

**Comprehensive Behavioral Health Management/College Health IPA
Policy and Procedure Manual**

Policy Name: Claims Settlement Practices & Dispute Resolution	Claims
Date: 10-01 Last Reviewed by QI Committee: 7-06, 7-07, 7-08, 7-09, 7-10 Last Revised by QI Committee: 12-03, 7-09	Page: 1 of 6 Policy Number: CL-6

Purpose: To inform Comprehensive Behavioral Health Management/College Health IPA (CBHM/CHIPA) providers regarding rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes.

Policy:

1.0 Claim Submission Instructions

- 1.1 Claims for services provided to patients assigned to CBHM/CHIPA must be sent to the following:

**College Health IPA
17100 Pioneer Blvd, #420
Cerritos, CA 90701**
- 1.2 For claim filing requirements or status inquiries, providers may contact CBHM/CHIPA's Claims Customer Service department by calling: **(800) 779-3825 Option 5**

2.0 Claim Submission Requirements

- 2.1 Participating Providers must submit their billing 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, www.comprehensivebehavioral.com.
- 2.1.1 The claim **must** include:

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- 2.1.1.1 Correct and complete Patient ID number
- 2.1.1.2 Patient Name and Address
- 2.1.1.3 Patient Date of Birth
- 2.1.1.4 Patient’s Relationship to Insured
- 2.1.1.5 Subscriber Name
- 2.1.1.6 Assignment of Benefits – Signed by patient or “signature on file” reflected in HCFA box 12 and 13
- 2.1.1.7 Treating Practitioner Name and Address
- 2.1.1.8 Billing Practitioner Federal Tax ID Number
- 2.1.1.9 Date(s) of Service
- 2.1.1.10 Place of Service
- 2.1.1.11 Procedure Code(s) – CPT-4
- 2.1.1.12 Charges
- 2.1.1.13 Days/Units
- 2.1.1.14 Diagnostic Code(s) – DSM-IV or ICD-9 Codes

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2.1.2 Claims missing this information, or which do not have this information in the required field, may be contested via a Remittance Advice (RA) to the practitioner. Providers may submit a new completed claim for consideration.

2.2 Institutional Services

Participating Providers must submit their billing within 90 days of the Date of Service using a UB92. Non-Participating Providers must submit their billing within 180 days of the Date of Service using the UB92.

2.2.1 The claim **must** include:

- 2.2.1.1 Correct and complete Patient ID number
- 2.2.1.2 Patient Name and Address
- 2.2.1.3 Patient Date of Birth
- 2.2.1.4 Patient’s Relationship to Insured
- 2.2.1.5 Statement Covers Period
- 2.2.1.6 Attending Physician Name
- 2.2.1.7 Billing Provider Name and Address
- 2.2.1.8 Billing Provider Federal Tax ID Number
- 2.2.1.9 Admission Date
- 2.2.1.10 Date(s) of Service
- 2.2.1.11 Charges
- 2.2.1.12 Days/Units
- 2.2.1.13 Procedure Code(s) – CPT-4 or Revenue Codes
- 2.2.1.14 Diagnostic Code(s) – DSM-IV or ICD-9 Codes

2.2.2 Claims missing this information, or which do not have this information in the required field, may be contested via a Remittance Advice (RA) to the provider. Providers may submit a new completed claim for consideration.

2.3 General Policies for Providers

2.3.1 Providers must collect any co-payments due from CBHM/CHIPA patients and must accept payment from CBHM/CHIPA as payment-in-full for covered services.

2.3.2 Providers may not balance bill patients.

2.3.3 Providers may bill for missed or cancelled managed care appointments **only** if the patient has been advised of, and has agreed to in writing, the provider's no-show policy.

2.3.4 Providers must advise patients in writing prior to providing excluded services that services will not be covered by CBHM/CHIPA and patient will be responsible for paying the provider directly for these services.

2.4 General Policies for CBHM/CHIPA

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- 2.4.1 CBHM/CHIPA shall pay providers within 30 business days of receipt by CBHM/CHIPA of a completed "Clean" Claim for covered services.
- 2.4.2 CBHM/CHIPA shall process all "unclean" claims within 30 business days of being made "Clean".
- 2.4.3 A "Clean" claim is one that has no defect or impropriety, including lack of any required substantiating documentation for non-contracting providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. This includes UB92, (CMS) HCFA 1500, attachments and supplemental information or documentation which provides "reasonably relevant information" and "information necessary to determine payor liability" as defined in the regulations.
- 2.4.4 Claims not paid within the required state prompt payment guidelines will be paid with interest as applicable for the state where services are rendered.

2.5 Claim Receipt Verification

For verification of claim receipt by CBHM/CHIPA, please contact our Claims Customer Service department at **(800) 779-3825 Option 5**

3.0 Dispute Resolution Process for Contracted Providers

3.1 Definition of Contracted Provider Dispute

A contracted provider dispute is a provider’s written notice to CBHM/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 CBHM/CHIPA’s provider ID number, provider’s contact information, and:

- 3.1.1 If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from CBHM/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;

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- 3.1.2 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
- 3.1.3 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.
- 3.2 Sending a Contracted Provider Dispute to CBHM/CHIPA.
Contracted provider disputes submitted to CBHM/CHIPA must include the information listed in Section 3.1 above, for each contracted provider dispute. To facilitate resolution, providers may use either the Provider Dispute Resolution Request form, available on our website at www.comprehensivebehavioral.com, or a personalized form to submit the required information. All contracted provider disputes must be sent to the attention of Provider Disputes at the following:
 - CBHM/CHIPA
Provider Disputes
17100 Pioneer Blvd, #420
Cerritos, CA 90701**
 - 3.2.1 Time Period for Submission of Provider Disputes
 - 3.2.1.1 Contracted provider disputes must be received by CBHM/CHIPA within 365 calendar days from CBHM/CHIPA’s action that led to the dispute or the most recent action if there are multiple actions that led to the dispute or
 - 3.2.1.2 In the case of inaction, contracted provider disputes must be received by CBHM/CHIPA within 365 calendar days after CBHM/CHIPA’s time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
 - 3.2.1.3 Contracted provider disputes that do not include all required information as set forth above in Section 3.1 may be returned to the submitter for completion. An amended contracted provider dispute that includes the missing information may be submitted to CBHM/CHIPA within thirty (30) working days of your receipt of a returned contracted provider dispute.
 - 3.2.2 Acknowledgment of Contracted Provider Disputes
CBHM/CHIPA will provide written acknowledgement of receipt of all contracted provider disputes within fifteen (15) Working Days of the Date of Receipt by CBHM/CHIPA.
 - 3.2.2 Contact CBHM/CHIPA Regarding Contracted Provider Disputes

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

3.2.3 Instructions for Filing Substantially Similar Contracted Provider 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 Provider Dispute Resolution Request – Multiple Like Claims form or a personalized form with the required information.

3.2.4 Time Period for Resolution and Written Determination of Contracted Provider Dispute
CBHM/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 provider dispute or the amended contracted provider dispute.

3.2.4 Past Due Payments
If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, CBHM/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.

4.0 Dispute Resolution Process for Non-Contracted Providers

4.1 Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider's written notice to CBHM/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 disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information: provider's name, billing provider's tax ID, contact information, and:

4.1.1 If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from CBHM/CHIPA to 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, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect; and

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4.1.2 If the non-contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees

4.2 Dispute Resolution Process. The dispute resolution process for non-contracted providers is the same as the process for contracted providers as set forth in sections 3.1 above.

5.0 Claim Overpayments

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

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

5.3 No Contest
If the provider does not contest CBHM/CHIPA's notice of overpayment of a claim, the provider must reimburse CBHM/CHIPA within thirty (30) Working Days of the provider's receipt of the notice of overpayment of a claim.