Commercial

Provider Manual

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

GHC22018

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,

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	**PHARMASTAR PBM** (888) 298-7770
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 CLAIM SUBMISSION – CLEARINGHOUSES

To expedite payment to you, the Cooperative encourages electronic billing whenever possible. Our most common payor ID is 95192. The Cooperative works with most major clearinghouses. In addition, the Cooperative exchanges electronic remittance advice with clearinghouses.

- Providers are not required to utilize a clearinghouse.
- The Cooperative does not charge claim submissions fees for a direct connection.
- Clearinghouses may charge a fee. It is the provider's responsibility to discuss these potential fees with the clearinghouse.

If you are able to create x12 837 files, you can fill out the one-page form found on the Cooperative's website at https://group-health.com/getmedia/291d65db-f48a-4a4a-ab73-9af24c6d68e6/ElectronicClaimsSub837.pdf to work on establishing a direct connection. No paperwork (including this form) is necessary to submit claims through a clearinghouse and is the preferred method.

In addition, the Cooperative has a setup form available for the following types of electronic transactions:

- Electronic Remittance Advice form
  https://group-health.com/getmedia/c86f506d-0830-4ad9-bddb-b2821b9389a7/ElectronicTransfer835.pdf
- Eligibility Benefit Inquiry and Response form
  https://group-health.com/getmedia/32c0d859-d0ac-485a-b91a-96fff06f7994/EligibilityBenefitInquiry270-271.pdf

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 http://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 re-submission of claims to ensure timely filing for resubmitted claims is followed.

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.

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. For your convenience, a provider appeal form can be located on the Cooperative's website at https://group-health.com/getmedia/f60c1176-f932-4a28-9408-029c7e388737/ProviderAppealForm.pdf

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) 836-7683 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) 836-7683 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 clinical processes are in place to provide our members quality care. This process allows the contracted provider and the Cooperative to develop a relationship. The Cooperative wishes to be a collaborative partner in the provision of health services.

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 at least ten weeks 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
    - Certified Nurse Anesthetists
    - 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.
- For Locum Tenens, the Cooperative requires prior written/telephone notification if the Locum Tenens will be providing services for less than 60 consecutive days.

- If the Locum Tenens will be providing services for more than 60 consecutive days, the Cooperative requires full credentialing.
- 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

Quality Improvement is an integrated process throughout the Cooperative organization. The mission statement for the Cooperative Quality Improvement program is:

"To objectively and systematically identify opportunities for improvement and to continuously assess the effect of improvement activities in order to meet or exceed internal and external customer expectations."

This statement provides specific direction regarding the focus of quality improvement for the Cooperative. In order to satisfy the goals of this mission statement, all the Cooperative providers and facilities must collaborate with and embrace the activities of quality improvement. Such activities include satisfaction surveys, population and random sample-based studies, and participation in multi-disciplinary teams for problem solving. These activities allow the organization to continuously improve upon processes of healthcare delivery in order to ensure that we are providing our members with highest quality of care in a cost-effective manner.

Activities of the quality improvement program are critically reviewed by NCQA. Members demand that organizations such as ours are held accountable for the services that are provided. Accreditation by NCQA provides the member with assurance that the Cooperative has appropriate quality improvement structures in place and that have a positive impact on healthcare delivery.

Providers are expected to cooperative with the Cooperative's QI activities to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of performance measurement data and participation in the organization's clinical and service measure QI programs and initiatives. The Cooperative may also use provider's performance data for quality improvement activities.

It is the Cooperative's policy to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs, in accordance with the National Standards of Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Cooperative has also aligned with the Wisconsin Department of Health Services initiatives in reducing health disparities. 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/quality-and-patient-safety.

HealthCare Effectiveness Data and Information Set (HEDIS)

The Cooperative uses HealthCare Effectiveness Data and Information Set (HEDIS) as both a clinical and service reporting tool. Each year employers and consumer groups use this tool to compare the performance of HMOs. HEDIS is the most widely used health care quality measurement tool in the United States. HEDIS reporting includes measures related access to services and preventive care across 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:

On an annual basis, The Center for the Study of Services (CSS) conducts the CAHPS Survey. This consumer satisfaction survey is nationally accepted and is a mandatory component of the HEDIS data submission. The CAHPS survey in addition to the HEDIS data submission (health-related measures) assist employer groups (along with the individual health plans) in evaluating the various health plans' performance at the state, regional, and national level through a publication called *Quality Compass*.

Information from quality improvement activities is actively shared with our providers and staff. We encourage constructive feedback and are available as a resource for quality improvement activities of Cooperative providers and facilities. Questions or requests for information should be directed to the Cooperative's Provider Services at (715) 552-4333 or (866) 563-3020.

Access Standards

All members have the right to receive timely access to medically necessary health care services. 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 Standards

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

Behavioral Health Care Provider 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

After Hours Coverage for Providers

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

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 in order 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.

SECTION 4 – COMMERCIAL MEMBER RIGHTS & RESPONSIBILITIES

Members have the RIGHT to:

- **Receive full benefits.** Receive all the benefits to which they are entitled under their plan.
- **Quality and timely care.** Receive quality health care through their Primary Care Clinic and network providers in a timely manner and in a medically appropriate setting.
- **Respect.** Be treated with respect and with due consideration for his or her dignity and privacy.
- **Privacy of health information.** Privacy and confidentiality concerning their medical care in accordance with the Cooperative's Notice of Privacy Practices, including the following rights:
  - Access and inspect health information. Request to access and/or inspect your protected health information in a designated record set. Please see the Notice of Privacy Practices for more information.
  - Accounting of disclosures. Receive an accounting of disclosures made by us of your protected health information after April 14, 2003. Please see the Notice of Privacy Practices for more information.
  - Restriction on disclosures. Request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. Please see the Notice of Privacy Practices for more information.
  - Copies of health information. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526
  - Alternate communications. Request that communications from the Cooperative be sent to an alternate location or by an alternate means. The Cooperative will accommodate reasonable requests for such confidential communications. You are not required to give a reason for this request.
- **Freedom from seclusions and restraints.** Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
- **Treatment options and alternatives.** Receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee's condition and ability to understand.
- **Cultural competency and nondiscrimination in service delivery.** Receive benefit and other important communications in alternate formats if needed, including non-English languages and via use of auxiliary aids/devices, in accordance with the Language and Accessibility Policy and Nondiscrimination Statement.
- **Informed consent.** Receive from a physician or other provider information necessary to give informed consent prior to the start of any procedure or treatment.

- **Participation in health care decisions.** Participate in discussion regarding his or her health care and appropriate or medically necessary treatment options, including the right to refuse treatment regardless of cost or benefit coverage.
- **Refuse treatment.** Refuse treatment to the extent permitted by law and to be informed of the medical consequences of that decision (including refusal to participate in research).
- **Benefit rules.** Receive written documentation regarding rules and regulations of their health care benefits.
- **Primary Care coordination.** Expect their Primary Care Clinic to coordinate and monitor their care.
- **Grievances and complaints.** Voice complaints or appeals about the Cooperative or the care it provides without facing discrimination.
- **Powers of Attorney and Advance Directives.** Designate an individual to make treatment decisions on their behalf in the event that they are unable to do so.
- **Direct access to certain care.** Receive direct access (without authorization or referral) to in-network women's health specialists for females seeking routine and preventive services, including mammography; and certain immunizations in an office setting (such as influenza and meningococcal).
- **Organization.** Right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities and make recommendations regarding the members rights and responsibilities policy.

Members have the RESPONSIBILITY to:

- **Select a network primary care provider.** Select their Primary Care Clinic from the Cooperative's Provider Directory. Primary Care Clinics will coordinate and monitor their member's health care needs.
- **Use the network for most services.** Use the Cooperative's providers, hospitals, laboratories or other diagnostic facilities whenever possible, unless members are in an emergency.
- **Provide accurate health information.** Provide complete and honest information about their health care status, including medications and allergies.
- **Report changes in health condition.** Report unexpected changes in their medical condition to their medical providers, and make it known whether they understand the contemplated course of action and what is expected of them.
- **Keep provider appointments.** Keep appointments and notify the medical office of their cancellation.
- **Notify us of demographic changes.** Notify the Cooperative whenever they change their address or phone number so that records may be updated.
- **Read and understand their benefits.** Read and understand their Member Handbook, policy form/documents, authorization guidelines, and other benefit and coverage information.

- **Coordinate benefits.** Provide accurate and complete information to the Cooperative about other health care coverage and/or insurance benefits they may carry.
- **Follow treatment plans.** Actively participate in care and follow the treatment plan recommended by their doctor.
- **Provide information on advance directives.** Notify the Cooperative and providers of any advance directives that may affect care.
- **Understand health problems.** 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.

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:

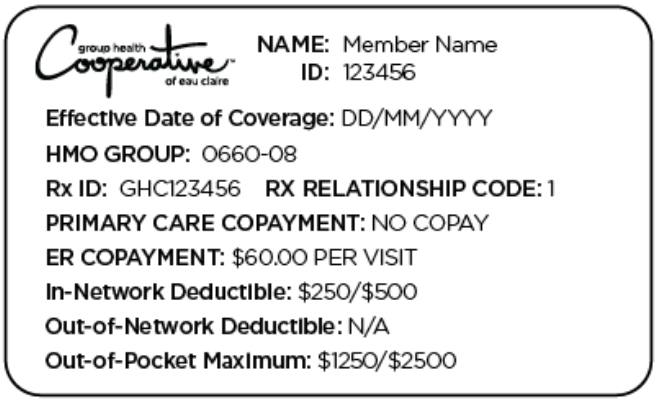
- The member's identification card (the Primary Clinic is shown on the front of the card.)
- If the Member does not have their identification card, call the Cooperative's Provider Services at (715) 552-4333 or (866) 563-3020; Monday through Friday from 7 a.m. to 6 p.m. to verify eligibility and benefits.

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

SAMPLE IDENTIFICATION CARDS:

Cooperative Commercial Members

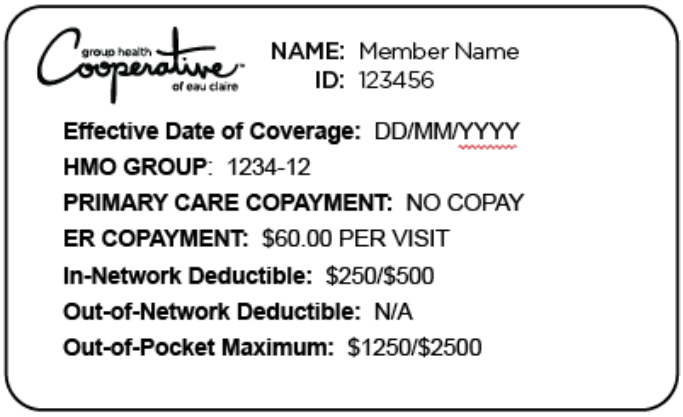
Front



Back

Cooperative State of Wisconsin Members

Front



Back

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 REVIEWS FOR MEDICAL NECESSITY

OVERVIEW OF 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 selected 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, Untied States Preventive Services Task Force, JNC 8, NHLBI asthma guidelines, 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 these conclusions 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).

DEFINITIONS

Concurrent Review: A collaborative process with hospital staff and/or attending physicians to provide information necessary for inpatient management. Information is transmitted by telephone or fax unless the anticipated length of stay for the patients' diagnosis is lengthened.

Prior Authorization: The process for obtaining an approval from the Cooperative that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by the Cooperative.

Medically Necessary: A service, treatment, procedure, equipment, drug, device, or supply provided by a network hospital, physician, or other health care provider that is required to identify or treat a member's illness or injury. That which is medically necessary is determined by the Cooperative using the following criteria: is consistent with symptom(s) or diagnosis and treatment of the member's illness or injury; is not primarily for the convenience of the member, physician, hospital, or other health care provider; is the most appropriate service, treatment, procedure, equipment, drug, device, or supply which can be safely provided to the member and accomplishes the desired result in the most cost-effective manner.

Non-Network Provider (or "out-of-network"): Non-contracted physicians, providers, clinics, and facilities outside the Cooperative's service area and/or those which do not have a contractual relationship with the Cooperative. The most current provider directory lists the Cooperative's network providers. All services, except emergency services, received from any non- network provider require prior authorization from the Cooperative.

Primary Care Clinic: A clinic contracted to provide primary care services to Cooperative members. The member must choose a primary care clinic for their care. Each member may have a different primary care clinic.

Primary Care Provider: The primary care provider evaluates the member's total health needs and provides personal medical care in one or more medical fields. Primary care providers include the following: Family Practice, Internal Medicine, Pediatric, and OB/GYN physicians.

INPATIENT CARE – UTILIZATION MANAGEMENT

All admissions to a hospital, inpatient rehabilitation facility and skilled nursing facility are reviewed for medical appropriateness of admission and continued stay. Notification to the Utilization Management Department of an inpatient admission and non-emergent intra facility transfer is required by the next business day. The Utilization Management staff will assess, in partnership with the facility, medical necessity of continued stay, assist in discharge planning and refer to case management services if appropriate.

Hospital admission notification associated with labor and delivery is only required if discharge is greater than two days following vaginal delivery or greater than four days following Cesarean delivery.

Concurrent Review

Concurrent Review for inpatient management is a collaborative process with hospital staff to provide concurrent review when the anticipated length of stay for the patient's diagnosis is lengthened. The concurrent review process may include, but is not limited to, the Cooperative staff providing review of medical records, discharge planning assistance, explaining health management decisions, and facilitating post-discharge care.

Authorization for services during concurrent review does not guarantee payment for services. Payment for services may be dependent on other non-medical criteria such as the benefits associated with a member's specific plan and eligibility issues.

- Utilization Management Staff use clinical decision support criteria to evaluate medical necessity and appropriateness of care;
- Potential quality issues identified during concurrent review are reported to the Cooperative's CMO.

Discharge Planning

Evaluation of discharge planning opportunities begins with the initial notification that an inpatient admission is being contemplated or has occurred. To facilitate an individualized discharge plan that effectively promotes the efficient use of medical resources in the most appropriate clinical setting, Utilization Management staff collect information from a variety of

sources such as medical records, the member, physician interaction and input from hospital nursing and discharge planning staff. Utilization Management staff identify patients whose diagnosis, intensive treatment requirements or co-morbidity factors make them likely candidates for intense discharge planning or specialized case management by the Cooperative.

SERVICES REQUIRING PRIOR AUTHORIZATION

All services requiring prior authorization must have prior authorization prior to delivery or, as in the case of an emergency inpatient admission, the next business day. Requests will be evaluated for medical necessity using evidence-based guidelines. When prior authorization is required, the facility, ancillary provider or physician rendering the services must verify with the Cooperative's Provider Services department that prior authorization has been approved before the services are performed.

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.

SECTION 7 – BEHAVIORAL HEALTH & ALCOHOL AND OTHER DRUG ABUSE (AODA) SERVICES

SERVICES REQUIRING PRIOR AUTHORIZATION

A complete list of the prior authorization guidelines can be found on the Cooperative's website at https://group-health.com/providers/prior-auth-guidelines.

SECTION 8 – PRIOR AUTHORIZATION GUIDELINES

Prior authorization for services does not guarantee payment for services. Payment for services is dependent on other non-medical criteria such as the benefits associated with a member's specific plan and eligibility issues. Prior authorization guidelines must be followed even if the Cooperative is secondary to another insurance plan, including Medicare.

If a member receives services that require an approved prior authorization by the Cooperative and such prior authorization is not obtained, or the prior authorization was denied because services were not deemed medically necessary, all services (including out-of-network and future related services and/or follow-up care related to the services) will be denied. This includes any ancillary, facility, and professional charges.

The current Prior Authorization Guidelines are located on the Cooperative's website. Also, providers are encouraged to contact Provider Services at (715) 552-4333 or (866) 563-3020 to confirm if a service requires a prior authorization and if a prior authorization request has been received and/or completed.

Any request for a member to obtain services from an out-of-network provider requires prior authorization by the Cooperative. The referring provider or out-of-network provider should complete the required request form located on the website.

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 Laws
   1. False Claims Act (31 U.S.C. Sections 3729-3733)
      a. The federal False Claims Act makes it a crime for any person or organization who:
         i. Knowingly files a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care program;
         ii. Knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care program; or
         iii. Conspires to defraud Medicare, Medicaid or other federally funded health care program by attempting to have a false or fraudulent claim paid.
      b. "Knowingly" means:
         i. Having actual knowledge that the information on the claim is false;
         ii. Deliberately ignoring whether the claim is true or false; or
         iii. Seeking payment recklessly without caring whether or not the claim is true or false.
   2. Program Fraud Civil Remedies Act (31 U.S.C. Sections 3801-3812)
      a. The Program Fraud Civil Remedies Act ("PFCRA") creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be enforced under the federal False Claims Act.
      b. The PFCRA imposes liability on people or entities that file a claim that they know or have reason to know:
         i. Is false, fictitious, or fraudulent
         ii. Includes or is supported by any written statement that contains false, fictitious, or fraudulent information;
         iii. Includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or
         iv. Is payment for property or services not provided as claimed.

B. State False Claims Laws
   1. Medicaid Fraud Statute, s. 49.49 (1), Wis. Stats.
      a. This state Medicaid fraud statute prohibits any person from:
         i. Knowingly and willfully make or cause to be made any false statement or representation of a material fact in any application for any benefit or payment.
         ii. Knowingly and willfully make or cause to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment.
         iii. Having knowledge of the occurrence of any event affecting the initial or continued right to any such benefit or payment or the initial or continued right to any such benefit or payment of any other individual on whose behalf someone has applied for or is receiving such benefit or payment, conceal or fail to disclose such event with an intent to fraudulently secure

such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.

iv. Having made application to receive any such benefit or payment for the use or benefit of another, and having received it, knowingly and willfully convert such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.

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. 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.