

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

Policy Name: Claims Electronic Submission	Claims
Date: 09-09	Page: 1 of 2
Reviewed by QI Committee: 09-09, 7-10	Policy Number: CL-4
Revised by QI Committee:	

Purpose: To ensure that Comprehensive Behavioral Health Management/College Health IPA (CBHM/CHIPA) adheres to all state and federal regulations concerning electronic claim submission.

Definitions:

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

Electronic claim submission is the use of an Electronic Data Interface (EDI) to submit electronic claims for processing.

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

Policy:

1.0 Electronic Data Interface (EDI)

- 1.1 CBHM/CHIPA has a contractual relationship with Office Ally to serve as the initial clearinghouse for electronic claims files from providers.
- 1.2 Office Ally offers their services at no cost to CHIPA providers.
- 1.3 CHIPA providers submit claims to Office Ally through an online interface using a designated code for CBHM/CHIPA. Claims submission by providers can either be a single claim or multiple claims.
- 1.4 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 CBHM/CHIPA for processing.
- 1.5 Office Ally forwards all clean claims to CBHM/CHIPA via an electronic claims file.

2.0 Electronic Claims Process

- 2.1 Auto-adjudicated claims – all claims received electronically that match an existing CBHM/CHIPA authorization will automatically be posted for payment.
- 2.2 Pended claims – claims that do not match an existing CBHM/CHIPA authorization will be pended for review by a claims processor. This review may result in one or more of the following actions.
 - 2.2.1 Patient is not covered by CBHM/CHIPA. Claim is rejected back to Office Ally who notifies provider.
 - 2.2.2 Patient identification was wrong. Correct patient file is chosen and claim is processed.
 - 2.2.3 Patient is not eligible. Eligibility is re-verified and claim is either processed for payment or denied for ineligibility.
 - 2.2.4 Authorization number was not correct. Claim is matched with correct authorization and processed for payment.

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- 2.2.5 All services cannot be processed on designated authorization. Claim is split to allow processing under two separate authorizations.
- 2.2.6 No authorization on file. Claim is either denied for no pre-authorization or a Contact Follow-up Manager (CFM) form is created requesting creation of appropriate authorization. The CFM may also require setting up a new patient file and/or setting up a new provider file.
- 2.3 Reversing claims – once a claim has been processed from the electronic file, a processor has until the end of the day to either reject a previously processed claim or process a previously rejected claim. At the end of the day, all electronic processes will be finalized resulting in the creation of the EOB and check files.
- 3.0 Electronic Response to Office Ally
 - 3.1 When the claims data file is received from Office Ally, an automatic electronic verification is sent back to them. The verification indicates how many claims were received and accepted.
 - 3.2 At the end of each business day a second electronic file is sent to Office Ally indicating any claims that were rejected by CBHM/CHIPA