

Frequently Asked Questions

The information below is a highlight of frequently asked questions by providers. Should you have any further questions or request for clarification, please contact our Network Management Department at (800) 779-3825 option 6, option 3.

Select the link below to go to the questions specific to that category:

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CHIPA Network Requirements

Who can I contact with specific questions or comments?

For general information and contractual questions, contact Network Management at 1-(800) 779-3825 and ask the operator to transfer you or chose option 6 then 3.

Do I have to notify anyone if I change my name, address, telephone number, or Tax Identification Number?

Yes. You are required to notify CHIPA within 10 calendar days, in writing, of any changes to your practice information. This is especially important for accurate claims processing.

Can I be considered a participating Clinician at one practice location and non-participating at another?

Yes. However, your Participation Agreement with CHIPA is not specific to a location or Tax Identification Number. It is important to provide CHIPA with all practice locations and the Tax Identification Numbers under which you bill.

Since our practice group has a CHIPA contract, does that mean all of our affiliated Clinicians are considered participating network Clinicians?

No. Only Clinicians contracted with CHIPA are considered CHIPA network Clinicians. The certification of a group does not guarantee that all Clinicians in practice there are network Clinicians.

May I bill for Mental Health/Substance Abuse (MH/SA) services that another practitioner, intern or assistant provides to CHIPA members in my office?

No. Under the insurance benefit, the treating provider must be licensed to practice independently in California. Authorizations are only issued to treating providers and should never be assigned to an intern. Please visit our website (www.comprehensivebehavioral.com) to review the guidelines.

As a contracted group, are we required to notify CHIPA in the event that we discontinue or change a program or service?

Yes. Contracted groups are required to provide CHIPA with written notification of changes in the services they offer within 10 calendar days.

As a contracted group, would the addition of programs, services or locations require review of our current contract with CHIPA?

Yes. Contact the Network Management Department to initiate a review.

If my practice is filling up or if I am going to take a leave of absence from my practice, may I choose to be unavailable for new CHIPA referrals?

Yes. You may request to be listed in our database as unavailable at one or more of your practice locations for up to six months. You are required to notify Network Management within 10 calendar days of your lack of availability for new referrals.

Are there procedures to follow if I withdraw from the CHIPA network?

Yes. The terms and conditions for withdrawal from the network are outlined in your Participation Agreement. For additional details, or to initiate the process, contact Network Management.

Benefit Plans, Obtaining Certifications and Access to Care

Should I routinely contact CHIPA regarding eligibility and benefits?

Yes. Services and/or conditions not covered under the members' specific benefit plan are not eligible for payment. Each Health plan complies with regulatory requirements related to coverage election periods and payment grace periods. These requirements can lead to delays in CHIPA's knowledge of a members' eligibility status. As a result, the member is usually the best source for timely information about eligibility; coverage changes and services utilized to-date.

How can I tell which contract my member is under?

The authorization letter lists the contract under Benefit Information, Insurance.

AB = Anthem BlueCross

AT = Aetna Behavioral Health

MHN = Managed Health Network

PB = PacifiCare/United Behavioral Health

TM = Talbert Medical Group

Which authorization number should I use when submitting claims to CHIPA?

Use the "Certification Number" (e.g., 555555-01-01).

Can I inquire about a member's current eligibility, certification and benefits?

Yes. You can inquire about eligibility and benefits by calling our intake department at 1-(800) 779-3825.

Can members initial certification of benefits for routine outpatient MH/SA services?

Yes. The certification for routine outpatient services is typically obtained through a telephone contact between the member or family member and an Intake Staff. However, if a certification has not been issued at the time you inquire about eligibility, then you need to request it. You may do this by calling the Intake Department.

Do all members require prior certification for outpatient treatment?

Yes. For CHIPA members whose benefit plan does not require prior certification, there is no need to ensure that a certification has been issued by CHIPA. It is a good practice to verify with the member the current status of his or her coverage. You may also inquire about a member's benefit plan requirements by contacting the Intake Department.

Are all services I provide covered under a MH/SA authorization?

No. The certification issued to members' covers most common routine outpatient MH/SA services you provide.

Please note that psychological testing, home visits, intensive outpatient care and other non-routine outpatient MH/SA services still require Clinician-specific or program-specific certification of benefits prior to providing those services. To obtain those certifications, please call the Intake Department.

UBH/PBH Only: Is the Wellness Assessment (WA) administered more than once?¹

Yes. The WA is administered at the first session or in the second session if the member presents in crisis during the first session. It is administered again preferably at the third visit, but may be given at either the fourth or fifth visit. The exact timing is at the Clinician's discretion. An additional WA may be requested typically at session eight, nine, or ten for a subset of members who have been identified as "at-risk". Note that if the member does not return for a second session and did not complete a WA in the first session, please complete the member and Clinician demographic sections located at the top of the WA and return it to CHIPA as indicated on the instruction page.

UBH/PBH Only: If a member discontinues treatment but returns several months later, is another WA required at that time?¹

Yes. You should consider this a new episode of care, requiring the completion of a new WA with the filing of a 90801 CPT code. Keep in mind that if the member returns to treatment within six months of his or her last certification, that certification is still valid up to the benefit limit as long as the member's eligibility remains active. Renewal of certification will be required at the end of that one-year period.

UBH/PBH Only: When I work with couples or families, should each person seen be given a WA?¹

No. The member for whom you make claims submissions should complete the WA. In the case of members who are minors (except for minors who are emancipated or able to consent to their own treatment under the laws of your state), the parent or guardian should be asked to complete the Wellness Assessment – Youth, answering the questions as they relate to the identified member.

¹ Applied to PBH/CHIPA members only

UBH/PBH Only: Is there a way to ensure confidentiality with the WA for emancipated minors who are requesting services?¹

Yes. In these circumstances, you should only complete the demographic sections located at the top of the WA and return it to CHIPA. Fill in the bubble labeled “MRef” for member refusal. A follow-up assessment will not be sent to the adolescent’s home.

UBH/PBH Only: Are psychiatrists and A.P.R.N.s with prescriptive authority expected to participate with ALERT®?¹

No. While administering the WA is not required, psychiatrists and A.P.R.N.s may utilize this instrument to track member outcomes.

Is there a time limit in which an Authorization of services is valid?

Yes. The authorizations of services is typically valid for one year from the date of issue up to the benefit limit as long as the member’s eligibility remains active.

Will I be notified when an authorization expires?

No. Please refer to the effective date on the most recent authorization letter. The authorization is typically valid for 12 months from the date of issue (up to the benefit limit as long as the member’s eligibility remains active).

Does the use of the authorization change the requirements for medical necessity?

No. All care certified by CHIPA, even under the authorization process, must meet medical necessity standards.

Is a consultation with a Care Manager necessary to refer members directly to inpatient day treatment or intensive outpatient services?

Yes. Inpatient and subacute level of care admissions are pre-certified by an Intake Specialist. In the even of an emergency admission, facilities should immediately notify CHIPA.

Do I have to request additional authorizations through case management?

Yes. Claims department does not have access to create authorizations due to established accounting guidelines.

Treatment Philosophy

Can I get a copy of CHIPA’s Level of Care Guidelines and Best Practice Guidelines?

Yes. The Level of Care and Best Practice Guidelines are available on our website along with the Supplemental and Measurable Guidelines. You may also contact Network Management or the specific Health Plan, to have a paper copy of these documents mailed to you.

Am I expected to coordinate care with a member's primary care physician or other health care professionals?

Yes. CHIPA requires network Clinicians, both in and out of facilities, to pursue coordination of care with the member's primary physician as well as other treating medical or behavioral health Clinicians. A signed release of information should be maintained in the clinical record. In the event that a member declines consent to the release of information, his or her refusal should be documented along with the reason for the refusal. In either case, the education you provide regarding risks and benefits of coordinated care should be noted.

Compensation and Claims

Can members be billed prior to claims submissions?

No. Members are never to be charged in advance of the delivery of services. Members should be billed for deductibles after claims processing yields an Explanation of Benefits indicating member responsibility.

Do I collect co-pay or deductibles from members?

Yes. To determine which co-pay to collect: read the notes on the bottom of the authorization letter regarding parity diagnosis. If your billing diagnosis is listed under the parity diagnosis collect the lower parity co-pay. If your billing diagnosis is not listed, collect the standard co-pay.

How should I submit claims?

Claims can be faxed to CHIPA, using the HCFA Form to 1-877-563-3480.

Is there one format to be used for diagnosis on claims?

Yes. Submit your claims with standard DSM-IV codes or ICD-9-CM diagnostic codes for facilities.

Are there different methods or claim forms I should use when submitting claims to CHIPA?

Yes. See below.

Electronic Claims: CHIPA recommends electronic submission of claims for the most efficient claims processing. Network Clinicians and group practices can submit MH/SA claims electronically through Office Ally. This is another secure transactions are accessed through a registered User ID. [To obtain a user ID](#), contact Office Ally. In addition, any Clinician or POD/Group practice, or facility provider can submit claims electronically through EDI clearing house using payer ID CHIPA.

Clinician Claim Forms: paper claims for MH/SA service should be submitted to CHIPA using the CMS-1500 Claims Form, or its successor form. All paper claims must be typewritten.

Facility Claim Forms: Paper claims should be submitted to CHIPA using the UB-04 billing format, or any successor forms as appropriate.

With all of the different products that CHIPA manages, is there an easy way for me to determine where to send my claim?

Yes. Send via fax to the CHIPA Claims Department at 1-877-563-3480.

Do I have to submit my claims within a certain period in order for them to be paid?

Yes, with Aetna, MHN and Talbert you have 365 calendar days from date of service to file your claim. With PBH/CHIPA you will have 90 calendar days from date of service to file if not then your claim may be denied for timely filing.

How many dates of services can I bill at one time?

Each HCFA form allows billing of up to six dates of service. If you are billing for more than six dates of service at a time, you must submit on multiple HFCA Forms (e.g. ten dates of service equals two HCFA Forms, six on one, and 4 on the other).

May I bill the member for “no-shows” or late cancellation?

No. Providers can bill member for a no show or late cancellation only after member has signed acknowledgement that they will be charged for a non-covered service. Therefore, if it is the first session that is either a late cancellation or no show, you cannot bill the member.

May I bill the member for “no-shows” or late cancellation?

No. Exceptions may be made on a case-by-case basis only after provider has spoken with a CHIPA Case Manager.

May I bill the member for any sessions denied by CHIPA?

No. The only time a provider can bill patients for sessions is if:

- 1) Member was ineligible at the time of service
- 2) Patient’s benefit was exhausted
- 3) Service provided was not covered under the benefit.

If denial is due to lack of pre-authorization and/or authorization outside of authorization dates, member cannot be billed. In these situations, member can only be charged their co-pay.

May I submit a claim to CHIPA for telephone counseling or after-hours calls?

No. CHIPA covers telephone counseling in some situations, when clinically necessary and appropriate. Telephone counseling must be pre-certified by CHIPA.

May I balance bill the member above what CHIPA pays me?

No. You may not balance bill members for services provided during eligible visits, which means you may not charge the members the difference between your usual and customary charges and the aggregate amount reimbursed by CHIPA and member co-payments.

Legal and Ethical Practices

What do I do if I'm treating a couple with insurance?

While couples therapy is a covered benefit as a treatment strategy, ***all insurance benefits are administered under a single individual.*** As a result, ***providers must designate the "identified patient"*** and complete all charting and billing as it pertains to this individual.

- The treatment plan must address the diagnosis and symptoms of the identified patient and not the couple as a unit.
- Progress notes must indicate the identified patient's response to treatment.
- Couples therapy claims (90847) can only be submitted under the identified patient's record.
- If the partner of the identified patient needs to be seen individually, a completely separate authorization, chart, and claim is required.
- Individual sessions for the partner cannot be documented in the identified patient's chart and cannot be billed under the identified patient's authorization.

Not Acceptable Documentation	Acceptable Documentation
John and Helen seen together. Helen reported increased depression due to ongoing arguments with John over finances. John quiet and withdrawn. Practiced assertive communication skills.	Patient and spouse seen together. Patient quiet and withdrawn in response to increased arguments in home over finances. Practiced assertive communication skills to engage patient.

Confidentiality concerns are created whenever medical records include clinical information for both partners in a single chart. If the couple ends their relationship and one partner later requests the medical records, the chart can not be released without both partner's signatures. To release records without both partners' signatures is a breach of confidentiality for the non-requesting partner.

The recommendation is that providers create a separate informed consent form for couples' treatment, which clearly describes the manner in which documentation is kept and the requirements to release documentation. Both partners should sign this consent form.

Quality Improvement

Does CHIPA audit Clinicians and Group Practices?

Yes. CHIPA representatives conduct treatment record audits with reviews of select high-volume Clinicians, random routine audits, telephone audits, and audits to address quality of care issues brought to the attention of CHIPA.

Privacy Practices

Do HIPAA Regulations allow me to exchange Protected Health Information (PHI) to CHIPA?

Yes. The HIPAA Privacy Rule permits Clinicians and CHIPA to exchange PHI, with certain protections and limits, for activities involving Treatment, Payment, and Operations (TPO).

Do I need a National Provider Identification to submit electronic claims?

Yes. HIPAA mandates that all health care providers conducting standard electronic transactions (such as electronic claims submission) must obtain and use a unique identification number known as the National Provider Identifier (NPI). Some states presently require an NPI for paper claims as well.

Appeals

Can I initiate the Appeals process if I disagree with CHIPA's decision not to authorize services I have requested?

Yes. Although, CHIPA is not delegated for the appeals process for any of the primary insurance companies. CHIPA can assist by direct providers to the appropriate Appeals and Grievance Departments for the purpose of filing a formal appeal.

- An expedited appeal can be requested for any member that is determined to be at risk as a result of denied services. An expedited appeals should be pursued as quickly as possible following an adverse determination. Expedited appeals must be responded to by the primary insurance company within 72 hours from the time the appeal is filed.
- For routine appeals, there is an established 180-day time frame in which a Clinician or member can request the appeal. These time frames apply unless otherwise mandated by state law. Routine appeals must be responded to by the primary insurance company within 30 days from the time the appeal is filed.

Are there different contacts for issues with claims processing or payment?

No. You can call CHIPA at 1-(800) 779-3825, select option 5 for claims department. You may mail a Claims Dispute Resolution Request to CHIPA at the claims address:

College Health, IPA
Attention: Claims Department
17100 Pioneer Boulevard, Suite 420
Cerritos, CA 90701
or
Fax: 1-(877) 563-3480