Santa Clara Family Health Plan™

ENHANCED CARE MANAGEMENT
BILLING, PAYMENT, AND SERVICE GUIDE

Medi-Cal Provider Guide CY 2022

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Santa Clara Family Health Plan™

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ECM Billing Guide Overview

The purpose of this guide is to describe Santa Clara Family Health Plan's (SCFHP's) expectation regarding billing for Enhanced Care Management (ECM) by community based Providers contracted for ECM services. As required by the Department of Health Care Services (DHCS), SCFHP and all contracted ECM Providers are expected to administer program services starting on January 1, 2022 for members with qualify and/or enroll under one of the ECM Populations of Focus (POF):

1. Individuals and Families Experiencing Homelessness
2. Adult High Utilizers
3. Adult Serious Mental Illness and Substance Use Disorder
4. Individuals Transitioning from Incarceration
5. Adults Living in the Community who Are at Risk for Long-Term Care (LTC) Institutionalization
6. Nursing Facility Residents Transitioning to the Community
7. Children and Youth

ECM Submission Topics Included in this Guide

1. SCFHP Billing and Payment
2. DHCS Approved Encounter Code Table for ECM
3. Member Tiering and Payments
4. Z-Codes
5. Invoicing for Services and Outreach
6. Viewing Claim Status and Retrieving Remittance Advice

SCFHP Billing and Payment

Billing

A. Claim Submission
   a. For each ECM services performed, the CB-CME will submit an 837 Professional (837P) claim. The 837P is the standard format used by health care professionals and suppliers to transmit health care claims electronically.
   b. Claims are to be submitted through a clearinghouse that has a contractual relationship with SCFHP (Change HealthCare and OfficeAlly) using payor ID 24077.

B. Minimum Required Fields for the 837P claim:
   a. Member Identification Information: Name, Date of Birth (DOB), Medi-Cal Client Identification Number (CIN), etc.
   b. Rendering Provider[1]
   c. Billing Provider

[1] Rendering Provider will need an NPI. The Billing NPI can be the same as the Rendering Provider NPI. Providers should bill using an organization/facility NPI, if available. National Provider Identifier (NPI) Application A Step-by-Step Guide for Providers Participating in the ECM and Community Supports Programs," DHCS. Available here.

d. Dx[2]
e. Date of Service (DOS)
f. Place of Service (POS)
g. Procedure Code
    i. G9008 or G9012
    ii. Modifier
        a. Refer to billing table 1.1 under section "Payment"
        b. Each claim should have one service modifier and one population modifiers
    iii. Units
        a. 1 unit of service is 15 minutes [3]
    iv. Location[4]

Payment

C. For service modifiers U1 and U2 with or without GQ, assigned Providers are paid on the first claim submitted for that service month, then $0 for following claims submitted on the same month for that **enrolled** member. Providers are required to bill for all services provided for each month, even for services provided that are paid $0
    a. For ECM billed services for enrolled members, the provider must submit on HCPC code (G9008, G9012), with one service modifier (U1, U1-GQ, U2, U2-GQ) and one population modifier (O1, O2, O3, O4)
D. For outreach modifier U8 with or without GQ, assigned Providers are paid on the first two claims submitted for that service month, then $0 for the following claims submitted on the same month for that **eligible (not enrolled)** member
    a. For ECM outreach, the Provider must submit one HCPC code (G9008, G9012), with one outreach modifier (U8, U8-GQ) and one population modifier (OA, OB)
    b. Number of outreach attempts should follow according to the member's tier and billed as such for frequency
E. Providers who are submitting multiple claims for the same member and for the same service month, should bill all claims that do not qualify for payments with the payment amount of $0 or bill the same amount as the payable claims.
F. Members reassigned from one Provider to another Provider should begin services the month the member is reflected on the Provider's member information file (MIF)
    a. Two Providers cannot bill for the same member within the same month
G. Retro submissions (additions and/or deletions) are allowed up to 12 months

[2] At least one Dx is required. May use Z02.9
[3] Round up for services = or >8 minutes. Round down for services <7 minutes.
[4] Actual address where service was provided is not necessary, as long as the CB-CME bill with the correct NPI for each clinic and provider rendering the services

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Billing Table 1.1			
HCPCS Level II Code	**HCPCS Description**	**Modifiers**	**Modifier Description**
G9008	ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1	Used by Managed Care with HCPCS code G9008 to indicate Enhanced Care Management services
G9008	ECM Phone/Telehealth: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1, GQ	Used by Managed Care with HCPCS code G9008 to indicate Enhanced Care Management services.
G9008	ECM Outreach In Person: Provided by Clinical Staff. Other specified case management service not elsewhere classified.	U8	Used by Managed Care with HCPCS code G9008 to indicate a single in-person Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management.
G9008	ECM Outreach Telephonic/Electronic: Provided by Clinical Staff. Other specified case management service not elsewhere classified.	U8, GQ	Used by Managed Care with HCPCS code G9008 to indicate a single telephonic/electronic Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management. Telephonic/electronic methods can include text messaging or secure email individualized to the Member. However, mass communications (e.g., mass mailings, distribution emails, and text messages) do not count as outreach and should not be included.
G9012	ECM In-Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services

G9012	ECM Phone/Telehealth: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2, GQ	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services.
G9012	ECM Outreach In Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U8	Used by Managed Care with HCPCS code G9012 to indicate a single in – person Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management.
G9012	ECM Outreach Telephonic/Electronic: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U8, GQ	Used by Managed Care with HCPCS code G9012 to indicate a single telephonic/electronic Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management. Telephonic/electronic methods can include text messaging or secure email individualized to the Member. However, mass communications (e.g., mass mailings, distribution emails, and text messages) do not count as outreach and should not be included.

Additional Modifiers for Populations		
HCPC Level II Code	Population Modifiers[5]	Modifier Description
G9008, G9012	O1	Monthly touch-In for WPC/HHP SNF, Homeless, and SMI
	O2	Monthly touch-in for WPC/HHP High Utilizers, Incarcerated, LTC, Children
	O3	Monthly touch-in for newly eligible ECM members for SNF, Homeless, and SMI
	O4	Monthly touch-in for newly eligible ECM members for High Utilizers, Incarcerated, LTC, and Children

[5] Population modifiers use the letter "O" and not the number zero

	OA	Non-enrolled outreach for newly eligible Homeless, SMI, and SNF
	OB	Non-enrolled outreach for newly eligible High Utilizer, Incarcerated, LTC, and Children

HCPCS Codes and Modifiers Combinations for ECM Services			
Reimbursement POF	**Acceptable HCPC Codes**	**Acceptable Modifiers for Service**	**Modifier for POF**
WPC/HHP SNF WPC/HHP Homeless WPC/HHP SMI	• G9008 • G9012	• U1 • U1, GQ • U2 • U2, GQ	O1
WPC/HHP High Utilizers WPC/HHP Incarceration WPC/HHP LTC WPC/HHP Children	• G9008 • G9012	• U1 • U1, GQ • U2 • U2, GQ	O2
Non WPC/HHP SNF Non WPC/HHP Homeless Non WPC/HHP SMI	• G9008 • G9012	• U1 • U1, GQ • U2 • U2, GQ	O3
Non WPC/HHP High Utilizers Non WPC/HHP Incarceration Non WPC/HHP LTC Non WPC/HHP Children	• G9008 • G9012	• U1 • U1, GQ • U2 • U2, GQ	O4

HCPCS Codes and Modifiers Combinations for ECM Outreach			
Reimbursement POF	**Acceptable HCPC Codes**	**Acceptable Modifiers for Service**	**Modifier for POF**
Non WPC/HHP SNF Non WPC/HHP Homeless Non WPC/HHP SMI	• G9008 • G9012	• U8 • U8, GQ • U8 • U8, GQ	OA
Non WPC/HHP High Utilizers Non WPC/HHP Incarceration Non WPC/HHP LTC Non WPC/HHP Children	• G9008 • G9012	• U8 • U8, GQ • U8 • U8, GQ	OB

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Member Tiering and Payments

Overview

Member tiering (risk grouping) allows for members with higher acuity levels to receive more intensive ECM services. To ensure ECM Providers are providing services and billing appropriately in accordance with a member's tier, SCFHP will monitor claim submissions. During this process, SCFHP will be looking to see that each ECM Provider submits claims for eligible, enrolled members for appropriate services and eligible, assigned members for appropriate outreach. Each ECM Provider should submit claims for services provided to eligible members on a timely basis – recommendation is within 30 days of service.

SCFHP will assign a preliminary tier to all ECM members the first month the member qualifies for ECM. This is reflected on the MIF. After receiving and reviewing the MIF, Providers are required to reassess the member's tier to ensure the member's needs meets the level of service determined by their tier. If the member's tier should be change to reflect a more appropriate tier, the ECM Provider will report this through inbound transmission file.

Defining Outreach

A. In-person: Outreach completed in the community to locate the member and/or meet the member where they are the most comfortable in the community
B. Telephonic:
    a. Outreach completed over the phone. The member answered and the conversation lasted at least for seven minutes, explaining the program and addressing the member's needs.
    b. Outreach completed over the phone. Member did not answer but Provider attempted at least one additional attempts on the same day and/or sought out an alternative phone number from member's PCP.
C. Mail and Email: Outreach completed by mail or email. Provider completed outreach by mail or email for a specific member. Mail cannot be mass mailing or email. Letter should address and identify the purpose of the program, the member's assigned care manager, and contact information.

Tier Requirements for Outreach for ECM

The ECM Provider are required to follow SCFHP's tiering criteria and provide the appropriate levels of outreach. Billing for outreach should follow the member's tier:

A. Tier 1 (highest acuity):
    a. Members will receive at least two outreach attempt per month in-person or through other lines of communications outlined under, "Defining Outreach" in the first three month the Member is eligible for ECM services. This includes:

i. The ECM Provider must connect with one of the member's health providers (primary care, behavioral health, housing provider, etc.) to assist in locating the member.
ii. At least one outreach attempt must be done by mail notifying the member of their outreach efforts.

b. Three months after their initial eligibility, the ECM Provider continues to conduct additional outreach attempts at least once per month
    i. Outreach will continue until Member no longer qualifies or has declined services.

B. Tier 2 (middle acuity): Members will receive at least one outreach per month attempt by phone or in-person the first four months the Member is eligible for ECM
    a. Members will receive at least one outreach attempt per month in-person or through other lines of communications outlined under, "Defining Outreach" in the first four months the Member is eligible for ECM services. This includes:
        i. The ECM Provider must connect with one of the member's health providers (primary care, behavioral health, housing provider, etc.) to assist in locating the member.
        ii. At least one outreach attempt must be done by mail notifying the member of their outreach efforts.
    b. Four months after their initial eligibility, ECM Providers continues to conduct additional outreach attempts at least once every other month either by phone, in-person, or by mail.
    c. Outreach will continue until Member no longer qualifies or has declined services.

C. Tier 3 (lowest acuity): Members will receive at least one outreach attempt every other month by phone or in-person the first six months the Member is eligible for ECM.
    a. In the first four months of the member's initial eligibility, at least one attempt to contact the member's Provider to locate the member is required:
        i. At least one outreach attempt by mail notifying the member of their outreach efforts
    b. Six months after their initial eligibility, the ECM Provider continues to conduct additional outreach attempts at least once every quarter by phone, in-person, or by mail
        i. Outreach will continue until Member no longer qualifies or has declined services

Tier Requirements for Monthly Case Management Service

Once the member consents to enroll into ECM, the ECM Provider will begin providing monthly ECM services under one of the core services:

1) Comprehensive Assessment and Care Management Plan
2) Enhanced Coordination of Care
3) Health Promotion
4) Comprehensive Transitional Care

5) Member and Family Supports
6) Coordination of and Referral to Community and Social Support Services

To ensure appropriate levels of care are being provided to the member, the ECM Provider is required to follow SCFHP's tiering criteria:

1) **Tier 1**: Requires two in-person visits per month in addition to other ECM services
2) **Tier 2**: Requires one in-person visit per month in addition to other ECM services
3) **Tier 3**: Requires one in-person or telehealth visit per month in addition to other ECM services
    - Members in tier 3 are ready to "graduate"[6] from ECM services

[6] Graduate members are member who are well managed. Members have met their care plan goals, are continuing to meet their health care providers, and/or are able to manage their health independently, may include taking their medications regularly

Utilizing Z-Codes

In accordance with All Plan Letter 21-009, DHCS prioritizes the submission and tracking of Priority Social Determinants of Health (SDOH) Codes. DHCS has issued a list of 18 DHCS Priority SDOH Codes, based on the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), for managed care plans and providers to utilize when coding for SDOH to ensure correct coding and capture of reliable data. The DHCS Priority SDOH Codes were chosen based on an assessment of existing managed care plan code utilization and by determining what may have the greatest impact on identifying and addressing SDOH. In partnership with DHCS, SCFHP expects contracted ECM Providers to use DHCS Priority SDOH Codes and incorporate in ECM billing, when applicable to the member.

DHCS Priority Social Determinants of Health Codes	
Z55.0	Illiteracy and low-level literacy
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances (foreclosure, isolated dwelling, problems with creditors)
Z59.811	Housing instability, housed with risk of homelessness
Z59.812	Housing instability, homelessness in past 12 months
Z59.819	Housing instability, unspecified
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Additional Z-Codes

The following Z-codes should be utilized if it applies to the member:

Z59.9	Problem related to housing and economic circumstances, unspecified
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment
Z60.4	Social exclusion and rejection
Z60.9	Other problems related to social environment
Z56.0	Unemployment, unspecified
Z62.3	Other upbringing away from parents
Z62.810	Personal history of physical and sexual abuse in childhood
Z62.811	Personal history of psychological abuse in childhood
Z62.813	Personal HX forced labor/sex exploit in childhood
Z62.9	Problem related to upbringing, unspecified
Z65.0	Conviction in civil and criminal proceedings without imprisonment
Z65.3	Problems related to other legal circumstances
Z81.1	Family history of alcohol abuse and dependence
Z81.3	Family history of other psychoactive substance abuse and dependence
Z81.4	Family history of other substance abuse and dependence

Invoicing for Services and Outreach

Enhanced Care Management (ECM) will be expected to submit claims to SCFHP using national standards (e.g., ANSI ASC x12N 837P) to the greatest extent possible. Providers who are unable to submit compliant claims may instead submit invoices to SCFHP with "minimum necessary data elements defined by DHCS." This guidance defines these "minimum elements," which include information about the Member, service(s) rendered, and the Provider, as well as standards for file formats, transmission methods, submission timing, and adjudication. The purpose of this guidance is to standardize invoicing to mitigate provider burden and promote data quality.

Data Elements	Required
Billing Provider National Provider Identifier (NPI)[7]	Yes
Billing Provider Tax Identification Number (TIN)	Yes
Billing Provider Name	Yes
Billing Provider First Name	Optional
Billing Provider Last Name	Optional
Billing Provider Phone Number	Yes
Billing Provider Address	Yes
Billing Provider City	Yes
Billing Provider State	Yes
Billing Provider Zip	Yes
Rendering Provider National Provider Identifier (NPI)	Yes

[7] Providers should bill using an organization/facility NPI, if available. National Provider Identifier (NPI) Application A Step-by-Step Guide for Providers Participating in the ECM and Community Supports Programs," DHCS. Available here.

Rendering Provider Tax Identification Number (TIN)	Yes
Rendering Provider Name	Yes
Rendering Provider First Name	Optional
Rendering Provider Last Name	Optional
Rendering Provider Phone Number	Yes
Rendering Provider Address	Yes
Rendering Provider City	Yes
Rendering Provider State	Yes
Rendering Provider Zip	Yes
Member Client Identification Number (CIN)	Yes
Medical Record Number (MRN)	Optional
Member First Name	Yes
Member Last Name	Yes
Member Homelessness Indicator	Yes
Member Residential Address	Yes
Member Residential City	Yes
Member Residential Zip	Yes
Member Date of Birth (MM/DD/YYYY)	Yes
Primary Payer Identifier	Yes
Payer Name	Yes
Procedure Code(s)	Yes
Procedure Code Modifier(s)	Yes
Service Start Date	Yes
Service End Date	Yes
Service Name(s)	Optional
Service Unit Count(s)	Yes
Place of Service (POS)	Yes
Member Diagnosis Code(s)	Yes
Service Unit Cost(s)	Yes
Service Charge Amount(s)	Yes
Invoice Amount	Yes
Invoice Date (MM/DD/YYYY)	Yes
Invoice Number	Yes
Control Number	Optional
Authorization Number	Optional

Viewing Claim Status and Retrieving Remittance Advice

Payspan

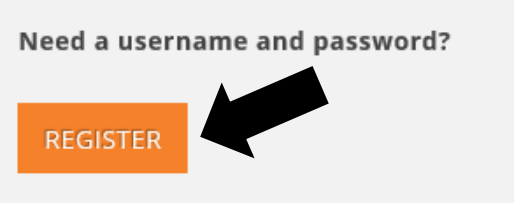
SCFHP has transitioned to Payspan, a new payment system at no cost to our providers. This change occurred during the claims payment cycle of November 15, 2021 and had no effect on any relationship you have with claims clearinghouse partners. Providers who register for Payspan will have access to payment details and be able to initiate or resume receipt of electronic payments from the plan in place of hard copy checks.

Providers who have not yet registered for Payspan email should request a registration code by emailing providersupport@payspanhealth.com or by visiting https://www.payspanhealth.com/RequestRegCode.

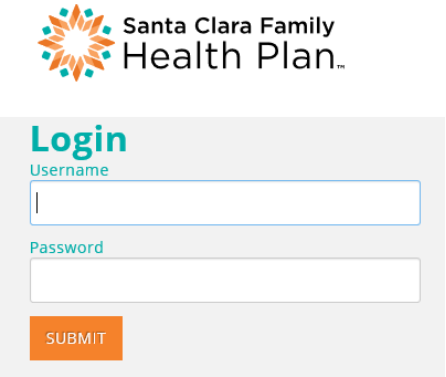
The submitting provider would then receive their registration code along with instructions to complete registration within 24 to 48 hours from the time of the submitted request. Payspan registration can be completed at any time. Registration instructions will be included with hard copy checks. Questions specific to registration and related steps should be directed to the Payspan Customer Service by writing providersupport@payspanhealth.com.

Provider Portal

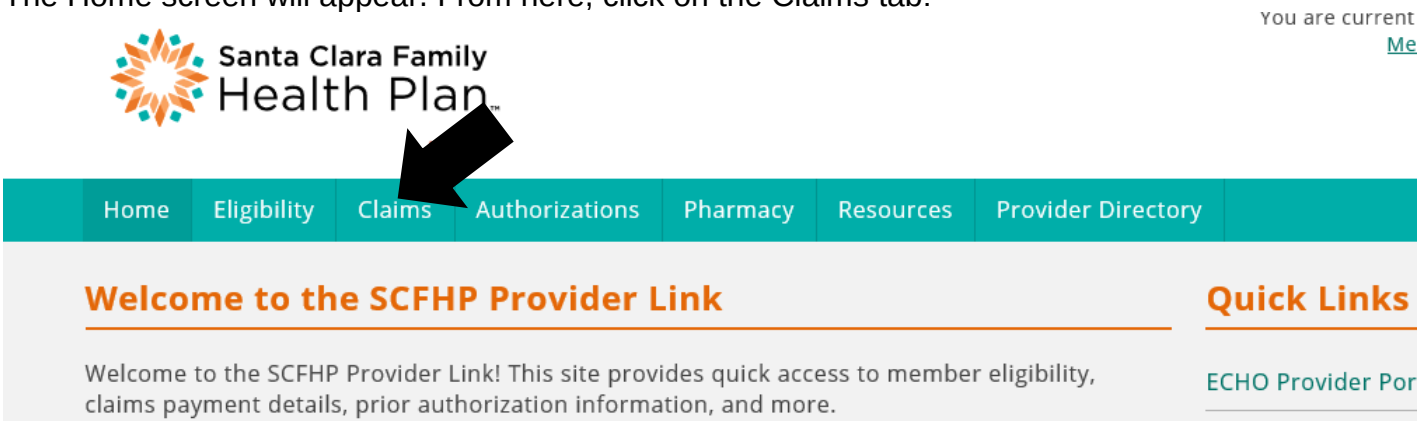
To check status on claims, go to the portal at: https://providerportal.scfhp.com.If you have not registered to use the portal, click on “REGISTER”:



If you are already registered, under “Login”, enter your Username and Password and click “SUBMIT”:



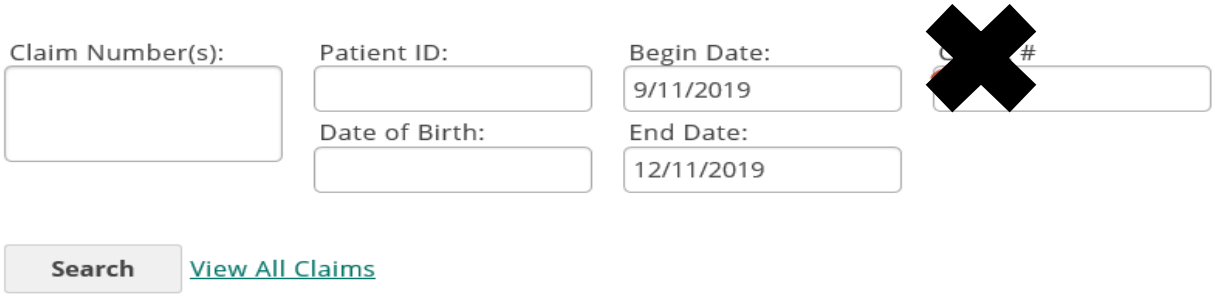
The Home screen will appear. From here, click on the Claims tab:



The default is to show the last 3 months claims. Enter other parameters in the available boxes as desired and click “Search”.

Notes:

- Max date range search is 3 months, but you can search any 3 months in history.
- “Check #” does not apply for HHP Program. Checks are provided each month through the supplemental kick process and not through claims.



Click on any claim number to see more details.
To download the list as an Excel file, click on “Download Results”