Behavioral Health Policy and Procedure Manual for Providers /

College Health IPA (CHIPA)

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1.1 Introduction to CHIPA

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 Services
- Clinical Focus
- 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.

1.2 About CHIPA

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 million members with a provider panel of over 2,500 network providers.

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.

OUR 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 clinicians' use of evidenced-based, "best practice" treatments
- Maximizing operational efficiencies and providing cost effective solutions.

OUR 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.

1.3 CHIPA Resource Guide

CHIPA WEBSITE

Our website, available at www.chipa.com, is an excellent first-line resource for:

- Downloading standard forms
- Finding department contacts
- Reviewing clinical guidelines

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 on our website or by calling CHIPA at 800.779.3825.

CUSTOMER SERVICE

Clinical Services	800.779.3825
Inpatient	Option 6, Option 1
Outpatient	Option 6, Option 2
Provider Relations	Option 6, Option 3
Claims	Option 5

To ensure proper processing of claims, it is important to contact Provider Relations if you change your Tax ID number or other practice information.

FAX NUMBERS

Provider Relations *(Demographic updates, site changes, updated W-9s)*	800.646.9371
Claims	877.563.3480
Clinical	866.422.3413

Chapter 2

Network Requirements

2.1. 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 specialties. 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.

2.2. Non-Discrimination

CHIPA does not deny or limit the participation of any clinician or group in the network, and/or otherwise discriminate against any clinician or 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 group because the clinician or group representative:

- Advocated on behalf of a member
- Filed a complaint against a health plan
- Appealed a decision of CHIPA or the payer
- 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 ng policy and practice of CHIPA.

2.3. Clinician Credentialing and Recredentialing

CHIPA does not conduct credentialing or recredentialing. 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 re-credentialing 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 completed 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.

2.4. Credentialing and Recredentialing Rights and Responsibilities

As an applicant to the CHIPA network, or as a network clinician in the process of recredentialing, 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 recredentialing 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 re-credentialing 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

2.5. 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 Provider Relations 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 Provider Relations 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 Provider Relations.

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.

2.6. Telephone Contact

A clinician's office staff should only contact a patient by phone if they are returning a patient's and 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.

Clinicians 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:

- When possible, at least 24-hour's notice of cancellation should be given to patient
- When possible, a choice of alternative appointments should be offered at the time of the cancellation.
- 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.

2.7. 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.

2.8. 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.

2.9. 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.

2.10. Compliance with Plan Contracts

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

2.11. Termination of a Clinician or Group Participation

The participation of a clinician or 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 Provider Relations.

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.

2.12. 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.

Chapter 3

Access/Referral and Utilization Management

3.1. 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 Member Services Representatives and professionally licensed clinicians work efficiently to ensure that each member receives the opportunity for an effective and positive treatment experience.

Access and referral services include:

- 24-hour a day, seven 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

3.2. Appointment Access Standards

TABLE 3-1: APPOINTMENT STANDARDS AND SERVICE AVAILABILITY

TYPE OF APPOINTMENT/SERVICE	APPOINTMENT MUST BE OFFERED:
General Appointment Standards	
Routine/Non-Urgent Services	Within 10 business days
Urgent Care	Within 48 hours
Emergency Services	Immediately, 24 hours a day, seven days a week; directed to 911 or County services
Aftercare Appointment Standards	Inpatient service must schedule an aftercare follow-up prior to a member's discharge for patients determined to have mild or moderate mental health needs and dependent on non-urgent or urgent needs under general appointment standards.

SERVICE AVAILABILITY	HOURS OF OPERATION
On-Call	▪ 24-hour on-call services for all members in treatment

SERVICE AVAILABILITY	HOURS OF OPERATION
	▪ Ensure that all members in treatment are aware of how to contact the treating or covering provider after hours and during provider vacations
Crisis Intervention	▪ Services must be available 24 hours per day, 7 days per week. ▪ Outpatient facilities, physicians, and practitioners are expected to provide these services during operating hours. ▪ After hours, providers should have a live telephone answering service or an answering machine that specifically directs a member in crisis to a covering physician, agency-affiliated staff, crisis team, or hospital emergency room.
Outpatient Services	▪ CHIPA is required to make outpatient services available, Monday through Friday, from 9 a.m. to 5 p.m. at a minimum as well as evening and weekend hours. In order to meet these requirements, CHIPA expects contracted providers to have office hours a minimum of 20 hours per week.
Interpreter Services	▪ Under state and federal law, providers are required to arrange for interpreter services to communicate with individuals with limited English proficiency or those who are deaf or hard-of-hearing at no cost to the member. To arrange for an interpreter, providers should contact CHIPA member services at 800.779.3825, least three business days in advance of the appointment.
Cultural Competency	▪ Providers must ensure that members have access to qualified medical interpreters, signers and TTY services to facilitate communication when necessary, and ensure that clinicians and agencies are sensitive to the diverse needs of all plan members. Contracted providers are expected to provide services in a culturally competent manner at all times and to contact CHIPA immediately if they are referred a member who presents with cultural and/or linguistic needs they may not be qualified to address.

Providers are required to meet these standards, and to notify CHIPA if they are temporarily or permanently unable to meet the standards

3.3. Utilization Management

Utilization management (UM) is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, care management, discharge planning and retrospective review.

CHIPA has entered into a management services agreement with Beacon Health Options (Beacon), to provide management services in support of CHIPA's UM functions in accordance with URAC Health UM Standards, NCQA Managed Behavioral Health Organization (MBHO) standards, and state and federal regulations.

CHIPA's UM program is administered by licensed, experienced clinicians, who are specifically trained in UM techniques and in Beacon's standards and protocols. All CHIPA clinicians with responsibility for making UM decisions have been made aware that:

- All UM decisions are based upon CHIPA's and/or health plans' level of care criteria (medical necessity) for psychiatric treatment and American Society of Addiction Medicine (ASAM) criteria for all substance abuse treatment
- Financial incentives based on an individual UM clinician's number of adverse determinations or denials of payment are prohibited
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization

All requests for authorization are reviewed based on the information provided, according to the following definition of medical necessity:

Medically necessary services are healthcare and services that are:

A. Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM,) that threatens life, causes pain or suffering, or results in illness or infirmity

B. Expected to improve an individual's condition or level of functioning

C. Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs

D. Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications

E. Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available

F. Not primarily intended for the convenience of the recipient, caretaker, or provider

G. No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency

H. Not a substitute for non-treatment services addressing environmental factors

I. Reasonable and necessary to protect life, prevent illness or disability, or to ease pain through the diagnosis or treatment of disease, illness or injury

The UM 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 Services, Director of Intensive Services, and Director of Outpatient Clinical Services monitor for compliance of all approved targets and standards including:

- Access and referral
- Post-discharge follow-up appointments
- Denials and appeals
- Continuity of care authorizations
- Primary care coordination
- Utilization trends
- Utilization management review timeliness

CHIPA uses its or health plan's level of care criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member's needs, strengths, and treatment history in determining the best placement for a member. CHIPA's or the health plan's level of care criteria are applied to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular level of care. However, the individual's needs and characteristics of the local service delivery system are taken into consideration.

3.4. Authorization Procedures and Requirements

This section describes the processes for obtaining authorization for inpatient, diversionary and outpatient levels of care, and for CHIPA's medical necessity determinations and notifications. In all cases, the treating provider, whether admitting facility or outpatient practitioner is responsible for following the procedures and requirements presented, in order to ensure payment for properly submitted claims.

Administrative denials may be rendered when applicable authorization procedures, including time frames, are not followed.

MEMBER ELIGIBILITY VERIFICATION

The first step in registering a member for care or seeking authorization is to determine the member's eligibility. Since member eligibility changes occur frequently, providers are advised to verify a plan member's eligibility upon admission to, or initiation of treatment, as well as on each subsequent day or date of service to facilitate reimbursement for services.

EMERGENCY SERVICES

Emergency services are those physician and outpatient hospital services, procedures, and treatments, including psychiatric stabilization and medical detoxification from drugs or alcohol, needed to evaluate or stabilize an emergency medical condition. The definition of an emergency medical condition follows:

"…a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a

behavioral condition, placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person."

Emergency care will not be denied; however, subsequent days do require pre-service authorization. The facility must notify CHIPA as soon as possible and no later than 24 hours after an emergency admission and/or learning that the member is covered by the health plan. If a provider fails to notify CHIPA of an admission, CHIPA may administratively deny any days that are not prior-authorized.

Emergency Screening and Evaluation

Plan members must be screened for an emergency medical condition by a qualified behavioral health professional from the hospital emergency room, or by a Psychiatric Evaluation Team (PET). This process allows members access to emergency services as quickly as possible and at the closest facility or by the closest crisis team.

After the emergency evaluation is completed, the facility or program clinician should call CHIPA to complete a clinical review if admission to a level of care that requires pre-certification is needed.

Clinician Availability

Our clinicians are experienced licensed clinicians who receive ongoing training in crisis intervention; triage and referral procedures are available 24 hours a day, seven days a week, to take emergency calls from members, their guardians, and providers. If CHIPA does not respond to the call within 30 minutes, authorization for medically necessary treatment can be assumed, and the reference number will be communicated to the requesting facility/provider by the utilization review clinician within four hours.

3.5. 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 wellbeing of a member following acute care. (See also the "Treatment Record Documentation Requirements" chapter of this manual.)

A UM clinician will work with you to begin the discharge or treatment planning process for members at the time that services are initiated.

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 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 Care Effectiveness 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.

3.6. Communication with Primary Health Care 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.

Chapter 4

Member Rights and Responsibilities

4.1. Member Rights and Responsibilities

MEMBER RIGHTS

CHIPA is firmly committed to ensuring that members are active and informed participants in the planning and treatment phases of their behavioral health and substance use services. We believe that members become empowered through ongoing collaboration with their healthcare providers, and that collaboration among providers is also crucial to achieving positive health care outcomes. Members must be fully informed of their rights to access treatment and to participate in all aspects of treatment planning. All members have the following rights:

Right to Receive Information

Members have the right to receive information about CHIPA's services, benefits, practitioners, their own rights and responsibilities, as well as the clinical guidelines. Members have a right to receive this information in a manner and format that is understandable and appropriate to the member's needs free of charge.

Right to Respect and Privacy

Members have the right to respectful treatment as individuals regardless of race, gender, gender identity, veteran status, religion, marital status, national origin, physical disabilities, mental disabilities, age, sexual orientation or ancestry.

Right to Confidentiality

Members have the right to have all communication regarding their health information kept confidential by CHIPA staff and all contracted providers, to the extent required by law.

Right to Participate in the Treatment Process

Members and their legal guardian have the right to actively participate in treatment planning and decision-making. The behavioral health provider will provide the member, or legal guardian, with complete current information concerning a diagnosis, treatment and prognosis in terms the member, or legal guardian, can be expected to understand. All members have the right to review and give informed consent for treatment, termination, and aftercare plans. Treatment-planning discussions may include all appropriate and medically necessary treatment options, regardless of benefit design and/ or cost implications.

Right to Treatment and Informed Consent

Members have the right to give or refuse consent for treatment and for communication to PCPs and other behavioral health providers.

Right to Clinical/Treatment Information

Members and their legal guardian have the right to, upon submission of a written request, review the member's medical records. Members and their legal guardian may discuss the information with the designated responsible party at the provider site.

Right to Appeal Decisions Made by CHIPA

Members and their legal guardian have the right to appeal CHIPA's decision not to authorize care at the requested level of care, or CHIPA's denial of continued stay at a particular level of care according to the clinical appeals procedures. Members and their legal guardians may also request the behavioral health or substance use healthcare provider to appeal on their behalf according to the same procedures.

Right to Submit a Complaint or Concern

Members and their legal guardians have the right to file a complaint or grievance regarding any of the following:

- The quality of care delivered to the member by a CHIPA contracted provider
- The CHIPA utilization review process
- The quality of service delivered by any CHIPA staff member or CHIPA contracted provider
- Members and their legal guardians may call their health plan directly to file a complaint, or they may call CHIPA at 800.779.3825 to request assistance in filing a complaint with their health plan.

Right to Contact CHIPA Ombudsperson

Members have the right to contact CHIPA's Office of Ombudsperson to obtain a copy of CHIPA's Member Rights and Responsibilities statement. The CHIPA Ombudsperson may be contacted at 800.779.3825 or by TTY at 800.735.2929.

Right to Make Recommendations about Member Rights and Responsibilities

Members have the right to make recommendations directly to CHIPA regarding CHIPA's Member's Rights and Responsibilities statement. Members should direct all recommendations and comments to CHIPA's Ombudsperson. All recommendations will be presented to the appropriate CHIPA review committee. The committee will recommend changes to the policies as needed and as appropriate.

Prohibition on Billing Members

Health plan members may not be billed for any covered service or any balance after reimbursement by CHIPA except for any applicable co-payment or member share of cost.

Further, providers may not charge the plan members for any services that are not deemed medically necessary upon clinical review or which are administratively denied. It is the provider's responsibility to check benefits prior to beginning treatment of this membership and to follow the procedures set forth in this manual.

MEMBER RESPONSIBILITIES

Members of the health plan agree to do the following:

- Choose a PCP and site for the coordination of all medical care. Members may change PCPs at any time by contacting their health plan.
- Carry the health plan identification card and show the card whenever treatment is sought.
- In an emergency, seek care at the nearest medical facility and call their PCP within 48 hours. The back of the plan identification card highlights the emergency procedures.

- Provide clinical information needed for treatment to their behavioral health care provider.
- To the extent possible, understand their behavioral health problems and participate in the process of developing mutually agreed-upon treatment goals.
- Follow the treatment plans and instructions for care as mutually developed and agreed-upon with their practitioners.

POSTING MEMBER RIGHTS AND RESPONSIBILITIES

All contracted providers must display in a highly visible and prominent place, a statement of members' rights and responsibilities. This statement must be posted and made available in languages consistent with the demographics of the population(s) served. This statement can either be CHIPA's statement or a comparable statement consistent with the provider's state licensure requirements.

INFORMING MEMBERS OF THEIR RIGHTS AND RESPONSIBILITIES

Providers are responsible for informing members of their rights and respecting these rights. In addition to a posted statement of member rights, providers are also required to:

- Distribute and review a written copy of Member Rights and Responsibilities at the initiation of every new treatment episode and include in the member's medical record signed documentation of this review.
- Inform members that CHIPA does not restrict the ability of contracted providers to communicate openly with plan members regarding all treatment options available to them, including medication treatment, regardless of benefit coverage limitations.
- Inform members that CHIPA does not offer any financial incentives to its contracted provider community for limiting, denying, or not delivering medically necessary treatment to plan members.
- Inform members that clinicians working at CHIPA do not receive any financial incentives to limit or deny any medically necessary care.

4.2. Interpreter Services

Under state and federal law, providers are required to arrange for interpreter services to communicate with individuals with limited English proficiency and those who are deaf or hard of hearing, at no cost to the member. To arrange for a face to face interpreter, providers should call CHIPA Member Services at 800.779.3825 at least three business days in advance of the appointment. Telephonic interpretation services are available 24 hours a day, seven days a week by contacting CHIPA with the member at 800.779.3525.

4.3. Cultural Competency

Providers must ensure that members have access to medical interpreters, signers and TTY services to facilitate communication when necessary and ensure that clinicians and the agency are sensitive to the diverse needs of members. Contracted providers are expected to provide services in a culturally competent manner at all times and to contact CHIPA immediately if they are referred a member with cultural and/or linguistic needs they may not be qualified to address.

Chapter 5

Treatment Records

5.1. Treatment Record Reviews

CHIPA reviews member charts and uses data generated to monitor and measure provider performance in relation to the Treatment Record Standards and specific quality initiatives established each year. The following elements are evaluated:

- Use of screening tools for diagnostic assessment of substance use, adolescent depression and ADHD
- Continuity and coordination with primary care providers and other treaters
- Explanation of member rights and responsibilities
- Inclusion of all applicable required medical record elements as listed below
- Allergies and adverse reactions; medications; physical exam

CHIPA may conduct chart reviews onsite at a provider facility, or may ask a provider to copy and send specified sections of a member's medical record to CHIPA. Any questions that a provider may have regarding CHIPA's access to the plan member information should be directed to CHIPA's privacy officer at 800.779.3825.

5.2. Treatment Record Content Standards

To ensure that the appropriate clinical information is maintained within the member's treatment record, providers must follow the documentation requirements below, based upon NCQA standards. All documentation must be clear and legible.

Treatment Documentation Standards

TABLE 5-1: APPOINTMENT STANDARDS AND SERVICE AVAILABILITY

Member Identification Information	The treatment record contains the following member information: ▪ Member name and health plan ID # on every page ▪ Member's address ▪ Employer or school ▪ Home and work telephone # ▪ Marital/legal status ▪ Appropriate consent forms ▪ Guardianship information, if applicable
Informed Member Consent for Treatment	The treatment record contains signed consents for the following: ▪ Implementation of the proposed treatment plan ▪ Any prescribed medications ▪ Consent forms related to interagency communications ▪ Individual consent forms for release of information to the member's PCP and other behavioral health providers, if

	applicable; each release of information to a new party (other than CHIPA or the plan) requires its own signed consent form. ▪ Consent to release information to the payer or MCO (In doing so, the provider is communicating to the member that treatment progress and attendance will be shared with the payer) ▪ For adolescents, ages 12–17, the treatment record contains consent to discuss behavioral health issues with their parents ▪ Signed document indicating review of patient's rights and responsibilities
Medication Information	Treatment records contain medication logs clearly documenting the following: ▪ All medications prescribed ▪ Dosage of each medication ▪ Dates of initial prescriptions ▪ Information regarding allergies and adverse reactions are clearly noted ▪ Lack of known allergies and sensitivities to substances are clearly noted
Medical and Psychiatric History	Treatment record contains the member's medical and psychiatric history including: ▪ Previous dates of treatment ▪ Names of providers ▪ Therapeutic interventions ▪ Effectiveness of previous interventions ▪ Sources of clinical information ▪ Relevant family information ▪ Results of relevant laboratory tests ▪ Previous consultation and evaluation reports
Substance Use Information	Documentation for any member 12 years and older of past and present use of the following: ▪ Cigarettes ▪ Alcohol ▪ Illicit, prescribed, and over-the-counter drugs
Adolescent Depression Information	Documentation for any member 13-18 years who was screened for depression

	▪ If yes, was a suicide assessment conducted? ▪ Was the family involved with treatment?
ADHD Information	Documentation that members aged 6-12 were assessed for ADHD ▪ Was family involved with treatment? ▪ Is there evidence of the member receiving psychopharmacological treatment?
Diagnostic Information	▪ Risk management issues (e.g., imminent risk of harm, suicidal ideation/intent, and elopement potential) are prominently documented and updated according to provider procedures ▪ All relevant medical conditions are clearly documented, and updated as appropriate ▪ Member's presenting problems and the psychological and social conditions that affect their medical and psychiatric status ▪ A complete mental status evaluation is included in the treatment record, which documents the member's: a. Affect b. Speech c. Mood d. Thought control, including memory e. Judgment f. Insight g. Attention/concentration h. Impulse control i. Initial diagnostic evaluation and DSM diagnosis that is consistent with the stated presenting problems, history, mental status evaluation, and/or other relevant assessment information j. Diagnoses updated at least quarterly basis
Treatment Planning	The treatment record contains clear documentation of the following: ▪ Initial and updated treatment plans consistent with the member's diagnoses, goals and progress ▪ Objective and measurable goals with clearly defined time frames for achieving goals or resolving the identified problems ▪ Treatment interventions used and their consistency with stated treatment goals and objectives

	▪ Member, family and/or guardian's involvement in treatment planning, treatment plan meetings and discharge planning ▪ Copy of *Outpatient Review Form(s)* submitted, if applicable
Treatment Documentation	The treatment record contains clear documentation of the following: ▪ Ongoing progress notes that document the member's progress towards goals, as well as his/her strengths and limitations in achieving said goals and objectives ▪ Referrals to diversionary levels of care and services if the member requires increased interventions resulting from homicidality, suicidality or the inability to function on a day-to-day basis ▪ Referrals and/or member participation in preventive and self-help services (e.g., stress management, relapse prevention, Alcoholics Anonymous, etc.) is included in the treatment record. ▪ Member's response to medications and somatic therapies
Coordination and Continuity of Care	The treatment record contains clear documentation of the following: ▪ Documentation of communication and coordination between behavioral health providers, primary care physicians, ancillary providers, and health care facilities. (See Behavioral Health – PCP Communication Protocol later in this chapter, and download *Behavioral Health – PCP Communication Form*) ▪ Dates of follow-up appointments, discharge plans, and referrals to new providers
Additional Information for Outpatient Treatment Records	These elements are required for the outpatient medical record: ▪ Telephone intake/request for treatment ▪ Face-sheet ▪ Termination and/or transfer summary, if applicable ▪ The following clinician information on every entry (e.g., progress notes, treatment notes, treatment plan, and updates) should include the following treating clinician information: a. Clinician's name b. Professional degree c. Licensure d. NPI or CHIPA identification number, if applicable e. Clinician signatures with dates

Additional Information for Inpatient and Diversionary Levels of Care	These elements are required for inpatient medical records: ▪ Referral information (ESP evaluation) ▪ Admission history and physical condition ▪ Admission evaluations ▪ Medication records ▪ Consultations ▪ Laboratory and x-ray reports ▪ Discharge summary and *Discharge Review Form*
Information for Children and Adolescents	A complete developmental history must include the following information: ▪ Physical, including immunizations ▪ Psychological ▪ Social ▪ Intellectual ▪ Academic ▪ Prenatal and perinatal events are noted

5.3. 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

5.4. 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.

5.5. 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.

5.6. 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.

5.7. 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, group, facility, or other entity designated by HIPAA for the purposes of treatment, payment, or health care operations[1].

5.8. 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.

[1] *"'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.*

5.9. 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.

5.10. Disclosure to Health Plans

Summary health information may be released to a plan sponsor 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 website and is also available in paper copy by contacting Network Management.

5.11. 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. 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.

Chapter 6

Quality Management and Improvement Program

6.1. Quality Management and Improvement Program Overview

CHIPA's Quality Management and Improvement (QM & I) Program goal is to continually monitor and improve the quality and effectiveness of behavioral health services delivered to members. CHIPA's QM & I Program integrates the principles of continuous quality improvement (CQI) throughout our organization and the provider network.

PROGRAM PRINCIPLES

- Continually evaluate the effectiveness of services delivered to health plan members
- Identify areas for targeted improvements
- Develop QI action plans to address improvement needs
- Continually monitor the effectiveness of changes implemented, over time

PROGRAM GOALS AND OBJECTIVES

- Improve the healthcare status of members
- Enhance continuity and coordination among behavioral health care providers and between behavioral healthcare and physical healthcare providers
- Establish effective and cost-efficient disease management programs, including preventive and screening programs, to decrease incidence and prevalence of behavioral health disorders
- Ensure members receive timely and satisfactory service from CHIPA and network providers
- Maintain positive and collaborative working relationships with network practitioners and ensure provider satisfaction with CHIPA services
- Responsibly contain healthcare costs

PROVIDER ROLE

CHIPA employs a collaborative model of continuous QM & I, in which provider and member participation is actively sought and encouraged. In signing the participation agreement, all providers agree to cooperate with CHIPA and the plan QI initiatives. CHIPA also requires each provider to have its own internal QM & I Program to continually assess quality of care, access to care and compliance with medical necessity criteria.

To participate in CHIPA's Provider Advisory Council, contact the Provider Relations department. Members who wish to participate in the Member Advisory Council, should contact the Member Services Department.

6.2. Quality Monitoring

CHIPA monitors provider activity and uses the data generated to assess provider performance related to quality initiatives and specific core performance indicators. Findings related to provider compliance with performance standards and measures are also used in benchmarking and to identify individual provider and network-wide improvement initiatives. CHIPA's quality monitoring activities include, but are not limited to:

- Site visits
- Treatment record reviews
- Satisfaction surveys
- Internal monitoring of: timeliness and accuracy of claims payment; provider compliance with performance standards, including but not limited to:
    - Timeliness of ambulatory follow-up after behavioral health hospitalization;
    - Discharge planning activities;
    - Communication with member PCPs, other behavioral health providers, government and community agencies; and
    - Tracking of adverse incidents, complaints, grievances and appeals
- Other quality improvement activities

On a quarterly basis, CHIPA's QM & I Department aggregates and trends all data collected and presents the results to the QI Committee for review. The QI Committee may recommend initiatives at individual provider sites and throughout CHIPA's behavioral health network as indicated.

A record of each provider's adverse incidents and any complaints, grievances or appeals pertaining to the provider is maintained in the provider's file, and may be used by CHIPA in profiling and network (re)procurement activities and decisions.

6.3. Reportable Incidents and Events

CHIPA requires that all providers report adverse incidents, other reportable incidents and sentinel events involving the plan members to CHIPA as follows:

- You must notify a CHIPA Case Manager within one business day of the occurrence by calling 800.779.3825

TABLE 6-1: REPORTABLE INCIDENTS AND EVENTS - OVERVIEW

	ADVERSE INCIDENTS	SENTINEL EVENTS	OTHER REPORTABLE INCIDENTS
Incident/Event Description	An adverse incident is an occurrence that represents actual or potential serious harm to the well-being of a health plan member who is currently receiving or has been recently discharged	A sentinel event is any situation occurring within or outside of a facility that either results in death of the member or immediately jeopardizes the safety of a health plan member receiving services in any level of care.	An "other reportable incident" is any incident that occurs within a provider site at any level of care that does not immediately place a health plan member at risk but warrants serious concern.

	ADVERSE INCIDENTS	SENTINEL EVENTS	OTHER REPORTABLE INCIDENTS
	from behavioral health services.		
Incidents/Events include the following:	▪ All medico-legal or non-medico-legal deaths ▪ Any absence without authorization (AWA) involving a member who does not meet the criteria above ▪ Any injury while in a 24-hour program that could or did result in transportation to an acute care hospital for medical treatment or hospitalization ▪ Any sexual assault or alleged sexual assault ▪ Any physical assault or alleged physical assault by a staff per-son or another patient against a member ▪ Any medication error or suicide attempt that requires medical attention beyond general first aid procedures ▪ Any unscheduled event that results in the temporary evacuation of a program or facility (e.g., fire resulting in	▪ All medico-legal deaths ▪ Any medico-legal death is any death required to be re-ported to the medical examiner or in which the medical examiner takes jurisdiction. ▪ Any AWA involving a patient involuntarily admitted or committed and/or who is at high risk of harm to self or others ▪ Any serious injury resulting in hospitalization for medical treatment ▪ A serious injury is any injury that requires the individual to be transported to an acute care hospital for medical treatment and is subsequently medically admitted. ▪ Any medication error or suicide attempt that requires medical attention beyond general first aid procedures ▪ Any sexual assault or alleged sexual assault ▪ Any physical assault or alleged physical assault by a staff per-son against a member ▪ Any unscheduled event that results in the evacuation of a program	▪ Any non-medico-legal death ▪ Any AWA from a facility involving a member who does not meet the criteria for a sentinel event as described above ▪ Any physical assault or alleged physical assault by or against a member that does not meet the criteria of a sentinel event ▪ Any serious injury while in a 24-hour program requiring medical treatment, but not hospitalization ▪ A serious injury, defined as any injury that requires the individual to be transported to an acute care hospital for medical treatment and is not subsequently medically admitted ▪ Any unscheduled event that results in the temporary evacuation of a program or facility, such as a small fire that requires fire department response. Data regarding critical incidents is gathered

	ADVERSE INCIDENTS	SENTINEL EVENTS	OTHER REPORTABLE INCIDENTS
	response by fire department)	or facility whereby regular operations will not be in effect by the end of the business day and may result in the need for finding alternative placement options for member	in the aggregate and trended on a quarterly basis for the purpose of identifying opportunities for quality improvement.
Reporting Method	▪ CHIPA's Clinical Department is available 24 hours a day ▪ Providers must call, regardless of the hour, to report such incidents and direct all such reports to their CHIPA clinical manager or UR clinician by phone ▪ Incident and event reports should not be emailed unless the provider is using a secure messaging system		
Provide the following	Providers should be prepared to present: ▪ All relevant information related to the nature of the incident ▪ The parties involved (names and telephone numbers) ▪ The member's current condition		

6.4. 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.

6.5. 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.

6.6. 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 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 group
- Terminate your participation status with CHIPA

Cooperation when placed on 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 group
- Informing current members of status and their option to transfer to another network clinician or group
- Assisting with stable transfers to another network clinician or group at the member's request

6.7. 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.

Chapter 7

Compensation and Claims Processing

7.1. 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 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.

7.2. Co-Payments, Co-Insurance, 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.

7.3. Balance Billing for Covered Services

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.

7.4. Billing for Non-Covered Services – No Show Visits

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:

- That you have informed the member that CHIPA is unable to certify such services for coverage under the member's benefit plan
- The reason given by CHIPA for not authorizing the services
- 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 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.

7.5. Claims Submission

Although claims are reimbursed based on the network fee schedule or 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 5665 Plaza Drive Suite 400 Cypress, CA 90630
Fax:	800.563.3480

ELECTRONIC DATA INTERFACE

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.

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), 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

7.6. 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 members. Should another health plan exist, the provider agrees to:

1. Notify CHIPA of the health plan name and member identification number
2. Bill CHIPA for covered services in accordance with the participation agreement

7.7. 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-1500. Non-participating providers must submit their billing within 180 days of the date of service using the CMS-1500. The CMS-1500 is available on our website.

This section explains the basic billing guidelines required for CHIPA processing of hard copy medical CMS-1500 and UB04 claim forms. For more information on how to complete the CMS-1500 and UB04 claims forms, please refer to the Department of Health Care Services (DHCS) website at: www.dhcs.ca.gov.

Following these guidelines helps ensure that CHIPA can pay a provider's hard copy claim quickly and accurately:

1. **Type in Designated Area Only**—All claims are scanned, so it is important that providers input data on the claim form only in the designated fields. Be sure the data falls completely within the text space and is properly aligned. This will ensure that claims are scanned accurately and avoid rejections or payment delays. Handwritten claims must be legible.
2. **Use Alpha or Numeric Characters Only**— Use only alphabetical letters or numbers in data entry fields as appropriate. Symbols such as "$,#, cc, gm" or positive (+) and negative (–) signs may be used when entering information in the Specific Details/Explanation/Remarks or the Reserved for Local Use fields of the claim form only.
3. **Do Not Use Highlighting Pens**— Please do not highlight information. When the form and attachments are scanned on arrival, the highlighted area will show up as a black mark, covering the information highlighted.
4. **Follow the Date Format**— Enter dates in the six-digit format (MMDDYY) without slashes.

5. **Cover Corrections**— Do not strike over errors; do not use correction fluid; do not use correction tape.
6. **Be Sure to Reference Claim Fields or Procedures on Attachments**— Attached documents for medical claim forms and Provider Dispute Resolution forms should clearly reference the claim field number or procedure that requires additional documentation.

Note: Do not highlight or use tape to fasten attachments to the claim form. Do not use original claims as attachments since it may not be interpreted as an original claim. Carbon copies of documentation are not acceptable.

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 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.

7.8. 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 provider's name, billing provider's tax ID number or CHIPA's provider ID number, provider's contact information, and:

- 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

- If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue
- If the contracted provider dispute involves a 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 a 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 PROVIDER DISPUTE

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, 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:

CHIPA Provider Disputes
5565 Plaza Drive Suite 400
Cypress, CA 90630

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 30 working days of your receipt of a returned contracted clinician dispute.

ACKNOWLEDGMENT OF CONTRACTED PROVIDER DISPUTE RESOLUTIONS

CHIPA will provide written acknowledgement of receipt of all contracted clinician disputes within 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 45 working days after the date of receipt of the contracted clinician dispute or the amended contracted clinician dispute

PAST PAYMENTS DUE TO CLINICIANS

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 working days of the issuance of the written determination.

7.9. Claims 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 30 working days of the clinician's receipt of the notice of overpayment of a claim.

Chapter 8

Appeals

8.1. Appeals Overview

To ensure patient rights regarding their benefit, 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.

8.2. 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 enrollees of 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.

8.3. 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.

8.4. Appeals Process

APPEAL RIGHTS

Appeal rights are available upon request to any patient, provider, or 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, 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 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 three calendar days to the patient and attending physician or other ordering provider or 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 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.

Chapter 9

Manual Updates and Governing Law

9.1. 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 our website at www.chipa.com or you may request a paper copy by contacting Network Management.

9.2. Governing Law and Contracts

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 1

Frequently Asked Questions

#	QUESTION	ANSWER
CHIPA Network Requirements		
1	**Who can I contact with specific questions?**	For general information and contractual questions, contact Provider Relations at 800.779.3825; chose option 6 then 3.
2	**Do I have to notify anyone if I have any demographic change or if I change my name?**	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. You may notify Provider Relations via email at provider.inquiry@beaconhealthoptions.com or by calling 800.779.3825; chose option 6 then 3.
3	**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 ID. It is important to provide CHIPA with all practice locations and the Tax ID under which you bill.
4	**Since our group practice 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.
5	**May I bill for mental health/substance use disorder 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.chipa.com) to review the guidelines.
6	**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.
7	**As a contracted group, would the addition of programs, services, or locations require review of our current contract with CHIPA?**	Yes. Contact Provider Relations to initiate a review.
8	**If my practice is filling up or if I am going to take a leave of**	Yes. You may request to be listed in our database as unavailable at one or more of your practice locations for up

#	QUESTION	ANSWER
	absence from practice, may I choose to be unavailable for new CHIPA referrals?	to six months. You are required to notify Provider Relations within 10 calendar days of your lack of availability for new referrals.
9	**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 Provider Relations.
Benefit Plans, Obtaining Registrations, and Access to Care		
10	**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.
11	**How can I tell which contract my member is under?**	The registration letter lists the contract under benefit information, plan code. ▪ AB = Anthem BlueCross ▪ AT = Aetna Behavioral Health ▪ MHN = Managed Health Network ▪ UBH = United Behavioral Health/Optum Health Behavioral Solutions
12	**Which authorization number should I use when submitting claims to CHIPA?**	Use the "CHIPA Reference Number" (e.g., 555555-01-01).
13	**Can I inquire about a member's current eligibility, certification and benefits?**	Yes. You can inquire about eligibility and benefits by calling Member Services at 800.779.3825.
14	**Can members initiate registrations of benefits for routine outpatient mental health/substance use disorder services?**	Yes. The certification for routine outpatient services is typically obtained through a telephone contact between the member or family member and a Member Services Representative. However, if a registration has not been issued at the time you inquire about eligibility, then you

#	QUESTION	ANSWER
		need to request it. You may do this by calling the Member Services Department.
15	**Do all members require prior registration for outpatient treatment?**	Yes. For CHIPA members whose benefit plan does not require prior registration, 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 Member Services Department.
16	**Are all services I provide covered under a mental health/substance use disorder authorization?**	No. The registration issued to members covers most common routine outpatient mental health/substance use disorder services you provide. *Please note: Psychological testing, home visits, intensive outpatient care and other non-routine outpatient MH/SA services still require clinician-specific or program-specific authorization of benefits prior to providing those services. To obtain an authorization, please call Member Services.*
17	**Is there a time limit in which a registration for services is valid?**	Yes. The authorizations of services is typically valid for one year form the date of issue up to the benefit limit as long as the member's eligibility remains active.
18	**Will I be notified when a registration expires?**	No. Please refer to the effective date on the most recent registrations letter. The registration 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).
19	**Does the use of a registration change the requirements of medical necessity?**	No. All care certified by CHIPA, even under the registration process, must meet medical necessity standard.
20	**Is a consultation with a UM clinician necessary to refer members directly to inpatient day treatment or intensive outpatient services?**	Yes. Inpatient and subacute level of care admissions are pre-authorized by an UM clinician. In the event of an emergency admission, facilities should immediately notify CHIPA.
Treatment Philosophy		
21	**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 Provider

#	QUESTION	ANSWER
		Relations or the specific health plan, to have a paper copy of these documents mailed to you.
22	**Am I expected to coordinate care with a member's primary care physician or other health care professional?**	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 even 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		
23	**Can members be billed prior to claims submission?**	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.
24	**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 registration letter regarding parity diagnosis. If your billing diagnosis is listed under the parity diagnosis collect the lower parity co-pay. If the billing diagnosis is not listed, collect the standard co-pay.
25	**How should I submit claims?**	CHIPA recommends electronic submission of claims for the most efficient claims processing. Network clinicians and group practices can submit claims electronically through Office Ally. To obtain a user ID, contact Office Ally. In addition, claims can be electronically submitted through any other EDI clearinghouse using Payer ID CHIPA. Claims can be faxed to 877.563.3480. They can also be mailed to the following address: CHIPA 5665 Plaza Drive Suite 400 Cypress, CA 90630
26	**Is there one format to be used for diagnosis on claims?**	Yes. Submit your claims with standard ICD-10 diagnostic code.

#	QUESTION	ANSWER
27	**Do I have to submit my claims within a certain period in order for them to be paid?**	Yes. With Aetna and MHN, you have 365 calendar days from date of service to file your claim. With UBH, you will have 90 calendar days from date of service to file if not then your claim may be denied for timely filing.
28	**How many dates of service can I bill at one time?**	Each CMS-1500 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 CMS-1500 Forms (e.g. ten dates of service equals two CMS-1500 Forms, six on one, and 4 on the other).
29	**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.
30	**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.
31	**May I submit a claim to CHIPA for telephone consulting 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.
32	**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		
33	**Do HIPAA Regulations allow me to exchange Protected**	Yes. The HIPAA Privacy Rule permits clinicians and CHIPA to exchange PHI, with certain protections and limits, for

#	QUESTION	ANSWER
	Health Information (PHI) to CHIPA?	activities involving Treatment, Payment, and Operations (TPO).
34	**Do I need a National Provider Identification (NPI) 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 NPI. Some states presently require an NPI for paper claims as well.
Legal and Ethical Practices		
35	**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 registration, 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 registration. **Not Acceptable Documentation Example**—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. **Acceptable Documentation Example**—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*

#	QUESTION	ANSWER
		partner later requests the medical records, the chart cannot be released without both partners' 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		
36	**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		
37	**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 appeal 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.
38	**Are there different contacts for issues with claims processing or payment?**	No. You can call CHIPA at 800.779.3825 and select option 5 for our Claims Department. You may mail a Claims Dispute Resolution Request to CHIPA at the following claims address:

#	QUESTION	ANSWER
		Claims can be faxed to 877.563.3480. They can also be mailed to the following address: CHIPA Attn: Claims Department 5665 Plaza Drive Suite 400 Cypress, CA 90630 Fax: 877.563.3480

Appendix 2

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.

TERM	DEFINITION
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 a 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 group requesting payment from a member for the difference between the CHIPA contracted rate and the clinician or group's usual charge for the service.
Behavioral Health Care	Assessment and treatment of mental health and/or substance use disorders.
Clean Claim	A 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-10 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 percent complete with no missing or illegible information
Clinician	A licensed professional that has contracted to deliver behavioral health care services to members (also known as a network clinician).

TERM	DEFINITION
Co-insurance	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 group is accepted in 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.
Employee Assistance Program (EAP)	Services that are designed for brief intervention, assessment and referral. These services are short-term in nature.
Electronic Claim	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	The use of an Electronic Data Interface (EDI) to submit electronic claims for processing.
Electronic Data Interface (EDI)	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 an 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

TERM	DEFINITION
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).
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 website at 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 at which the patient can be safely and effectively treated while maintaining maximum independence of living.
Level of Care Guidelines	Objective, evidence-based admission and continuing stay criteria for mental health/substance use disorder services. These guidelines are intended to standardize care advocate decisions regarding the most appropriate and available level of car 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: and 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)

TERM	DEFINITION
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/SUD	Mental health and/or substance use disorder
Open Registration	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 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.
Registration	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). Registrations 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 Registration).
Rejected Claim	A claim that 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.