

Compensation and Claims Processing

Compensation

The network rate for eligible outpatient visits is reimbursed to you at the lesser of (1) your customary charge, less any applicable co-payments, coinsurance and deductibles due from the member, or (2) the CHIPA fee maximum, less any applicable co-payments, coinsurance and deductibles due from the member. Fee maximums can vary based on different insurance plans and are available upon request.

The contracted rate for Clinicians and POD/Groups is referenced in the Payment Appendix of the Participation Agreement and defines rates applicable to inpatient and/or outpatient care. For inpatient services: when the contracted rates include physician fees, the facility is responsible for payment of all treating physicians and for notifying the physicians that payment will be made by the facility and not CHIPA.

Financial records concerning covered services rendered are required to be maintained from the date of service for the greater of 10 years, or the period required by applicable state or federal law, whichever is longer. Any termination of the Participation Agreement has no bearing on this legal obligation.

Co-payments, Coinsurance and Deductibles

In most benefit plans, members bear some of the cost of behavioral health services by paying a co-payment, coinsurance, and/or deductible. Deductible amounts and structure may vary from plan to plan. Some deductibles are combined with medical services or there may be separate individual or family deductible amounts. Members should be billed for deductibles after claims processing yields an Explanation of Benefits indicating member responsibility. For co-payments, we encourage you to require payment at the time of service to avoid uncollectible bad debts. It is your sole responsibility to collect member payments due to you. Members are never to be charged in advance of the delivery of services. Benefit plans often provide for annual co-payment or coinsurance maximums. If a member states that he or she has reached such a maximum, call CHIPA to confirm the amount and status of the member's co-payment maximum.

Balance Billing For Covered Services is Prohibited

Under the terms of the Participation Agreement, you may not balance bill members for covered services provided during eligible visits, which means you may not charge members the difference between your usual and customary charges and the aggregate amount reimbursed by CHIPA and member co-payments.

Billing for Non-Covered Services and “No Shows”

In the event that you seek prior certification of benefits for behavioral health services and CHIPA does not certify the requested services, the member may be billed under limited circumstances. The member may be billed only if a written statement is signed by the member in advance of receiving such services. The statement must include: (1) that you have informed the member that CHIPA is unable to certify such services for coverage under the member's benefit plan; (2) the reason given by CHIPA for not authorizing the services; and (3) that as a result, the member may not receive coverage for such services under their benefit plan and will be financially

responsible. You are expected to continue providing services to members who have exhausted their covered benefits under the benefit contract. Members can be billed directly for those services and are to be charged no more than the network or POD/Group contracted rate. A sample Member Financial Responsibility Form can be found on our website. We encourage you to use this or a similar form when billing members for non-covered services.

CHIPA does not pay for sessions that a member fails to attend. You may not bill CHIPA for such sessions or services. A member who misses a scheduled appointment may be billed directly, provided you have advised the member in advance that this is your policy and the member has acknowledged the policy in writing. The member should be billed no more than the network or facility contracted rate. Note that some plan designs, as well as the government-funded programs Medicaid and Medicare, prohibit billing members for no-shows under any circumstance. Members are never to be charged a deposit or advance payment for a potential missed appointment.

Claims Submission

Although claims are reimbursed based on the network fee schedule or POD/Group contracted rate, your claims should be billed with your customary charges indicated on the claim.

Claims for services provided to patients assigned to CHIPA must be sent to the following:

Address: **College Health IPA**
17100 Pioneer Blvd, #420
Cerritos, CA 90701
Fax: **(877) 563-3480**

Electronic Data Interface (EDI): Electronic Data Interface (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interface between a practitioner (physician, psychologist, social worker) and a payer (CHIPA). You may choose to submit your claim electronically through Office Ally, which serves as the initial clearinghouse for electronic claims from providers. Office Ally offers their services at no cost to CHIPA providers. Our providers may submit claims through Office Ally through an online interface using the designated code for CHIPA. Claims submission by providers can be either a single claim or multiple claims. Office ally screens all electronic claims submitted by providers and notifies providers regarding any claims missing key information (e.g., diagnosis, CPT, Tax ID, etc.), which cannot be forwarded to CHIPA for processing. Office Ally forwards all clean claims to CHIPA via an electronic claims file. For more information on Electronic claims please go to our website and review our policy and procedure.

Clinician Claim Forms: Paper claims can be submitted to CHIPA using the CMS-1500 (formerly HCFA-1500) claims form, the UB-04 claim form, or their successor forms. The claims should include itemized information such as diagnosis (DSM-IV-TR or it's successor), length of session, member and subscriber names, member and subscriber dates of birth, member identification number, dates of service, type and duration of service, name of Clinician (i.e. individual who actually provided the service), credentials, tax ID and NPI numbers.

Claims Customer Service (800) 779-3825 option 5

Coordination of Benefits (COB)

Some members are eligible for coverage of allowable expenses under one or more additional health benefit plans. In these circumstances, payment for allowable expenses shall be coordinated with the other plan(s).

If one of our health plans is a secondary plan, you will be paid up to the contracted rate with CHIPA. You may not bill members for the difference between your customary charge and the amount paid by the primary plan(s) and CHIPA.

The provider is expected to cooperate and coordinate with CHIPA for the proposed determination of COB and to inform CHIPA of any other insurance reported by Enrollees. Should another health plan exist, the provider agrees to (1) notify CHIPA of the health plan name and Enrollee identification number, and (2) bill CHIPA for Covered Services in accordance with the Participation Agreement.

Processing and Payment of Claims

Participating providers must submit all information necessary to process claims to CHIPA within 90 days of the Date of Service using a **CMS (HCFA) – 1500**. Non-Participating Providers must submit their billing within 180 days of the Date of Service using the CMS (HCFA) –1500. The CMS (HCFA)-1500 is available on our web site.

The claim **must** include:

- Correct and complete Patient ID number
- Patient Name and Address
- Patient Date of Birth
- Patient’s Relationship to Insured
- Subscriber Name
- Assignment of Benefits – Signed by patient or “signature on file” reflected in HCFA box 12 and 13
- Treating Practitioner Name and Address
- Billing Practitioner Federal Tax ID Number
- Date(s) of Service
- Place of Service
- Procedure Code(s) – CPT-4
- Charges
- Days/Units
- Diagnostic Code(s) – DSM-IV or ICD-9 Codes
- Provider NPI

Claims should be submitted as directed by CHIPA. We strongly recommend that you keep copies of all claims for your own records should there ever be any questions raised regarding submission of claims. You permit CHIPA, on behalf of the payer, to bill and process forms (for third-party claims or for third-party payers), and execute any documents reasonably required or appropriate for this purpose. In the event of insolvency of the member’s employer or CHIPA, your sole redress is against the assets of CHIPA or the applicable payer, not the member. You must agree to continue to provide services to members through the period for which premiums

have been paid. Any termination of the Participation Agreement has no bearing on this requirement.

Generally, claims that contain all required information and match the referral certification will be paid within 30 calendar days after receipt, or as required by state and federal law. This may exclude claims that require Coordination of Benefits (COB) determination. Benefits are payable provided coverage is in force at the time expenses are incurred, and are subject to all limitations, provisions and exclusions of the plan. You will be paid for covered services by CHIPA and will not under any circumstances seek payment through CHIPA for plans for which CHIPA is not the payer or administrator.

As a reminder, claims submitted using Office Ally, are generally processed more quickly than paper claims.

CHIPA may occasionally make corrective adjustments to any previous payments for services and may occasionally audit claims submissions and payments to ensure compliance with applicable procedures, state and federal laws. CHIPA may obtain reimbursement for overpayments directly or by offsetting against future payments due as allowed by law.

The procedure for submitting and processing claims will be modified as necessary to satisfy any applicable state and federal laws.

Provider Dispute Resolution Process

A contracted provider dispute is a provider's written notice to CHIPA challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum, the following information: provider's name, billing provider's tax ID number or CHIPA's provider ID number, provider's contact information, and:

1. If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from CHIPA to a contracted provider the following must be provided: original claim form number (located on the RA), a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;
2. If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and
3. If the contracted provider dispute involves an patient or group of patients, the name and identification number(s) of the patient or patients, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and an patient's written authorization for provider to represent said patients.

All inquiries regarding the status of a contracted Clinician dispute or about filing a contracted Clinician dispute or other inquiries must be directed to the Provider Dispute Department at CHIPA at 800-779-3825 Option 5.

How to send a Contracted Provider Dispute to CHIPA

Contracted Clinician disputes submitted to CHIPA must include the information listed above, for each contracted Clinician dispute. To facilitate resolution, Clinician may use either the Provider Dispute Resolution Request form, available on our website at www.comprehensivebehavioral.com, or a personalized form to submit the required information. All contracted provider disputes must be sent to the attention of Provider Disputes at the following:

**CBHM/CHIPA
Provider Disputes
17100 Pioneer Blvd, #420
Cerritos, CA 90701**

► Instructions for Filing Substantially Similar Contracted Clinician Disputes

Substantially similar multiple claims, billing or contractual disputes, should be filed in batches as a single dispute, and may be submitted using either the Clinician Dispute Resolution Request – Multiple Like Claims form or a personalized form with the required information.

Time Period for Submission of Provider Disputes

Contracted Clinician disputes must be received by CHIPA within 365 calendar days from CHIPA's action that led to the dispute or the most recent action if there are multiple actions that led to the dispute or

In the case of inaction, contracted Clinician disputes must be received by CHIPA within 365 calendar days after CHIPA's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

Contracted Clinician disputes that do not include all required information as set forth above may be returned to the submitter for completion. An amended contracted Clinician dispute that includes the missing information may be submitted to CHIPA within thirty (30) working days of your receipt of a returned contracted Clinician dispute.

Acknowledgment of Contracted Provider Disputes and Resolution

CHIPA will provide written acknowledgement of receipt of all contracted Clinician disputes within fifteen (15) Working Days of the Date of Receipt by CHIPA.

CHIPA will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Working Days after the Date of Receipt of the contracted Clinician dispute or the amended contracted Clinician dispute.

Past Due Payments to Clinician

If the contracted Clinician dispute or amended contracted Clinician dispute involves a claim and is determined in whole or in part in favor of the Clinician, CHIPA will pay

any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) Working Days of the issuance of the written determination.

Claim Overpayments

Notice of Overpayment of a Claim

If CHIPA determines that it has overpaid a claim, CHIPA will notify the Clinician in writing through a separate notice. The notice will clearly identify the claim, the name of the patient, the Date of Service(s) and a clear explanation of the basis upon which CHIPA believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

Contested Notice

If the Clinician contests CHIPA's notice of overpayment of a claim, the Clinician, within 30 Working Days of the receipt of the notice of overpayment of a claim, must send written notice to CHIPA stating the basis upon which the Clinician believes that the claim was not overpaid. CHIPA will process the contested notice in accordance with CHIPA's contracted provider dispute resolution process described above.

No Contest

If the Clinician does not contest CHIPA's notice of overpayment of a claim, the Clinician must reimburse CHIPA within thirty (30) Working Days of the Clinician's receipt of the notice of overpayment of a claim.