CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
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Credit Balance Report: Provider Instructions

General

Central California Alliance for Health (the Alliance) requires all participating Hospital Providers to complete a *Credit Balance Report* on a quarterly basis. This report is used to monitor, identify and recover "credit balances" owed to the Alliance for improper or excess payments made to the provider resulting from claims processing errors. Examples of credit balances include instances where a provider is:

- Paid twice for the same service either by the Alliance or another insurer;
- Paid for services planned but not performed,
- Paid for services that are considered non-covered services;
- Overpayments due to errors in calculating beneficiary deductible and/or coinsurance amounts; or
- Overpayments made for outpatient services included in a beneficiary's inpatient claim.

For purposes of completing this form, a credit balance is defined as an amount determined to be refundable to the Alliance.

Generally, when a hospital provider receives an improper or excess payment for a claim, it is reflected in the accounting records (patient accounts receivable) as a "credit." However, credit balances due to the Alliance include all overpayments made by the Alliance regardless of the classification within a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period; e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability. In these instances, the provider must identify and repay all monies due the Alliance. Only Alliance credit balances are reported on this form.

Credit Balance Report Due Dates

Credit Balance Reports are due within thirty (30) days after the close of each calendar quarter. All credit balances as of the last day of the reporting quarter including transfer, holding or other general accounts used to accumulate credit balance funds should be included in the report.

Quarters	Due Date
Quarter 1 (Jan 1-Mar 31)	April 30th
Quarter 2 (Apr 1- June 30)	July 31st
Quarter 3 (July 1-Sep 30)	October 31st
Quarter 4 (Oct 1-Dec 31)	January 31st

Providers are responsible for reporting and repaying all excess payments received from the time they began participating in Alliance programs. Each credit balance should be reported only once and does not need to be posted to subsequent reports.

Submission of Credit Balance Report Form(s)

The Credit Balance Report consists of two forms. They are the:

- Certification Page, and
- Detail Page.

Credit Balance Report forms must be signed and submitted to the Alliance each quarter as attestation of credit balance status even if the credit balance is zero. Reports may be submitted to the Alliance using one of the methods below. All emails and faxes sent to the Alliance must utilize HIPAA compliant standards.

Email to:
Dave Gardner, Cost Efficiency Director
DavidG@ccah-alliance.org

Fax to:
Central California Alliance for Health
Reinsurance and Recoveries Administrator
FAX Number: (831) 430-5871

Mail to:
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981

Filling out the Credit Balance Report Form(s)

Certification Page

Each quarter the provider must submit a Certification Page which has been signed by the Chief Financial Officer, Chief Executive Officer, or the Administrator of the Provider facility. If the credit balance for the quarter is zero; it is not necessary to file a Detail Page.

The Certification Page includes the following information:

- Provider Facility full name;
- Facility's provider number,
- Note: If there are multiple provider numbers for dedicated units within the facility (e.g., psychiatric, physical medicine and rehabilitation), complete a separate report for each provider number;
- Quarter end date (e.g, 12/31/20XX),
- Signature of Officer or Administrator of Provider,
- Name/Title Printed,
- Date,
- Name and telephone number of the individual who may be contacted regarding any questions on the credit balance report, and
- Number of Credit Report Detail Pages attached, and

- Confirmation if there is no Alliance credit balances to report for the quarter (No Detail Pages attached).

Detail Page
The *Detail Page* includes specific information for each claim that has a credit balance. The detail page provides space to document seventeen (17) claims. This form may be reproduced as many times as necessary to accommodate all of the credit balances during the quarter for the report.

The following data should be completed on the Credit Balance Detail Page. When a credit balance is the result of a duplicate primary payment; providers should report the data pertaining to the most recently paid claim.

Column 1 - The last name and first initial of the Alliance Beneficiary, (e.g., Doe, J.).

Column 2 - The multiple-digit Claim Control Number (CCN) assigned by the Alliance when the claim is processed.

Column 3 - The 3-digit number explaining the type of bill; e.g., 111 - inpatient, 131 - outpatient, 831 -same day surgery. (See the Uniform Billing instructions, [each provider manual has the appropriate cite for the manual].)

Columns 4/5 -The month, day and year the beneficiary was admitted and discharged, if an inpatient claim; or "From" and "Through" dates (date service(s) were rendered), if an outpatient service. Numerically indicate the admission (From) and discharge (Through) date (e.g., 01/01/07).

Column 6 - The month, day and year (e.g., 01/01/07) the claim was paid. If a credit balance is caused by a duplicate Alliance payment, ensure the paid date and CCN number correspond to the most recent payment.

Column 7 - The amount of the Alliance credit balance that was determined from patient/ accounting records.

Column 8 - The amount of the Alliance credit balance identified in column 9 being repaid with the submission of the report. (As discussed below, repay Central California Alliance for Health credit balances at the time you submit the form.)

Column 9 –
- Place a "C" in column 9 when you submit a check with the form to repay the credit balance,
- Place an "A" in column 9 if a claim adjustment is being submitted in hard copy (e.g., adjustment bill in UB-92 format) with the form,
- Place a "Z" in column 9 if payment is being made by a combination of check and adjustment bill with the form and
- Place an "X" in column 9 if an adjustment bill has already been submitted electronically or by hard copy.

Column 10 - The amount of the Alliance credit balance that remains outstanding. Show a zero ("0") if payment has been previously submitted with the form or a claim adjustment has been made by the Alliance.

Column 11 – Place the reason number in Column 11 which explains the type of credit balance.
- Enter "1" for duplicate payment,

- Enter “2” for primary payment by another insurer,
- Enter “3” for “other reasons” (Provide an explanation on the detail page for each credit balance with a “3”.

Column 12 - The name and billing address of the primary insurer identified.

NOTE: After a credit balance is reported; it should not be reported on subsequent reports.

Recovery of Overpayments made by the Alliance

All amounts owed (column 9 of the report) must be paid at the time the credit balance report is submitted. Payments may be made by check or an electronic recovery by Alliance staff.

Submission of the detail information on the Credit Balance Report will not be accepted by the Alliance as an adjustment bill.

If the amount owed to the Alliance is so large that immediate repayment would cause financial hardship, the provider may contact the Alliance Finance Department, Recoveries line at (831) 430-2505 to discuss an extended repayment schedule.

Credit Balance Report Form
Certification

The Central California Alliance for Health (the Alliance) *Credit Balance Report Form* is required to be completed every quarter.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared by:

Provider Name

Provider 6-Digit Number [CMS Certification Number (CCN)]

For the calendar quarter ended and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable federal laws, regulations and instructions.

_____
Signature of Officer or Administrator of Provider

Name and Title

Date

Check One:

- ☐ Qualify as low utilization provider.
- ☐ Credit Balance Detail Page(s) attached.
- ☐ No Alliance credit balances to report for this quarter (no detail pages attached)

Contact Person Telephone Number

Credit Balance Report Form

Credit Balance Details

(1) Beneficiary Name	(2) CCN	(3) Type of Bill	(4) Admission Date	(5) Discharge Date	(6) Paid Date	(7) Amount of Alliance Credit Balance	(8) Amount of Medicare Credit Balance Repaid	(9) Method of Payment	(10) Amount of Alliance Credit Balance Outstanding	(11) Reason for Alliance Credit Balance	(12) Primary Payer (Name & Billing Address)

Provider Name:

Provider Billing Number:

Quarter Ending:

Contact Person:

Phone Number: