Contra Costa Health Plan Orientation

Long-Term Care Providers

- Intermediate Care-Developmental Disabilities
- Skilled Nursing
- Subacute Care

A Division of Contra Costa Health Services

A Culture of Caring for Over 40 Years

www.cchealth.org/health-insurance

CONTRA COSTA HEALTH

Rev. 1/10/2024

Chief Executive Officer
Sharron Mackey, M.P.A, M.H.S

Contra Costa Health Plan's vision is member centric:

- Keep members as healthy as possible
- Facilitate relationship between providers and members/family
- Assure an integrated system of timely and quality services for both in-patient and outpatient services while managing the cost

Healthcare System Relationships

CONTRA COSTA
HEALTH

Health Plan

Providers

Members

Regulatory Oversight

- OVERSIGHT AGENCIES
- CENTER OF MEDICAID & MEDICARE
  - Department of Health Care Services
  - Department of Managed Health Care
  - County Board of Supervisors
- ACCREDITATION
  - National Committee for Quality Assurance (NCQA)
  - Healthcare Effectiveness Data and Information System (HEDIS) Measures
- Accreditation is an evaluative, rigorous, transparent, and comprehensive process in which a health care organization undergoes an examination of its systems, processes, and performance by an impartial external organization (accrediting body) to ensure that it is conducting business in a manner that meets predetermined criteria and is consistent with national standards.

CCHP Facts

- CCHP is the oldest County-sponsored Federally Qualified Health Maintenance Organization (HMO) in the country. Currently CCHP has multiple product lines – Medi-Cal, Commercial, IHSS.
- CCHP is an integral entity within the Contra Costa County Heath Services Department (CCHS) and has over 45 years of collaboration with the County Public Hospital and Federally Qualified Health Center (FQHC) Ambulatory Health Center, as well as the Public Health, Mental Heath, and Substance Abuse Divisions within the Health Services Department.
- CCHP is Knox-Keene Licensed.
- CCHP is accredited by NCQA.
- CCHP has over 270,000 Medi-Cal and Commercial members (94% are Medi-Cal).

CCHP offers a choice of two Primary Care Networks for **Medi-Cal and Commercial members** which includes:

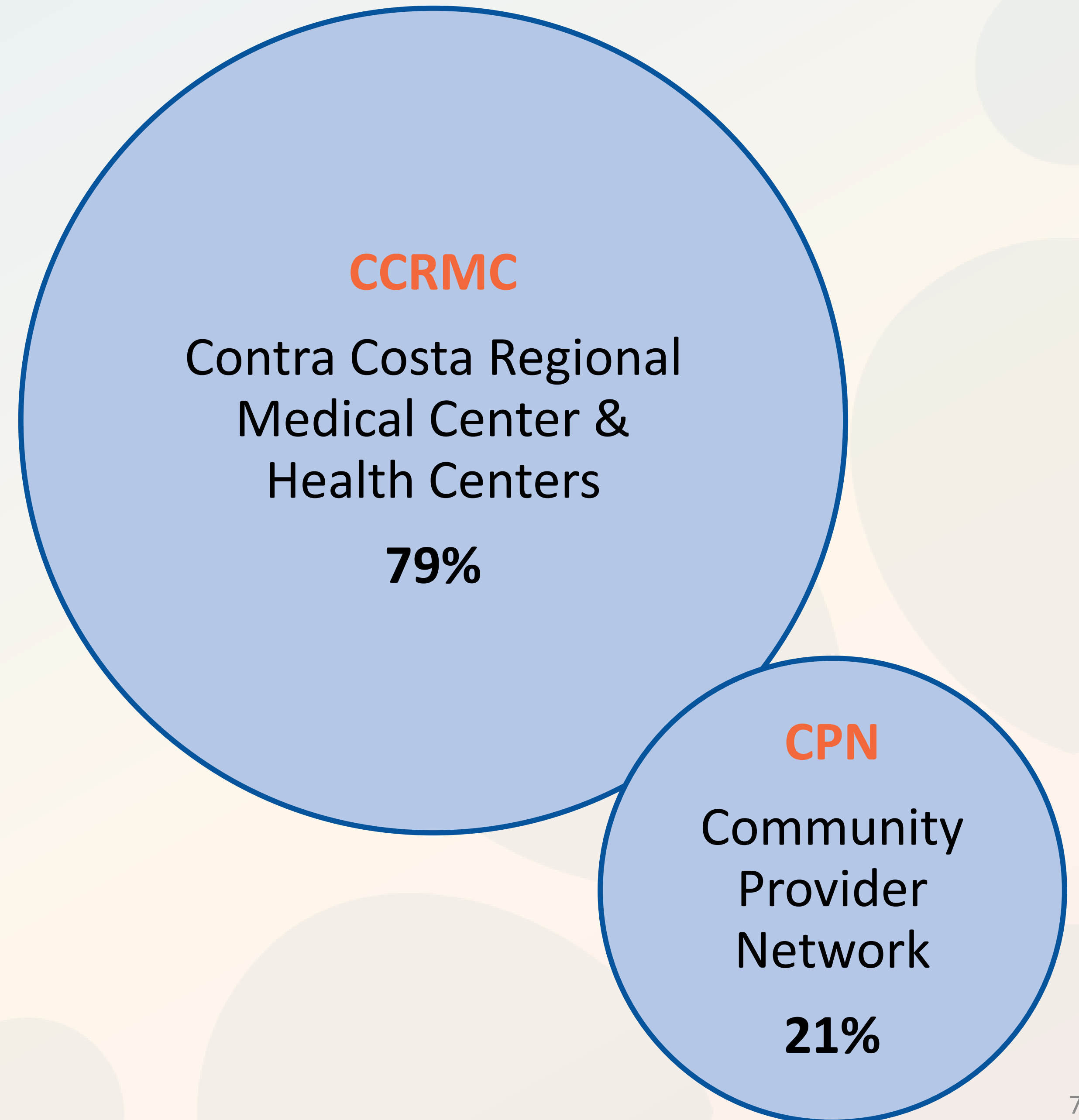
- Contra Costa Regional Medical Center (CCRMC)
- Community Provider Network (CPN)

Contracting & Credentialing

- All Facilities must be enrolled as a Medi-Cal Provider, if there is a path for enrollment to be contracted.
- CCHP only contracts with LTC Facilities enrolled and licensed by the California Department of Public Health (CDPH).
- Facilities are required to be credentialed with CCHP and recredentialed every three years.

CCHP Provider Network

The distribution of members among our two primary care networks



CCHP Networks Based on Member's Insurance

- **Commercial A, A2, A2-IHSS**:

  PCP at CCRMC only, specialty care at CCRMC only (if services not available at CCRMC then prior authorization needed to go to CPN)

- **Commercial B**:

  PCP at CCRMC or CPN, specialty care at CCRMC or CPN

- **Medi-Cal**:

  PCP at CCRMC or CPN, specialty care at CCRMC + CPN (for CCRMC or CPN assigned)

- All networks need prior authorization for tertiary care. Authorization is reviewed and approved on a case-by-case basis.

Our Contracted Hospitals

- Alta Bates Medical Center – Berkeley & Summit Oakland Campus
- Contra Costa Regional Medical Center (CCRMC)
- John Muir – Concord & Walnut Creek Medical Center
- Stanford Health Care – ValleyCare Medical Center
- Sutter Delta Medical Center – Antioch
- Sutter Solano Medical Center – Vallejo
- UCSF Benioff Children's Hospital – Oakland Campus

Behavioral Health Centers

- John Muir Health, Behavioral Health Center
- St. Helena Hospital Center for Behavioral Health

Tertiary Care Only Facilities (Prior Auth Required, only available for services NOT available at other contracted, non-tertiary care facilities)

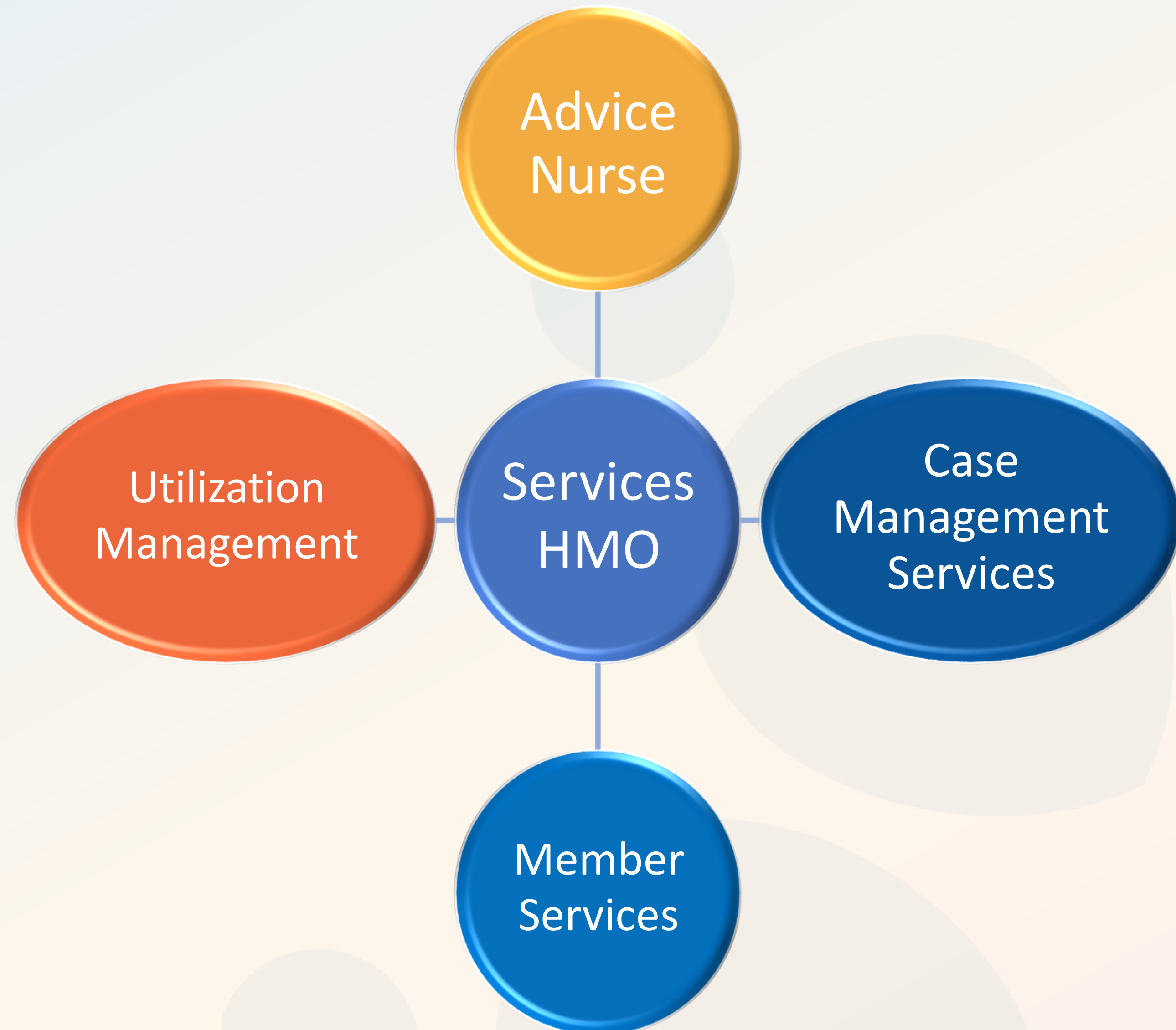
- Cal Pacific Medical Center
- Lucile Packard Children's Hospital at Stanford
- Stanford Hospital & clinics
- UCSF Medical Center

Contra Costa Health Plan
Regional Medical Center and
Community Provider Network
UC DAVIS
Napa
Sonoma
Solano
Sacramento
Marin
San Joaquin
Contra Costa
Alameda
San Francisco
San Mateo
St. Helena Hospital - Center for Behavioral Health
Crockett
Port Costa
Rodeo
Hercules
Pinole
El Sobrante
San Pablo
Richmond
El Cerrito
Martinez
Pacheco
Concord
Pleasant Hill
Clayton
Walnut Creek
Lafayette
Orinda
Moraga
Alamo
Diablo
Danville
San Ramon
Bay Point
Pittsburg
Antioch
Oakley
Brentwood
Knightsen
Bethel Island
Discovery Bay
Byron
George and Cynthia Miller Wellness Center
Contra Costa Regional Medical Center
Martinez Health Center
John Muir Medical Center Concord
Concord Health Center
Concord Health Center 2
La Clinica De La Raza
John Muir Medical Center Walnut Creek
Bay Point Family Health Center
Pittsburg Health Center
La Clinica de La Raza
Antioch Health Center
Sutter Delta Medical Center
Brentwood Health Center
West County Health Center
LifeLong Brookside San Pablo
Doctors Medical Center
North Richmond Center for Health
LifeLong Brookside Richmond
LifeLong Medical Care
Alta Bates Medical Center, Alta Bates Campus
Children's Hospital Oakland
Alta Bates Medical Center, Summit Campus
University of California San Francisco Medical Center
Axis Community Health Group
ValleyCare Medical Center
Legend
Contra Costa Regional Medical Center
Community Provider Network (CPN) Hospital
CCRMC Health Center
Community Health Center
Urgent Care Center
CPN Primary Care Providers (n=172)
1 Star = 2
CPN Primary Care Provider
CPN Specialists (n=1,398)
1 Dot = 6
CPN Specialists
N
W
E
S
0 1.75 3.5 7 10.5 14 Miles
Contra Costa Public Health, Epidemiology, Planning and Evaluation, December 2014
12/16/2014

Health Maintenance Organization Services

Gatekeeper Model

- **Advice Nurse - 24/7 Operations**
  Phone: **(877) 661-6230, Option 1**
- **Case Management Services**
  Phone: **(925) 313-6887**
- **Member Services**
  Phone: **(877) 800-7423, Option 1**
- **Utilization Management**
  Phone: **(877) 800-7423, Option 3**
- **Health Education Services**
  Phone: **(925) 313-6019**
- **Disease Management Program**
  Phone: **(925) 313-6968**



Advice Nurse

24X7 Members Can Call to Speak to a Nurse

- Team of experienced nurses at member's fingertips
- Health Care Advice and get a prescribed order for medications
- Infectious disease exposure questions with a clinical answer
- Vaccine information for children
- Health resources within the County
- Connect you to a physician or urgent care

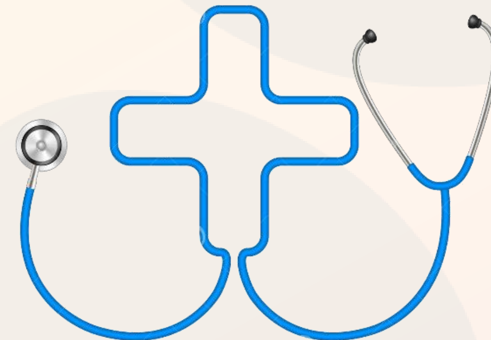
Advice Nurse Phone: (877) 661-6230, Option 1

Case Management

Assists Members to Navigate the Health Delivery System and Keep Members from Hospital Stays and Emergency Room Usage

- Referrals mostly come from Primary Care Physicians for members with chronic conditions and serious health problems (asthma, diabetes, cancer, surgery)
- Members can self-refer to have a Case Manager
- Family members can refer members for services
- The Health Services Division, such as Public Health and California Children Services, can refer members to enroll in Care Management
- Monitors high incidents of health care services usages – members frequently going to the ER for care

Case Management Phone: (925) 313-6887



Complex Case Management Services

Complex Case Management services are provided by CCHP Nurses and Medical Social Workers to support members who need assistance with managing and navigating their health and health-related services.

- **Eligibility criteria listed below are used to identify members who may benefit most from Complex Case Management services.**
- **However, any member may be referred to Complex Case Management, (either by self-referral or provider referral), to be evaluated and assessed for available care management programs.**
- **Services are provided only with the consent of the member and are limited to telephonic communications.**

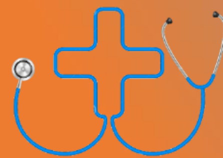
2+ hospitalizations within the last 12 months with one related to a chronic condition

Currently taking 15+ medications

3 ED visits in the last 6 months with one related to a chronic condition.

Transplant candidate, recipient or donor.

Case Management Phone:
(925) 313-6887



Supplemental Case Management Services: Transitions

- Transitions is a service within Case Management that assists Members transitioning through the health care continuum.
- Contra Costa Health Plan case managers & care coordinators facilitate Members' transition from one healthcare environment to another until placement in the most appropriate setting is achieved.
- The goal is to prevent institutionalization & re-institutionalization of Members.

ACUTE CARE
- Hospital
- Long Term Acute Care
- Post Acute Care (Acute Rehabilitation)

LONG TERM CARE
- Intermediate Care/Developmental Disabilities
- Subacute Care
- Skilled Nursing Facility

COMMUNITY
- Assissted Living
- Board & Care
- Home (with support)

California Children’s Services (CCS)

- California Children’s Services (CCS) offers medical coverage and case management services to children for catastrophic or chronic illness on a financial sliding scale.
- When a CCHP Medi-Cal child has a CCS condition, the medical services related to the CCS condition are covered by CCS.
- CCHP will cover eligible medical services until CCS eligibility is determined and will cover services that are not related to the CCS condition.
- Submitting a Prior Authorization Form through the Web Portal assures the request will be evaluated by the Utilization Review Team and referred to CCS for ongoing medical supervision if the condition is eligible.
- The physician's office can also send a direct referral by fax to CCS. In either instance, copies of medical documentation must accompany the referral.
- A listing of CCS eligible providers can be found on the CCS website here: https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx
- CCS reimburses only CCS-paneled providers and CCS-approved hospitals within Plan's network; and only from the date of referral.
- The PCP is responsible for performing an appropriate baseline health assessment and diagnostic evaluation for children who are identified with conditions that may be CCS eligible.
- Early identification of possible CCS eligible conditions is an important step to timely specialty care with a CCS provider. Once CCS determines that a child has a CCS medically eligible condition, the provider can fax prior authorization requests related to the CCS, to the local CCS Office.

California Children’s Services (CCS) Fax: 925-372-5113

Member Services

Front Line Communications for Member Interactions

- Gateway to members accessing services daily Monday – Friday, 8am – 5pm
- Members can get assigned a Primary Care Physician to manage their health care
- Members can access information on providers that are part of the CCHP Provider Network
- Members can get information on the Medi-Cal Benefit Plan that shows what services are covered
- Members can get access to Transportation services

Member Services Phone: (877) 800-7423, Option 1

How do I check member eligibility?

Prior to providing services, check eligibility by either:

- Using the online ccLink Provider Portal
- If you do not have access to the ccLink Provider Portal, please download the ccLink Provider Portal Agreement form here:

  ccLink Provider Portal Information

- Calling the automated eligibility line at:

1-877-800-7423
Option 1

The ccLink Provider Portal provides:

- On-line access to CCHP Member information
- Real-time eligibility inquiries
- Ability to submit and check the status of any required referral
- Ability to check the status of a submitted claim
- A list of patients that are assigned to you if you are the Member's PCP or if you are the referred to Specialist
- Facilitation of communication & streamlines patient care across location and disciplines

A Member's Rights

Among a member's rights is also the member's right to:

- Talk to someone who speaks his or her own language.
- See the files pertaining to their concern, such as medical records, plan policies, and any information maintained by CCHP.
- Designate a friend, family member, or lawyer to help them.
- Have the member's Evidence of Coverage (EOC) made available for them to read more about the complaints and grievances process.

Refer members to Member Services if they would like a copy of the CCHP Grievance Policy.

Member's phone number for Member Services: (877) 661-6230, Option 2

Member Complaints and Grievances

As a reminder, **ALL expressions of member dissatisfaction must be submitted to CCHP for investigation** and should also be reported to the clinic supervisor.

The member should be offered the CCHP grievance form to complete. If completed, the form should be returned immediately to CCHP's Member Services Department.

Members have the option to submit their grievances:

- Online at **https://www.cchealth.org/health-insurance/my-contra-costa-health-plan/member-services**
- By calling Member Services at **(877) 661-6230, Option 2**
- By faxing the completed form to **(925) 313-6047**
- By going to the CCHP office to talk to Member Services staff in person
- Or by mailing the printed form to:

CCHP Member Services Department
595 Center Avenue, Suite 100
Martinez, CA 94553

Interpreter Services

Why Using Family Members as Interpreters is Not Best for the Patient?

CCHP has received grievances from non-English speaking members who experienced misunderstanding and miscommunication. These members used family members as interpreters instead of a qualified interpreter.

Providers are required by regulations to offer free interpreter services as provided by CCHP. Please discourage patients from using their own interpreters, such as family members, friends or minors. If patient insists that they want to use their adult family member, you must document in the patient chart.

Why are Family and Friends Not Recommended as Interpreters?

- They can make serious mistakes
- May have their own agenda
- They may hold information from patient due to embarrassment, protection, emotional involvement
- May cause guilt or trauma if they make a mistake
- May create liability issues

Getting Proper Linguistic Access Helps to:

- Reduce medical errors
- Increase patient satisfaction
- Increase compliance
- Decrease costs for diagnostic testing and unnecessary admissions
- Create more efficient member interactions

To use our Telephonic Interpreter Services, call: **(866) 874-3972** and provide your 6-digit Client ID
(Call 877-800-7423, Option 4 for the Client ID)

To see the Guidelines for Face-to-Face Interpreter Services, go to:
https://www.cchealth.org/health-insurance/information-for-providers/interpreter-services

Benefits for Medi-Cal Transportation Services

- Non-Emergency Transportation
- Emergency Transportation
- Non-Medical Transportation

Transportation Phone:

(855) 222-1218

Utilization Management
Heartbeat of the HMO Operations

- Referrals for specialty care are authorized by the UM Department
- Three classes of services:
  - No referral/no auth needed (in network only)
  - Referral needed/no auth needed (in network only)
  - Referral + Prior Auth needed (in and out of network)
- Team of Physicians, Nurses and Health Plan Representatives that work daily on meeting prior authorization requests from physicians:
  - Urgent referrals may take up to 72 hours
  - Routine referrals may take up to 5 business days
- Concurrent review of all inpatient hospital stays
- Provide authorizations for Long Term Acute Care, Skilled Nursing Facilities, DME and Home Health Services

Utilization Management

- Phone: **(877) 800-7423, Option 3**
- E-mail: CCHPauthorizations@cchealth.org

Utilization Management *(continued)*

- If additional services are needed, please request via the provider portal.
- For authorized Skilled Patients, CCHP will conduct weekly concurrent review.
- For authorized custodial patients, CCHP will conduct monthly concurrent review (subject to change after further experience).

Utilization Management Bed Hold & Leave of Absence

- Bed holds are required for all Members at a custodial level of care who are transferred from a LTC facility to a general acute care hospital, and then return to a LTC level of care due to medical necessity.
- This will allow the Member to return to the same LTC Facility where they previously resided under the leave of absence and bed hold policies.
- The facility is required to notify CCHP of the acute care admission and when the Member returns to the LTC Facility.
- The facility is responsible for notifying the Member, or the Member's authorized representative, in writing of the right to exercise the bed hold provision.

Provider Disputes

Providers and facilities may submit a dispute regarding unsatisfactory, disputed, or resubmission of a claim payment. If a provider has never requested a clinical review, they can submit a request within **180 days** from DOS to initiate a Retrospective Review process.

The disputing party must submit a **written provider dispute** request within **365 days** from the receipt of a service or claim denial or modification, or in case of inaction, the expiration of the applicable claim/authorization filing period. Failure to submit a dispute within the **specific timeframe** may result in the denial of a dispute request. No punitive action is taken against a provider who submits a dispute.

Submitted disputes are resolved within **45 business** days.

All other provider disputes need the following:

- A written letter of dispute with correspondence mailing address and a contact person
- The date(s) of service(s) being disputed
- Copy of denial letter (if available) within the dispute timeframe
- Any pertinent medical records or justification for date(s) being disputed
- Clinic notes, pertinent labs or diagnostics, MD/RN notes, MAR, hospital face sheet, discharge summary)
- Note: CCHP is now accepting medical records on disc

You may call the CCHP Authorization Unit at **1-877-800-7423, option 3** if you have any questions.

Provider Disputes

Providers and Facilities must submit Provider Disputes through the ccLink Provider Portal

- The ccLink Appeal and Dispute Entry Process can be found here: **ccLink Submitting Appeals and Disputes**
- For questions regarding submitting a provider dispute, email: **Appeals@cchealth.org**
- For questions regarding the ccLink Provider Portal, email: **CCHPportalsupport@cchealth.org**

Provider is Appealing on "behalf" of a Member Appeals

- This appeal must be filed within 60 days of Receipt of Notice of Action.
- Provider needs to have written consent form signed by member.
- Consent forms can be found here: **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**

Contra Costa Health Plan
Member Services Department
595 Center Avenue, Suite 100
Martinez, CA 94553
Phone: (877) 661-6230

What About Medi-Cal Member Pharmacy Coverage?

- How Pharmacies Submit Prescriptions
  - Medi-Cal Rx
    - Processing through Magellan
    - Formulary (Contracted Drug List) available on the Medi-Cal Rx website
    - Large network of pharmacies throughout California including Walgreens, Rite Aid, CVS and Walmart (network available on the Medi-Cal Rx website)

If experiencing problems, please call the CCHP Pharmacy Department at **(925) 957-7260, option 1**

To reach the DHCS Medi-Cal Rx Customer Service Department call

(800) 977-2273 or go to **https://medi-calrx.dhcs.ca.gov/home/**.

What About Commercial Plan Member Pharmacy Coverage?

CCHP uses a preferred drug list/formulary (PDL)

PDL is available online at https://www.cchealth.org/health-insurance/information-for-providers/preferred-drug-list

Epocrates hosts the CCHP formulary

CCHP Network consist of 2 national pharmacy chains and some independently owned pharmacies in Contra Costa County.

Rite Aid

The Pharmacy Directory is available online at: https://www.cchealth.org/health-insurance/my-contra-costa-health-plan/provider-directory

Select “Begin Your Search Here,” “Facility” tab, then Facility Type “Pharmacy.

Billing & Claims

All LTC Facilities

- **Claims must be submitted electronically on a UB-04**
- All Claims must be submitted within 180 days from the date of service.
- Contact for Claim questions or issues - ClaimStatus@cchealth.org
- Submit claims for all authorized CPT codes
- Excludable services are billed as a line item.
- Commercial Members billing remains unchanged.

Billing Guidance

- **Skilled Nursing Facilities-**Code sets to be used on the UB-04 claim form for each accommodation code and its related revenue codes:
  - Skilled Services are billed with Rev Code 0101 Custodial care are billed with Rev Code 0120.
  - Leave/Bed Hold are billed with Rev Code 0180.
  - Medicare Share of Cost Value Code 23 to indicate the amount of SOC collected.
  - HCPCS codes must be used for Physical Therapy, Speech Therapy and Occupational Therapy services

Subacute Adult

Billing Guidance

- Accommodation Code 75 (FS/SA – Ventilator Dependent) Rev 190 value code 75
- Accommodation Codes 76 (FS/SA – Non-Ventilator Dependent) Rev code 190 value code 76
- Accommodation Code 77 & 81 (FS/SA – Ventilator Dependent Leave Days) Rev code 185 value code 77 and Rev code 180 value 81
- Accommodation Code 78 & 82 (FS/SA – Non-Ventilator Dependent Leave Days) Rev code 185 value code 78 Rev code 180 value code 82

Subacute Pediatric Billing Guidance

Pediatric Free Standing

- Accommodation Code 91 Ventilator Dependent Rev code 190 Value code 91
- Accommodation Code 92 Non-Vent Dependent Rev code 190 Value code 92
- Accommodation Code 93 & 95 Ventilator Dependent Bed Hold/Leave of Absence Rev code 0185 Value Code 93 and Rev code 0180 Value code 95
- Accommodation Code 94 & 96 Non-Vent Dependent Bed Hold/Leave of Absence Rev Code 0185 Value Code 94 and Rev code 0180 Value Code 96
- Accommodation Code 97 Rehab Therapy Rev code 0199 Value code 97
- Accommodation Code 98 Vent Weaning Rev code 099 Value code 98

Subacute Pediatric Billing Guidance

Pediatric-Distinct Part

- Accommodation code 83 Rehab therapy Rev code 199 Value code 83
- Accommodation code 84 Vent weaning Rev code 199 Value code 84
- Accommodation code 85 Ventilator Rev code 190 Value code 85
- Accommodation code 86 Non-Vent rate Rev code 190 Value code 86
- Accommodation code 87 & 89 Bed Hold/Leave of Absence rate Rev code 185 Value code 87 and Rev code 180 Value code 89
- Accommodation code 88 & 90 Bed Hold/Leave of Absence rate Rev code 185 Value code 88 and Rev code 180 Value code 90

Intermediate Care Facilities - Developmental Disabilities

Billing Guidance

Facility Type	Billing Code	Billing Code (Bed Hold)
ICF/DD 1-59 Beds	Rev code 0101 Value Code 41	Rev code 0180 Value Code 43
ICF/DD 60+ Beds	Rev Code 0101 Value Code 42	Rev code 0180 Value Code 44
ICF/DD-H 4-6 Beds	Rev Code 0101 Value Code 61	Rev Code 0180 Value Code 63
ICF/DD-H 7-15 Beds	Rev Code 0101 Value Code 65	Rev Code 0180 Value Code 68
ICF/DD-N 4-6 Beds	Rev Code 0101 Value Code 62	Rev Code 0180 Value Code 64
ICF/DD-N 7-15 Beds	Rev Code 0101 Value Code 66	Rev Code 0180 Value Code 69

Introducing the CCHP New Website!

https://www.cchealth.org/health-insurance

About Contra Costa Health | Get Care | Health Insurance | Services and Programs | Health and Safety Information

Contra Costa Health Plan

A culture of caring for over 50 years

Advice Nurse
24/7 medical advice

Provider Directory
Find doctors in our network

Benefits
See what medical benefits are covered in your plan

CCHP ID Card
Get a new membership card

New Member Orientation
Info for new CCHP members

Member Services
Helping you get the care you need

Change Your Primary Care Doctor
Call us or fill out an online form

For Providers
Info for providers in our network

Hi! I can help with common Member questions.

This is for you.

The Website

Information for CCHP Providers | Contra Costa Health (cchealth.org)

News Jobs Contact For Providers Search Translate

About Contra Costa Health | Get Care | Health Insurance | Services and Programs | Health and Safety Information

- Information for CCHP Providers
  - Authorization and Referrals Department
  - CalAIM Programs
  - Case Management Programs
  - Claims Information
  - Claims Information - Mother and Newborn
  - Clinical Guidelines
  - Contact Us - For CCHP Providers
  - FSR Tool
  - Interpreter Services
  - Join Our Provider Network
  - LGBTQ Resources for Providers
  - Medi-Cal Rx Transition
  - Mental Health Network Provider
  - Preferred Drug List
  - Pharmacy and Therapeutics
  - Provider Network News
  - Provider Manual
  - Provider Portal

Health Insurance »

INFORMATION FOR CCHP PROVIDERS

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ccLink Provider Portal

Members of our Community Provider Network: use the ccLink Provider Portal to file a claim, make an appeal, and more.

CONTRA COSTA HEALTH

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About Contra Costa Health | Get Care | Health Insurance | Services and Programs | Health and Safety Information

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Health Insurance » Information for CCHP Providers »

CLAIMS INFORMATION

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Submitting Claims

The claim submission timeframe for Contra Costa Health Plan is 180 days from the date of service, or primary explanation of benefits (EOB), for both contracted and non-contracted providers. Claims received after 180 days will be denied for untimely filing. Providers have 365 days to dispute claim processing.

Using Availity

- Contra Costa Health Plan (CCHP) uses Availity as our clearinghouse.
- You must register with Availity in order to submit EDI claims to CCHP. You may begin your registration process on the Availity site.
- The CCHP payer ID is **CCHS**.

Step 1 to file for claims.

Other information on this page includes:

- Using the ccLink Portal
- Filing paper claims
- How to establish electronic payments, (this function will expedite your payments).

Claims Information

https://www.cchealth.org/health-insurance/information-for-providers/claims-information

- Information for CCHP Providers
  - Authorization and Referrals Department
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  - Provider Network News
  - Provider Manual
  - Provider Portal
  - Provider Preventable Conditions Reporting Form
  - Telehealth Information
  - + Trainings
  - Uncompensated Care Relief Payment Program

Health Insurance » Information for CCHP Providers »

CLAIMS INFORMATION

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Register for Availity

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- The CCHP payer ID is CCHS.

Using the ccLink Provider Portal

- You may also sign up for CCHP's ccLink Provider Portal where you can enter and submit claims directly to CCHP.
- Sign up on Information for Providers, complete the ccLink Provider Portal Access Agreement form, and email it to CCHPportalsupport@cchealth.org.
- If you have already signed up for ccLink Provider Portal access, reference the website for instructions on submitting claims.

Paper Claims

If you must submit a paper claim, mail your completed claim form along with all required supporting documents to:

CCHP Claims Department
P.O. Box 5122
Lake Forest, CA 92609

Claims submission guides

If you are a **non-contracting provider** and have never submitted a claim to CCHP or within the last 2 years, you must submit a current W9 to ARsupport@cchealth.org for IRS verification through the County Auditor's office. If you do not submit a W9 before submitting claims, your claims will not be processed until we receive a W9. As a courtesy, CCHP may reach out to you to request a W9. However, if a W9 is not received within 14 calendar days, your claims will be voided and you must resubmit your claims to be processed.

Payments

CCHP continues to offer **electronic payments** to providers. To register, please submit your request to EDIsupport@cchealth.org. To receive a RA (Remittance Advice) electronically, please sign up for our ccLink Provider Portal based on the instruction above.

Resources

- EFT Deposit Agreement
- ccLink Claims Entry Process Tip Sheets
- CMS1500 Claim Submission Guide
- UB04 Claim Submission Guide
- FAQs for Clearinghouse Transition to Availity 9/20/21
- DHCS Encounter data reporting Mother and Newborn Coding Guidance
- NDC Required HCPCS, revised 4/2021
- DHCS Local Code Crosswalk
- CDC Supplement Coding encounters related to COVID-19, eff 2/20/20
- EPSDT Reporting Guide

UB-40 Form for Billing Medical Claims

PAGE ___ OF ___ CREATION DATE TOTALS

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

[No Title]

UB-04 Claim Form Submission Instructions

https://www.cchealth.org/home/showpublisheddocument/641/638239869547500000

UB04 Claim Form Submission Instruction

Providers must use UB04 form when submitting claims to Contra Costa Health Plan (CCHP) for inpatient and outpatient services performed at institution facilities. The data elements are the same for both paper and electronic claims submission. All fields must be completed unless otherwise noted in these instructions.

Field Number	Requirement	Description and Additional Requirements
1	Required	Rendering provider's name and full address including city, state, zip code, and phone number
2	Required	Pay-to provider's name and full address including city, zip code, and phone number
3a	Optional	Patient Control Number – this number is reflected on the explanation of benefits for reconciling payments if needed
3b	Not required	Medical Record Number – not required (please see instruction for box 60)
4	Required	Type of Bill – enter the four-character type of bill code as specified in the National Uniform Billing Committee (NUBC) UB04 data specifications manual
5	Required	Federal Tax Number – Enter the federal tax ID for the billing facility
6	Required	Statement Covers Period – Enter the "from" and "through" dates covered in the claim
7	Not required	Not used
8a	Not required	Not used. Please use box 8b for patient's name
8b	Required	Please enter patient's last name, first name, and middle initial. If you are submitting a claim for a newborn, please enter infant's name in box 8b.
9	Optional	Patient Address
10	Required	Patient Birthdate – enter patient's birthday in the month, date, and year (MMDDYYYY) format
11	Required	Patient Sex – use the capital letter "M" for male or "F" for female
12	Required	Admission Date – enter the date of hospital admission in the six-digit: month, date, and year (MMDDYY) format
13	Required	Admission Hour – enter the hour of patient's admission
14	Required	Admission / Visit Type – enter the numeric code indicating the necessity for admission to the hospital. 1 – Emergency, 2 – Elective
15	Required	Admission Source – enter the numeric code indicating the source of admission or transfer:

UB04 Claim Form Submission Instruction

		1 – Non-Healthcare Facility Point of Origin 2 – Clinic or physician's office 4 – Transfer from a Hospital (Different facility) 5 – Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) 6 – Transfer from Another Healthcare Facility 7 – Emergency Room 8 – Court / Law Enforcement 9 – Information Not Available D – Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the payer E – Transfer from Ambulatory Surgery Center (ASC) F – Transfer from a Hospice Facility
16	Required	Discharge hour – enter the discharge hour for inpatient only
18-28	Optional	Condition Codes – enter the Medi-Cal codes used to identify the condition(s) relating to this claim
29	If applicable	Accident State – If the service is related to an accident, enter the state in which the accident occurred
30	Not required	Not Used
31-34	If applicable	Occurrence Codes and Dates – enter the codes and associated dates related to the claim
35-36	Not required	Occurrence Span Codes and Dates
37	Not required	Internal Control Number / Document Control Number
38	If applicable	Responsible Party's Name and Address - Enter if the party responsible for payment is different from the name in box 50
39-41	Not required	Value Codes and Amounts
42	Required	Revenue Code – For inpatient billing, enter the four-digit revenue code for the services provided
43	Required	Revenue Description – Identify the description of the revenue code entered in box 42 or HCPCS code in box 44. If applicable, include NDC/UPN Codes in this box
44	Required	HCPCS / Rate – Enter the applicable HCPCS codes and modifiers
45	Required	Service Date – Enter the service date in MMDDYY format for outpatient billing

UB04 Claim Form Submission Instruction

46	Required	Units of Service – Enter the actual number of times or units a single procedure or item was performed or provided for the date of service
47	Required	Total Charges for the procedure or item
48	Not required	Non-Covered Charges
49	Not required	Not Used
50	Required	Payer Name – Enter "Contra Costa Health Plan"
51	Not required	Health Plan ID
52	Not required	Release of Info Certification
53	Not required	Assignment of Benefit Certification
54	If applicable	Prior Payments – Enter any prior payments received from Other Coverage in full dollar amount
55	Not required	Estimated Amount Due
56	Required	NPI – Enter NPI number
57	Not required	Other Provider IDs
58	If applicable	Insured's Name – enter the mother's name if billing for an infant using mother's ID. Otherwise, leave blank
59	If applicable	If billing for an infant using the mother's ID, enter "03" for child
60	Required	Insured's Unique ID – enter the patient's CCHP ID as it appears in the member's ID card. Enter the mother's ID number for a newborn infant for the month of birth and the month after only. Do not use the SSN
61	Not required	Insured Group Name
62	Not required	Insured Group Number
63	If applicable	Treatment Authorization Code – Enter any authorization numbers in this field. Member information from the authorization must match the claim
64	Not required	Document Control Number
65	Not required	Employer Name
66	Required	Diagnosis / Procedure Code Qualifier
67	Required	Principal Diagnosis Code / Other Diagnosis Codes – Enter all letters and/or numbers of the ICD-10 CM code describing the chief reason for performing the service
68	If applicable	Other Diagnosis Codes – Enter all letters and/or numbers of the secondary ICD-10 CM code

UB04 Claim Form Submission Instruction

69	If applicable	Admitting Diagnosis – Enter all letters and/or numbers of the ICD-10 CM code describing the patient's diagnosis or reason for visit at the time of admission
70	Optional	Patient's Reason for Visit
71	Optional	Prospective Payment System Code
72	Not required	External Cause of Injury Code
73	Not required	Not Used
74	If applicable	Principal Procedure Code / Date
75	Not required	Not Used
76	Required	Attending Provider's NPI, name, and ID-Qualifier
77	If applicable	Operating Provider's NPI, name, and ID-Qualifier
78-79	If applicable	Other Provider's NPI, name, and ID-Qualifier
80	If applicable	Remarks
81CC	Not required	Code – Code Field / Qualifiers

Claims Submission

Claims can be submitted:

- **Electronically through a clearinghouse**
  - To get set up with electronic claims submissions email **EDIsupport@cchealth.org**

- **Electronically through the ccLink Provider Portal**
  - Instructions regarding the claim entry process: **https://www.cchealth.org/health-insurance/information-for-providers/claims-information**

- **USPS**: **Contra Costa Health Plan**
  Attn: Claims
  PO Box 5122
  Lake Forest, CA 92609

- Claim Questions: Call **(877) 800-7423, Option 5**
- Phone hours: 8:00 am – 1:00 pm

Helpful Hints on CCHP Website

Information for Providers:

https://www.cchealth.org/health-insurance/information-for-providers

How to get access to ccLink

INFORMATION FOR CCHP PROVIDERS

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ccLink Provider Portal

Members of our Community Provider Network: use the ccLink Provider Portal to file a claim, make an appeal, and more.

Enter the Provider Portal

ccLink New Account Agreement and Forms *(New Account and Add/Delete Users)*:

- ccLink Provider Portal Access Agreement
- ccLink Provider Add/Delete Request Form
- cclink Provider Portal Access Agreement – 3rd Party Biller
- ccLink Provider Portal for 3rd Party Billers Instructions

Join our Community Provider Network

The Community Provider Network is growing. Are you interested in joining?

Join the network

Social Determinants of Health Resources

Resources and criteria for offering enhanced care management (ECM) and Community Supports services:

- Community Supports (CS) Criteria
- ECM Criteria

For general ccLink questions, email CCHPportalsupport@cchealth.org

Other Resources

- Claims Information
- Clinical Guidelines
- Case Management
- Interperter Services
- Pharmacy
- Behavioral Health Providers
- Stay Up To Date
- Get in Touch

Utilization Management

Information, policies and forms related to utilization management.

- AMSC: AUDIT | AUDIT-C
- Contact Information for Noncontracting Hospitals
- Chronic Pain Management Policy
- Disclosure of UM Criteria or Guidelines Request Form
- Enhanced Care Management (ECM) Criteria
- Bariatric Surgery Mental Health Assessment
- Minor Consent Form Transportation-NEMT
- Neurosurgical Referral Guidelines
- Physician Certification Statement (PCS) for NEMT
- Prior Authorization Request/Referral (PA) Form
- Prior Authorization Request/Referral (PA) Form – Bariatric Bypass
- Synagis Prior Authorization Request form

ccLink-Provider Portal

https://www.cchealth.org/health-insurance/information-for-providers

Pharmacy and Therapeutics
Provider Network News
Provider Manual
Provider Portal
Provider Preventable Conditions Reporting Form
Telehealth Information
+ Trainings
Uncompensated Care Relief Payment Program

ccLink Provider Portal

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Enter the Provider Portal

ccLink New Account Agreement and Forms *(New Account and Add/Delete Users)*:

- ccLink Provider Portal Access Agreement
- ccLink Provider Add/Delete Request Form
- cclink Provider Portal Access Agreement – 3rd Party Biller
- ccLink Provider Portal for 3rd Party Billers Instructions

For **technical support** or to **reset your password**, call 925-957-7272.

Once you have access to the portal you can access from this page.

On the information for providers tab in the blue menu on the left you will find this information. You will need to complete all these requirements for portal access.

The Portal

https://cclinkproviderportal.cchealth.org/Planlink/common/epic_login.asp

Provider Manual:

https://www.cchealth.org/health-insurance/information-for-providers/provider-manual

PROVIDER MANUAL

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CCHP Provider Manual

Appendices

Appendix A - Abuse Reporting Forms

- Child Abuse Instructions
- Child Abuse Report
- Domestic Violence Legal Requirements for Reporting
- Elder Abuse

Appendix B

- Advanced Health Care Directive (English/Spanish)

Appendix C - Case Management Referral

- Form
- Brochures - Provider
- Brochures - Member
- Minor Consent Form - Transportation-NMT

Appendix D - Claims

- Corrected Claim Submission Guideline
- Appeal and Dispute Form
- Tracer Form

Appendix E

- Confidential Morbidity Report

Appendix F

- Contracted Hospitals - Hospitals Listing by City

Appendix G

- Disease Management Referral Form

Appendix H

- Fraud/Waste and Abuse Training for Providers

Appendix I - Pharmacy

- Medication - Prior Authorization Request
- Request for Formulary Review

Appendix J - Member Services

- Member Grievance and Appeal Form
  - Member Grievance and Appeal Form (Spanish)
- Member ID Cards
  - Member ID Cards Sample
- Member Rights
  - Member Rights (Spanish)
- Member Consent for Provider to File an Appeal
  - Member Consent for Provider to File an Appeal (Spanish)
  - Member Consent for Provider to File an Appeal (Chinese)
- List of Member Rights and Responsibilities
  - List of Member Rights and Responsibilities (Spanish)

Appendix K

- Behavioral Health Evaluation
- Behavioral Health Referral for Child
- Behavioral Health Referral for Adult

Appendix L

- CHDP Billing

Appendix M

- Prior Authorization Request (PA) Form
- Prior Authorization Request/Referral (PA) Form - Bariatric Bypass
- Minor Consent Form Transportation-NEMT
- Disclosure of UM Criteria or Guidelines Request Form
- Physician Certification Statement (PCS) for NEMT

- CHDP Billing

Appendix M

- Prior Authorization Request (PA) Form
- Prior Authorization Request/Referral (PA) Form - Bariatric Bypass
- Minor Consent Form Transportation-NEMT
- Disclosure of UM Criteria or Guidelines Request Form
- Physician Certification Statement (PCS) for NEMT

Appendix N

- Provider and Member Call Centers

Appendix O

- Provider Complaint Form

Appendix P

- Seniors and Persons with Disabilities Cultural Sensitivity Training

Appendix Q - WIC Referrals

- Pregnant Postpartum/Breastfeeding Woman
- Pediatric Referral

Appendix R

- CPN PCP Orientation
- CPN Specialist Orientation
- CPN Urgent Care Orientation
- CPN Organizational Provider Orientation
- CCRMC Orientation
- Community Health Worker Provider Training
- Skilled Nursing ICF DD Sub Acute Final

See more information designed specifically for health care providers.

Provider Complaints

Complaints regarding CCHP Members or network Providers should be sent to CCHP for resolution.

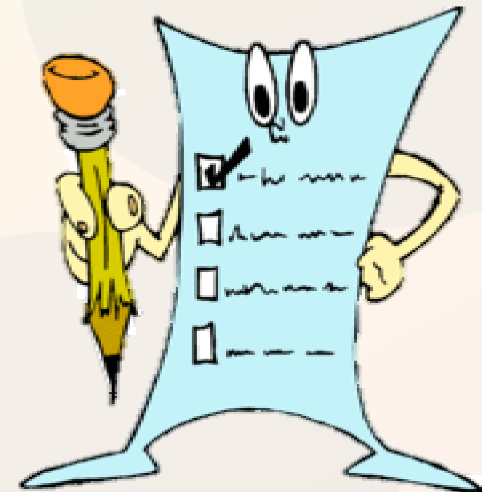
Please use the Provider Complaint Form (located in Appendix O of the Provider Manual):

CCHP Provider Complaint Form

Email the completed form to NetworkManagementTeam@cchealth.org

Quarterly Provider Network Updates

- CCHP is mandated by the Department of Health Services (DHCS) to survey all contracted providers quarterly to verify the information on file for your practice. Please be sure to complete these electronic surveys within 5 business days of receipt of the email.
- In between quarterly surveys, changes should be emailed to CCHPcredentialing@cchealth.org.



Cultural Competency Training

Effective July 1, 2017, due to new regulations under Final Rule, 42CFR 431.10, H/1/vii, the California State Department of Health Care Services (DHCS) now requires all health plans to list in their on-line and hard copy directories if a contracted provider has completed Cultural Competency training.

To meet this requirement, CCHP is offering a **FREE** and easy **Cultural Competency Training** *(no more than 15 minutes)*:

Click here to complete the Cultural Competency Training

Be sure to click the link on the last page (Attestation Requirements) to complete the training. Your submission automatically updates our database and directories stating you completed the training.

If you have already taken a similar training for another health plan, please send the documentation to **CCHPcredentialing@cchealth.org**, along with the name of the training and the other health plan's name, and we will accept it as completion of the training.

Fraud, Waste, and Abuse Training

On January 1, 2009, The Centers for Medicare and Medicaid Services (CMS) requirements for Fraud, Waste and Abuse (FWA) training for all contracted entities became effective. The requirements can be found in 42 C.F.R. 422.503 (b) (4) (VI) and 42 C.F.R. 423.504 (b) (4) (VI). The review and acknowledgment of completion is required on a yearly basis.

CCHP views the integrity of its staff, providers, contractors and members to be paramount and uncompromising. The materials provided reiterate the procedure for handling discovery of fraudulent activity involved with CCHP and to remind contracting entities that you must also have appropriate policies and procedures to address FWA.

You will receive an email yearly requesting acknowledgment of receipt of this information. For reference, the Fraud, Waste, and Abuse documents (also available in the Provider Manual) are available here:

Policy 705-C CCHP Fraud, Waste, and Abuse

Contact Us

We are here to help! Below is the contact information of the various CCHP departments who can help answer your questions. Email and usage of our ccLink Provider Portal is the preferred method of communicating with CCHP staff. It is our goal as a health plan to embrace and leverage technology. We are requesting that providers send us a quick email when you have a question. We will respond within 1 to 3 business days, as opposed to having your staff call and wait on the lines. By sending us written questions it can also help us develop educational tools such as Frequently Asked Questions.

**Please note that our response time may be delayed if we experience a high number of requests or inquiries.*

Authorization Department / Hospital Transition Nurse

- Phone: **(877) 800-7423, option 3**
- **ALL authorization requests should be entered through the CCHP Provider Portal.**
- **For out-of-network hospitals or non-contracted facilities, please contacts CCHP Utilization Management by phone or email to receive the out-of-network fax number.**
- Email Auth Questions (**do not email auth requests**):
  - For general UM: CCHPauthorizations@cchealth.org
  - For Long term care/custodial SNF care: CCHP-LTC-Authorization@cchealth.org
  - For skilled SNF care: CCHPSNF-Auth@cchealth.org

Claims Department

- Phone: **(877) 800-7423, option 5**
- Email Claims Questions: ClaimStatus@cchealth.org
- Email Claim Disputes: ProviderDispute@cchealth.org
- Email Electronic Claims/Payments (EDI program): EDIsupport@cchealth.org

Appeals and Grievances Department

- Email Appeals Questions: Appeals@cchealth.org

Facility Site Review Department

- **Email:** CCHPfsr@cchealth.org

Contact Us (cont.)

ccLink Provider Portal

- ccLink Provider Portal Application: **https://www.cchealth.org/health-insurance/information-for-providers**
- Email ccLink Provider Portal Application and Questions: **CCHPportalsupport@cchealth.org**
- IT Support to reset password or access issues: **(925) 957-7272**

Electronic Fund Transfer (EFT)

- Electronic payments to providers email **EDIsupport@cchealth.org** to initiate the request.

Electronic Claims Submission:

- Electronic claim submission, email **EDIsupport@cchealth.org**.

Interpreter Services

- Phone: **(877) 800-7423, option 4**

Member Eligibility and Primary Care Physician Assignment

- Phone: **(877) 800-7423, option 1**

Member Services Department (calling on behalf of a member that is with you)

- Phone: **(877) 800-7423, option 7**

Pharmacy Department

- Phone: **(877) 800-7423, option 2**

Provider Relations Department

- Phone: **(877) 800-7423, option 6**
- Fax: **(925) 608-9411**
- Email General Questions: **ProviderRelations@cchealth.org**
- Email Contract Related Questions: **CCHPcontracts@cchealth.org**
- Email Credentialing Related Questions: **CCHPcredentialing@cchealth.org**

Additional resources can be found on the CCHP website: **http://www.cchealth.org/health-insurance**

- Provider Manual: **https://www.cchealth.org/health-insurance/information-for-providers/provider-manual**
- Provider Directory: **https://www.cchealth.org/health-insurance/my-contra-costa-health-plan/provider-directory**
- CCHP Departments: **https://www.cchealth.org/health-insurance/information-for-providers/contact-us-for-providers**