Commercial Provider Manual

2024

Administered by:
Group Health Cooperative of Eau Claire
2503 North Hillcrest Parkway | Altoona, WI 54720
715.552.4300 or 888.203.7770
group-health.com

GHC24028

(Rev. 06/26/2024)

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

Dear Provider:

We are pleased that your organization is a participant in the Group Health Cooperative of Eau Claire network of healthcare providers. We are committed to providing you with current and accurate information.

This provider manual has been developed as a resource for Group Health Cooperative's Commercial HMO members. Updates to this manual will take place periodically and will be available online. If you have any questions on updates or anything contained in this manual, please do not hesitate to call our Provider Relations Department.

Included in this manual is a list of our departments that will be happy to help you with specific questions or concerns. You can also visit our website at group-health.com. We understand the need to have your questions answered in a clear and timely manner. We look forward to a mutually beneficial partnership.

Sincerely,

Sarah North
CEO & General Manager

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DEPARTMENT CONTACTS

Group Health Cooperative of Eau Claire Department Contacts for Providers

Call our **Provider Services Department** for: • Member Benefits, Coverage or Eligibility • Member Concerns • Claims Status • Billing & Payment Procedures • Electronic Billing • Provider Log-In Assistance	**PROVIDER SERVICES** DEPARTMENT (715) 552-4333 or (866) 563-3020 Fax Number: (715) 836-7683 **MEMBER SERVICES** DEPARTMENT (715) 552-4300 or (888) 203-7770 Fax Number: (715) 836-7683
Call our **Utilization Management Department** for: • Prior Authorization questions	**UTILIZATION MANAGEMENT** DEPARTMENT (715) 552-4333 or (866) 563-3020
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	**CREDENTIALING** DEPARTMENT (715) 852-2093 Fax Number: (715) 598-7534
Call our **Pharmacy Benefits Manager** (PBM): • Formulary questions	**EXPRESS SCRIPTS** (888) 327-9791
Call our **Quality Improvement Department** for: • HEDIS Measures • Quality Reviews	**QUALITY IMPROVEMENT** DEPARTMENT (715) 552-4333 or (866) 563-3020 Fax Number: (715) 598-7530

SECTION 1 – CLAIMS INFORMATION

CLAIMS SUBMISSION

In order to facilitate timely payment of claims submitted to Group Health Cooperative of Eau Claire (the Cooperative), please utilize the appropriate claim forms and follow standard submission guidelines for your provider type.

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, 7 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

To expedite payment to you, the Cooperative encourages electronic billing whenever possible. Group Health Cooperative of Eau Claire has partnered with ECHO Health, Inc. to provide electronic payment and remittance advice methods. Our payor ID is 95192.

835 Electronic Remittance Advice (ERA):

Providers who enroll for EFT payments will continue to receive the associated ERAs from ECHO with the Payer ID. If you have not already, please make sure that your Practice Management System is updated to accept Payer ID: 95192. 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.

For more detailed information regarding electronic payment and remittances, please view the "Claims Payment Changes" update posted on 12/18/2023 at https://group-health.com/providers/news.

ELECTRONIC CLAIMS SUBMISSION

Providers can submit electronic claims in a variety of ways:

- Providers can utilize a clearinghouse but it is not required.
  - Clearinghouses may charge a fee. It is the provider's responsibility to discuss these potential fees with the clearinghouse.
- Providers can create a direct connection. Requirements include:
  - If you are able to create x12 837 files, you can fill out the one-page form found on the Cooperative's website at ghc-ec.com/ElectronicClaimsSubmission to work on establishing a direct connection.
  - The Cooperative does not charge claim submissions fees for a direct connection.

In addition, the Cooperative has a setup form available for Eligibility Benefit Inquiry and Response at ghc-ec.com/EligibilityBenefitInquiry.

Contact the Cooperative's Provider Services at (715) 552-4333 or (866) 563-3020 for more information.

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 866-563-3020 between 7 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 https://group-health.com/QuickClaim.

BALANCE BILLING/CO-PAYMENT INFORMATION

Provider (with the exception of collecting deductibles, coinsurance and co-payments) may not bill, charge, collect a deposit from, seek remuneration from, or have any recourse against a Cooperative member for covered benefits.

SUBROGATION AND RECOUPMENT

As a member-owned and governed, non-profit cooperative, the Cooperative applies subrogation practices to keep member premiums and cost-sharing as reasonable as possible. This means that whenever another insurance policy, including a member's other insurance coverage, is responsible for making payment on a medical claim that would otherwise be payable by the Cooperative under this policy, the Cooperative's coverage may be secondary to that coverage. This includes, but is not limited to, medical payments on an auto or homeowner's policy and worker's compensation coverage.

The Cooperative does not deny claims for third-party liability coverage. See below for additional detail.

The Cooperative reserves all legal, statutory, and contractual subrogation and recoupment rights related to paid claims and will enforce its right in all cases, unless waived in writing by the Cooperative.

Claims Submissions
All medical payment coverage benefits (auto medical payments, uncontested worker's compensation, etc.) are considered primary to the Cooperative's commercial coverage, subject to appliable law. The Cooperative reserves the right to process claims accordingly.

All claim submissions must be within a provider's timely filing limits.

Providers must submit claims to the member's primary coverage prior to submitting claims to the Cooperative. Following the primary carrier's determination, if the carrier denies or pays a claim in whole or in part, a copy of the original explanation of benefits, denial or medical payment exhaust must be submitted with the applicable claim(s), to the Cooperative for review, regardless of the balance due.

All accident or injury claims should be coded with the appropriate ICD codes to reflect both the injury itself and the type of injury sustained. This is required for all treatment related to the injury (initial and subsequent care). Where unspecified coding is used, claims may be denied for medical records/notes prior to review for coordination of benefits.

If accident or injury related claims are submitted to the Cooperative without the appropriate documentation from the primary carrier, claims will be denied for coordination of benefits using the appropriate ANSI codes. The denial reason(s) will be noted on the Cooperative's remittance to the provider.

Medical Payment and Worker's Compensation Coverage
Both medical payment coverage and worker's compensation coverage are primary to the Cooperative's coverage, subject to applicable law. The Cooperative reserves the right to process claims accordingly and to coordinate benefits with any available medical payment coverage until that coverage has been exhausted, or any uncontested worker's compensation coverage has been denied.

Medical payment coverage and uncontested worker's compensation coverage are not considered third-party coverage for coordination of benefits purposes.

Any coverage for medical payments that is available and issuable without regard to liability is considered primary to the Cooperative's coverage. This includes a member's own auto or other liability policy that includes medical payment provisions separate from liability-related payments. If a member is involved in an auto accident, the Cooperative will deny claims for coordination of benefits until the medical payment coverage has been exhausted and an itemization of payments made has been received by the Cooperative. Accident or injury related claims submitted for

reconsideration must include a copy of the original medical payment exhaust, explanation of benefit form, or denial to be considered.

If a worker's compensation carrier issues a denial of benefits on a previously uncontested claim, a copy of the original denial, explanation of benefits form, or other correspondence denying coverage under the worker's compensation plan should be submitted with related claims for reconsideration.

With both medical payment coverage and worker's compensation coverage, provider generated explanation of benefits or denials will not be accepted.

In situations where the medical payment coverage has been issued to a member directly, and the payment is itemized and clearly attributable to specific claims, the Cooperative will deny payment of the same claims and the provider should seek payment directly from the member.

Duplicate Payments
If the Cooperative becomes aware that both the Cooperative and another insurer have issued payment on the same claim, upon receipt of the itemized explanation of benefits form from the other insurance carrier, the Cooperative's payment will be recouped.

Recoupments/Refunds
All recoupment and refund requests, where a medical payment or worker's compensation carrier's payment is involved, should be submitted to the Cooperative, Attn: Subrogation Department. Requests should include a copy of the original explanation of benefits form from the other carrier. Provider generated forms will not be accepted.

Noncompliant Members
The Cooperative requires providers to make three good-faith attempts to get insurance information from members. Attempts may verbal or written, but each request must be at least one week apart. Requests to the member should be for other medical payment or worker's compensation coverage, so that the provider is able to coordinate benefits appropriately.

If a member is noncompliant in responding to a provider, the provider may submit a log of the attempts made or copies of letters sent, as proof the three attempts were made. Documentation should clearly identify the member, date of contact and type of contact made. A .pdf document is preferred. All noncompliance documentation should be submitted within the provider's timely filing limits.

Note: If the Cooperative has coverage information on file, noncompliance documentation will not be accepted without a denial, explanation of benefits, or exhaust letter from the carrier.

COORDINATION OF BENEFITS

If a member carries other insurance through more than one insurer, the Cooperative will coordinate the benefits to ensure maximum coverage without duplication of payments.

Provider must submit claims to the primary insurance before submitting to the Cooperative. Following the primary insurance determination, a copy of the original claim form and a copy of the primary insurance Remittance Advice (RA) must be submitted to the Cooperative for secondary benefit determination (regardless of balance due). Provider must submit the documents within 90 days from the date on the primary RA.

If the Provider fails to comply or is unaware of the primary insurance, claims for which the Cooperative is secondary will be denied. This denial reason will print on the Provider's RA.

If primary insurance is discovered after charges have been processed and both the Cooperative and the primary insurance make payment, the Provider may have an overpayment, and will be required to return the balance to the Cooperative.

If the Cooperative discovers a primary insurance after charges have been processed, the Cooperative will reverse its original payment. The adjustment will be reflected on the Provider's RA.

If the primary insurance denies a claim because of lack of information, the Cooperative will also deny.

If a member has Medicare and/or other insurance, complete information must be on the CMS-1500 claim or UB-04 claim for the claim to be processed efficiently.

- On the CMS-1500 claim, box 11d should be checked "Yes" if there is any other insurance information. If box 11d is checked "Yes", boxes 9a – 9d on the CMS-1500 claim must be completed with the other insurance information. (See sample CMS-1500 claim form).

- On the UB-04 claim, box 50 is completed if there is any other insurance information. (See sample UB-04 claim form).

- Other insurance RAs must accompany each CMS-1500 claim and UB-04 claim when other insurance is indicated on the claim.

For any questions regarding Coordination of Benefits, call Provider Services at (715) 552-4333 or (866) 563-3020.

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 would be used. Claims that are corrected and/ or resubmitted to the Cooperative are subject to the claim appeal time frame

identified in the Claim Appeal Process section of this Provider Manual or as identified in the Provider Service Agreement.

Send or fax paper claims to:

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

BILLING AND REIMBURSEMENT OF PROFESSIONAL SURGICAL SERVICES

Service must be a covered procedure in order for it to be considered for reimbursement. 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 https://group-health.com/providers/prior-auth-guidelines.

Please bill all services in full. The Cooperative will apply procedural reductions in accordance with Medicare and the Cooperative's policies and procedures. The Cooperative will determine when a procedure or service is included in another procedure or service based on Medicare, CPT and the professional association guidelines of that procedure or service. Modifier 22 or any other modifier that may receive additional reimbursement based on the extent of the procedure should be billed without the additional amount. The Cooperative will determine the amount of additional reimbursement.

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

Co-Surgeons

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. The Cooperative allows for co-surgeons based on the surgical procedure and medical necessity.

Surgical Assistants

Submit the appropriate surgical code along with modifier 80, 81, 82 or AS. The Cooperative reimburses surgical assistants only when the surgery allows for an assistant surgeon based on the surgical procedure and medical necessity.

Bilateral Surgeries

Bill with one procedure code, utilize modifier 50 (bilateral procedure) with a quantity of 1.0 unit on the claim. Please bill all services in full. The Cooperative will apply procedural reductions in accordance with Medicare and the Cooperative's policies and procedures.

Multiple Surgeries
The surgical procedure with the highest billed amount will be reimbursed as the primary procedure. Please bill all services in full. The Cooperative will apply procedural reductions in accordance with Medicare and Cooperative policies and procedures.

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.

Global 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.

Note: Separate reimbursement is allowed for postoperative management when it is performed by a provider other than the surgeon. Use the appropriate modifier.

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.

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 at (715) 552-4333 or (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, or as outlined in the Provider Services Agreement. The appeal must contain the member name and ID number, the provider name, date of service, date of billing, date of rejection, and reason for reconsideration. The provider appeal form is located on the Cooperative's website at ghc-ec.com/ProviderAppealForm.

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:

Attention: Provider Appeals
Group Health Cooperative of Eau Claire
PO Box 3217
Eau Claire, WI 54702-3217

If you disagree with the Cooperative's decision on your appeal, you may also request a 2nd Appeal in writing within 30 days of the initial Appeal determination notice. This is the final level of appeal. The appeal must contain the member name and ID number, the provider 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:

Attention: Provider Appeals
Group Health Cooperative of Eau Claire
PO Box 3217
Eau Claire, WI 54702-3217

CLAIMS CODING SECTION

Accurate claims submission will allow for a more timely payment of claims.

The Cooperative utilizes several policies for reimbursement of services rendered to our members. If you have claim questions, please contact Provider Services at (715) 552-4333 or (866) 563-3020. This information provides an overview of the claims processing policies related to correct coding and reimbursement. The Cooperative uses reasonable discretion when applying claims processing policies to reimburse for services rendered to our members. Additional factors impact reimbursement, including but not limited to a member's benefit coverage, legislative mandates and other primary insurance. The Cooperative's claims processing policies are subject to change.

Providers are to bill in full. Payment will be reduced appropriately upon receipt of the claim. It is the responsibility of the provider to notify the Cooperative of any billing changes within 30 days of the change. The Cooperative reserves the right to reprocess and recoup any claims that were processed erroneously due to a billing change.

Below is a list of commonly billed modifiers and the Cooperative's claims processing policies. Please be advised that this is not an all-inclusive list. If you have a question on a claims processing policy, please contact Provider Services at (715) 552-4333 or (866) 563-3020.

Modifier	Description	Cooperative Claims Processing Policy
22	Increased procedural services	When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, and severity of patient's condition, physical and mental effort required).
23	Unusual anesthesia	Does not impact reimbursement
24	Unrelated evaluation and management service by the same physician during a postoperative period	Documentation must support reasons for visit unrelated to the original procedure.
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service	E&M services appended with the modifier -25 are considered for reimbursement when the documentation supports: • the complaint or problem stands alone as a billable service • the key components of the E&M service were met • either a different diagnosis for a significant portion of the visit, or if the diagnosis is the same, there was extra work that significantly extended beyond the pre-service work associated with the procedural code.
26	Professional component	Do not bill global fee in addition to a Professional Component
TC	Technical component	Do not bill global fee in addition to a Technical Component
32	Mandated services	Not reimbursable
47	Anesthesia by surgeon	Does not impact reimbursement
50	Bilateral procedure	Reimbursed at 150%
51	Multiple procedures	Highest dollar amount billed considered primary procedure and is reimbursed at 100%. All other procedures reimbursed at 50% of billed charges.
52	Reduced services	Reimbursed at 50%
53	Discontinued procedure after anesthesia induction (physician charges)	Reimbursed at 50%

Modifier	Description	Cooperative Claims Processing Policy
54	Surgical care only	Reimbursed at 80%
55	Postoperative management only	Reimbursed at 20%
56	Preoperative management only	Not covered (included in surgical care)
57	Decision for surgery	An E&M service that resulted in the initial decision to perform a major surgery (90 day global) may be identified by adding modifier 57 to the appropriate E&M level.
58	Staged or related procedure or service by the same physician during postoperative period	Does not impact reimbursement
59	Distinct procedural service	Requires review. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion or separate injury, etc.
62	Two surgeons (i.e. co-surgery)	Each surgeon reimbursed at 62.5%
63	Procedure performed on infants less than 4 kgs.	Does not impact reimbursement
66	Surgical team	Does not impact reimbursement
73	Discontinued outpatient hospital/ ASC procedure prior to anesthesia administration. (For physician reporting of a discontinued procedure, see modifier 53)	Reimbursed at 50%. This modifier is appropriate when a surgical procedure is terminated due to the onset of medical complications after the patient has been prepped for surgery and taken to the O.R. but before anesthesia has been induced.
74	Discontinued outpatient hospital/ ASC procedure after anesthesia administration. (For physician reporting of a discontinued procedure, see modifier 53)	Does not impact reimbursement
76	Repeat procedure by same physician	Does not impact reimbursement
77	Repeat procedure by another physician	Does not impact reimbursement
78	Unplanned return to the operating room during the postoperative period for a related procedure	Reimbursed at 70%
79	Unrelated procedure or service during the postoperative period	Does not impact reimbursement

Modifier	Description	Cooperative Claims Processing Policy
80	Assistant surgeon (when qualified resident not available)	Reimbursed at 20%. Assistants at surgery are covered when an assistant is considered medically necessary and appropriate. Documentation must support why assistant was needed.
82	Assistant surgeon (when qualified resident not available)	Reimbursed at 20%. Assistants at surgery are covered when an assistant is considered medically necessary and appropriate. Documentation must support why assistant was needed.
90	Reference (outside) laboratory	Does not impact reimbursement
91	Repeat clinical diagnostic laboratory test	In the course of treatment of the patient it may be necessary to repeat the same laboratory test on the same day to obtain subsequent test results. This modifier is not appropriate when different specimens from different anatomical sites are tested.
99	Multiple modifiers	Does not impact reimbursement
AA	Anesthesia services performed personally by anesthesiologist	Does not impact reimbursement
AD	Medical supervision by a physician: more than 4 concurrent anesthesia procedures	Bill as quantity of three
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	Reimbursed at 13.6%. Assistants at surgery are covered when an assistant is considered medically necessary and appropriate. Documentation must support why assistant was needed.
P1	A normal healthy patient (anesthesia modifier)	Does not impact reimbursement
P2	A patient with mild systemic disease (anesthesia modifier)	Does not impact reimbursement
P3	A patient with severe systemic disease (anesthesia modifier)	Provider may bill one additional unit when appropriate
P4	A patient with severe systemic disease that is a constant threat to life (anesthesia modifier)	Provider may bill two additional units when appropriate
P5	A moribund patient who is not expected to survive without the operation (anesthesia modifier)	Provider may bill three additional units when appropriate

Modifier	Description	Cooperative Claims Processing Policy
P6	A declared brain-dead patient whose organs are being removed for donor purposes	Does not impact reimbursement
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	Reimbursed at 50%
QX	CRNA service: with medical direction by a physician	Reimbursed at 50%
QY	Anesthesiologist medically directs one CRNA	Reimbursed at 50%
QZ	CRNA service: without medical direction by a physician	Does not impact reimbursement

Supporting Notes Are Required For The Following:

- 62 modifier
- 66 modifier
- Corrected claims
- Prolonged services (99354-99355, 99356-99357, 99358-99359)
- Unlisted CPT codes

Supporting Notes May Be Required For The Following:

- 22 modifier
- 24 modifier
- 25 modifier
- 59 modifier
- Consultation codes (99241-99245, 99251-99255)

This is not an all-inclusive list. Notes may be requested for other services and or other modifiers. Category III codes are not reimbursable.

SECTION 2 – CREDENTIALING

The Cooperative is proud of the professionals and facilities that make up the network of healthcare providers. Providers and facilities must meet rigorous credentialing standards in order 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 is accredited by the National Committee for Quality Assurance (NCQA). Providers and facilities are reviewed against the standards set by NCQA, including a current valid license, clinical privileges, valid DEA or CDS certification, educational background (including board

certification), work history, malpractice claims history, professional liability 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 wishes to be a collaborative partner in the provision of health services. Questions or requests for information should be directed to the Credentialing Department at (715) 852-2093.

The Cooperative also welcomes providers to consider an agreement for delegated credentialing. Please contact the Provider Relations Department at (715) 852-5706 for information and consideration.

CREDENTIALING GUIDELINES:

- The Cooperative will not pay claims to a provider who is not fully credentialed at the time services are provided to the Cooperative 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 payor. 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 members as patients. This is to allow the Cooperative adequate time to process the application and complete all the required primary source verification.
- The Cooperative currently credentials:
    - Medical Doctors
    - Oral surgeons
    - Chiropractors
    - Osteopaths
    - Podiatrists
    - Nurse practitioners
    - Psychiatrists and other physicians
    - Doctoral or master's-level psychologists
    - Master's-level clinical social workers
    - Master's-level clinical nurse specialists or psychiatric nurse practitioners

  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 with a letter stating the Credentialing Committee decision and effective date.

- The Cooperative will re-credential network providers every 36 months. Any provider not credentialed within 36 months from previous credentialing approval date will no longer be considered part of the provider 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 to: credentialing@group-health.com. Items should be crossed out, no white out will be accepted.
- 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 3 – 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. Our 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 allow 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 network providers. Questions or requests for information should be directed to the Cooperative's Provider Services Department at (715) 552-4333 or (866) 563-3020.

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 providers, and we work to ensure our entire network understands the different cultural and linguistic needs of our members. To learn more about CLAS information and training, visit https://group-health.com/providers/clas-education-and-training.

Continuity and Coordination of 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 to 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 to improve continuity and coordination of care and communication between providers on our website at https://group-health.com/providers/quality-care-and-patient-safety

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 health care they receive from their providers.

Providers are also rated on how well they communicate including:

- How well they explained things?
- How well they listened?
- Did they show respect?
- Did they spend enough time?
- Did they coordinate care?

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.

Primary Care Provider Access Standards

Service	Access Standard
Life-threatening emergencies	Immediate access
Urgent Care	Within 48 hours
Routine preventive exam	Within 30 days

Prenatal Care Provider and OB/GYN Provider Access Standards

Prenatal Care Providers must provide medically necessary high-risk prenatal care within two weeks of the member's request for an appointment. Wait times for an appointment shall be no more than 30 days. OB/GYN access will be no more than 30 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 30 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 enrollee'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 https://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 on our website at https://group-health.com/providers/quality-care-and-patient-safety.

SECTION 4 – COMMERCIAL MEMBER RIGHTS & RESPONSIBILITIES

MEMBER RIGHTS

- A right to receive information about the Cooperative, its services, its practitioners and providers and member rights and responsibilities.
- A right to be treated with respect and recognition of their dignity and their right to privacy.
- A right to participate with practitioners in making decisions about their health care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about the Cooperative or the care it provides.
- A right to make recommendations regarding the Cooperative's member rights and responsibilities policy.

MEMBER RESPONSIBILITIES

- A responsibility to supply information (to the extent possible) that the Cooperative and its practitioners and providers need in order to provide care.
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Upon request a copy of the Member Rights and Responsibilities will be made available to members and providers via email, fax, or paper at no cost.

YOUR CIVIL RIGHTS

The Cooperative provides covered services to all eligible members regardless of:

- Age
- Color
- Disability
- National origin
- Political beliefs
- Race
- Religion
- Sex
- Sexual orientation

SECTION 5 – MEMBER IDENTIFICATION

TO IDENTIFY A COOPERATIVE MEMBER

- When the Cooperative member first arrives at the primary clinic, the member should have the Cooperative identification card available. The receptionist should courteously request to see the member's identification card. The clinic/provider staff should always verify a recipient's eligibility before rendering services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage.

- The Cooperative has on-line eligibility access available to contracted providers. If you do not currently have on-line eligibility access, please contact the Provider Services Department at (715) 552-4333 or (866) 563-3020 to establish an account. Execution of a Confidentiality Agreement is required for initial set-up.

  If the receptionist is unable to verify coverage by using one of the above options, the receptionist should call the Cooperative's Provider Services at (715) 552-4333 or (866) 563-3020; Monday through Friday from 7 a.m. to 6 p.m. to verify eligibility and benefits.

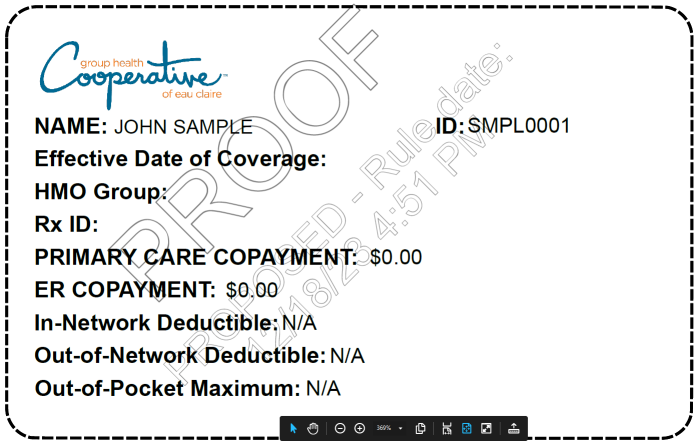
TO IDENTIFY THE MEMBER'S PRIMARY CLINIC

- The member's identification card (the Primary Clinic is shown on the front of the card.)
- If the Member does not have their identification card, call the Cooperative's Provider Services at (715) 552-4333 or (866) 563-3020; Monday through Friday from 7 a.m. to 6 p.m. to verify eligibility and benefits.

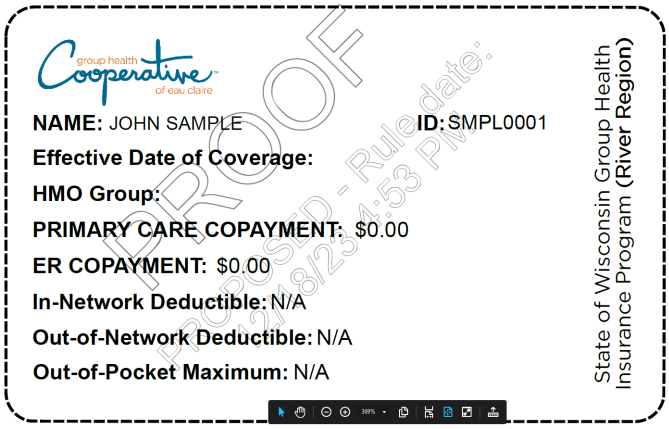
Note: Requests for a Primary Clinic change may be made by the patient only.

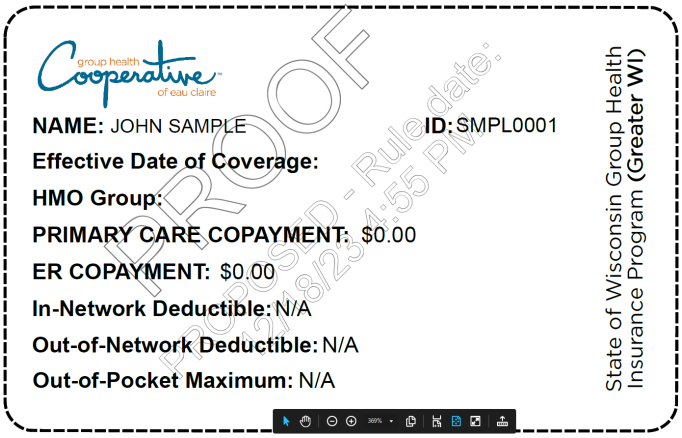
SAMPLE IDENTIFICATION CARDS

Cooperative Commercial Members



Cooperative State of Wisconsin Members





TERMINATION OF COVERAGE

Termination of a member's coverage may take place under many different circumstances, and can occur at any time. They are as follows:

- Group Coverage
  - Loss of Employment
  - Loss of Eligibility
  - Employee's Request
  - Employer Group's Request
  - Ineligible Dependents
- Individual Coverage
  - Subscriber's Request
  - Non-Payment of Premium
  - Loss of Eligibility (Age 65)
  - Ineligible Dependents

To verify coverage, call (715) 552-4333 or (866) 563-3020.

Recoupment of Claim Payments may occur if the patient is no longer covered on the date of service. If claims have been paid in error for an ineligible patient, our claims processors will contact the provider and request a refund.

SECTION 6 – UTILIZATION MANAGEMENT PROGRAM

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. The 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.

Our Utilization Management staff is not rewarded for issuing denials of coverage or service and is not given any financial incentives for health management decisions.

Medical necessity determinations are made using the following guidelines which are based on nationally recognized evidence-based clinical practice guidelines.

- InterQual medical necessity criteria sets and LOS 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 Policy and Procedures are developed when there is no InterQual criteria set or Hayes 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.

We expressly reserve 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 Center for Medicare and Medicaid Services (CMS). This is in no way to imply that providers cannot advocate for member resources.

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 https://group-health.com/members/tools-and-resources/health-and-wellness-programs.

EMERGENCY DEPARTMENT SERVICES

The Cooperative instructs all members to call their primary care clinic during regular office hours or contact Teladoc at 1-800-835-2362 after clinic hours, before proceeding to the emergency department, unless there is an "emergency medical condition" defined by the State of Wisconsin as:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in:

A. Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy.
B. Serious impairment of bodily functions.
C. Serious dysfunction of any bodily organ or part.
D. Or, with respect to a pregnant woman in active labor:
    a. There is inadequate time to affect a safe transfer to another hospital before delivery.
    b. The transfer may pose a threat to health and safety of the woman or the unborn child.

Other emergency situations as stated:

A. A psychiatric emergency involving a significant risk of serious harm to oneself or others.

B. A substance abuse (alcohol or other drug abuse) emergency exists if there is a significant risk of serious harm to a member or others, or there is a likelihood of return to drug abuse without immediate treatment.

C. Emergency dental care is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, fever, or trauma. In all emergency situations, the managed care program must document the nature of the emergency in the recipient's dental records.

In the absence of a finding by the Cooperative's Chief Medical Officer of justifying circumstances, including serious jeopardy to the health of the woman or her unborn child, obstetrical delivery of a child or children outside of the service area during or after the ninth (9th) month of pregnancy will not constitute an emergency medical condition.

Members and the providers who serve them should contact Group Health Cooperative's Health Management Department at (800) 218-1745 for all authorization and referral needs.

SECTION 7 – 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 https://group-health.com/providers/prior-auth-guidelines.

SECTION 8 – PHARMACY BENEFIT

The pharmacy formulary, including a list of drugs, restrictions, and preferences, is available at https://group-health.com/providers. Information about pharmaceutical management procedures including limits, quotas, generic substitution, step therapy protocols, and therapeutic substitutions can be found at the above link. The Cooperative website, https://group-health.com, also provides information on how to review lists of pharmaceuticals, copayment structure for restricted pharmaceuticals, and limitations on prescribing and access to pharmaceuticals. The "Formularies" link will direct you to the formulary. Members and prescribing practitioners can find information on how to submit an exception request by selecting "Forms and Resources." Exception policies for

coverage of non-formulary pharmaceuticals can be found here. Prior authorization resources and prior authorization forms are located within this section too.

SECTION 9 – PROVISIONS FOR INTERPRETERS/TRANSLATORS

As a contracted provider, access to interpreters must be available at all times. 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.

Assistance in locating translation/interpretation services is available online at the Wisconsin Department of Human Services website at www.dhs.wi.gov and specifically on the Limited English Proficiency Resources link at http://www.dhs.wisconsin.gov/civilrights/LEPresources.HTM.

SECTION 10 – 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 as well as commercial insurance services.

DEFINITIONS OF FRAUD, WASTE AND 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 cost.

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 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

B. State False Claims Laws

1. Medicaid Fraud Statute, s. 49.49 and s. 946.91, Wis. Stats.

a. This state Medicaid fraud statute prohibits any person from:

i. Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact in a claim for Medicaid benefits or payments.
ii. Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact for use in determining rights to Medicaid benefits or payments.
iii. Having knowledge of an act affecting the initial or continued right to Medicaid benefits or payments or the initial, or continued right to Medicaid benefits or payments of any other individual on whose behalf someone has applied for or is receiving the benefits or payments, concealing or failing to disclose such event with an intent to fraudulently secure Medicaid benefits or payments whether in a greater amount or quantity than is due or when no benefit or payment is authorized.
iv. Making a claim for Medicaid benefits or payments for the use or benefit of another, and after receiving the benefit or payment, knowingly and willfully converting it or any part of it to a use other than for the use and benefit of the intended person.
v. Anyone found guilty of the above may be imprisoned for up to six years, and fined not more than $25,000, plus three times the amount of actual damages.

The above laws are not exhaustive, merely a representation of certain FWA laws that may apply to any given circumstance. Please contact your Compliance Department and/or legal counsel 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 as a result 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.

Anyone who has concerns about retaliation should contact the Cooperative's Compliance Department immediately. The federal False Claims Act and Wisconsin statutes also protect those who report concerns.

To report instances of fraud, waste or abuse, or to report suspected retaliatory actions, please call the Cooperative's Compliance Department toll free at (715) 852-5725.