



Section 7

Claims Procedures

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CLAIMS SUBMISSION PROCEDURES

CCHCA Central Billing Division (CBD)

CCHCA can submit the claims for physician offices through CCHCA's Central Billing Division. Benefits to physician offices are: no more billing hassles, cleaner claims, faster reimbursement, and monthly claims reports.

For more information on services provided by CCHCA CBD, please contact:

CCHCA Central Billing Division Manager at: (415) 216-0088 Ext. 2828 or email to: CBD@cchca.com

Timely Filing Guidelines

- Claims must be submitted to CCHCA within 90 calendar days from the date of service.

Filing Electronic Claims

CCHCA highly recommend billers to submit claims electronically. If providers are submitting claims electronically through a clearinghouse, please submit the claims with the payer ID 94302 as CCHP has a clearinghouse, Emdeon One, to receive electronic claims.

OR

Filing Paper Claims

Claims are processed for CCHCA by our TPA, Chinese Community Health Plan (CCHP).

All paper claims for CCHCA must be submitted on a **CMS 1500 Form** to:

Claims Department
445 Grant Ave., Suite 700
San Francisco, CA 94108

Checking Claims Status

Claims status can be checked on-line by using DST ePower provided by our TPA, CCHP. To use DST ePower, please go to www.cchphealthplan.com/providers-filing-claims . For more information on using DST ePower, please contact our TPA, CCHP at 415-955-8800.

Claim Payment Timelines



- Commercial claims are processed within 45 business days from claim received date
- Medicare claims are processed within 60 calendars days from claim received date

Claim Submissions

All claims should be submitted on a CMS 1500 Form. Important elements that are necessary for billing include:

1. Patient's name, address.
2. Patient ID number (including suffix #, i.e. 01, 02, 03, etc.)
3. Date of birth
4. Date of service
5. Provider's name, address, NPI, tax ID number, and provider signature.
6. Usual charges
7. ICD-10 diagnosis codes
8. J Codes (if applicable)
9. CPT procedure codes
10. Place of service codes
11. Completion of item 11. If there is insurance primary to Medicare, the insured's policy or group number should be entered. If there is no insurance primary to Medicare, then "none" should be entered.

The ensuing pages list "place of service" codes and some CPT codes.

If you use computer generated forms, such forms must carry the same information. Provider signature should be on all paper claim forms.

Claims for Referred Services

For electronic claims, the CCHCA specialist physician must indicate the name of the referring CCHCA physician on the electronic claim.

For paper claims, the CCHCA specialist physician must indicate the name of the referring CCHCA physician on the claim and submit a copy of the CCHCA Consultation Referral Form with the claim.

For CCHCA OB/Gyn Specialists submitting paper claims for patients accessing women's health services without a referral from the primary care physician (See Section 4, Page 3)

Claims for Authorized Services

Be sure that a claim for authorized services includes the following:

- a) The procedure code(s) that was authorized on the Service Authorization Form (SAF) matches the code on the claim form,



- b) The reference number for the authorization,
- c) And, when submitting a paper claim, attach a copy of the approved SAF.

Claims Resubmission Policy

To avoid duplicate claims, please first check the status of your claims either on our Web site or by calling the phone number listed in Section 1 to confirm receipt. Resubmission of a claim should be no earlier than 60 days following the original claims.

Refunds

When submitting a refund, please include a copy of the remittance advice, an explanation why you believe there is an overpayment, a check in the amount of the refund, and a copy of the primary payer's remittance advice (if applicable).



PLACE OF SERVICE CODES

<u>CODES</u>	<u>DEFINITION</u>
11	Office
12	Patient Home
19	Off Campus- Outpatient Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	On Campus- Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Center
31	Skilled Nursing Facility
32	Nursing Home/Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance (Land)
42	Ambulance (Air or Water)
51	Inpatient Psychiatric Facility
52	Psych Facility-Partial Hospitalization
53	Community Mental Health Center
54	Intermediate care Facility/Individuals with Intellectual Disabilities
55	Residential Treatment Center/Substance Abuse
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehab Facility
62	Comprehensive Outpatient Rehab Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service



GUIDELINES FOR CLAIMS SUBMISSIONS

All claims should have sufficient information to allow for justification of the coding level. (eg. diagnosis, copy of H & PE, consultation, op report, progress notes.)

PRIMARY CARE SERVICES

1. NEW PATIENTS:

All primary care physicians performing a new patient evaluation should determine their billing, on CPT definitions, including intensity of decision making.

Generally, the following specialties have a lower level of decision making, and should submit adequate explanation in the diagnosis, or documentation such as the history and physical to demonstrate the level of decision making, if billing a 99205:

- Family Practice / General Practice
- Obstetrics (as primary)
- Pediatrics

2. ANNUAL EXAMINATIONS:

Primary care physicians may continue to perform an annual medical assessment which may be a *detailed or comprehensive follow up* for their patients as needed once yearly.

The following specialties generally have a lower level of decision making. These specialties should particularly submit an adequate diagnosis/explanation or a copy of the history and physical for 99215:

Family Practice / General Practice
Obstetrics (as primary)
Pediatrics

Family/ General Practice should use 99214 for annual medical assessment or submit documentation of more complicated decision making.

Pediatricians should be utilizing the preventive medicine codes for such examinations in accordance to the AAP schedule.

Preventive services codes 99381-99397 are available for routine annual assessment.

There should be sufficient documentation, including diagnosis or complications to document need for complex decision making to justify 99215. Lack of same will justify potential down coding during review.



SPECIALIST SERVICES AND CONSULTATIONS

The following specialties generally perform detailed or comprehensive consultations 99213 or 99214 due to the scope of their specialties. {In using 99214, the diagnosis & complexity of decision making must be significant}. When 99215 or 99223 claims are submitted, adequate documentation must be attached. They are expected to submit consultation reports for 99215 or 99223 consultations. (This is the current rule):

Cardiology	Infectious Diseases	Neurosurgery
Endocrinology	Nephrology	Pulmonary
Hematology/Oncology	Neurology	Rheumatology

The following specialties generally perform consultations limited to their scope of practice, and the majority of their claims are 99213 or below. Billings for consultations from the following surgical and medical subspecialties should have the consultation accompanying the claim, or sufficient information with the claim documenting the intensity of service (e.g. multiple trauma, evaluation of carcinoma, or evaluation of complex systems such as low back pain) as follows:

Allergy	Gynecology	Otolaryngology
Dermatology	Obstetrics (As specialist)	Plastic Surgery
Gastroenterology	Ophthalmology	Podiatry
General Surgery	Orthopedics	Urology



CLAIMS TIPS

The CPT is utilized to identify services and procedures.

A. Certain procedures and services however are not payable by CCHCA.

These include but not limited to the following:

1. 99050 - additional payments for Sunday and holiday calls are not normally payable. However, when emergency services are provided, after usual hours, on weekends or on holidays, a supplementary fee of up to \$10 is payable.
2. 99223 and 99233 - Services rendered as complex consultation should be accompanied with a copy of the consultation.

Consultations and referral follow-up visits should be accompanied with the approved SAF.

Billings for services requiring a higher than average level of service, including detailed or comprehensive services, should be submitted with adequate documentation. These services are subject to review against the definitions in the CPT. If documentation does not justify the level billed, the claim will be changed to the perceived appropriate level. You can avoid changes by submitting adequate documentation with the claims, either directly on the claims form, such as indicating the acute or critical nature of the illness, or with an accompanying document. You may appeal any changes by submitting further information.

Name of Injection Needed

When billing for an injection, the type of drug injected (e.g. Penicillin, Furosemide, etc.) including quantity used must be included in the description of the injection. Including this description in the original billing will help expedite your claim.

When billing for immunizations, please use the CPT codes that best describes the service. Administrative codes should be billed as separate line items.



PROVIDER DISPUTES

Provider Dispute Resolution Procedure

CCHCA has a Provider Dispute Resolution (PDR) process that ensures provider disputes are handled in a fast, fair and cost effective manner. A provider dispute is a written notice from a provider that:

- Challenges, appeals or requests reconsideration of a claim (including a bundled group of similar claims) that has been denied, adjusted or contested, or
- Challenges a request for reimbursement for an overpayment of a claim, or
- Seeks resolution of a billing determination or other contractual dispute.

Providers have 365 days from the date of the CCHCA's action or inaction to submit a provider dispute. If a provider disputes the failure to take action on a claim, the provider has 365 days from the last date on which the Plan could have either paid, denied or contested the claim (consistent with claims payment timeliness rules) to submit the dispute.

How to Submit Provider Disputes

Providers must use a Provider Dispute Resolution Request Form. A copy of the form is included in this section. You may download the PDR Request Form and Instructions for Submitting Provider Disputes at <http://www.cchca.com/provider-disputes.php>

Disputes may be mailed to:

Provider Dispute Department
445 Grant Avenue, Suite 700
San Francisco, CA 94108

Disputes can be faxed to: 415-955-8815

Acknowledgement of Provider Disputes

Acknowledgement of a provider dispute will be made within 15 business days of receipt. Provider disputes received electronically must be acknowledged within 2 working days from the date of receipt.

Resolution Timeframe

Each provider dispute will be resolved within 45 business days following receipt of the dispute, and will provide the provider with a written determination stating the reasons for the determination.



PROVIDER DISPUTE RESOLUTION PROCEDURE

Chinese Community Health Care Association

As required by Assembly Bill 1455, the California Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care. This information notice is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for commercial HMO, POS, and, where applicable, PPO products where Chinese Community Health Care Association [CCHCA] is delegated to perform claims payment and provider dispute resolution processes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

I. Dispute Resolution Process for Contracted Providers

- A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to CCHCA and/or the member's applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider's name; provider's identification number, provider's contact information, and:
- i. If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from CCHCA to a contracted provider the following must be provided: 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;
 - ii. If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and
 - iii. If the contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.



Sending a Contracted Provider Dispute to CCHCA: Contracted provider disputes submitted to CCHCA must include the information listed in Section I.A., above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of *Provider Dispute Department* at the following:

Via Mail:

*Provider Dispute Department
445 Grant Avenue, Suite 700
San Francisco, CA 94108*

Via Physical Delivery [by messenger or hand delivery]:

*Provider Dispute Department
445 Grant Avenue, Suite 700
San Francisco, CA 94108*

*This office is open to accept provider disputes from 8:30 am to 5:00 pm,
Monday to Friday, except for holidays*

Via e-mail: *Not available at this time.*
Via Fax: *415-955-8815*

B. Time Period for Submission of Provider Disputes.

- (i) Contracted provider disputes must be received by CCHCA within 365 days from CCHCA's action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or
- (ii) In the case of CCHCA's inaction, contracted provider disputes must be received by CCHCA within 365 days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
- (iii) Contracted provider disputes that do not include all required information as set forth above in Section II.A may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to CCHCA within thirty (30) working days of your receipt of a returned contracted provider dispute.

C. Acknowledgment of Contracted Provider Disputes. CCHCA will acknowledge receipt of all contracted provider disputes as follows:

- i. Electronic contracted provider disputes will be acknowledged by CCHCA within two (2) Working Days of the Date of Receipt by CCHCA.



- ii. Paper contracted provider disputes will be acknowledged by CCHCA within fifteen (15) Working Days of the Date of Receipt by CCHCA.
- D. Contact CCHCA Regarding Contracted Provider Disputes. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to CCHCA at: 415-955-8800.

Instructions for Filing Substantially Similar Contracted Provider Disputes. Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

- i. *Sort provider disputes by similar issue*
 - ii. *Each batch must include a complete claim copy with attachments for each claim contested.*
 - iii. *Provide cover sheet for each batch*
 - iv. *Number each cover sheet*
 - v. *Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheets*
- E. Time Period for Resolution and Written Determination of Contracted Provider Dispute. CCHCA will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Working Days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute.

Past Due Payments. If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, CCHCA will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) Working Days of the issuance of the written determination.



PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS	
<ul style="list-style-type: none"> Please complete the below form. Fields with an asterisk (*) are required. Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME. Provide additional information to support the description of the dispute. Do include a copy of the claim that was previously processed. Multiple "LIKE" claims are for the same provider and dispute but different members and dates of service. For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form. Mail the completed form to: Chinese Community Health Care Association 445 Grant Avenue, Suite 700 San Francisco, CA 94108 ATT: Provider Dispute Resolution 	

*PROVIDER NPI:	PROVIDER TAX ID:
*PROVIDER NAME:	
PROVIDER ADDRESS:	

PROVIDER TYPE MD Mental Health Professional Mental Health Institutional Hospital ASC
 SNF DME Rehab Home Health Ambulance Other _____
(Please specify type of "other")

CLAIM INFORMATION Single Multiple "LIKE" Claims (complete attached spreadsheet) Number of claims: ____

* Patient Name:		Date of Birth:
* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE

<input type="checkbox"/> Claim	<input type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Disputing Request For Reimbursement Of Overpayment	<input type="checkbox"/> Other:

* DESCRIPTION OF DISPUTE:

EXPECTED OUTCOME:

Contact Name (please print)	Title	Phone Number
Signature	Date	() Fax Number

[] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)

<i>For Health Plan RBO Use Only</i>	
TRACKING NUMBER _____	PROV ID# _____
CONTRACTED _____	NON-CONTRACTED _____

Revised 1/07



PROVIDER DISPUTE RESOLUTION REQUEST
For use with multiple "LIKE" claims (claims disputed for the same reason)

	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid
	Last	First						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

Page _____ of _____

[] CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
 (Please do not staple)