Section 6 - Claims Procedures

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CLAIMS SUBMISSION PROCEDURES

CCHCA Central Billing Division (CBD)

CCHCA can submit the claims for physician offices through CCHCA 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 AAMG1. The following clearinghouses are accepted:

- Emdeon
- Office Ally
- Trizetto Gateway
- Emdeon/Change Healthcare
- Optum ENS
- Availity
- HeW
- NueMD
- PayerPath

OR

Filing Paper Claims

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

CCHCA Claims Department
PO BOX 2118
San Leandro, CA 94577

Checking Claims Status

Claims status can be checked on-line by using AAMG CCHCA's online provider portal. For more information on using the provider portal, please contact our Provider Relations Department at (415) 216-0088 or by email at Provider.Relations@cchca.com.

Claim Payment Timelines

The first date stamp on a claim begins the counting of days. The counting of days ends when the check is in the mail.

CMS/Medicare Plans

- Clean claims from non-contracted providers are to be paid or denied within thirty (30) calendar days of receipt.
- Clean claims from contracted providers are to be paid or denied within sixty (60) calendar days of receipt.

Commercial Plans

- Clean claims from non-contracted providers are to be paid within forty-five (45) working days or receipt or provide notice of any dispute or question within thirty (30) days of receipt.
- Clean claims from contracted providers are to be paid or denied within forty-five (45) working days of receipt.

Medi-Cal Plans

- Clean claims from providers are to be paid or denied within forty-five (45) business days of receipt.

Claim Submissions

All claims should be submitted on a CMS 1500 Form or UB04 as appropriate. 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. Modifiers (if applicable)
9. J Codes (if applicable)
10. Authorization number if the procedure(s) need(s) and Authorization
11. Rendering Provider ID #/NPI

12. Federal Tax ID Number
13. CPT procedure codes
14. Place of service codes
15. 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.

Reference to the following link for the elements that should be used for claim processing:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26pdf.pdf

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.

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 19.

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 Treatment Authorization Form (TAF) 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 TAF.

Claims Resubmission Policy

To avoid duplicate claims, please first check the status of your claims either on AAMG CCHCA provider portal or by sending an email to claims@cchca.com or calling AAMG CCHCA Claims Department at (415) 216-0088 to confirm receipt.

Refunds

When submitting a refund, please include a copy of the corresponding remittance advice, an explanation of 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

CODES	DEFINITION
02	Telehealth
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

For a full list of Place of Servcie, please refer to the link below:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

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 SERVICES AND PROCEDURES

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.

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.

<u>Name of Injection Needed</u>

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. Not all CPT codes for immunizations are accepted by CCHCA, please check with CCHCA for currently accepted immunizations (CPTs). 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 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 CCHCA 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 obtain the PDR Request Form and Instructions for Submitting Provider Disputes by contacting our Provider Relations Department at (415) 216-0088 or by email at Provider.Relations@cchca.com. Provider Dispute Resolution form is located at: https://www.cchca.com/provider-disputes.php

Acknowledgement of Provider Disputes

Acknowledgement of a provider dispute will be made within 15 business days 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.

B. Sending a Provider Dispute to CCHCA: Provider disputes submitted to CCHCA must include all relevant information in support of the dispute, for each dispute.

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

C. Time Period for Submission of Provider Disputes.
   i. Provider disputes must be received by CCHCA within 365 days from CCHCA's last 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 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. Contracted provider disputes that do not include all required information will be returned to the submitter for completion. **CCHCA will not ask a contracted provider to resubmit information that was previously submitted to CCHCA as part of claims process. A contracted provider has thirty (30) working days from the date of receipt of a returned dispute to submit an amended dispute.**

D. Acknowledgment of Contracted Provider Disputes. CCHCA will acknowledge receipt of all contracted provider disputes as follows:
   i. Paper contracted provider disputes will be acknowledged by CCHCA within fifteen (15) working days of the date of receipt

E. Contact CCHCA Regarding Contracted Provider Disputes. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute are be directed to CCHCA.

F. Instructions for Filing Substantially Similar Provider Disputes. Substantially similar 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 separate coversheets for each batch

iv. Number each coversheet

v. Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheets

vi. Disputes must be submitted using a Provider Dispute Resolution Request Form. When there are multiple similar disputes, the provider must also submit a "Multiple Like" Claim Form. Provider may submit similar multiple claims disputes and other billing or contractual disputes as a single provider dispute. CCHCA will utilize a numbering scheme that identifies each dispute in the bundled dispute.

G. Time Period for Resolution and Written Determination of 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.

H. 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 FORM
INFORMATION SUPPLEMENT

What is a Provider Dispute?

A provider dispute is a written notice from a provider that challenges, appeals, or requests consideration in any of the following categories:

- **Claim** (including a bundled group of similar claims) that were previously denied, adjusted or contested
- **Billing Determination**
- **Appeal of Medical Necessity** (Appeal of a Clinical Decision)
- **Utilization Management Decision** (e.g. Appeal of an Administrative Decision such as Eligibility or Benefit Coverage)
- **Request For Reimbursement of Overpayment**
- **Contract Dispute** or other billing determination
- Any **Other** category of dispute that does not fall into any of the above categories

To submit a provider dispute, complete the attached form. Check the appropriate **category** under **DISPUTE TYPE** when submitting this form to us. Disputes must include:

- Provider's Name / ID Number
- Contact information including phone number
- The number assigned to the original claim (on the EOB)

Unless required by any state or federal law or regulation, **provider disputes must be received within 365 days** from denial or payment determination or in the case of inaction, within 365 days of the time for contesting or denying claims.

Can a dispute be submitted by the Provider on a member's behalf?

Any Disputes submitted on behalf of a member are processed through the member appeal process, as long as the member has authorized the provider to appeal on their behalf

Members have the right to authorize a representative to act on their behalf at any level of the grievance/appeal process. A signed authorization is not required if the grievance/appeal is submitted by he parent, guardian, conservator, relative or other designee (Provider) of the member if the member is a minor, or incompetent or incapacitated.