original request, our decision may be extended up to a total of 14 days after the receipt of the request so that we may obtain a PSS.

2. *Expedited*: An expedited (urgent) request is defined as a request in a situation when making routine or non-life-threatening determination could seriously harm the patient's life, health, or ability to regain maximum function.

   Expedited request forms should be completed and submitted online or via fax. The Cooperative makes decisions on expedited requests within 24 hours. For formulary exceptions, step therapy exceptions, quantity limit exceptions, and tiering exceptions, a prescriber's supporting statement (PSS)* is required. If a PSS is not provided with the original request, our decision may be extended up to a total of 14 days after the receipt of the request so that we may obtain a PSS.

*Physician's Supporting Statement (PSS): A PSS is a statement that a drug is medically necessary. For formulary exceptions, the PSS must indicate that all covered Part D drugs on any tier of the plan's formulary would not be as effective for the member as the requested drug and/or would have adverse effects.

- For quantity limit exceptions, the PSS must indicate that the number of doses available under the quantity limit has been ineffective in the treatment of the member's condition or would likely be ineffective (based on sound clinical, medical, and scientific evidence, the known relevant physical or mental characteristics of the member and known characteristics of the drug regimen).
- For step therapy exceptions, the PSS must indicate that the prerequisite drugs have been ineffective or caused an adverse reaction or other harm for the member or that it would likely be ineffective or would cause adverse effects (based on sound clinical, medical, and scientific evidence, the known relevant physical or mental characteristics of the member and known characteristics of the drug regimen).
- For tiering exceptions, the PSS must indicate that the drug(s) in the applicable lower cost-sharing tier(s) for the treatment of the member's condition would not be as effective as the requested drug and/or would have adverse effects.

Non-Covered Part D Drugs

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

1. Our plan's Part D drug coverage cannot cover a drug in situations where it would be covered under Medicare Part A or Part B.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the FDA.

- Generally, coverage for "off-label use" is allowed only when the use is supported by certain references (Medicare-approved compendia). These compendia are the *American Hospital Formulary Service Drug Information (AHFS-DI)*, the *DRUGDEX Information System,* and the *USPDI* or its successor. If the use of a Part D drug is not supported by the drug's FDA-approved label or a Medicare-approved compendia, then our plan cannot cover its use.

Also, by law, these categories of drugs are not covered by Medicare Part D plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs covered under Part D that may be self-administered in a hospital outpatient setting such as an emergency room, observation unit and surgery center, or pain clinic if not required for the medical condition being treated.

Non-discrimination to Dual Eligible Members

Cooperative Advantage providers must not discriminate against members based on their payment status or refuse to service members because they receive assistance with Medicare cost-sharing from a state Medicaid program. Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual eligible program that exempts members from Medicare cost-sharing liability. The prohibition on collecting Medicare cost-sharing is limited to services covered under Parts A and B, low-income subsidy copayments still apply for Part D benefits. The Cooperative will use this complaint procedure and issues identified through the CMS complaint Tracking Module to monitor compliance with balance billing rules and provide education to providers not abiding by the rules set forth in

the 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, 42 C.F.R. 422.504(g)(1)(iii) and the Medicare Managed Care Manual, Chapter 4, Section 10.5.2.

Model of Care (MOC) Overview
The MOC provides a framework for delivering consistent, high-quality, patient-centered healthcare by outlining how services are organized, coordinated, and managed to meet specific member needs.

All providers are required annually to review and complete MOC training on our Provider page.

Important components of the MOC include:

- Outlining how to identify the special needs population (SNP), including those most at risk
- How the coordination of care is administered to the SNP population
    - Use of appropriately trained staff
    - Use of the Health Risk Assessment Tool (HRAT)
        - The HRAT for SNP members includes a comprehensive set of questions designed to assess their medical and behavioral health history, psychosocial, functional, and cognitive needs and identify risks.
    - Direct staff to member encounters
    - Utilizing an Individualized Care Plan (ICP)
        - The ICP is generated from the health needs assessment and information gathered from the ICT.
    - Utilizing an Individualized Care Team (ICT)
        - The team that is involved in the planning, provision, and monitoring of the member's care and services
    - Use of care transition protocols for continuity of care
    - Maintaining a robust provider network
    - Utilizing current clinical practice guidelines
    - Providing ongoing continuing education on the MOC to the provider network
    - Quality measurement and performance improvement executables
    - Producing measurable goals and outcomes to guide the MOC
    - Measuring and responding to member satisfaction concerns

SECTION 12 – PROVISIONS FOR INTERPRETERS/TRANSLATORS

As a contracted provider, access to interpreters must always be available. Family members, especially children, should not be used as interpreters in assessments, therapy, and other situations where impartiality is critical.

Interpreters are to be scheduled at the same time the appointment is made.

In the case of an emergency, or if interpreters are not available in the clinic, local interpreters must be contacted to assist by phone or in person if possible.

It is the responsibility of the provider of healthcare to pay for interpreters.

Documentation is to be made in the patient's medical record of all efforts made to schedule an interpreter and if an interpreter was utilized.

The Cooperative provides free aids and services to people with disabilities to communicate effectively, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Free language services are available to people whose primary language is not English, including qualified interpreters and information written in other languages. If these services are needed, contact Member Services at: (800) 460-4641 (TTY: 711).

SECTION 13 – FRAUD, WASTE & ABUSE

It is the policy of the Cooperative to comply with all applicable federal and state laws pertaining to fraud, waste, and abuse in federal healthcare programs. All contracted entities and business associates of the Cooperative are also required to act in compliance with all federal and state laws that address fraud, waste, and abuse in both federal and state programs such as Medicare and Medicaid. All employees of the Cooperative participate in annual education activities and submit attestations of doing so, regarding FWA.

DEFINITIONS OF FRAUD, WASTE & ABUSE (FWA)

Fraud:
A person makes a material statement of fact. The statement is false and the person making the statement knows that it is false. The person making the false statement intends to deceive or mislead the person to whom the statement was made with the expectation of receiving something of value. The person to whom the false statement is made is expected to rely on the statement to his or her detriment.

Waste:
Overutilization of items or services or other practices that result in unnecessary costs.

Abuse:
Any activity that unjustly robs the health care system, but does not constitute fraud. In abuse, a provider or consumer may obtain money or health care services to which the provider or consumer is not entitled, but there is not the intent to deceive that is necessary for fraud to have occurred. This includes provision of services that are not medically necessary.

Examples of Federal and State FWA Laws

A. Federal False Claims/FWA Laws

1. False Claims Act [31 U.S.C. § § 3729-3733]
   - This law establishes civil liability for offenses related to acts of false or fraudulent claims, records, or statements to the government. No specific intent to defraud the government is required.
   - It includes actual knowledge, as well as deliberate ignorance or reckless disregard for truth.

2. Physician Self-Referral Law [42 U.S.C. § 1395nn]
   - This law prohibits providers from referring patients to receive health services payable to Medicare or Medicaid in which the provider or an immediate family member has a financial relationship.
   - It is a strict liability law, which means proof of specific intent to violate the law is not required.

3. Anti-Kickback Statute [42 U.S.C. § 1320a-7b(b)]
   - This law prohibits knowing and willful offers, payments, solicitations, or receipt of any remunerations in cash or kind, to induce or in return for referring an individual for the furnishing or arranging of any item or service for which payment may be made under a federal health care program.
   - Remuneration means anything of value and can include gifts, under-market value for the services provided.

4. Exclusion Statute [42 U.S.C. § 1320a-7]
    - All health care programs, individuals, and entities convicted of: Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid; patient abuse or neglect; felony convictions for other health-care-related fraud, theft, or other financial misconduct; and felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances are excluded from participation in the federal health care programs.
    - Excluded physicians may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice.
5. Civil Monetary Penalties Law [42 USC § 1320a-7a]
    - Allows OIG to seek civil monetary penalties for conducting any kind of Fraud, Waste, or Abuse of Federal Health Care Programs

The above laws are not exhaustive, merely a representation of certain FWA laws that may apply to any given circumstance. Please contact the Compliance Department at 534-444-3451 for more detailed compliance guidance. Both civil and criminal penalties may apply.

Anti-Retaliation Protections

The Cooperative has a zero-tolerance policy against retaliation to protect those who report fraud, waste, or abuse concerns, in good faith, from adverse action. Individuals who observe activities or behavior that may violate the law in some manner and who report their observations to management or to governmental agencies are provided protection under certain laws.

1. The federal False Claims Act provides protection for those who file lawsuits as described above. The False Claims Act states that any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful actions taken as indicated above is entitled to recover damages. A person is entitled to "all relief necessary to make the employee whole," including reinstatement with the same seniority status, twice the amount of back pay (plus interest), and compensation for any other damages the employee suffered because of the discrimination. An employee can also be awarded litigation costs and reasonable attorneys' fees.

2. Wisconsin statute 146.997, Health Care Worker Protection, also protects health care workers who disclose any of the following to an appropriate individual or agency:
    a. Information that a health care facility or provider has violated any state law or rule or federal law or regulation.
    b. A situation in which the quality of care provided by, or by an employee of, the health care facility or provider violates established standards and poses a potential risk to public health or safety.

c. A health care facility or provider cannot take disciplinary action against an individual who reports the above in good faith. A health care facility or provider who violates this statute shall be subject to not more than a $1,000 fine for a first violation.

To report instances of fraud, waste, or abuse, or to report suspected retaliatory actions, please call the Cooperative's Compliance Department at 534-444-3451.