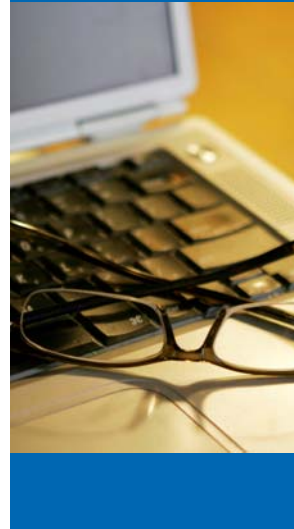


# Network Manual



College Health, IPA  
Comprehensive Behavioral Health Management



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# Introduction

Welcome to CHIPA! We are excited to have you as a member of our growing network of high-quality Clinicians. By joining our panel, you're helping us in serving more than 1.4 million members of various populations. CHIPA is distinguished by:

**Our network and services**

**Our clinical focus**

**Our innovation**

Our Network Manual is a comprehensive document that explains our company, and how to do business with us. We strongly encourage our network participants to become familiar with all aspects of this manual. Because we value your time, we have incorporated a list of principal contacts and a FAQs section for quick reference on the key things you will need to know how to work effectively with CHIPA.

CHIPA believes we are engaged in a partnership with our network Clinicians and Groups, and that the basis of this partnership is mutual benefit, and benefit to the members we mutually serve. We strongly encourage dialogue, and are open to your ideas. Thank you for participating.



**Randy Davis, PhD**  
CEO and President  
College Health, IPA

# About College Health IPA

Beginning in 1990, Comprehensive Behavioral Health Management and its partner College Health IPA, identified a need to provide cost effective and efficient high quality behavioral healthcare that was provider driven. Since that time this successful relationship has grown to become a leading regional behavioral health delivery system in California by serving more than 1.4 million members with a provider panel of over 2,500.

Today, CHIPA is building upon our longstanding commitment and record of accomplishment for adding value to the lives of our members, providers and business partners by expanding our scope of service to meet the needs of the emerging market for specialty behavioral healthcare management services.

## Mission

To achieve excellence in the delivery of integrated behavioral health and wellness services by:

- Exceeding national standards for quality
- Enhancing the coordination of care between healthcare organizations and providers
- Promoting consumer awareness and choice
- Encouraging Clinician' use of evidenced-based, "best practice" treatments

Maximizing operational efficiencies and providing cost effective solutions.

## Vision

To improve the quality of healthcare by advancing the integration of behavioral health and wellness services through collaborative partnerships with consumers, providers, employers and healthcare organizations.



# CHIPA Resource Guide

## Web Site

[www.comprehensivebehavioral.com](http://www.comprehensivebehavioral.com)

Our Clinician Web site is an excellent first-line resource to:

- Download standard forms
- Find Department contacts
- Review clinical guidelines
- Locate current and archived issues of our Newsletters

This website does not require you to log on with a user ID.

## Key Forms and What You Need to Know

You may obtain forms by calling CHIPA at 1(800) 779-3825 or by going to our website mentioned above.

## Customer Service/Claims

Clinical Services	(800) 779-3825
Inpatient	Option 6, Option 1
Outpatient	Option 6, Option 2
Claims Department	Option 5

To ensure property processing of claims, it is important to contact Network Management if you change your Tax ID number or other practice information.

## Fax Numbers

Claims Department	(877) 563-3480
Clinical Services	(877) 803-3182
Network Department	(877) 349-1135

## For Further Assistance

For general information and contractual questions, contact Network Management **at 1(800) 779-3825 option 6 then option 3.**

# CHIPA Network Requirements

## Clinical Network Development and Credentialing

CHIPA is responsible for maintaining an adequate range of providers for the membership we cover. Therefore, we offer a network consisting of licensed qualified professionals from the disciplines of psychiatry, psychology, psychiatric nursing, clinical social work, and licensed counseling. These Clinicians represent an array of clinical and cultural specialities. The network includes a variety of programs and levels of services which allows us to meet the clinical, cultural and geographical needs of our members.

CHIPA provides all network development and assists in provider credentialing activities. The network development department is responsible for identifying and maintaining the provider and POD/Group directory. This is an ongoing project which is monitored closely to make certain that at all times provider numbers, diversity and specialties meet the expectation of our various business partners, therefore, providing a comprehensive choice to their members. The College Health IPA Provider Network is divided into two groups. 1) PODS (Priority Office Designations) which are multi-disciplinary group practices and 2) Wraparound Network which includes individual providers who are utilized when the member request is unable to be met by the PODS. Network development models have been developed to ensure that there is timely access to services in all geographic regions where College Health IPA is contracted.

## Non Discrimination

CHIPA does not deny or limit the participation of any Clinician or POD/Group in the network, and/or otherwise discriminate against any Clinician or POD/Group based solely on any characteristic protected under state or federal discrimination laws.

Furthermore, CHIPA has never had a policy of terminating any Clinician or POD/Group because the Clinician or POD/Group representative: (1) advocated on behalf of a member; (2) filed a complaint against a health plan; (3) appealed a decision of CHIPA or the payer; or (4) requested a review of a termination decision or challenged a termination decision of CHIPA or their health plans. Nothing in the Participation Agreement should be read to contradict, or in any way modify, this long-standing policy and practice of CHIPA.

## Clinician Credentialing and Re-Credentialing

CHIPA does not conduct credentialing or re-credentialing. However, we do submit the provider application to the applicable health plans the provider is applying to join. The criteria include (but are not limited to) satisfaction of the following standards:

- Independent licensure or certification in your state(s) of practice
- Licensure at the independent level for at least two years
- License is in good standing and free from restriction and/or without probationary status
- Board Certification or Board Eligibility (to complete prior to the recredentialing cycle) for psychiatrists

- Current certification through the Federal Drug Enforcement Agency (DEA) for prescribing Clinicians
- Professional Liability Coverage: a minimum of \$1 million occurrence/\$3 million aggregate for master's-level and doctoral-level Clinicians and a minimum of \$1 million/\$3 million for physicians (exceptions to these require insurance amounts may be made as required by applicable state law)

You will be asked to sign a release of information granting CHIPA and its health plans access to information pertaining to your professional standing. This requirement for primary verification and/or review of records from any professional society, hospital, insurance company, present or past employer, or other entity, institution, or organization that does or may have information pertaining to your professional standing. This is necessary to complete the credentialing process. Failure to provide such release will not allow credentialing to be complete and will adversely affect your ability to participate in the network.

There are specific requirements for identified specialty areas. If you request recognition of a specialty area, an attestation statement may be required documenting the specific criteria met for the identified specialty. Current competency of a designated specialty is randomly audited to ensure that network Clinicians remain active and up-to-date in their specialty field attestations.

The Participation Agreement addresses the requirements for participation and the events justifying disciplinary action, including termination of participation in the network. The Participation Agreement can be mailed at your request by contacting Network Management.

## POD/Group Credentialing and Re-Credentialing

As part of the credentialing and re-credentialing process, facilities are required to submit documentation supporting their professional and community standing and defining their program offerings. This documentation includes (but is not limited to):

- Current copies of all licenses required by your state for the services you offer
- Current copies of accreditation certificate and/or letter from accrediting body
- General and professional liability insurance certificates
- W-9 forms
- Signed malpractice claims statement/history
- Staff roster, including attending physicians
- Daily program schedules
- Program description
- POD/Group Billing Information Form

The Participation Agreement addresses the requirements for participation and the events justifying disciplinary action by CHIPA, up to and including termination of participation. You may request a paper copy of the Participation Agreement may which can be mailed to you by contacting the Network Management Department.

## Credentialing and Re-Credentialing Rights and Responsibilities

As an applicant to the CHIPA network, or as a network Clinician in the process of re-credentialing, you are entitled to:

- Be informed of your rights
- Be informed of credentialing or re-credentialing status upon request
- Review information submitted to support your credentialing or re-credentialing application; this does not apply to personal or professional references, internal CHIPA documents, or other information that is peer-review protected or restricted by law
- Make corrections to erroneous information identified by CHIPA in review of credentialing or recredentialing application

In addition to the above rights, you have the following responsibilities:

- To submit any corrections to your credentialing or re-credentialing application in writing within 10 business days of your notification by CHIPA
- To provide updated demographic information within 10 calendar days of the occurrence of any changes

## Written Notification of Status Changes for Clinicians or PODs/Groups

You are required to notify CHIPA in writing within 10 calendar days of any changes to:

- The status of the practice, including changes in practice location, billing address, or telephone or fax number (or changes in practice ownership)
- The status of professional licensure and/or certification such as revocation, suspension, restriction, probation, termination, reprimand, inactive status, voluntary relinquishment, or any other adverse action
- The status of professional liability insurance
- Potential legal standing (any malpractice action or notice of licensing board complaint filing)
- The Tax Identification Number (TIN) used for claims filing
- The programs you offer (services you provide must continue to meet our credentialing criteria)

Changes submitted in writing, via mail or fax, should be sent by Clinicians to Network Management (see the CHIPA Resource Guide chapter of this manual).

## Clinician Unavailable Status

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. You will be sent a letter confirming

that your request has been processed. When you have been on unavailable status for five consecutive months, we will send you a letter reminding you that you will be returned to active status within 30 calendar days. You may contact Network Management to request an extension of your unavailable status. Should you decide that you want to return to active status sooner than expected, you may notify Network Management.

Some common reasons for requesting unavailable status are extended illness, vacation or leave plans, and lack of available appointments. Please note that while on unavailable status your contract remains in effect.

## Telephone Contact

A Clinician's office staff should only contact a patient by phone if they are returning a patient's call or the patient has given permission through CHIPA for the Clinician to contact the patient. Clinician or staff, when leaving a message with anyone other than the patient, including an answering machine, should leave only their name and phone number. No other identifiers, including type of doctor, nature of the call, or office name should be left on a machine.

Clinician's should return all patient phone messages within one business day.

When a Clinician has telephone contact with a patient to arrange for an initial appointment s/he should assess the reason patient is seeking treatment in order to determine if referral is appropriate. Clinicians should also provide crisis intervention as needed.

When a Clinician must cancel a scheduled appointment, the following guidelines should be followed:

1. When possible, at least 24 hours notice of cancellation should be given to patient
2. When possible, a choice of alternative appointments should be offered at the time of the cancellation.
3. When the Clinician leaves a message for the patient, the provider should attempt to make telephone contact with the patient at least one time per day until an alternate appointment has been scheduled.

## On-Call and After-Hours Coverage

You must provide or arrange for the provision of assistance to members in emergency situations 24 hours a day, seven days a week. You should inform members about your hours of operation and how to reach you after-hours in case of an emergency. In addition, any after-hours message or answering service should provide instructions to the members regarding what to do in an emergency situation. When you are not available, coverage for emergencies should be arranged with another participating Clinician. Because certification of benefits may be required, CHIPA must be contacted.

## Appointments

If a patient walks into a clinical practice without an appointment and it is clear that the patient is covered by CHIPA, the provider should attempt to call CHIPA staff member.

- CHIPA staff will determine eligibility and provide verbal authorization for appropriate treatment. Written authorization is faxed or mailed within one business day.
- CHIPA staff will be available to assist with crisis intervention and emergency services as needed.

If a CHIPA patient arrives at a scheduled appointment and the provider does not have a copy of the authorization, the provider should attempt to call a CHIPA staff member and/or ask the patient to call.

- CHIPA staff will ensure authorization is in place and verbally confirm with provider. Written authorization is faxed or mailed within one business day.
- Provider should keep appointment as scheduled.

## Psychological Assistants and Interns

In accordance with the Participation Agreement, the services you provide must be provided directly by you for all members. Participating Clinicians may not submit claims in their name for treatment services that were provided by a psychological assistant, nurse practitioner, intern, or another Clinician. If you have questions regarding coverage for psychological testing, interpretation or report writing, you can contact the Clinical Services Department for assistance with such questions.

## Compliance with Plan Contracts

The participating provider hereby agrees to be bound by any and all provisions of agreements between IPA and contracting Plans, medical groups and independent practice associations which are specifically applicable to, or required of, Participating Professionals.

## Termination of Clinician or PODs/Groups Participation

The participation of a Clinician or a POD/Group with CHIPA can end for a variety of reasons. Both parties have the right to terminate the contract with CHIPA and its health plans, upon written notice, pursuant to the terms of the Participation Agreement.

If you need clarification on how to terminate your agreement, you may contact Network Management.

In some cases, you may be eligible to request an appeal of a termination or restriction of your participation with the applicable health plans. If you are eligible for an appeal, CHIPA will notify you of this in writing within 15 calendar days of the adverse action. The written request for appeal must be received by the health plan within 30 calendar days of the date on the letter which notified you of any adverse action decision. Failure to request the appeal within this timeframe constitutes a waiver of all rights to appeal and acceptance of the adverse action.

The appeal process includes a hearing committee of at least three members, appointed by the Health plan, who are not in direct economic competition with you, and who have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. You may be

represented by a person of your choice at the Appeal Hearing, including legal counsel. The Appeals Committee's decision is by a majority vote of the members. The decision of the Appeals Committee may uphold, overturn, or modify the recommendation of Health plan. The Appeals Committee's decision is final and the specific reasons for the decision are sent to you via certified letter within 30 calendar days after the due date for you to have submitted any final written summary.

## Continuation of Services after Termination

Network Clinicians who voluntarily withdraw from the CHIPA network are required to notify CHIPA, in writing, 90 calendar days prior to the date of withdrawal. With the exception of terminations due to quality-related issues, fraud or change in license status, Clinicians are obligated to continue to provide treatment for all CHIPA members under their care for a period of 90 calendar days after the effective date of the contract termination until one of the following conditions is met (whichever is shortest):

- The member is transitioned to another CHIPA Clinician
- The current episode of care has been completed
- The member's benefit limit has been reached
- The member's Health plan benefit is no longer active

Please note that state-specific laws will be followed when they provide for a longer post-termination timeframe. To ensure continuity of care, CHIPA will notify members affected by the termination of a Clinician at least 30 calendar days prior to the effective date of the termination whenever feasible. CHIPA will assist these members in selecting a new Clinician.

# Access/Referral and Utilization Management

## Access and Referral

Our number one priority is to offer members timely referrals to the appropriate level of care. Whether the member, primary care physician, or family member is calling for a routine, urgent or emergency referral, CHIPA Intake Specialists and professionally licensed Clinicians work efficiently to insure that each member receives the opportunity for an effective and positive treatment experience.

### Access and Referral services include:

- 24 hour 7 day a week access for referrals
- Clinical Assessment conducted by licensed professional staff for all urgent/emergent referrals
- Culturally diverse staff
- All calls answered live through Automatic Call Distribution Center
- Prompt, warm transfer scheduling for all urgent and emergent referrals
- Coordination with facilities for admissions to higher levels of care
- All NCQA call standards for access are met on a consistent basis

## Utilization Management

The Utilization Management Department is responsible for establishing and monitoring all clinical services provided by CHIPA. Through the UM Committee structure the CHIPA Medical Director, Vice-President of Clinical Service, Director of Intensive Services, and Director of Care Management monitor for compliance of all approved targets and standards including:

- Access & Referral
- Post Discharge Follow Up Appointments
- Denials and Appeals
- Continuity of Care Authorizations
- Primary Care Coordination
- Utilization Trends
- Case Management Review Timeliness

**Case Management** is one of the major activities of the Utilization Management Department. All case management services for ambulatory and inpatient services are provided by licensed staff, in accordance with approved clinical guidelines. Level of care and medical necessity criteria are part of the case management function while quality of care remains a primary focus. Case Management services include:

- Outpatient/Ambulatory Concurrent Review
- Continuity of Care
- Primary Care Coordination
- Inpatient Review
- Physician to Physician Review
- Intensive Case Management
- Identification of High Risk Populations
- Denials and Appeals
- Provider Education & Training

# Treatment Philosophy

Comprehensive Behavioral Health Management/College Health IPA (CHIPA) treatment philosophy, integrated throughout our intensive and outpatient programs, reflects the clinical “values” we believe research and clinical practice have shown to be the most effective means of producing the kind of rapid, generalizable behavioral gains which we and our patients seek.

- We mutually identify and actively address the critical biological, psychological, and social impairments, which have necessitated each patient’s treatment.
- We strive to develop an empathetic understanding of each patient.
- We focus on reinforcing each patient’s strengths and resources, and together build on this healthy foundation through the teaching of specific, practical cognitive/behavioral and interpersonal skills.
- We Coordinate care with other healthcare providers.
- We promote patient empowerment, rather than dependency.
- We promote interventions, which emphasize goals of self-efficacy and self-mastery, beginning at the point of first patient contact.
- We assist each patient in the process of his or her ongoing development.
- We employ interactive techniques, which promote self-efficacy skills and stable, generalized treatment gains.
- We encourage the active involvement of significant others in treatment.
- We avoid producing iatrogenic illness by discouraging overt or covert reinforcement of regression or an unhealthy fixation on psychopathology.
- We maintain an awareness of time, by recognizing the effectiveness of therapy and the overcoming resistance to change is unrelated to length or frequency of therapy.

## Recommended Practices

CHIPA has developed some policy and procedures to provide guidance to our staff and Clinicians when providing clinical services to patients with Attention Deficit/Hyperactivity Disorder (ADHD), Bipolar Disorder, Major Depression, and Treatment of Minors. These policies provide suggestions and recommended practices but does not prescribe treatment. The Clinician should consider these guidelines in the treatment of a patient but may depart from them when clinically indicated. These are available online or upon request through the Quality Improvement Department.

## Treatment Discharge Planning

Effective discharge planning addresses how a member’s needs will be met during transition from one level of care to another or to a different treating Clinician. This planning begins with the onset of care and should be documented and reviewed over the course of care. Treatment planning will focus on achieving and maintaining a desirable level of functioning after the completion of the current episode of care. Effective treatment and discharge planning is a key indicator of the ongoing health and well-being of a member following acute care. (See also the “Treatment Record Documentation Requirements” chapter of this manual.)

Case Managers will work with you to begin the discharge or treatment planning process for members at the time that services are initiated. As appropriate, the discharge or treatment planning process will involve you, a Case Manager, the member, the member’s family and/or representative, the Clinician at the next level of care, and/or relevant community resources.

Discharge planning involves assessment of the member's needs including current functioning, resources, and barriers to treatment access or compliance.

Discharge instructions should be specific, clearly documented and provided to the member at least two sessions prior to discharge. For discharge from an acute inpatient level of care, CHIPA expects that a patient's follow-up appointment will be scheduled prior to discharge and within seven days of the date of discharge. This time frame is part of the Health Plan Employer Data and Information Set (HEDIS®) measure established by NCQA to compare health plans on meeting this follow-up standard for mental health services. It is assessed on an annual basis. Throughout the treatment and discharge planning process, it is essential that members be educated regarding the importance of enlisting community support services, communicating treatment recommendations to all treating professionals, and adhering to follow-up care. Members have the right to decline permission to release information to other treating professionals, but should be informed about the potential risks and benefits of this decision and how it affects coordination of care.

## Communication with Primary Physicians and Other Health Care Professionals

To coordinate and manage care between behavioral health and medical professionals, CHIPA expects that you will seek to obtain the member's consent to exchange appropriate treatment information with medical care professionals (e.g., primary physicians, medical specialists) and/or other behavioral health Clinicians (e.g., psychiatrists, therapists). Coordination and communication should take place at: the time of intake, during treatment, the time of discharge or termination of care, between levels of care and at any other point in treatment that may be appropriate. Coordination of services improves the quality of care to members in several ways:

- It confirms for a primary physician that his or her patient followed through on a behavioral health referral
- It minimizes potential adverse medication interactions for members who are prescribed psychotropic medication
- It allows for better management of treatment and follow-up for members with coexisting behavioral and medical disorders
- It can reduce the risk of relapse with members in some populations, as with substance use disorders

The following guidelines are intended to facilitate effective communication among all treatment professionals involved in a member's care:

- During the diagnostic assessment session, request the member's written consent to exchange information with all appropriate treatment professionals
- After the initial assessment, provide other treating professionals with the following information within two weeks:
  - Summary of member's evaluation
  - Diagnosis
  - Treatment plan summary (including any medications prescribed)
  - Primary Clinician treating the member
- Update other behavioral health and/or medical Clinicians when there is a change in the member's condition or medication(s)

- Update other health care professionals when serious medical conditions warrant closer coordination
- At the completion of treatment, send a copy of the discharge summary to the other treating professionals
- Attempt to obtain all relevant clinical information that other treating professionals may have pertaining to the patient's mental health or substance use problems

Some members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. CHIPA, as well as accrediting organizations, expect you to make a “good faith” effort at communicating with other behavioral health Clinicians or facilities and any medical care professionals who are treating the member.

## **Member Rights and Responsibilities**

You will find a copy of the CHIPA Member Rights and Responsibilities at the end of this manual and on our website. You may request a paper copy by contacting Network Management. These rights and responsibilities are in keeping with industry standards. All members benefit from reviewing these standards in the treatment setting. CHIPA requests that you display the Patient Rights and Responsibilities in your waiting room, or have some other means of documenting that these standards have been communicated to CHIPA members.

## **Services of Interpreters**

It is typically your responsibility to arrange for the services of interpreters, when indicated, for members under your care. Financial responsibility for such services varies depending on the benefit plan and/or governing law; accordingly, these costs may be assigned to you, to CHIPA, to the member or may be shared between any or among all three of these parties. You may contact an Intake Specialist to determine who is financially responsible.

# Treatment Record Documentation

In accordance with your Participation Agreement, you are required to maintain high quality medical, financial and administrative records related to the behavioral health services you provide. These records must be maintained in a manner consistent with the standards of the community, and conform to all applicable laws and regulations.

In order to perform required utilization management and quality improvement activities, CHIPA may request access to such records, including claims records. The federal, state and local government or accrediting agencies may also request such information necessary to comply with accreditation standards, laws or regulations applicable to CHIPA and its customers, Clinicians, and facilities. The HIPAA Privacy Rule permits the exchange between covered entities, such as your office and CHIPA, of protected health information (PHI) to be used for purposes that relate to treatment, payment or health care operations. The exchange of PHI for such purposes does not require the member's written permission

CHIPA may request copies of your records be submitted to CHIPA or may review them during a scheduled On-site Audit. An On-site Audit and/or Treatment Record Review can occur for a number of reasons, including:

- Pre-credentialing review of potential high-volume Clinicians
- Reviews of facilities without national accreditation
- Audits of high-volume Clinicians
- Routine random audits for quality of care or claims
- Audits concerning quality of care issues identified by CHIPA or brought to CHIPA's attention by members, family members or their representatives

The audits focus on the completeness and quality of documentation within treatment records. CHIPA has established a passing performance goal of 80% for both the Treatment Record Review and On-site Audit. On-site Audit or Treatment Record Review scores under 80% result in the requirement of submission of a written Corrective Action Plan, or a signed attestation statement. Scores under 70% require submission of a written Corrective Action Plan and a re-audit within six months of the initial audit.

## Treatment Record — Content Standards

CHIPA expects that all treatment records are written legibly in blue or black ink, and at a minimum include:

- The member's name or identification number on each page of the record
- The member's address; employer or school; home and work telephone numbers, including emergency contacts; marital or legal status; appropriate consent forms; and guardianship information
- Treatment record entries that include the date of service and the responsible Clinician's name, professional degree, license, and relevant identification number
- Treatment records should be made contemporaneously with treatment description and dated with the date of entry; if records are not contemporaneously made with treatment, then the date of service should be noted along with date of entry
- Clear and uniform modifications; any error is to be lined through so that it can still be read, then dated and initialed by the person making the change
- Clear documentation of medication allergies, adverse reactions and relevant medical conditions; if the member has no known allergies, history of adverse reactions or relevant medical conditions, this should be prominently noted

- Clear and uniform medication tracking that provides a clear picture of all medications taken by the patient from the onset of care through discharge, and includes standing, P.R.N. and STAT orders for all prescription and over-the-counter medications; each record should indicate the date medications are prescribed along with the dosage and informed member consent for medication, including the member's understanding of the potential benefits and risks of the medications; changes in medication and/or dosage should be clearly documented along with the clinical rationale for the changes; discharge notes should specify all medications and dosages at the time of discharge
- A clear summary of presenting problems, the results of mental status exam(s), relevant psychological and social conditions affecting the member's medical and psychiatric status, and the source of such information
- Prominent documentation of special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, including revisions as appropriate; it is also important to document the absence of such conditions
- A medical and psychiatric history including previous treatment dates, Clinician identification, therapeutic interventions and responses, sources of clinical data, and relevant family information; for children and adolescents, past medical and psychiatric history should include prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, and academic); for members 12 years of age and older, documentation includes past and present use of cigarettes or alcohol, as well as illicit, prescribed or over-the-counter medications
- Documentation of a DSM-IV diagnosis, including all five axes, consistent with the presenting problem(s), history, mental status examination, and other assessment data
- Treatment plans that:
  - Specify symptoms and problems
  - Prioritize the critical problems that will be the focus of this episode of care
  - Relate the recommended level of care to the level of impairment
  - Include the member in treatment planning and document participation
  - Focus on the Axis I diagnosis of the treatment episode
  - Have specific, behavioral, and measurable treatment goals
  - Identify progress on previously established goals
  - Provide the rationale for the estimated length of the treatment episode
- Progress notes that describe member strengths and limitations in achieving treatment plan goals and objectives, and reflect treatment interventions that are consistent with those goals and objectives; documented dates for follow-up visits or complete termination summaries
- Documentation of continuity and coordination of care activities between the primary Clinician and group, consultants, other behavioral health or medical Clinicians, and health care institutions; this includes communications that are clinically appropriate which occur in the course of care, including timely communications at discharge to ensure proper member care and safety across the continuum; if the member refuses to allow you to communicate with other treating Clinicians and facilities, this must be documented; the member's reason for refusal should also be noted
- Documentation of referrals to other Clinicians, services, community resources, and/or wellness and prevention programs

- Separate treatment records for each identified and diagnosed member of a family when care involves more than one family member; billing records should reflect the primary plan participant who was treated and the modality of care

## Guidelines for Storing Member Records

Below are additional guidelines for completing and maintaining treatment records for members.

- Practice sites must have an organized system of filing information in treatment records
- Treatment records must be stored in a secure area and the practice site must have an established procedure to maintain the confidentiality of treatment records in accordance with any applicable laws and regulations
- The practice site must have a process in place to ensure that records are available to qualified professionals if the treating Clinician is absent
- Treatment records are required to be maintained for seven years from the date of service, or in accordance with state or federal laws or regulations, whichever is longer; termination of the Participation Agreement has no bearing on this requirement
- Financial records concerning covered services rendered are required to be maintained from the date of service for 10 years, or the period required by applicable state or federal law, whichever is longer; termination of the Participation Agreement has no bearing on this requirement

## Member Access to Medical/Mental Health Records

A member, upon written request and with proper identification, may access his/her records that are in the possession of CHIPA. Before a member is granted access to his/her records, the record will first be reviewed to ensure that it contains only information about the member. Confidential information about other family members that is in the record will be excised.

# Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal law enacted to ensure privacy and security of a consumer's Protected Health Information (PHI). PHI is basically defined as individually identifiable health information that is transmitted or maintained in any form or medium. A few examples of PHI include an individual's name, social security number or consumer identification number, address, and date of birth.

All aspects of CHIPA operations are compliant with the required HIPAA privacy practices as well as other applicable state and federal laws. Below are some of the highlights of these practices.

## Uses and Disclosures of PHI

CHIPA has established policies relating to requests for and disclosure of PHI in accordance with HIPAA and other applicable federal and state laws. These policies ensure that only the minimum amount of information necessary is disclosed to accomplish the purpose of the disclosure or request.

## Release of Information

It is CHIPA policy to release information only to the individual, or to other parties designated in writing by the individual, unless otherwise required or allowed by law. For each party that the individual designates permission to access their PHI, he or she must sign and date a Release of Information specifying what information may be disclosed, to whom, and during what period of time. This policy is not applicable to PHI being exchanged with a CHIPA network Clinician, POD/Group, facility, or other entity designated by HIPAA for the purposes of Treatment, Payment, or Health Care Operations<sup>1</sup>.

## Identification and Authentication

CHIPA requires that anyone requesting access to PHI be appropriately identified and authenticated. Members and personal representatives, for example, are required to provide the member identification number or subscriber number and the member's or subscriber's date of birth. You or your administrative staff are identified and authenticated in a number of ways and may be asked for your federal tax identification number or physical address as part of this verification process.

## Internal Protection of Verbal, Written, and Electronic PHI

CHIPA works with the various health plans, to ensure that all physical and logical safeguards are in place to protect against the unauthorized use, disclosure, modification, and destruction of PHI across all media (e.g. paper records, electronic files, etc.). All employees of CHIPA receive training and are familiar with the HIPAA privacy practices relevant to their job duties and responsibilities.

<sup>1</sup>"Treatment, Payment, or Health Care Operations" as defined by HIPAA include: 1) Treatment – Coordination or management of health care and related services; 2) Payment purposes – The activities of a health plan to obtain premiums or fulfill responsibility for coverage and provision of benefits under the health plan; and 3) Health Care Operations – The activities of a health plan such as quality review, business management, customer service, and claims processing

## Disclosure to Health Plans

Summary health information may be released to a Plan Sponsor<sup>2</sup> without the authorization of the affected individual. This information may be used for the purpose of obtaining premium bids or modifying, amending, or terminating the Group Health Plan. It may also be used for providing access to employees of an employer or Plan Sponsor to carry out administrative duties of a Health Plan related to Treatment, Payment or Health Care Operations.

CHIPA members receive Privacy Notices from their health plans outlining the uses and disclosures of their PHI and their rights, as well as the legal duties of their health plan to ensure protection of their PHI under HIPAA. This Privacy Notice is posted on the CHIPA Web site under “HIPAA – Patient Rights”, or is available in paper copy by contacting Network Management.

## National Provider Identification

The purpose of a National Provider Identifier (NPI) is to improve the efficiency and effectiveness of the electronic transmission of health information. The implementation of this provision in 2007 is in compliance with HIPAA. CHIPA requires the billing Clinician to include NPI information on all electronic claims. In addition to all electronically submitted claims, some states mandate that the NPI be used on all claims (whether paper or electronic submission is used). For more information about obtaining an NPI, you may contact the Center for Medicare and Medicaid Services at [www.cms.hhs.gov](http://www.cms.hhs.gov).

# Quality Improvement

## Participation in the CHIPA Quality Improvement Program

CHIPA's Quality Improvement Program was created to provide a comprehensive system designed to assure that patient care is optimal within available resources and is consistent with the goals of our company and federal and state standards.

We strive to encompass all systems and providers as organizational components of CHIPA and assure that QI systems cover all operations. Our goal is to assist practitioners in improving care continuously by identifying opportunities for improvement, trends and patterns of difficult, and problems in processes by monitoring and evaluating activities. We maintain centralized data gathering and maintenance of effective systems of quality measurement.

## Sentinel events

Sentinel are defined as unexpected occurrences involving death or serious physical or psychological injury, or risk thereof, which occur during the course of a member receiving behavioral health treatment. If you are aware of a sentinel event involving a member, you must notify a CHIPA Case Manager within one business day of the occurrence.

CHIPA has established processes and procedures to notify the health plans so they can investigate and address sentinel events. This may include a centralized Sentinel Event Committee, chaired by medical directors within the health plan, and incorporates appropriate representation from the various behavioral health disciplines. You are required to cooperate with sentinel event investigations.

CHIPA supports the health plans and the Joint Commission on Accreditation of Healthcare Organizations' National Patient Safety Goals as they apply to behavioral health care. These Safety Goals are available on the Joint Commission web site at [www.jointcommission.org](http://www.jointcommission.org).

## Clinician Satisfaction Surveys

CHIPA regularly conducts a satisfaction survey of a representative sample of Clinicians delivering behavioral health services to CHIPA members. This survey obtains data on Clinician satisfaction with CHIPA services including intake, care management, provider services, and claims administration.

## Preventative Behavioral Health Services

CHIPA selects and designs its preventative behavioral health programs based on the demographic, cultural, clinical, and risk characteristics of members. You may be enlisted to participate in the design and implementation of preventative behavioral health programs. CHIPA encourages all Clinicians and facility-based clinical staff to review the content and process of CHIPA preventative health programs. If you would like a printed copy of these programs, please contact Network Management. In addition to keeping our website up to date, CHIPA periodically communicates additional information about these programs, including modifications in program process and content, in the provider newsletter.

## Complaint Investigation and Resolution

You are expected to cooperate with CHIPA in the compliant investigation and resolution process. If CHIPA requests written records for the purpose of investigating a member complaint, you should submit these to CHIPA within 14 business days, or sooner, as requested. You are responsible for obtaining any release of information or consent form that may need to be signed by the member or the member's guardian(s). Complaints filed by members should not interfere with the professional relationship between you and the member.

QI staff, in conjunction with Network Management staff, will monitor complaints filed against all Clinicians and PODs/Groups, and solicit information from them in order to address member complaints. For all complaints other than quality of care complaints, resolution will be communicated to the member.

CHIPA will require the development and implementation of appropriate action plans to correct legitimate problems discovered in the course of investigating complaints. Such action may include having CHIPA:

- Require you to submit and adhere to a Corrective Action Plan
- Monitor you for a specific period, followed by a determination about whether substandard performance or noncompliance with CHIPA requirements is continuing
- Require you to use peer consultation for specific types of care
- Require you to obtain specific additional training or continuing education
- Limit your scope of practice in treating members
- Hold referrals of any members to your care by changing your availability status to "unavailable" and/or reassigning members to the care of another participating Clinician or POD/Group
- Terminate your participation status with CHIPA.

Cooperation with an unavailable status associated with complaint, quality-of-care or sentinel event investigations may include:

- Informing members of unavailable status at the time of an initial request for services, and identifying other network Clinicians or POD/Group
- Informing current members of status and their option to transfer to another network Clinician or POD/Group
- Assisting with stable transfers to another network Clinician or POD/Group at the member's request

## On-site Audits

CHIPA representatives conduct visits to practice locations for On-site Audits with select high-volume Clinicians, potential high-volume Clinicians prior to credentialing, and facilities without national accreditation, as well as for random routine audits and audits to address specific quality of care issues brought to the attention of CHIPA.

During an On-site Audit, charts are reviewed for documentation of diagnosis, treatment plan, and verification of services provided to members. You are expected to maintain adequate medical records on all members. Prior to the audit visit, you will be notified of the specific types

of charts that will be reviewed. Failure to document services and/or dates of services may lead to a request for a Corrective Action Plan.

The On-site Audit and Treatment Record Review tools are based on NCQA, The Joint Commission and CHIPA standards. These forms are utilized during On-site Audits and are available on our website for reference.

# 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](http://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.

# Appeal Overview

To ensure patient rights regarding their benefit, Comprehensive Behavioral Health Management/College Health IPA (CHIPA) reviews for authorization and advises regarding opportunities for appeal whenever a denial of authorization is issued. The following procedure outlines the process for denial and appeal.

## Responsibility

Delegated accounts – When the CHIPA contract includes delegation for denial determinations, CHIPA completes the review process, makes determinations, and communicates the decision to members and providers.

Non-delegated accounts – When the CHIPA excludes delegation for denial determinations, CHIPA completes the review process, including Peer Review, and forwards any denial recommendations to the Health Plan Designee, who then reviews and makes denial determination.

Appeal delegation – All CHIPA contracts exclude appeal reviews. CHIPA assists patients and providers in exercising their appeal rights.

Once an authorization has been granted it cannot be rescinded or modified after the provider renders the health care service in good faith. Pursuant to the authorization for any reason, including, but not limited to the following: the plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the plan's subsequent determination that it did not make an accurate determination of the enrollee's or subscriber's eligibility. CHIPA does not reverse authorization decisions for services provided under an approved authorization. CHIPA closes authorizations for future services once a determination of ineligibility or exhaustion of benefits has been made. Closed authorizations are mailed or faxed to the provider within one business day following eligibility or benefit determination.

## Peer Review

If during Initial Review or Concurrent Review a licensed Clinician or UM Coordinator determines that medical necessity is not clear for authorization, the CHIPA Medical Director, a Board Certified Psychiatrist, will be consulted. If the Medical Director concurs, prior to issuance of a denial determination or recommendation to the Health Plan Designee, the provider will be contacted and offered a telephonic Peer Review with the CHIPA Medical Director to occur within 24 hours.

Following Peer Review a determination will be verbally communicated to the patient and provider within 24 hours (e.g., authorization, denial, and/or denial recommendation forwarded to Health Plan Designee).

If the provider chooses not to participate in the Peer Review process, a determination will be made based upon clinical information available and verbally communicated to patient and provider within *UM Timeliness Standards* (Timeliness Standards grid may be accessed online).

When a determination is made to recommend or issue a denial and no peer-to-peer conversation has occurred, the provider of service will be given an opportunity to discuss the

determination with either the peer making the original determination or a different clinical peer within one business day of request. If this peer-to-peer review does not result in approval, the provider of service and the patient will be informed of their appeal rights.

## Appeals Process

### Appeal Rights

Appeal rights are available upon request to any patient, provider, or POD/Group rendering service. A patient, provider, or facility may submit written documents, records, and other information related to the case. This information is taken into account during the appeals process without regard to whether such information was submitted or considered in the initial consideration of the case.

Expedited appeals are available for all urgent care requests.

### Standard Appeals

Verbal appeal instructions are given to the patient and provider at the time a denial determination or recommendation is made by CHIPA. The appeal instructions are included in the denial letter.

Whenever a provider, POD/Group, patient, or patient representative verbally request an appeal review, they are advised that they have 180 calendar days after receipt of denial letter to initiate appeal process. They are given verbal instructions for how to contact their designated health plans and/or the appropriate state agency.

Standard appeals are completed and written notification of the appeal decision issued, within 30 calendar days of the receipt of the request for appeal to the patient and attending physician or other ordering provider or POD/Group rendering the service.

### Expedited Appeals

Verbal appeal instructions are given to the patient and provider at the time a denial determination or recommendation is made by CHIPA.

Expedited appeals are completed by the Health Plan Designee with verbal notification of determination to the requesting party within 72 hours of the request followed by written confirmation of the notification within 3 calendar days to the patient and attending physician or other ordering provider or POD/Group rendering service.

### Upheld Denial Determinations

If an appeal results in the original denial determination being upheld, the health plan designee will issue a written notification of the adverse appeal decision to the patient and attending physician or other ordering provider or POD/Group rendering the service.

## Appeal Reversals

If an appeal results in a reversal of the initial denial decision, the Health Plan Designee will send a letter to the patient and provider. CHIPA will be notified verbally by the Health Plan Designee. An authorization will be created in the patient file and claims paid as needed.

# Manual Updates and Governing Law

## Manual Updates

This manual is updated periodically as procedures are modified and enhanced. You will be notified a minimum of 30 calendar days prior to any material change to the manual unless otherwise required by regulatory or accreditation bodies. The current version of the manual is always available on our website ([www.comprehensivebehavioral.com](http://www.comprehensivebehavioral.com)) or you may request a paper copy by contacting Network Management.

## Governing Law and Contract

This manual shall be governed by, and construed in accordance with, applicable federal, state and local laws.

To the extent that the provisions of this manual differ from your Participation Agreement, the terms and conditions of the Participation Agreement govern.

# Appendix

# Appendix I: Patient Rights and Responsibilities

Comprehensive Behavioral Health Management/College Health IPA (CHIPA) is committed to treating patients in a manner that respects their rights as well as recognizes their responsibilities.

## Patient Rights

Each patient has the right to receive information about CHIPA services and providers, clinical guidelines, UM and clinical necessity protocols, and members' rights and responsibilities, including:

- Informed consent information
  - o Provider's qualifications and training
  - o Diagnosis
  - o Treatment plan
  - o Possible risks or side effects of recommended treatment
  - o Expected results with or without recommended treatment
  - o Alternative treatments
  - o Limits of confidentiality
- Answers to your questions
- Explanation of financial responsibility
- Instructions for filing complaints

In addition, they have the right to be treated with dignity and respect, recognizing the need for privacy, including the confidentiality of your records.

- To receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment.
- To participate with providers in decision making regarding treatment planning
- To give or withhold your consent for treatment
- To voice complaints or appeals about CHIPA or the care provided.
- To have input into CHIPA rights and responsibilities policies

## Patient Responsibilities

Patients are responsible to provide, to the extent possible, information that CHIPA and its providers need in order to develop appropriate treatment plans. To follow the plans and instructions for care agreed upon. As well as, to participate, to the degree possible, in understanding behavioral healthcare problems and developing mutually agreed upon treatment goals.

# Appendix II: Frequently Asked Questions

## 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](http://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?<sup>1</sup>

**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?<sup>1</sup>

**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?<sup>1</sup>

**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.

<sup>1</sup> 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?<sup>1</sup>

**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®?<sup>1</sup>

**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 next page.

**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.

## 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.

## 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.

## 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 form 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

# Appendix III: Glossary

These definitions are general definitions applied for purposes of this manual. State law, certain practitioner agreements and individual benefit contracts define some of these terms differently. In such cases, the definitions contained in the applicable law or contract will supersede these definitions.

**Adverse Determination:** A denial, reduction, or termination of coverage, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial based on the eligibility of a member or beneficiary to participate in a plan; and a denial resulting from utilization review, the experimental or investigational nature of the service, or the lack of medical necessity or appropriateness of treatment.

**Algorithm:** A set of decision rules CHIPA applies to member-specific data to determine if there are any targeted clinical issues or risks.

**ALgorithms for Effective Reporting and Treatment (ALERT®):** An outcomes-based system using member responses to a validated survey, in conjunction with claims data, for the identification of members who are at moderate to high risk for poor clinical outcomes.

**All-Payer Contract:** An arrangement allowing for payment of health services delivered by a contracted Clinician regardless of product type (e.g., HMO, PPO) or revenue source (e.g., fully funded or self-funded).

**Appeal:** A specific request to reverse an adverse determination or potential restriction of benefit reimbursement.

**Balance Billing:** The practice of a Clinician or POD/Group requesting payment from a member for the difference between the CHIPA contracted rate and the Clinician or POD/Group's usual charge for that service.

**Behavioral Health Care:** Assessment and treatment of mental health and/or substance abuse (MH/SA) disorders.

**Intake Specialist:** A CHIPA employee who is a licensed clinical professional (e.g., nurse, doctor, psychologist, social worker, or professional counselor) who works with members, health care professionals, physicians, and insurers to maximize benefits available under a member's benefit plan.

**Certification:** The number of inpatient days or non-routine outpatient visits for which benefits have been applied as part of the member benefit plan for payment (formerly known as an Authorization). Certifications are not a guarantee of payment. Final determinations will be made based on member eligibility and the terms and conditions of the member's benefit plan at the time the service is delivered (Also see "Open Certification").

**Clean Claim:** meets the following conditions:

- Is sent on a CMS 1500 claim form, or an accepted electronic equivalent (National Standard Format Version 2.0)
- The information requested by CHIPA (i.e., authorized CPT code, ICD-9 code, rendering provider's tax ID number) is present and legible on the CMS 1500 or an

- accepted electronic equivalent) and the form is 100% complete with no missing or illegible information
- The claim is sent by a CHIPA and appropriate Payer contracted provider or provider group. The provider must be in “good” and “active” status in both panels or have signed a Single Case agreement (SCA) with CHIPA.

**Clinician:** A licensed professional that has contracted to deliver behavioral health care services to members (also known as a network Clinician).

**Coinsurance:** The portion of covered health care costs the member is financially responsible for, usually according to a fixed percentage. Coinsurance often is applied after a deductible requirement is met.

**Co-payment:** A cost-sharing arrangement in which a member pays a specified charge for a specified service, such as \$20 for an office visit, for example. The member usually is responsible for payment at the time the health care is rendered. Typical co-payments are fixed or variable flat amounts for Clinician office visits, prescriptions or hospital services. Sometimes the term "co-payment" generically refers to both a flat dollar co-payment and coinsurance (see above).

**Credentialing:** The process by which a Clinician or POD/Group is accepted into the applicable Health plan network and by which that association is maintained on a regular basis.

**Deductible:** The annual amount of charges for behavioral health care services, as provided in the member's benefit plan, which the member is required to pay prior to receiving any benefit payment under the member's plan.

**EAP (Employee Assistance Program):** Services that are designed for brief intervention, assessment and referral. These services are short-term in nature.

**Electronic Claim:** Is a claim formatted as an electronic data file, which is transmitted via a data connection rather than printed on a form and mailed.

**Electronic Claim Submission:** Is the use of an Electronic Data Interface (EDI) to submit electronic claims for processing.

**Electronic Data Interface (EDI):** Is the information technology, which allows acceptance of the electronic data file.

**Emergency:** A serious situation that arises suddenly and requires immediate care and treatment to avoid jeopardy to life or health. For appointment access standards see “Emergency - Life-threatening”, “Emergency — Non-life-threatening” and “Urgent”.

**Emergency — Life-threatening:** A situation requiring immediate appointment availability in which there is imminent risk of harm or death to self or others due to a medical or psychiatric condition.

**Emergency — Non-life-threatening:** A situation requiring appointment availability within six hours in which immediate assessment or care is needed to stabilize a condition or situation, but there is no imminent risk of harm or death to self or others.

**Exclusions:** Specific conditions or circumstances listed in the member’s benefit plan for which the policy or plan will not provide coverage reimbursement under any circumstances.

**Facility:** An entity that provides inpatient, residential, or ambulatory services and has contracted to deliver behavioral health care services to members (also known as a network facility).

**Facility Contract Manager:** A CHIPA professional dedicated to managing contractual relationships with hospitals and freestanding behavioral health programs and services for the CHIPA network.

**Fee Maximum:** The maximum amount a participating Clinician or facility may be paid for a specific health care service provided to a member under a specific contract. CHIPA reimburses Clinicians based upon licensure rather than degree.

**Health Plan:** A health maintenance organization, preferred provider organization, insured plan, self-funded plan, or other entity that covers health care services. This term also is used to refer to a plan of benefits.

**HIPAA:** The Health Insurance Portability and Accountability Act, by which a set of national standards are set for, among other topics, the protection of certain health care information. The standards address the use and disclosure of an individual’s “Protected Health Information” (PHI) by organizations subject to the Privacy Rule (“covered entities”). These standards also include privacy rights for individuals to understand and control how their health information is used. For more information, please visit the Department of Health and Human Services Web site at [www.hhs.gov](http://www.hhs.gov).

**Independent Review Organization:** An independent entity/individual retained by a private health plan, state agency or federal agency to review adverse determinations (based on medical necessity) that have been appealed by, or on behalf of, a member (also sometimes known as External Review Organizations).

**Least Restrictive Level of Care:** The Level of Care (LOC) at which the patient can be safely and effectively treated while maintaining maximum independence of living.

**Level of Care (LOC) Guidelines:** Objective, evidence-based admission and continuing stay criteria for MH/SA services. These guidelines are intended to standardize care advocate decisions regarding the most appropriate and available level of care needed to treat a member’s presenting problems.

**Medical Necessity:** Generally, the evaluation of health care services to determine if they meet plan criteria for coverage as medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to member benefit plans or state laws (also referred to as Clinical Necessity).

**Member:** An individual who meets eligibility requirements and for whom premium payments for specified benefits of the contractual agreement are paid. Also may be referred to as a plan participant or enrollee.

**MH/SA:** Mental Health and/or Substance Abuse.

**Network Management:** Consists of CHIPA Network Managers and Associates who provide service to CHIPA network Clinicians and facilities. Additionally, they work with Care Advocacy, Account Management and Sales to contract and retain experienced mental health and substance abuse treatment professionals.

**Open Certification:** Usually issued directly to members, this 12-calendar-month certification is not specific to any one particular network Clinician and covers most routine outpatient psychotherapy services.

**Participation Agreement:** A contract describing the terms and conditions of the contractual relationship between CHIPA and a Clinician or POD/Group under which mental health and/or substance abuse services are provided to members.

**Payer:** An organization that pays for health care expense coverage.

**Quality Assurance:** A formal set of activities to review and affect the quality of services provided. Quality assurance includes assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient services. Federal and state regulations typically require health plans to have quality assurance programs.

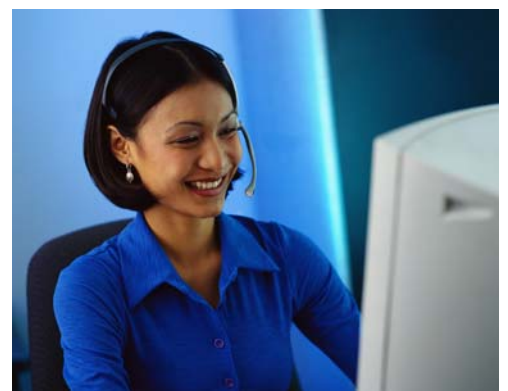
**Quality Improvement:** A continuous process that identifies opportunities for improvement in health care delivery, tests solutions, and routinely monitors solutions for effectiveness.

**Rejected Claim:** does not meet one of the above conditions of a “clean claim”.

**Routine:** A situation in which an assessment of care is required, with no urgency or potential risk of harm to self or others.

**Urgent:** A situation in which immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency situation. Availability should be within 48 hours or less or as mandated by state law.

**Wellness Assessment (WA):** A reliable, confidential, member-driven instrument used to help identify targeted risk factors in addition to establishing a baseline for tracking clinical change and outcomes.



# Notes



College Health IPA  
Comprehensive Behavioral Health