CalAIM Enhanced Care Management & Community Supports: Back to Basics Overview
CENTRAL CALIFORNIA ALLIANCE FOR HEALTH®
1

AGENDA:

1. Provider Set Up
2. Portal Information
3. Referral Process
4. Authorization Workflows/Process
5. Documentation
6. Closed Loop Referrals
7. Invoicing Expectations
8. Misc. Information

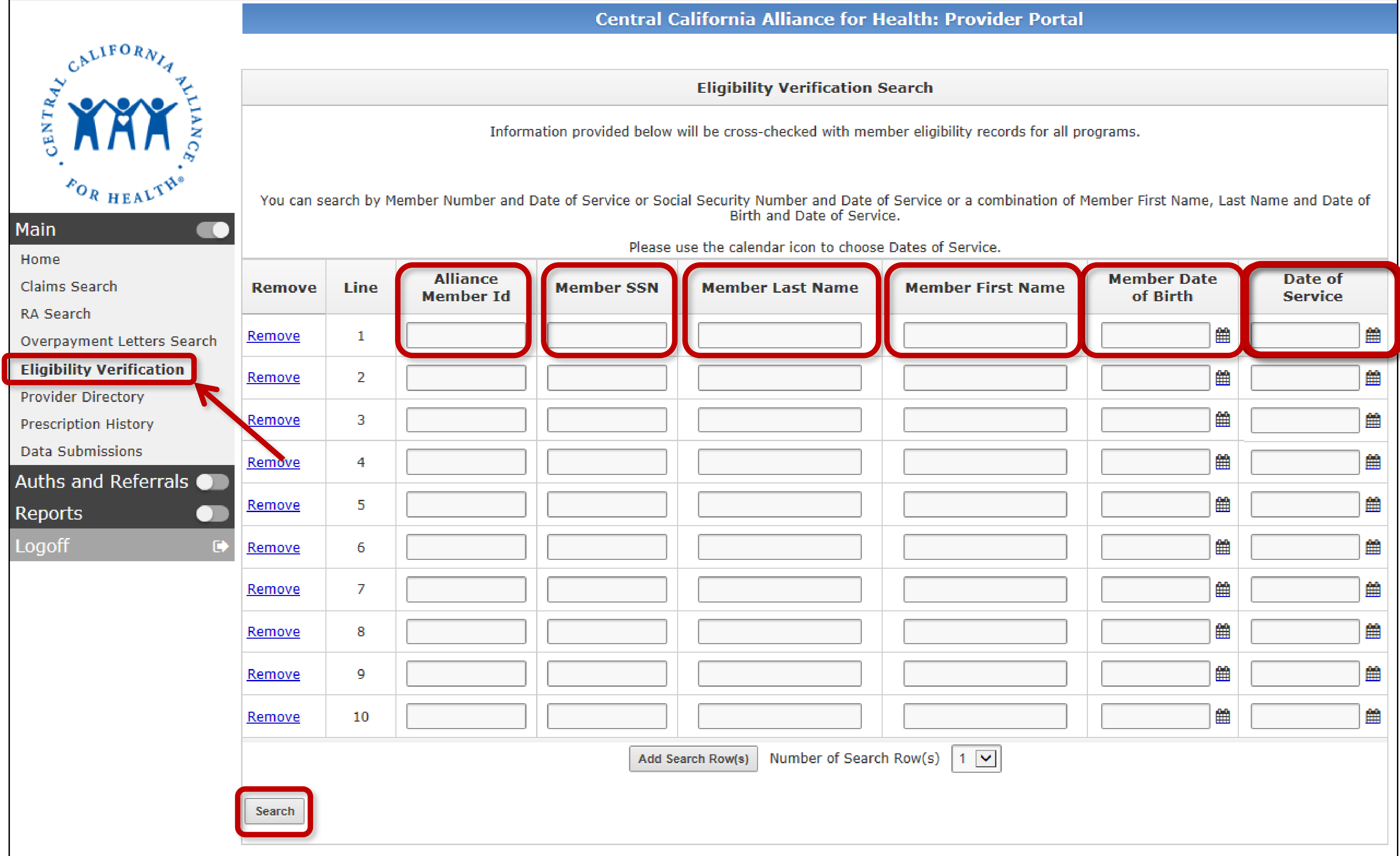
Provider Set Up

1. SFTP Folder
   – Bi-directional information exchange
2. Provider Portal
3. Care Management Platform
4. Change ECHO

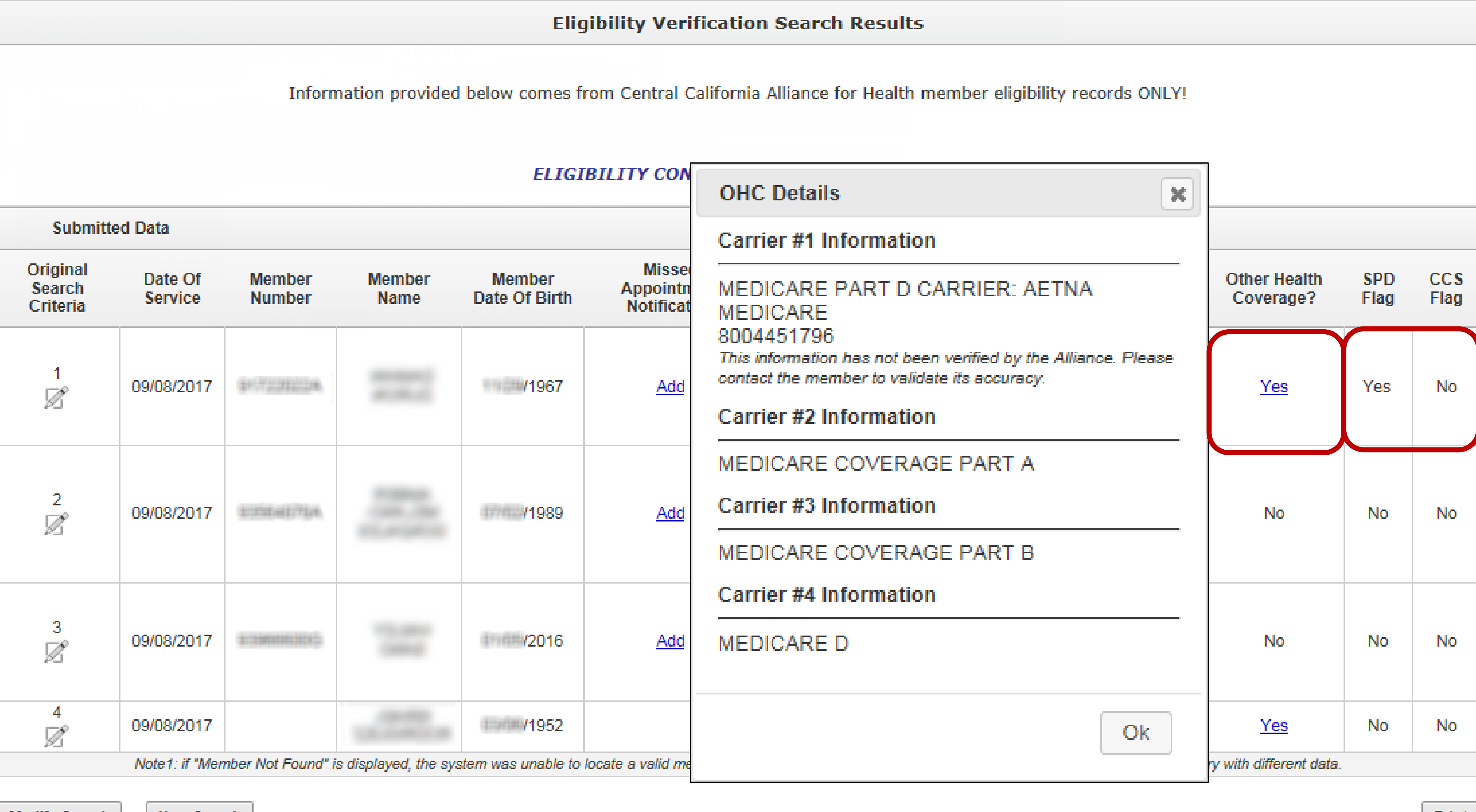
Information from CCAH to Providers (SFTP folder)

- New Member (daily)
  - members who have been newly authorized for services or outreach
- Enrolled Member (monthly)
  - snapshot of all current members who are authorized for services
- Eligible Member (monthly, optional)
  - members who we are referring that have not been authorized for services or outreach yet
- Capitation RA List (monthly)
  - All members you are receiving a capitation payment for and the amount

Eligibility verification

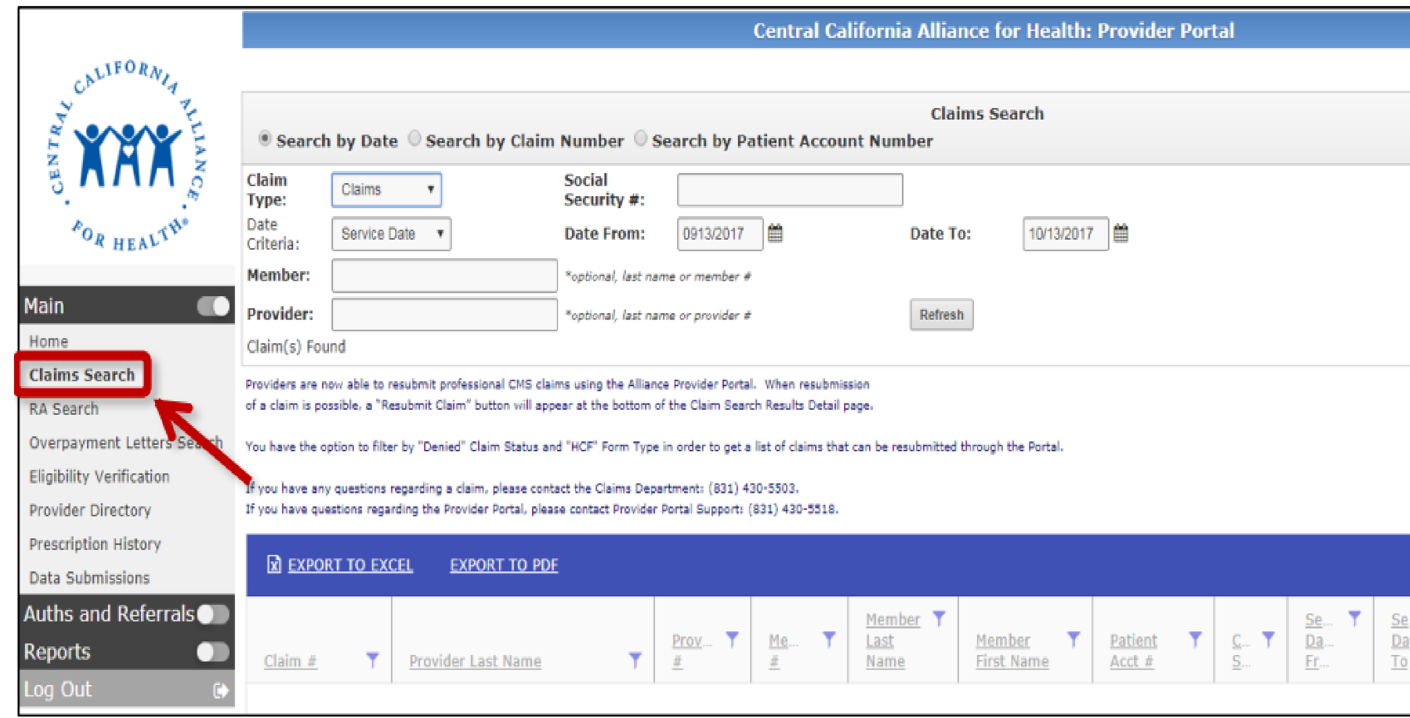


Eligibility verification results



Claims Search

- The portal allows you to search claims by Date, Claim Number and Patient Account Number.
- The search results returns only claims billed from your practice.
- If a professional claim denies with a specific denial code, you can resubmit the claim with additional or updated information.



Authorizations and referrals search

Central California Alliance for Health: Provider Portal

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

My Authorizations

J Jones is currently logged in.

HOME | LOG OUT

AG | PM | Portal | Core

- Main
  - Home
  - Claims Search
  - RA Search
  - Overpayment Letters Search
  - Eligibility Verification
  - Provider Directory
  - Prescription History
  - Data Submissions
- Auths and Referrals
  - **Authorization / Referral Search**
  - Authorization / Referral Entry
- Reports
- Logoff

Search Criteria

Auth Number:

Member ID:

Member First Name:

Member Last Name:

Member SSN:

Member DOB:

Authorization Class: -- Display All --

Authorization Sub Class: -- Display All --

Authorization Status: -- Display All --

Created Date Range: to

SEARCH

Authorizations and referrals entry

Central California Alliance for Health: Provider Portal

Submit Auth/Referral Request

INTERNAL – MELISSA KELLY-ORTEGA is currently logged in.

HOME LOG OUT

AG PM Portal Core

Main
- Home
- Claims Search
- RA Search
- Overpayment Letters Search
- Eligibility Verification
- Provider Directory
- Prescription History
- Data Submissions

Auths and Referrals
- Authorization / Referral Search
- **Authorization / Referral Entry**

Reports

Logoff

Step 1: Select a member and classification.

Fields in **bold** are required.

Submitted By: -- Select One --

Auth Class: -- Select One --

Auth Sub-Class: -- Select One --

Auth Type: -- Select One --

CONTINUE

Step 2: Complete detail fields.

Step 3: Attach supporting documentation.

Step 4: View confirmation and PDF summary.

ECM line: 831-430-5512
ECM email: listecmteam@ccah-alliance.org

Referral Process

1. The member or representative:
   - **Can complete a Referral Form** (web-based)
   - **Can call** and a member of the ECM team will walk through form
2. The provider completes:
   - **A Referral Form** available here: Referral Forms
     - Under the sub-section "How do I submit a ECM/CS referral form"
   - **A TAR Form [for contracted providers]** (fax or email return)
     - When submitting a post-service auth (i.e. ECM01) please ensure the correct start date is indicated on the form
   - **Authorization through the provider portal**
     - When submitting a post-service auth (i.e. ECM01) please ensure the correct start date is indicated on the auth
   - **Can call** and a member of the ECM team will review above processes

Referral Process

ECM line: 831-430-5512
ECM email: listecmteam@ccah-alliance.org

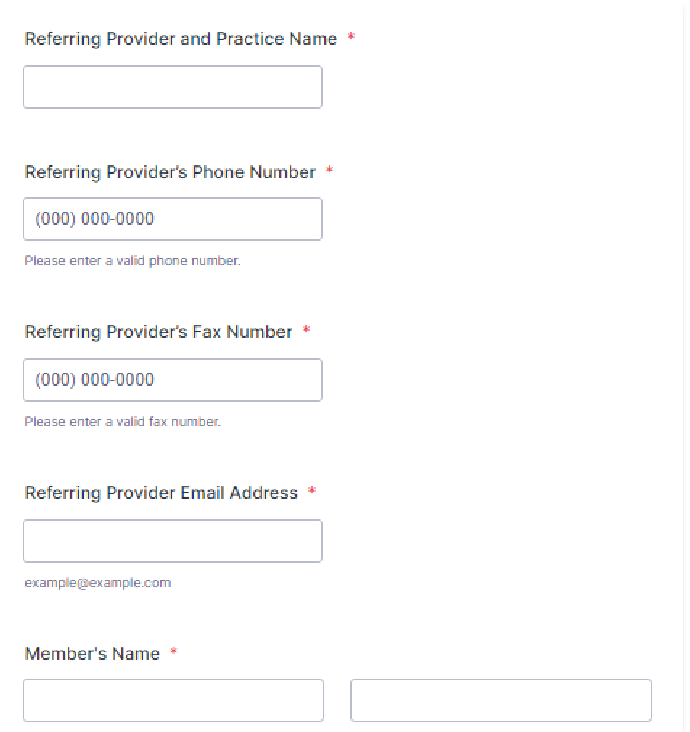
1. The Alliance will **fax authorization correspondence** to both the servicing and requesting provider.
   - Approval
   - Denial
   - Void (not information obtained)
     - CS referrals need verbal consent from members prior to approval
   - Status Change

2. The provider will receive **member demographic information** the following business day in SFTP folder
   - Outreach should begin once member demographic information has been obtained

Provider Referral Forms

Enhanced Care Management Provider Referral Form

For referrals to Enhanced Care Management services, provider or staff should complete this referral form.



Referring Provider and Practice Name *

Referring Provider's Phone Number *

(000) 000-0000

Please enter a valid phone number.

Referring Provider's Fax Number *

(000) 000-0000

Please enter a valid fax number.

Referring Provider Email Address *

example@example.com

Member's Name *

Community Supports: Housing Provider Referral Form

For referrals to Community Supports services, provider or staff should complete this referral form.

Referring Provider and Practice Name *

Referring Provider's Phone Number *

(000) 000-0000

Please enter a valid phone number.

Referring Provider's Fax Number *

(000) 000-0000

Please enter a valid fax number.

Referring Provider Email Address *

example@example.com

Member's Name *

First Name

Last Name

These forms are available on the Alliance Provider website:

- Enhanced Care Management Form
- Community Supports Housing Form
- Community Supports EAA Form
- Community Supports Meals Form

Member forms are available on the Alliance website

Enhanced Care Management Provider Referral Form

Community Supports Provider Referral Form

TAR Samples

CONFIDENTIAL PATIENT INFORMATION
FOR F.I. USE ONLY
CCN
TREATMENT AUTHORIZATION REQUEST
STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

DIAGNOSIS DESCRIPTION:
ECM Services

MEDICAL JUSTIFICATION:
Population of Focus:
Medical and Behavioral health history:
Lead ECM CM:
Indicate if Care Plan, ROI has been started- will need to be submitted

LINE NO.	AUTHORIZED YES	AUTHORIZED NO	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC / UPC OR PROCEDURE CODE	QUANTITY	CHARGES
1				ECM Services		ECM02	6	
2								
3								
4								

CONFIDENTIAL PATIENT INFORMATION
FOR F.I. USE ONLY
CCN
TREATMENT AUTHORIZATION REQUEST
STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

PROVIDER NAME AND ADDRESS
• CS Provider info

DIAGNOSIS DESCRIPTION:
Housing Services

MEDICAL JUSTIFICATION:
Requesting consent for CS services
Indicate which CS service is being requested
Description of any attached documentation

LINE NO.	AUTHORIZED YES	AUTHORIZED NO	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC / UPC OR PROCEDURE CODE	QUANTITY	CHARGES
1				Housing Transition/Navigation	mos	CS02	6	
2				Housing Tenancy/Sustaining	mos	CS01	6	
3				Housing Deposits	mos	CS03	6	
4								

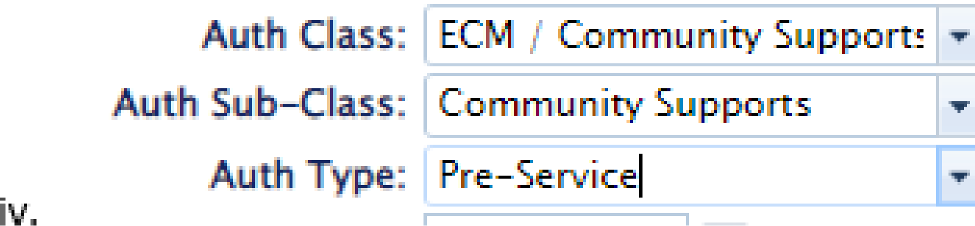
Portal Example

c. Submit an authorization through the ***provider portal***

i. Auth Class: *ECM/Community Supports*

ii. Auth Sub-Class: *Enhanced Care Management* or *Community Supports*

iii. Below is a sample for Community Supports

iv. 

v. Codes to use on Auths

- ECM Outreach: *ECM01 ECM Outreach*
- ECM Enrolled: *ECM02 ECM Enrolled in Services*
- Transition/Navigation: *CS02 Housing Transition/Navigation Services per Month*
- Tenancy/Sustaining: CS01 *Housing Tenancy/Sustaining Services per Month*
- Housing Deposits: CS03 *Housing Deposits*

Chief Complaint: List POF

Initiating Services

Providers should render services when:

An authorization is approved by the Alliance and faxed to the Provider- *(faxed authorization is initial step, member demographic information will come following business day in SFTP folder)*

Provider has confirmed Member is eligible for the date of service

Initiating Services

- **ECM01**
  - Outreach should occur as soon as possible, but no later than 5 business days after receiving member demographic information
  - If receiving a monthly eligibility list, all members on list should be contacted before the beginning of the following month
- **ECM02**
  - Outreach should occur as soon as possible, but no later than 5 business days after receiving member demographic information
- **Community Supports**
  - Outreach should occur within 48 hours of receiving member demographic information

Authorization Information

Auth Type	Units Approved in Essette	Dates for Approval
ECM 01 (Outreach)	1	30 days
ECM02 (Enrolled in Services)	6	6 months
CS01 (Tenancy/Sustaining)	6	6 months
CS02 (Transition/Navigation)	6	6 months
CS03 (Housing Deposits)	1	6 months
CS04 (Recuperative Care)	30	30 days
CS05 (STPHH)	60	60 days
CS06 (EAA)	6	6 months
S51740 (Meals)	168	12 weeks
S94703 (Nutritional Counseling)	3	12 weeks
H0014 (Sobering Center)	1	1 day

Authorization Information

- ECM01 (outreach)
  - Approved once every 6 months for members
  - ECM team will determine date of last outreach
  - If member has had outreach within 6 months, member will be approved for ECM02 only
- For authorizations that receive capitated payments:
  - Any auth requested after the 25th will be approved for the 1st of the following month
    - Ex: Auth request received 4/26, approval will be for 5/1
  - If provider submits a request in May for services rendered in April, they will not receive payment as the services are a per member per month, requests for auth approval should be received within the month services are rendered

Provider Change Request (PCR)

1. If a member needs to exit the program before the authorization period has been completed a PCR form needs to be completed or a change request initiated via the portal (this is needed for all services except ECM01)
   i. The request should include:
      - **A stop date**
        - Keep in mind if these are capitation payments, the stop date will always be the end of the month. For example: if a PCR is submitted 7/8, the stop date will be 7/31, because you are receiving a per member per month payment. And will be paid for the month of July, so the stop date will reflect the end of the month. However, if it is fee service, the stop date will be honored.
      - **Reason for the disenrollment**
        - The reasons should be as follows:
          - ❖ The member is ready to transition to a lower level of care;
          - ❖ The member is not actively participating and making progress on agreed upon interventions to achieve care plan goals;
          - ❖ The member or support person has threatened the ECM/CS case manager or staff with violence or has exhibited threatening behavior;
          - ❖ The member or support person exhibits inappropriate behavior toward the ECM/CS lead care manager or staff;
          - ❖ The member repeatedly cancels follow-up visits or fails to keep scheduled appointments with ECM/CS staff;
          - ❖ The member relocates outside of service area;
          - ❖ The member no longer wishes to receive ECM/CS or is unresponsive or unwilling to engage; and/or
          - ❖ The Provider has not been able to connect with the member after multiple attempts.

2. Submit request to listecmteam@ccah-alliance.org

3. **If unsuccessful contact should submit a PCR within a month**

Link to form: https://thealliance.health/for-providers/provider-change-request-pcr-form/

Provider Change Request (PCR) Portal

1. The process can be initiated through the portal as well
   i. You will go into the portal
   ii. Click the left triangle under the appropriate auth
   iii. Under Action
   iv. Select Change Request
   v. Under Details section include
      - Stop Date
      - Reason for change: Use one of the disenrollment reasons in previous slide

Portal Attachments

- When attaching a doc to approved auth, please indicate in note section what has been attached.
  - Brief Description
    - PCR attached
    - Care plan attached
    - Estimate completed

Care Coordination

Provider Reporting Requirements (DHCS)

- Number of encounters
- Dates of outreach attempts and methods
- SDOH data

Provision of Service (CCAH)

- **ECM**
  - Care Plan: Align with 7 core service components
  - ECM Care Plan overview available for reference
  - Elements required for care plan built into care coordination platform as assessments
- **Community Supports**
  - Housing Support Plan meeting all elements within Housing service
    - Available for reference
    - Elements required for support plan built into care coordination platform as assessments
  - Other CS services documentation expectations shared with providers
    - Sample assessments available for STPHH, RCP, and Sobering Center

Care Coordination Platforms:

- **Activate Care**
- **Unite Us (SC/Merced)**

Closed Loop Referrals

Allows for ECM/CS providers to refer to contracted and non-contracted providers for clinical/non-clinical social needs

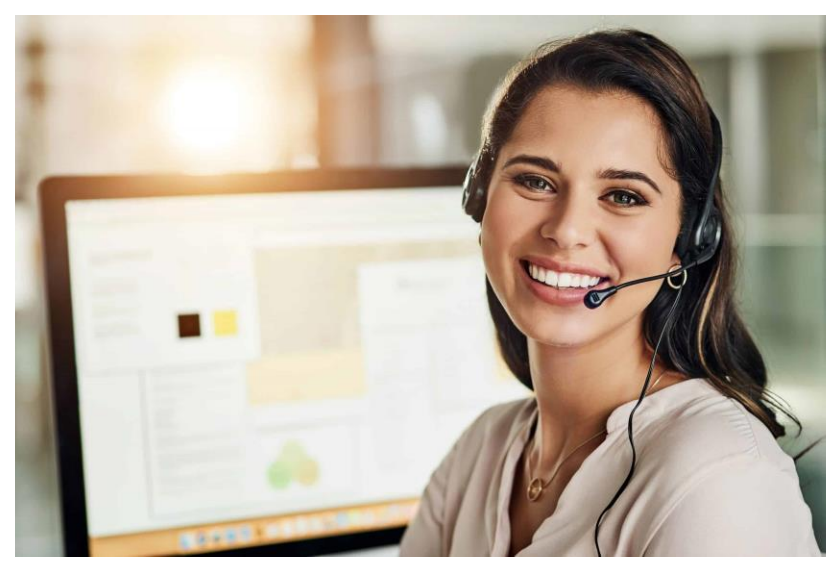
Unite Us (Santa Cruz/Merced)

- **ECM providers**
  - Send referrals to providers to assist with addressing member's non-clinical social needs
  - Need to submit referral request to CCAH- *if sending to a contracted CS provider*
  - Optional to receive outside referrals from entities within the platform (strongly encouraged)
- **CS providers**
  - Receiving referrals through Unite Us
  - Can also send referrals to other community providers
  - Need to submit referral request to CCAH- *if received from non-contracted provider*
  - Optional to receive outside referrals from entities within the platform (strongly encouraged)

Smart Referral Network (Monterey)

- **ECM./CS providers send and receive**
  - Network is open to all community providers within the network
  - Providers can accept or reject referral from community providers
    - If accepted, complete info within network platform and referral will be sent directly to CCAH to process

Who to Contact – Authorization & Referral Inquiries



ECM-CS SUPPORT CONTACT LIST			
ECM	General	831-430-5512	listecmteam@ccah-alliance.org

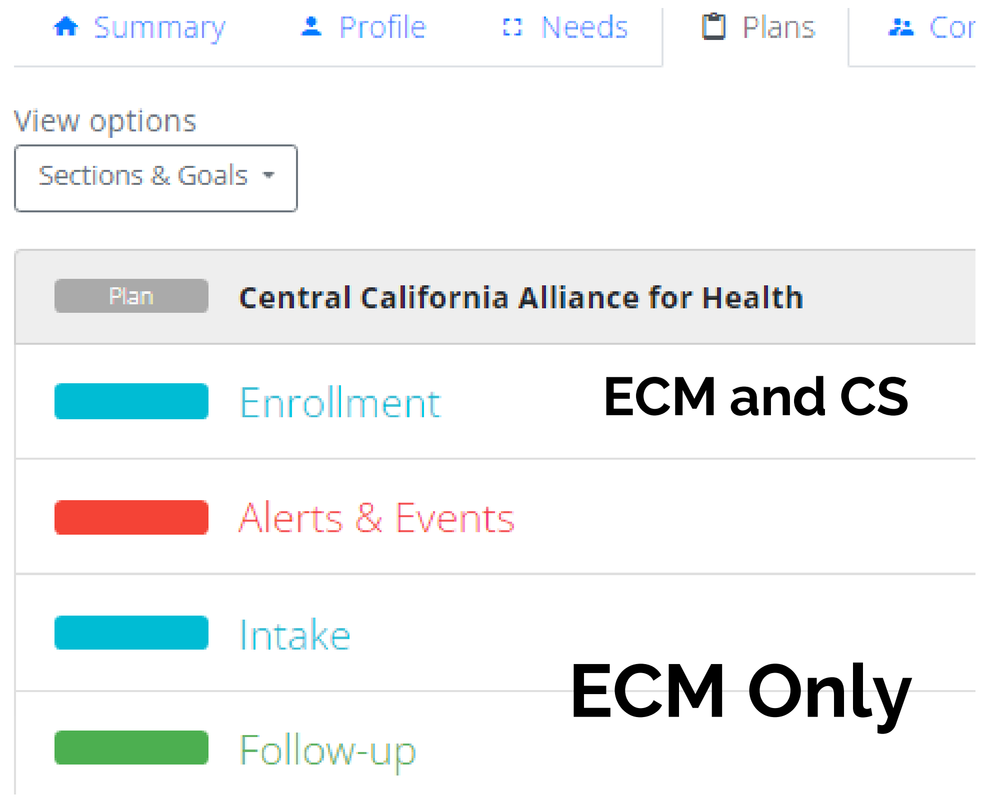
Documentation Expectations- ECM

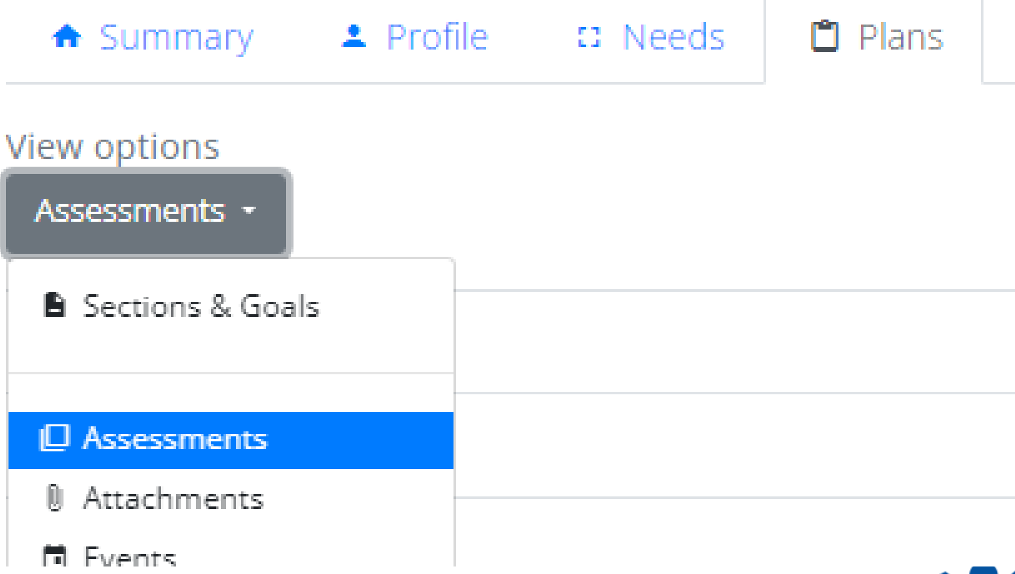
1. For each member enrolled in ECM02- ECM Enrolled in Services
2. If you are using Activate Care these plans are built into the system
    i. Under Plans tab
        - Intake
        - Follow Up
3. If you are using Unite Us these plans are built into the system
    i. Under Face Sheet
        - Forms
4. If you are not using the system each of the components listed in the support plans should be included in your documentation
5. These plans should be updated regularly to reflect any changes based on interactions with members
6. There is a disenrollment plan to be used when member is disenrolling from services

Documentation Expectations- CS Housing

1. For each member enrolled in Housing Transition Navigation and Housing Tenancy and Sustaining there should be a housing plan (CS) created
2. If you are using Activate Care these plans are built into the system
    i. Under Plans tab
        – Assessment
            » Add Assessment
                - Community Supports Transition/Navigation Intake Assessment
                - Community Supports Transition/Navigation Follow Up Assessment
                - Community Supports Tenancy/Sustaining Intake Assessment
                - Community Supports Tenancy/Sustaining Follow Up Assessment
3. If you are using Unite Us these plans are built into the system
    i. Under Face Sheet
        – Forms
4. If you are not using the system each of the components listed in the support plans should be included in your documentation
5. These plans should be updated regularly to reflect any changes based on interactions with members
6. There is a disenrollment plan to be used when member is disenrolling from services

Activate Care





Activate Care

Summary | Profile | Needs | Plans | Contacts | Outreach

View options

Assessments

Name	Status

+ Add an assessment

Select an assessment...

- Community Supports Transition/Navigation Intake Assessment
- Community Supports Tenancy/Sustaining Follow Up Assessment
- Patient Health Questionnaire (PHQ-2)
- AUDIT-C
- PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
- PROMIS-10: Patient-Reported Outcomes Measurement Information System
- Disenrollment Assessment
- Community Supports Transition/Navigation Follow Up Assessment
- PC-PTSD

ECM Care Plan

For ECM Assessments/Care Plans should contain the following information: **(Documented under Plan tab)**

1. Member's preferred method of contact/communication:
2. Member contact information:
3. Next care plan assessment to be completed by date:
4. Member has been informed on the process for changing ECM Providers, which is permitted at any time yes/no
5. Member has authorized for the sharing of Personally Identifiable Information between ECM, ILOS, Alliance, and other providers involved in the member's care to the extent required by federal law; include date of authorization
6. Authorized support person(s) to receive updates to member's care:
    a. Name(s)/Relationship:
    b. Contact information
7. Other providers/contact information who deliver services to meet member's physical, behavioral, developmental, oral health, long-term services and supports (LTSS), and other services that address social determinants of health (SDOH) needs
8. What was identified by the provider in the comprehensive assessment:
    a. Pertinent Medical diagnosis:
    b. Behavioral health:
    c. Developmental:
    d. oral health:
    e. Long-term services and supports (LTSS):
    f. Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services:
    g. Community Support (CS) services
    h. Other services that address social determinants of health (SDOH) needs

(Questions 9-15, are based on member responses):

9. Members Reported Needs/Support
10. Member Strengths
11. Goals of Care/Member Preferences
12. Clinical Support needed
13. Non-Clinical Support/Resources
14. Frequency of Contact/re-assessment- Include Alternate methods of contact if not available in person
15. Cultural/Linguistic Considerations:

Transition/Navigation Housing Plan

<table>
<tr><td colspan="2">Housing Support Plan</td><td colspan="4">Member Name:
DOB:
Member ID:
Member preferred contact information:
CS Provider:</td></tr>
<tr><td>ROI</td><td colspan="4">Member has authorized for the sharing of Personally Identifiable Information between ECM, ILOS, Alliance, and other providers involved in the member's care to the extent required by federal law:
Yes / No</td><td>ROI Date of Authorization:</td></tr>
<tr><td rowspan="3">To Be Completed at Initial Interview</td><td>Strengths:</td><td>Area of Need (Describe):</td><td>Cultural and Linguistic Considerations (Describe):</td><td colspan="2">Documents needed:
(Social Security card, birth certificate, prior rental history)</td></tr>
<tr><td>Voucher-In-Hand w/Expiration Date:</td><td>Transportation needs identified:</td><td>Tenant screening and housing assessment complete?</td><td colspan="2">Housing Preferences / Barriers:</td></tr>
<tr><td>Any Housing Applications Completed within the past three (3) months:</td><td colspan="4">Other Notes:</td></tr>
</table>

Transition/Navigation Housing Plan

<table>
<tr><td rowspan="2">To Be Updated Throughout Housing Navigation Activities</td><td>Voucher or Housing Subsidies Obtained during Housing Navigation:</td><td>One-Time Move-In Costs Identified:
(i.e., security deposit, moving costs, adaptive aids, environmental modifications, and other one-time expenses)</td><td>Landlord Advocacy / Education:
(i.e., Reasonable Accommodations, Cultural Considerations, ADA Compliance, etc.)</td><td>Unit Assessed for Safe Move-In / Housing Authority Inspection:</td></tr>
<tr><td>Additional Move-In Considerations for Successful Tenancy:</td><td>Community Resources to Help Maintain Housing:</td><td colspan="2">Other areas of need identified (describe):</td></tr>
<tr><td rowspan="7">Ongoing Goal and Action Management</td><td>Goals Identified for Successful Navigation / Tenancy</td><td>Action Steps</td><td>Date Action Initiated</td><td>Date Achieved</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
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</table>

Tenancy/Sustaining Housing Plan

<table>
<tr><td colspan="2">Housing Support Plan
Housing Tenancy and Sustainability</td><td colspan="3">Member Name:
DOB:
Member ID:
Member preferred contact information:
CS Provider: Front St</td></tr>
<tr><td>ROI</td><td colspan="3">Member has authorized for the sharing of Personally Identifiable Information between ECM, ILOS, Alliance, and other providers involved in the member's care to the extent required by federal law:
Yes / No</td><td>ROI Date of Authorization:</td></tr>
<tr><td rowspan="2">To Be Completed at Initial Interview
(can be carried over from Housing Navigation Plan if available and up-to-date)</td><td>Strengths:</td><td>Area of Need:</td><td>Cultural and Linguistic Considerations:</td><td>Voucher In Use:</td></tr>
<tr><td>Transportation needs identified:</td><td>Barriers related to tenancy:
(e.g., late rental payments, hoarding, substance use, other lease violations)</td><td>Documents needed:
(Social Security card, birth certificate, prior rental history)</td><td>Other Notes:</td></tr>
<tr><td>Tenant Education / Coaching</td><td>Education and training on the roles, rights, and responsibilities of the tenant and landlord complete?
Date of Completion:</td><td>Coaching opportunities to develop and maintain relationships with landlords with a goal of fostering successful tenancy:</td><td>Provision of independent living and life skills, assistance with and training on budgeting, and connection to community resources:</td><td>Additional education or training recommended:</td></tr>
</table>

Tenancy/Sustaining Housing Plan

<table>
<tr>
<td>Landlord Education / Coaching</td>
<td colspan="2">Landlord Advocacy / Education:
(i.e., Reasonable Accommodations, Cultural Considerations, ADA Compliance, etc.)</td>
<td colspan="2">Coordination with the landlord and case management to address identified issues that could impact housing stability:</td>
<td colspan="2">Describe any assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan:</td>
</tr>
<tr>
<td rowspan="2">To Be Updated Throughout Housing Sustainability Activities</td>
<td>One-Time Additional Costs Identified:
(i.e., moving costs, adaptive aids, environmental modifications, and other one-time expenses)</td>
<td colspan="2">Identified funding for situations in which the Member owes back rent or payment for damage to the unit:</td>
<td colspan="2">Health and safety visits:
(including unit assessment to determine habitability and safety for member. Date of visit/frequency of visit)</td>
<td>Assistance with the annual housing recertification process:</td>
</tr>
<tr>
<td>Continuing assistance with lease compliance, including ongoing support with activities related to household management:</td>
<td colspan="2">Community Resources to Help Maintain Housing:</td>
<td colspan="2">Coordination needed with community resources to prevent eviction:</td>
<td>Other areas of need identified:</td>
</tr>
</table>

Tenancy/Sustaining Housing Plan

	Goals Identified for Successful Tenancy	Action Steps	Date Action Initiated	Date Achieved
Ongoing Goal and Action Management				

Outreach Documentation for ECM and CS Housing Services

- **Every** touchpoint should be documented as an outreach
  - Successful phone calls
  - Unsuccessful phone calls
  - Phone calls on behalf of member
  - Going to appt with member
  - Meeting with member in person
  - Meeting with provider on behalf of member
- Outreaches are in 15 min increments
- Outreach can be documented in Activate Care, Unite Us, or in EMR system
  - If using Activate Care, request reports from CCAH (can customize reports as needed)
- Will use these for invoicing purposes

Documentation for other CS services

- Housing Deposits
  - Should be listed on Housing Support Plan
  - Itemized List
  - Lease Agreement
  - Number of beds/baths
  - Total amount spent
- EAA
  - Submit completion to auth
  - PCR for end date
- Sobering Center
  - Use provided word doc
  - Submit with auth
- Meals
- Recuperative Care/STPHH
  - Use provided excel documentation sheet
  - Submit monthly

Continued services

- Submit supporting documentation to request continuation of services
  - ECM Care Plan
  - Housing Support Plan
  - RCP/STPHH documentation
- After services expire/when requesting re-authorization
- Should be clear indication of why services need to be continued

Payment Structure - ECM

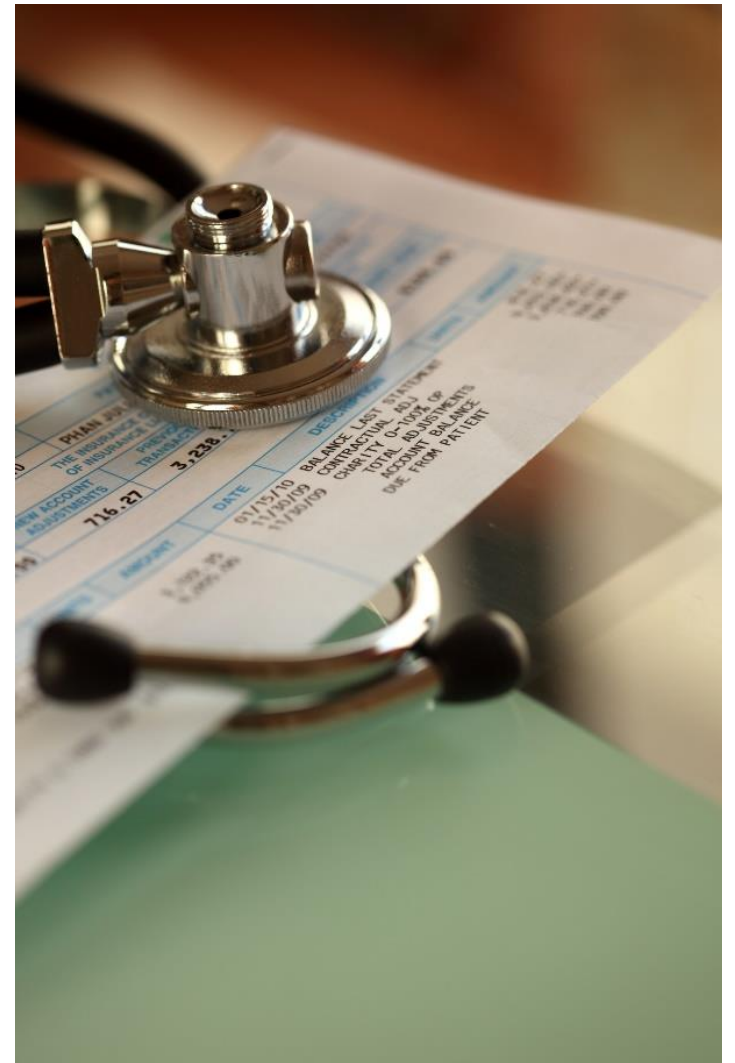
Capitation Payments	Fee For Service Payments
Providers receive capitation payments • Per member per month • These are lump sum payments based on the number of members enrolled in ECM02 services	Claims are paid based on the invoice submitted **ECM Outreach** • One lump payment for each member outreach was successfully conducted
Providers will receive a member list separately • This report contains the pertinent information of the members enrolled	
Providers submit invoices and claims are processed as a zero paid claim • You will get paid the same amount regardless of what is listed on the invoice • The invoice is to justify the payments • The Alliance uses this to confirm services are being provided as they are being paid	
We expect to receive a consistent number of claims based on the number of enrolled members • 100 linked members in the month would result in at least one service per member listed on the invoice for a total of 100 lines (claims) billed • These should indicate the encounters and services provided • Reports are run to validate claims vs. assigned members and shared with providers	
Submit invoices monthly at a minimum • Providers may submit weekly	

Payment Structure– Community Supports

Capitation Payments	Fee For Service Payments
Providers receive capitation payments • Per member per month • These are lump sum payments based on the number of members enrolled in CS01 (Tenancy and Sustaining Services) and CS02 (Transition and Navigation)	**Housing Deposits** • Cost-based reimbursement • One lump payment for each member based on itemized list • Max of 5k
These payments are sent out with a detailed report • This report contains the pertinent information of the members enrolled	**Medically Tailored Meals** • Based on number of meals delivered
Providers submit invoices and claims are processed as a zero paid claim • You will get paid the same amount regardless of what is listed on the invoice • The invoice is to justify the payments • The Alliance uses this to confirm services are being provided as they are being paid	**Sobering Center** • Per Diem **Recuperative Care** • Per Diem
We anticipate receiving a consistent number of invoices as it relates to the number of enrolled members • 100 linked members in the month would result in at least one service per member listed on the invoice for a total of 100 lines (claims) billed • These should indicate the encounters and services provided	**Short-Term Post Hospitalization Housing (STPHH)** • Per Diem
Submit invoices monthly at a minimum • Providers may submit weekly	**EAA** • Cost-based reimbursement • Max of 7.5k

Claims Department

- The Claims department is where claims come to be adjudicated
- Invoices are loaded into our claims processing system and are turned into claims
- Claims will hit a Remittance Advice document that is sent to the provider in approximately 30 days. This will include any FFS payments and Capitated services.



Claims Department – Alliance Website

Resources

- COVID-19
- Claims
  - View/Submit a Claim
- Forms
- News
- Provider Directory
- Provider Manual
- Timely Access to Care
- Training

Claims

The Alliance Claims Department is committed to processing your claims as quickly and accurately as possible.

We work with DHCS (Medi-Cal and Electronic Data Systems) to maintain the most current Medi-Cal benefits and allowances.

For the most current billing guidelines and updates, please reference the Claims section of the Provider Manual.

EXPAND ALL

- Claim Questions
- Electronic Data Interchange
- Remittance Advice Information
- Supplemental Payments
- ICD-10 Information and Resources

Contact Provider Services

General	831-430-5504
Claims Billing questions, claims status, general claims information	831-430-5503
Authorizations General authorization information or questions	831-430-5506
Authorization Status Checking the status of submitted authorizations	831-430-5511
Pharmacy Authorizations, general pharmacy information or questions	831-430-5507

Provider Resources

- Provider Portal

Claims Resources

- Self-Serve Password Reset for RTEDI

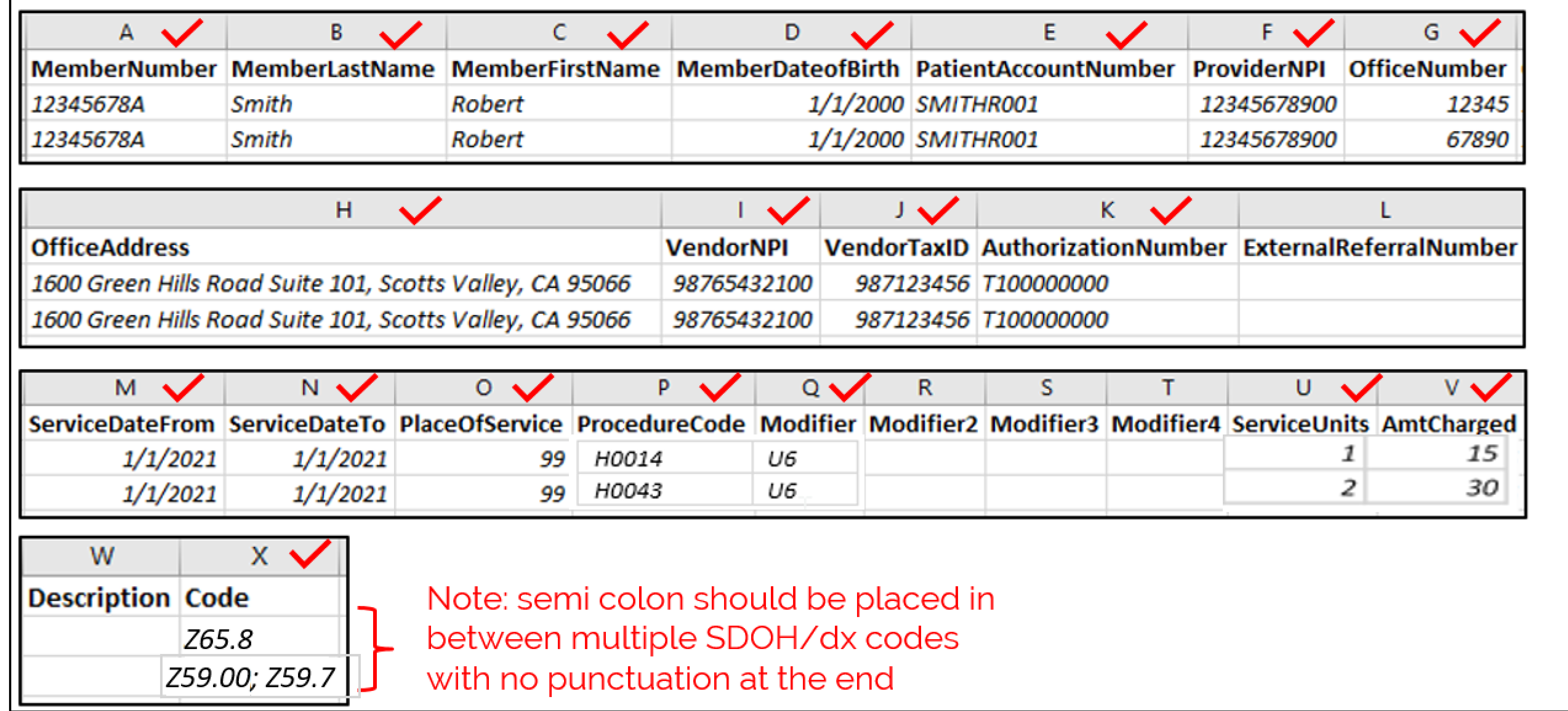
Latest Provider News

Provider e-Newsletter

Provider Newsletter | Issue 28
February 24, 2022

https://thealliance.health/for-providers/resources/claims/

Invoice Billing



	A	B	C	D	E	F	G
	MemberNumber	MemberLastName	MemberFirstName	MemberDateofBirth	PatientAccountNumber	ProviderNPI	OfficeNumber
	12345678A	Smith	Robert	1/1/2000	SMITHR001	12345678900	12345
	12345678A	Smith	Robert	1/1/2000	SMITHR001	12345678900	67890

H	I	J	K	L
OfficeAddress	VendorNPI	VendorTaxID	AuthorizationNumber	ExternalReferralNumber
1600 Green Hills Road Suite 101, Scotts Valley, CA 95066	98765432100	987123456	T100000000	
1600 Green Hills Road Suite 101, Scotts Valley, CA 95066	98765432100	987123456	T100000000	

M	N	O	P	Q	R	S	T	U	V
ServiceDateFrom	ServiceDateTo	PlaceOfService	ProcedureCode	Modifier	Modifier2	Modifier3	Modifier4	ServiceUnits	AmtCharged
1/1/2021	1/1/2021	99	H0014	U6				1	15
1/1/2021	1/1/2021	99	H0043	U6				2	30

W	X
Description	Code
	Z65.8
	Z59.00; Z59.7

Note: semi colon should be placed in between multiple SDOH/dx codes with no punctuation at the end

- The invoice template is an excel spread sheet
- Worksheet should remain named “Invoice Sample”
- If any of the required fields are left blank the entire file will be rejected
- 999 Acknowledgment will not be submitted back to the provider, provider will receive remittance advice

When submitting your invoice file, please **submit via the <u>SFTP</u>** in the “IN” folder

- **Name the file is as follows**: Mysftpname_YYYYMODD_service.
- **<u>Do not make any edits to the invoice template’s column names or the name of the sheet</u>**

Invoice Spread Sheet Required Fields

Column	Column Title	Use	Notes
A	Member Number	Required	Member's Medi-Cal I.D. number
B	Member Last Name	Required	
C	Member First Name	Required	
D	Member Date of Birth	Required	
E	Patient Account Number	Required	Provider's unique patient account or medical record number
F	Provider NPI	Required	
G	Office Number	Required	Alliance will provide the internal office number for location of services
H	Office Address	Required	
I	Vendor NPI	Required	
J	Vendor Tax ID	Required	
K	Authorization Number	Required	Alliance Authorization Number
L	External Referral Number	Situational	Alliance Referral Number
M	Service Date From	Required	
N	Service Date To	Required	
O	Place Of Service	Required	Where the service has taken place
P	Procedure Code	Required	The code that correlates to the service provided
Q	Modifier	Required	Primary
R	Modifier2	Situational	Secondary or additional
S	Modifier3	Situational	Additional
T	Modifier4	Situational	Additional
U	Service Units	Required	The quantity of units provided
V	Amt Charged	Required	Service billed amount
W	Description	Situational	Alliance will provide specific instructions if applicable
X	Code	Required	ICD10 Code(s) separated by a semicolon with nothing at the end

Billing Codes and Modifiers - ECM

Column P on the invoice spreadsheet

P	Q	R
ProcedureCode	Modifier	Modifier2
G9008	U1	
G9008	U8	

HCPCS BILLING CODE	DESCRIPTION	PRIMARY MODIFIER	PRIMARY MODIFIER DESCRIPTION	SECONDARY MODIFIER	SECONDARY MODIFIER DESCRIPTION	PAYMENT MODEL
G9008	ECM ENROLLED SERVICES PER MONTH	U1	ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	GQ	TELEHEALTH	Capitation
G9008	ECM OUTREACH ONLY	U8	ECM Outreach In Person: Provided by Clinical Staff. Other specified case management service not elsewhere classified.	GQ	TELEHEALTH	One time payment
G9012	ECM ENROLLED SERVICES PER MONTH	U2	ECM In-Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	GQ	TELEHEALTH	Capitation
G9012	ECM OUTREACH ONLY	U8	ECM Outreach In Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	GQ	TELEHEALTH	One time payment

Authorization Crosswalk - ECM

HCPCS BILLING CODE	MODIFIER	DESCRIPTION	AUTH CODE CROSSWALK
G9008	U8	ECM OUTREACH ONLY	ECM01
G9012	U8	ECM OUTREACH ONLY	ECM01
G9008	U1	ECM ENROLLED SERVICES PER MONTH	ECM02
G9012	U2	ECM ENROLLED SERVICES PER MONTH	ECM02

Billing Codes and Modifiers – Community Supports

Column P on the invoice spreadsheet

HCPCS BILLING CODE	DESCRIPTION	PRIMARY MODIFIER	PRIMARY MODIFIER DESCRIPTION	SECONDARY MODIFIER	SECONDARY MODIFIER DESCRIPTION	PAYMENT MODEL
H0014	ALCOHOL AND DRUG SERVICES AMBULATORY DETOXIFICATION	U6	Used by Managed Care with HCPCS code H0014 to indicate Community Supports Sobering Centers	N/A	N/A	Per Diem
H0043	HOUSING TRANSITION/SUPPORTED HOUSING	U6	Used by Managed Care with HCPCS code H0043 to indicate Community Supports Housing Transition/Navigation Services	GQ	TELEHEALTH	Capitation
H0043	SHORT TERM POST-HOPITALIZATION	U3	Used by Managed Care with HCPCS code H0043 to differentiate Short-Term Post Hospitalization Housing from Housing Transition/ Navigation Services.	N/A	N/A	Per Diem
H0044	HOUSING DEPOSITS	U2	Modifier used to differentiate housing deposits from Short-Term Post-Hospitalization (Used by Managed Care with HCPCS code H0044 to indicate Community Supports Housing Deposit)	GQ	TELEHEALTH	One time payment
H2016	HOUSING TRANSITION/COMPREHENSIVE COMMUNITY SUPPORT SERVICES	U6	Used by Managed Care with HCPCS code H2016 to indicate Transition/Comprehensive Community Supports Housing Transition/Navigation Services	GQ	TELEHEALTH	Capitation
T2033	RECUPERATIVE CARE	U6	Used by Managed care with HCPCS code T2033 to indicate Recuperative care services.	N/A	N/A	Per Diem
T2040	HOUSING TENANCY/FINANCIAL MANAGEMENT	U6	Modifier used by Managed Care with HCPCS code T2040 to indicate Community Supports Housing Tenancy and Sustaining Services	GQ	TELEHEALTH	Capitation
T2041	HOUSING TENANCY/SUPPORT BROKERAGE	U6	Modifier used by Managed Care with HCPCS code T2041 to indicate Community Supports Housing Tenancy and Sustaining Services	GQ	TELEHEALTH	Capitation
S5165	ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS	U6	Modifier used by Managed Care with HCPCS code S5165 to indicate Community Supports Environmental Accessibility Adaptations	N/A	N/A	Fee for service

Note: Billing must be in whole units

Authorization Crosswalk – Community Supports

HCPCS BILLING CODE	MODIFIER	DESCRIPTION	AUTH CODE CROSSWALK
T2033	U6	RECUPERATIVE CARE	CS04
T2040	U6	HOUSING TENANCY AND SUSTAINING SERVICES PER MONTH	CS01
T2041	U6	HOUSING TENANCY AND SUSTAINING SERVICES PER MONTH	CS01
H0043	U6	HOUSING TRANSITION/NAVIGATION SERVICES PER MONTH	CS02
H0043	U3	SHORT TERM POST-HOSPITALIZATION	CS05
H2016	U6	HOUSING TRANSITION/NAVIGATION SERVICES PER MONTH	CS02
H0044	U2	HOUSING DEPOSITS	CS03
H0014	U6	ALCOHOL AND DRUG SERVICES AMBULATORY DETOXIFICATION	H0014
S5165	U6	ENVIRONMENTAL ACCESSIBILITY ADAPTIONS	CS06

Examples of HCPCS Codes Crosswalk to Housing Activities

Transition and Navigation
H2016- Comprehensive Community Support Services
H0043- Supported Housing

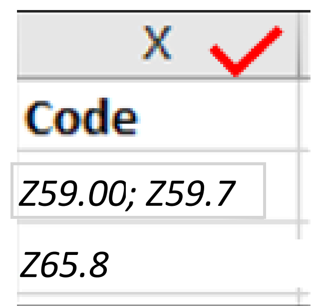
- Searching for housing and presenting options.
  - **H2016- comprehensive community support services**
- Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
  - **H0043- supported housing**

Tenancy and Sustaining
T2040- Financial Management
T2041- Support Brokerage

- Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
  - **T2041- support brokerage**
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the Member owes back rent or payment for damage to the unit.
  - **T2040- financial management**

SDOH Diagnosis Coding

	SDOH DIAGNOSIS CODES
Code	Description
Z55.0	Illiteracy And Low-Level Literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate Housing
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
Z59.811	Housing instability, housed, with rise of homelessness
Z59.812	Housing instability, housed, with rise of homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems Related To Living Alone
Z60.4	Social Exclusion And Rejection
Z62.819	Personal History Of Unspecified Abuse In Childhood
Z63.0	Problems In Relationship With Spouse Or Partner
Z63.4	Disappearance And Death Of Family Member
Z63.5	Disruption Of Family By Separation And Divorce
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



- Column X
- Required
- Separate by semi colon
- Updated list

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf

Place of Service Codes

POS CODE	PLACE OF SERVICE DESCRIPTION	POS CODE	PLACE OF SERVICE DESCRIPTION
01	Pharmacy	33	Custodial Care Facility
02	Telehealth Provided Other than in Patient's Home	34	Hospice
03	School	35 - 40	Unassigned
04	Homeless Shelter	41	Ambulance - Land
05	Indian Health Service Free - standing Facility	42	Ambulance - Air or Water
06	Indian Health Service Provider - based Facility	43 - 48	Unassigned
07	Tribal 638 Free - standing Facility	49	Independent Clinic
08	Tribal 638 Provider - based Facility	50	Federally Qualified Health Center
09	Prison/Correctional Facility	51	Inpatient Psychiatric Facility
10	Telehealth Provided in Patient's Home	52	Psychiatric Facility - Partial Hospitalization
11	Office	53	Community Mental Health Center
12	Home	54	Intermediate Care Facility/Individuals with Intellectual Disabilities
13	Assisted Living Facility	55	Residential Substance Abuse Treatment Facility
14	Group Home	56	Psychiatric Residential Treatment Center
15	Mobile Unit	57	Non - residential Substance Abuse Treatment Facility
16	Temporary Lodging	58	Non - residential Opioid Treatment Facility
17	Walk-in Retail Health Clinic	59	Unassigned
18	Place of Employment - Worksite	60	Mass Immunization Center
19	Off Campus - Outpatient Hospital	61	Comprehensive Inpatient Rehabilitation Facility
20	Urgent Care Facility	62	Comprehensive Outpatient Rehabilitation Facility
21	Inpatient Hospital	63 - 64	Unassigned
22	On Campus - Outpatient Hospital	65	End - Stage Renal Disease Treatment Facility
23	Emergency Room - Hospital	66 - 70	Unassigned
24	Ambulatory Surgical Center	71	Public Health Clinic
25	Birthing Center	72	Rural Health Clinic
26	Military Treatment Facility	73 - 80	Unassigned
27 - 30	Unassigned	81	Independent Laboratory
31	Skilled Nursing Facility	81 - 98	Unassigned
32	Nursing Facility	99	Other Place of Service

CMS 1500 Claim Form

cms comp
1

CMS-1500 Completion

Page updated: August 2020

The Health Insurance Claim Form (CMS-1500) is used by Allied Health professionals, physicians, laboratories and pharmacies to bill supplies and services to the Medi-Cal program. Providers are required to purchase *CMS-1500* claim forms from a vendor. Claim forms ordered through vendors must include red "drop-out" ink.

Most claims for these services and supplies may also be submitted through Computer Media Claims (CMC). For CMC ordering and enrollment information, refer to the *CMC* section in the Part 1 manual.

For additional billing information, refer to the *CMS-1500 Special Billing Instructions*, *CMS-1500 Submission and Timeliness Instructions* and the *CMS-1500 Tips for Billing* sections in this manual.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID X (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MEDI-CAL ID NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PATIENT'S LAST NAME, FIRST NAME

3. PATIENT'S BIRTH DATE MM DD YY — SEX: SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): PATIENT'S COMPLETE ADDRESS

6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other

7. INSURED'S ADDRESS (No., Street)

CITY: PATIENT'S CITY — STATE: ST

8. RESERVED FOR NUCC USE

ZIP CODE: PATIENT'S 9-DIGIT ZIP — TELEPHONE (Include Area Code): (PATIENT'S PHONE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO; b. AUTO ACCIDENT? YES NO PLACE (State); c. OTHER ACCIDENT? YES NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH / SEX M F; b. OTHER CLAIM ID (Designated by NUCC); c. INSURANCE PLAN NAME OR PROGRAM NAME; d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)

15. OTHER DATE QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. DIAGNOSIS CODE 1 B. DIAGNOSIS CODE 2 C. DIAGNOSIS CODE 3 D. DIAGNOSIS CODE 4
E. DIAGNOSIS CODE 5 F. DIAGNOSIS CODE 6 G. DIAGNOSIS CODE 7 H. DIAGNOSIS CODE 8
I. DIAGNOSIS CODE 9 J. DIAGNOSIS CODE 10 K. DIAGNOSIS CODE 11 L. DIAGNOSIS CODE 12

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: TAR CONTROL NUMBER

24. A. DATE(S) OF SERVICE From To | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

1 DOS FROM | DOS THRU | POS | PROC CODE | MODIFIERS | SERVICE CHARGES | QUANTITY | NPI | NON-NPI NUMBER / NPI

2–6 NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: PATIENT ACCOUNT NUMBER

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: TOTAL CHARGES

29. AMOUNT PAID

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE OF PROVIDER OR PERSON AUTHORIZED — SIGNED — DATE DATE

32. SERVICE FACILITY LOCATION INFORMATION: NAME AND ADDRESS OF SERVICE FACILITY — a. FACILITY NPI — b. NON-NPI NUMBER

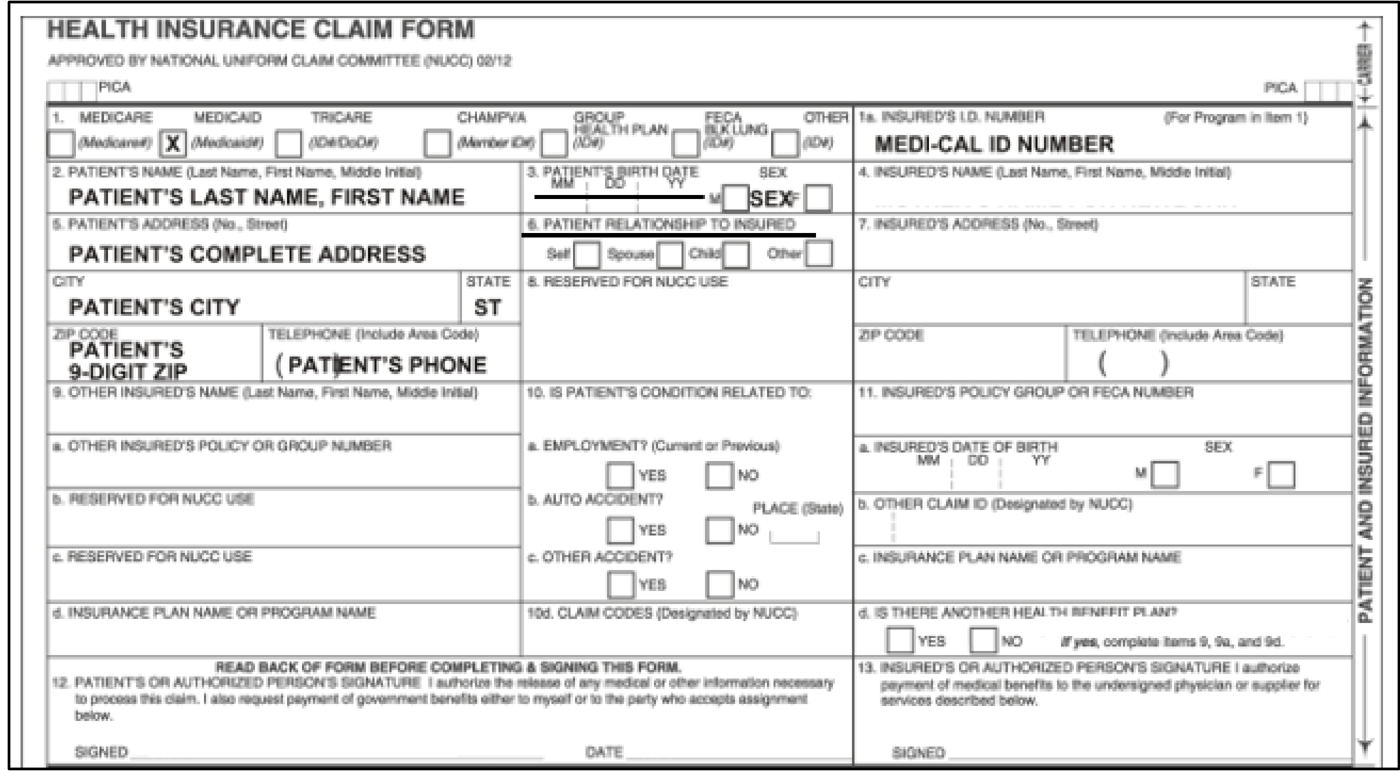
33. BILLING PROVIDER INFO & PH #: (PHONE NUMBER — BILLER ADDRESS — a. BILLER NPI — b. NON-NPI NUMBER

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — CR061653 — APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/cmscomp.pdf

Member Demographics



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

1. MEDICARE (Medicare#) MEDICAID X (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)
MEDI-CAL ID NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
PATIENT'S LAST NAME, FIRST NAME

3. PATIENT'S BIRTH DATE MM DD YY SEX M F
SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
PATIENT'S COMPLETE ADDRESS

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY
PATIENT'S CITY

STATE
ST

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE
PATIENT'S 9-DIGIT ZIP

TELEPHONE (Include Area Code)
(PATIENT'S PHONE

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

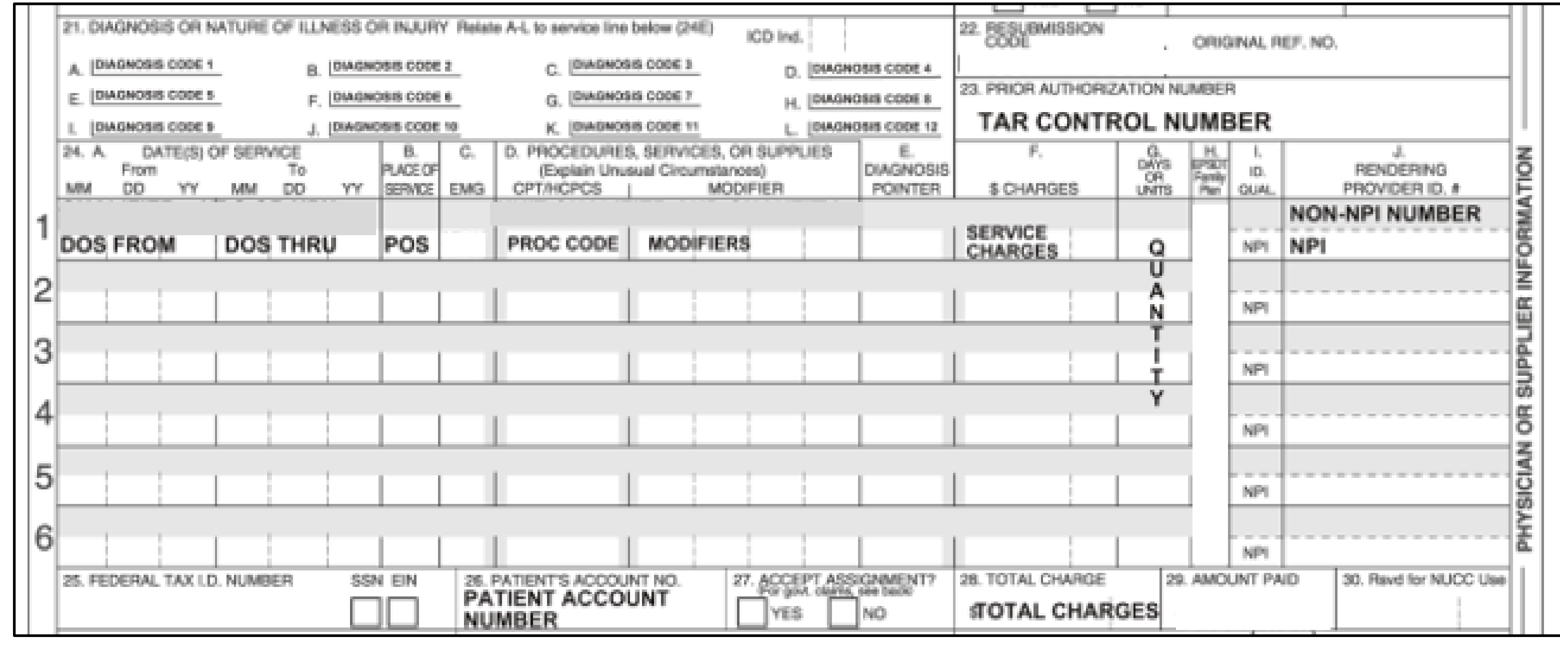
SIGNED

CARRIER

PATIENT AND INSURED INFORMATION

- 1 Medicaid Box
- 1a Member ID
- 2 Member Name
- 3 Member DOB & Gender
- 5 Member Address
- 6 Relationship Box

Services Rendered



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. DIAGNOSIS CODE 1
B. DIAGNOSIS CODE 2
C. DIAGNOSIS CODE 3
D. DIAGNOSIS CODE 4
E. DIAGNOSIS CODE 5
F. DIAGNOSIS CODE 6
G. DIAGNOSIS CODE 7
H. DIAGNOSIS CODE 8
I. DIAGNOSIS CODE 9
J. DIAGNOSIS CODE 10
K. DIAGNOSIS CODE 11
L. DIAGNOSIS CODE 12

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
TAR CONTROL NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1												NON-NPI NUMBER
	DOS FROM	DOS THRU	POS		PROC CODE	MODIFIERS		SERVICE CHARGES	QUANTITY		NPI	NPI
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.
PATIENT ACCOUNT NUMBER

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

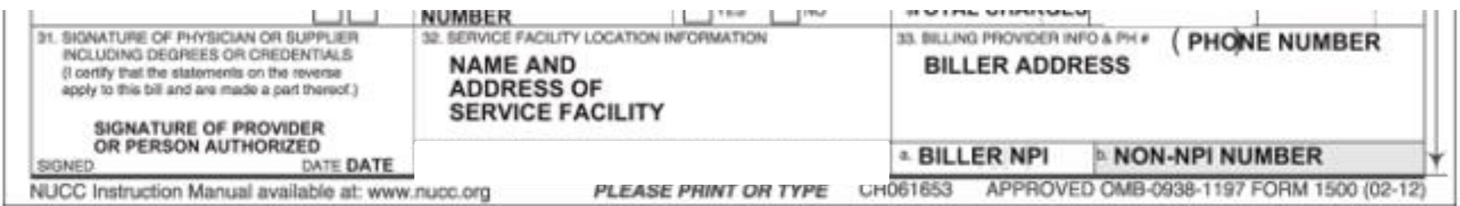
28. TOTAL CHARGE
TOTAL CHARGES

29. AMOUNT PAID

30. Rsvd for NUCC Use

- 21A-L Diagnosis Codes
- 23 Authorization Number
- 24A Dates of Service
- 24B Place of Service
- 24D Procedure Code & Modifiers
- 24F Billed Charges
- 24G Quantities/Units
- 24J Rendering NPI
- 26 Patient Account Number
- 28 Total Billed Charges

Provider Demographics



31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED

SIGNED DATE DATE

32. SERVICE FACILITY LOCATION INFORMATION

NAME AND ADDRESS OF SERVICE FACILITY

33. BILLING PROVIDER INFO & PH # (PHONE NUMBER

BILLER ADDRESS

a. BILLER NPI b. NON-NPI NUMBER

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- 31 Signature Line
- 32 Service Location Address
- 33 Billing Provider Address and Phone
- 33a Billing NPI

Claims Turnaround Time

<table>
<tr><th colspan="7">Meds Claims Turnaround Time Flowchart</th></tr>
<tr><th>Sun</th><th>Mon</th><th>Tue</th><th>Wed</th><th>Thu</th><th>Fri</th><th>Sat</th></tr>
<tr><td></td><td colspan="5">Electronically submitted claims received on any of these days
Hard copy claims received on any of these days</td><td></td></tr>
<tr><td></td><td colspan="5">Will be adjudicated on these days
Will be entered into our system on these days</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td>Payment Sent</td><td></td><td></td></tr>
<tr><td></td><td colspan="5">Will be adjudicated on these days</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td>Payment Sent</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Differences between Alliance Portal vs Change Echo

Change - Echo

- Owned and maintained by the vendor Change - Echo
- The site to view and pull RA's and check information
- Requires a log in given by Change – Echo
- Providerpayments.com

Provider Portal

- Owned and maintained by CCAH
- The site to check member eligibility, auth status and claim status
- Requires a log in given by CCAH
- thealliance.health

Resolving Denials

Contact the Claims Department

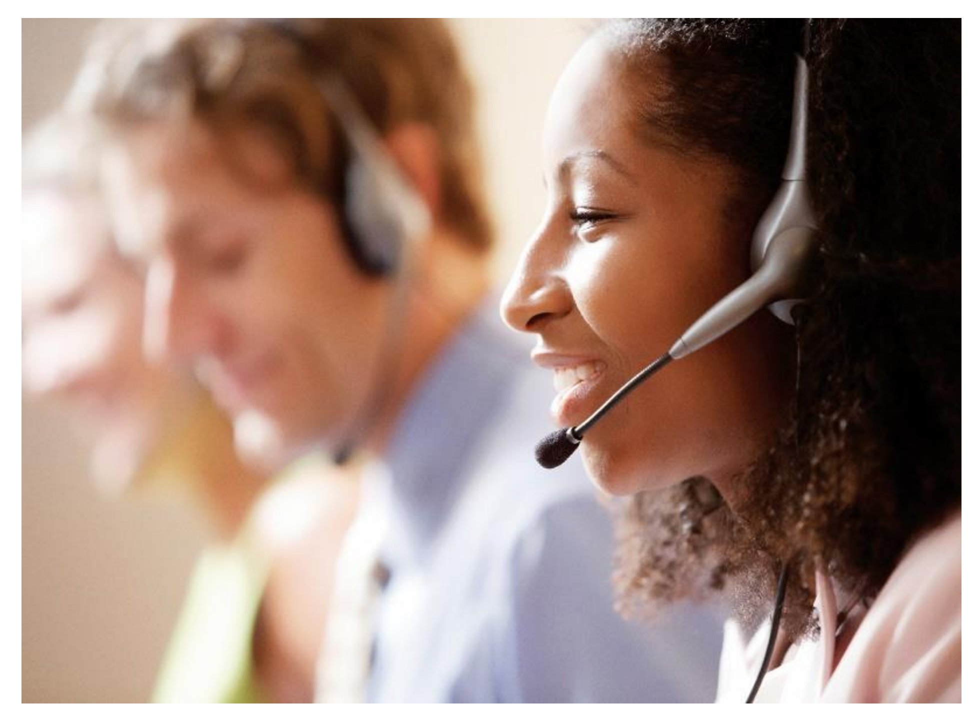
The Claims Customer service team is available from 8:30 – 4:30 to answer your questions and help you resolve claims issues. 831-430-5503

Review your EOB

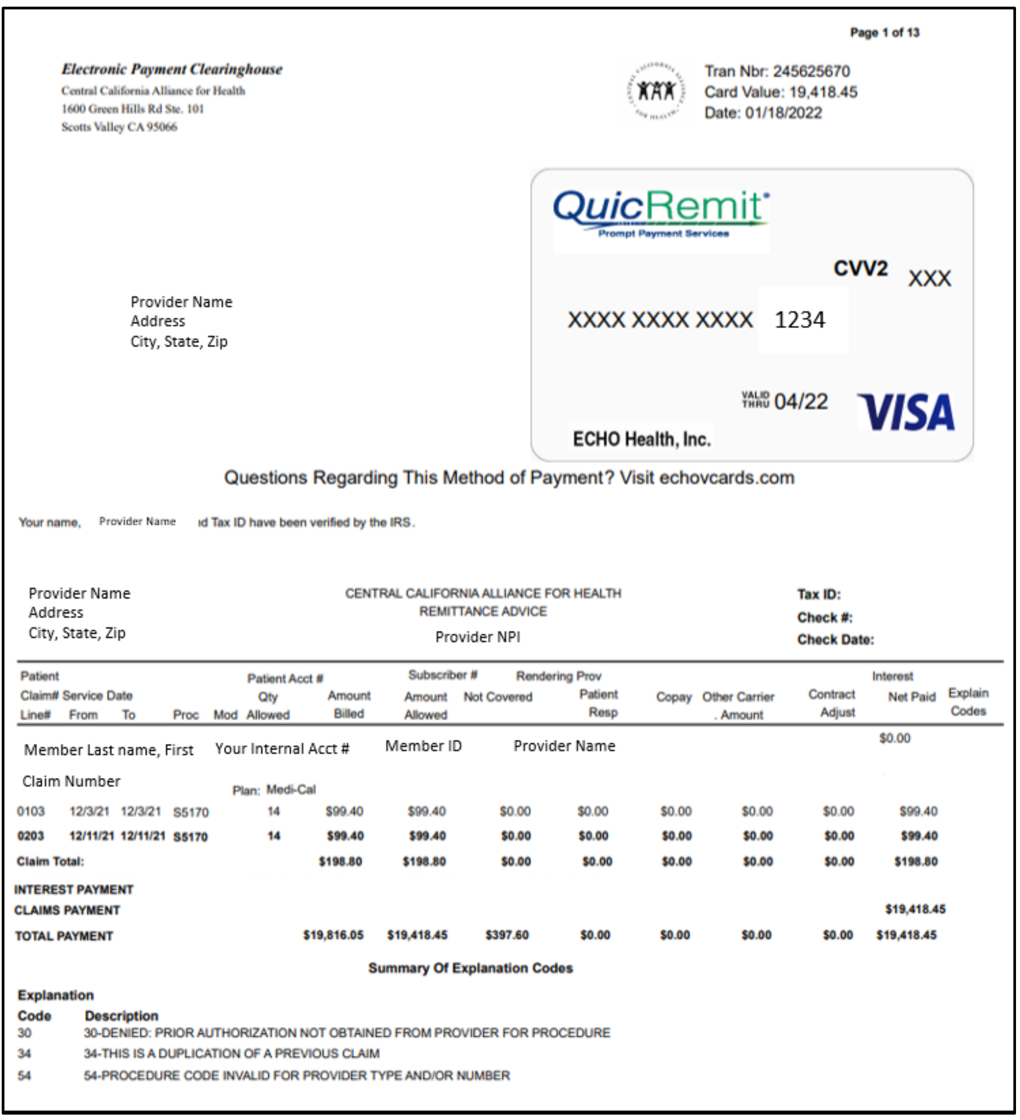
Details on next slide

Submit Corrected Claims

Column W to explain what is being corrected on a previously paid claim



Remittance Advice



Page 1 of 13

Electronic Payment Clearinghouse
Central California Alliance for Health
1600 Green Hills Rd Ste. 101
Scotts Valley CA 95066

Tran Nbr: 245625670
Card Value: 19,418.45
Date: 01/18/2022

QuicRemit
Prompt Payment Services

CVV2 XXX

XXXX XXXX XXXX 1234

VALID THRU 04/22

VISA

ECHO Health, Inc.

Provider Name
Address
City, State, Zip

Questions Regarding This Method of Payment? Visit echovcards.com

Your name, Provider Name id Tax ID have been verified by the IRS.

Provider Name
Address
City, State, Zip

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
REMITTANCE ADVICE
Provider NPI

Tax ID:
Check #:
Check Date:

Patient / Claim# / Line#	Service Date From	To	Proc	Mod	Patient Acct # / Qty / Allowed	Amount Billed	Subscriber # / Amount Allowed	Not Covered	Rendering Prov / Patient Resp	Copay	Other Carrier Amount	Contract Adjust	Interest / Net Paid	Explain Codes
Member Last name, First					Your Internal Acct #		Member ID		Provider Name				$0.00	
Claim Number					Plan: Medi-Cal									
0103	12/3/21	12/3/21	S5170		14	$99.40	$99.40	$0.00	$0.00	$0.00	$0.00	$0.00	$99.40	
0203	12/11/21	12/11/21	S5170		14	$99.40	$99.40	$0.00	$0.00	$0.00	$0.00	$0.00	$99.40	
Claim Total:						$198.80	$198.80	$0.00	$0.00	$0.00	$0.00	$0.00	$198.80	
INTEREST PAYMENT														
CLAIMS PAYMENT													$19,418.45	
TOTAL PAYMENT						$19,816.05	$19,418.45	$397.60	$0.00	$0.00	$0.00	$0.00	$19,418.45	

Summary Of Explanation Codes

Explanation Code	Description
30	30-DENIED: PRIOR AUTHORIZATION NOT OBTAINED FROM PROVIDER FOR PROCEDURE
34	34-THIS IS A DUPLICATION OF A PREVIOUS CLAIM
54	54-PROCEDURE CODE INVALID FOR PROVIDER TYPE AND/OR NUMBER

- a.k.a. Explication of Benefits (EOB)
- Payments on fee for service claims
- Initial payment is always made by Virtual Credit Card. Please let an Alliance representative know if you would like to opt out of VCC in favor of a paper check for your first payment
- Issued by Change - Echo

https://thealliance.health/wp-content/uploads/RA_Guide.pdf

Reading your Remittance Advice

Provider Name
Address
City, State, Zip

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
REMITTANCE ADVICE

Provider NPI

Tax ID:
Check #:
Check Date:

Patient Claim# Line#	Service Date From	To	Proc	Mod	Patient Acct # Qty Allowed	Amount Billed	Subscriber # Amount Allowed	Not Covered	Rendering Prov Patient Resp	Copay	Other Carrier Amount	Contract Adjust	Interest Net Paid	Explain Codes
Member Last name, First					Your Internal Acct #		Member ID		Provider Name				$0.00	
Claim Number					Plan: Medi-Cal									
0103	12/3/21	12/3/21	S5170		14	$99.40	$99.40	$0.00	$0.00	$0.00	$0.00	$0.00	$99.40	
0203	**12/11/21**	**12/11/21**	**S5170**		**14**	**$99.40**	**$99.40**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$99.40**	
Claim Total:						**$198.80**	**$198.80**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$198.80**	
INTEREST PAYMENT														
CLAIMS PAYMENT													**$19,418.45**	
TOTAL PAYMENT						**$19,816.05**	**$19,418.45**	**$397.60**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$19,418.45**	

Summary Of Explanation Codes

Explanation Code	**Description**
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Capitation Payment

Central California Alliance for Health
1600 Green Hills Rd Ste. 101
Scotts Valley CA 95066

Provider Name
Address
City, State, Zip

Your name PROVIDER NAME, and Tax ID have been verified by the IRS.

Check Date: 02/11/2022
Check #: 1024283379
Cap. Month: February
TAX ID: 123456789

Specialty Capitation List

Page 1 of 1

Summary	Subtotal
1141295: Provider Name	$44,997.47
Grand Total:	$44,997.47

Group Name	Program	Member Count	Amount
Group Name XX	XYZ		$44,997.47

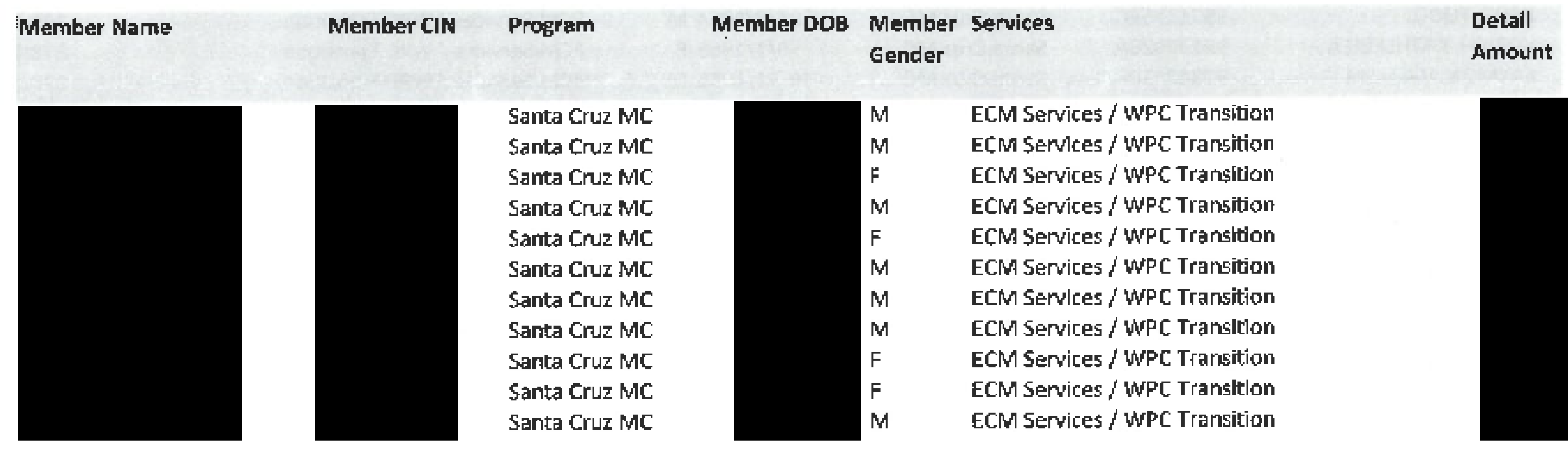
- Not the same as your Capitation RA list
  - Capitation RA list is distributed by the Alliance
- Capitation Payment Issued by Change - Echo

Capitation RA List

Check Date: 2/10/2022
Check #: CHC000105529
Total Amount: $
Cap. Month: January 2022
Provider:

ATTN: BUSINESS OFFICE

FEB 02 2022



Member Name	Member CIN	Program	Member DOB	Member Gender	Services	Detail Amount
		Santa Cruz MC		M	ECM Services / WPC Transition	
		Santa Cruz MC		M	ECM Services / WPC Transition	
		Santa Cruz MC		F	ECM Services / WPC Transition	
		Santa Cruz MC		M	ECM Services / WPC Transition	
		Santa Cruz MC		F	ECM Services / WPC Transition	
		Santa Cruz MC		M	ECM Services / WPC Transition	
		Santa Cruz MC		M	ECM Services / WPC Transition	
		Santa Cruz MC		M	ECM Services / WPC Transition	
		Santa Cruz MC		F	ECM Services / WPC Transition	
		Santa Cruz MC		F	ECM Services / WPC Transition	
		Santa Cruz MC		M	ECM Services / WPC Transition	

Misc. Information

- Office Hours
  - Can send questions ahead of time
  - Hop on to listen
  - No set agenda
  - Do not need to stay on the whole duration of meeting
- Capacity
  - Will receive monthly email from Minerva (Provider Services Rep)
  - To determine real time capacity
  - Not projected capacity
  - Numbers will be updated as well based on actual enrollment

Questions?