Enhanced Care Management (ECM) and Community Supports Claims Training

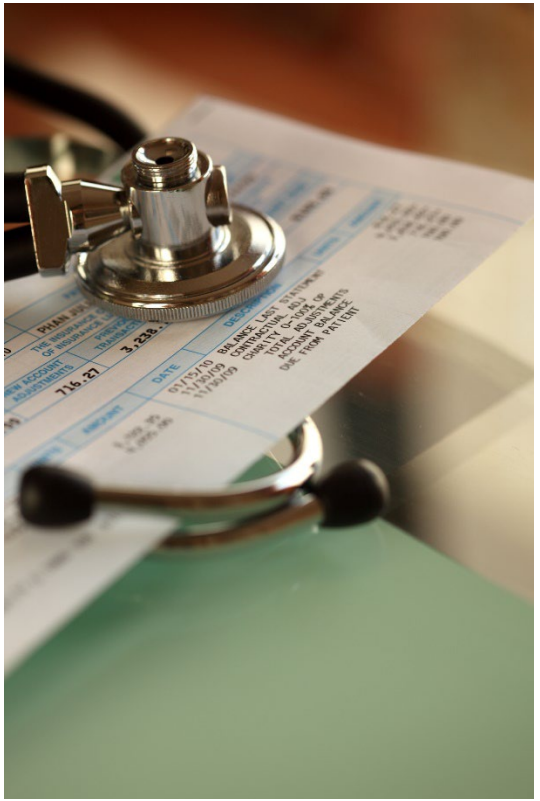
Update: June 17, 2026

AGENDA:

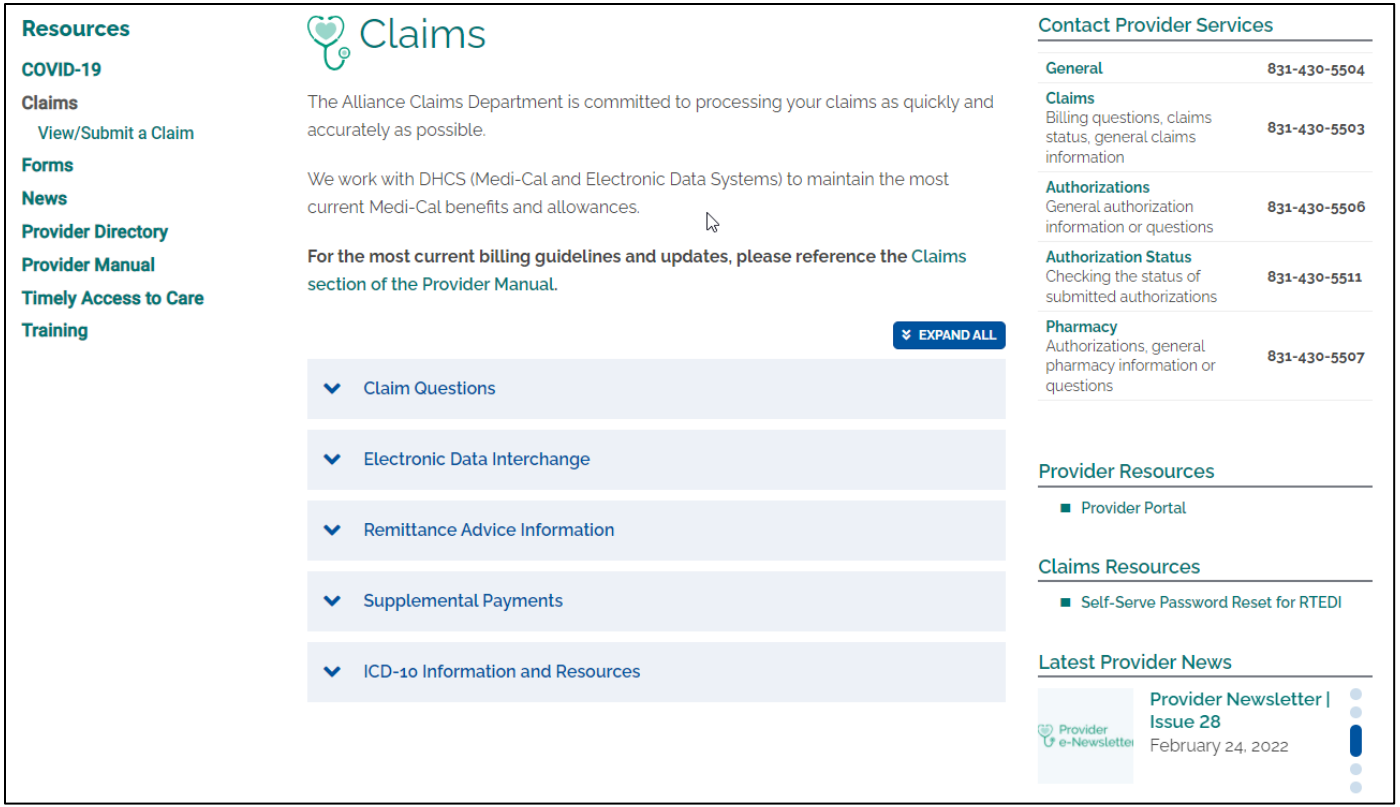
- Claims Department
- ECM Billing Codes and Modifiers
- CS Billing Codes and Modifiers
- ECM Outreach Payment Model
- SDOH Diagnosis Codes
- CMS 1500 Claim Form
- Provider Portal Invoice Submission
- Invoice Template
- Resolving Denials
- Reading your Remittance Advice

Claims Department

- The Claims department is where claims come to be adjudicated
- Invoices and EDI submissions are loaded into our processing system and are turned into claims
- Claims will hit a Remittance Advice document that is sent to the provider in approximately 30 days with information on payments or denials



Claims Department – Alliance Website



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

Billing Codes and Modifiers - ECM

BILLING CODE	DESCRIPTION	PRIMARY MODIFIER	REQUIRED MODIFIER DESCRIPTION	SECONDARY MODIFIER	SECONDARY MODIFIER DESCRIPTION	PAYMENT MODEL	1 UNIT =
G9008	ECM OUTREACH ONLY	U8	ECM Outreach In Person: Provided by Clinical Staff. Other specified case management service not elsewhere classified.	GQ	TELEHEALTH	Fee for Service	15 mins
G9012	ECM OUTREACH ONLY	U8	ECM Outreach In Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	GQ	TELEHEALTH	Fee for Service	15 mins
G9008	ECM ENROLLED SERVICES PER MONTH	U1	ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	GQ	TELEHEALTH	Fee for Service	15 mins
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	Fee for Service	15 mins

- Roll up same services per day and bill on one line
- Telehealth Services are obligated to be billed with correct POS 02 and Modifier GQ
- “Rule of 8’s” applies to these services, 1 15 Minute increment may only be billed if at a minimum of 8 mins has been spent performing the service

Authorization Crosswalk - ECM

HCPCS BILLING CODE	MODIFIER	DESCRIPTION	AUTH CODE CROSSWALK
G9008	U8	ECM OUTREACH ONLY	No Auth Required
G9012	U8	ECM OUTREACH ONLY	No Auth Required
G9008	U1	ECM ENROLLED SERVICES PER MONTH	ECM02
G9012	U2	ECM ENROLLED SERVICES PER MONTH	ECM02

Updates to Clinical and Non-Clinical Staff Definitions

The ECM Coding Guidance includes separate codes for care coordination and outreach provided by clinical and non-clinical staff

Policy Clarification: Clinical Staff and Non-Clinical Staff Definitions

- **Clinical Staff:** A clinical staff member is an individual who is qualified by licensure to perform ECM (e.g., licensed practical nurse (LPN), licensed vocational nurses (LVN), licensed clinical social worker (LCSW), registered nurses (RN), physician assistant (PA), nurse practitioner (NP), certified nurse specialist (CNS), Licensed Marriage Family Therapist (LMFT).
- **Non-Clinical Staff:** A non-clinical staff member refers to anyone who does not meet the clinical definition above, who can perform or assist in the delivery of ECM (e.g., medical assistant (MA), community health worker (CHW), promotoras de salud, doulas). Please note a clinical staff member may be certified, but this does not equate to licensure.
- **Note:** Both "clinical" and "non-clinical" staff can serve as Member's ECM lead care manager. DHCS's rationale for capturing the delineation between "clinical" and "non-clinical" staff is for DHCS to track the provider types that are serving Members.

ECM Outreach Payment Model

- Maximum outreach payment of $264 paid out at $44 per outreach up to 6 attempts
- One outreach attempt per day will be paid out
- A minimum of **2 in-person outreach attempts** expected if there is no successful enrollment or declination of services

Number of Outreaches + Method Per Member	Member ECM Enrollment Status	Total Payment Outreach per Member
2 in-person 1 not in-person	Member enrolls in ECM Program	$264
6 not in-person	Member enrolls in ECM Program	$264
1 in-person 5 not in-person	Member enrolls in ECM Program	$264
2 in-person 3 not in-person	Member neither enrolls in ECM Program nor declines to enroll	$220
1 in-person 3 not in-person	Member neither enrolls in ECM Program nor declines to enroll	No payment
1 in-person 3 not in-person	Member declines to enroll in ECM Program	$176
None	Member enrolls in ECM Program	No payment

Exhibit H

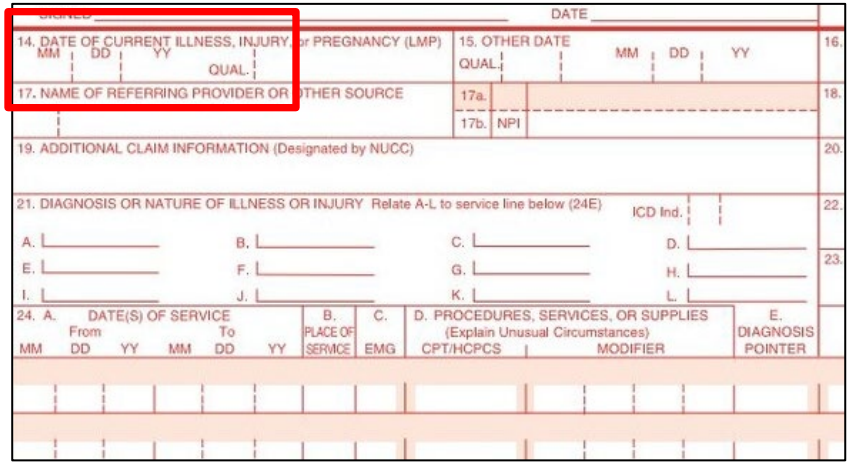
Unsuccessful Outreach

- Unsuccessful Outreach is defined as not having successfully reached a member
- Declination of Services is defined as member has been reached and has expressed that they do not wish to participate or enroll in ECM
- Member declined service should be documented with dx code *Z53.20: Procedure and treatment not carried out because of patient's decision for unspecified reasons*
- Do not append declination status to multiple dates of service as this is contradictory information and will result in denied or underpaid claims
- Use diagnosis pointers effectively to indicate the appropriate dx for the DOS
- Outreach is not considered unsuccessful with a declination of services

Documentation of Successful Enrollment

Providers must document the date of successful enrollment on the ECM "**Outreach"** claim that results in enrollment to qualify for the maximum outreach payment available

This is achieved by utilizing box 14 of the CMS 1500 claim form by entering the date member has accepted enrollment or by entering a date in columns Q and on the invoice template



Enrollment Date Documentation

- Enrollment date (ED) documentation should be the date that specific outreach resulted in successful enrollment
- ED should *only* be appended to claim for the outreach that resulted in successful enrollment
- Do not append enrollment dates on all dates of service where outreach occurred as this is contradictory information that may result in denied or under paid claims

Documentation Requirements for Clean Claims

- Homeless indication in member address must be accompanied by a SDOH code that reflects homelessness
- ECM/CS are meant to be submitted with SDOH codes
- Z53.20 document member has declined service
- On Set Date Box 14 on the CMS 1500/Column Q on invoice template
- ECM02, CS01, CS02 services may be billed at zero dollars

Billing Codes and Modifiers – Community Supports

BILLING CODE	DESCRIPTION	PRIMARY MODIFIER	REQUIRED MODIFIER DESCRIPTION	SECONDARY MODIFIER	SECONDARY MODIFIER DESCRIPTION	PAYMENT MODEL	1 UNIT =
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	Per Day
H0043	HOUSING TRANSITION/SUPPORTED HOUSING	U6	Used by Managed Care with HCPCS code H0043 to indicate Community Supports Housing Transition/Navigation Services	GQ	TELEHEALTH	Fee for service	15 mins
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	Per Day
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	$5000 max
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	Fee for service	15 mins
T2033	RECUPERATIVE CARE	U6	Used by Managed care with HCPCS code T2033 to indicate Recuperative care services.	N/A	N/A	Per Diem	Per Day
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	Fee for service	15 mins
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	Fee for service	15 mins
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	$7500 max
H0045	RESPITE CARE SERVICES, NOT IN THE HOME	U6	Modifier used by Managed Care with HCPCS code H0045 to indicate Community Supports Respite Services	N/A	N/A	Fee for service	1 Hour
S5151	UNSKILLED RESPITE CARE, NOT HOSPICE	U6	Modifier used by Managed Care with HCPCS code S5151 to indicate Community Supports Respite Services	N/A	N/A	Fee for service	1 Hour
S9125	RESPITE CARE SERVICES, IN THE HOME	U6	Used by Managed Care with HCPCS code S9125 to indicate Community Supports Respite Services	N/A	N/A	Fee for service	1 Hour
S5130	HOMEMAKER SERVICES	U6	Used by Managed Care with HCPCS code S5130 to indicate Community Supports Personal Care/Homemaker Services	N/A	N/A	Fee for service	15 mins
T1019	PERSONAL CARE SERVICES	U6	Used by Managed Care with HCPCS code T1019 to indicate Community Supports Personal Care/Homemaker Services	N/A	N/A	Fee for service	15 mins

Services must be billed on the DOS they were delivered or completed

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
S5165	U6	ENVIRONMENTAL ACCESSIBILITY ADAPTIONS	CS06
H0045	U6	RESPITE CARE SERVICES, NOT IN THE HOME	CS07
S5151	U6	UNSKILLED RESPITE CARE, NOT HOSPICE	CS07
S9125	U6	RESPITE CARE SERVICES, IN THE HOME	CS07
S5130	U6	HOMEMAKER SERVICES	CS08
T1019	U6	PERSONAL CARE SERVICES	CS08

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**
- Housing deposit, first month's rent, cleaning supplies…
  - **H0044- housing deposits**
    - **Step 1: Secure the auth**
    - **Step 2: Provide the service collecting receipts along the way**
    - **Step 3: Update the auth with the final dollar amount**
    - **Step 4: Submit the claim**

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

Z55.0	Illiteracy and low-level literacy	Z59.01	Sheltered homelessness	Z62.811	Personal history of phycological abuse in childhood
Z55.1	Schooling unavailable and unattainable	Z59.02	Unsheltered homelessness	Z62.812	Personal history of neglect in childhood
Z55.2	Failed school examinations	Z59.10	Inadequate housing, unspecified	Z62.813	Personal history of forced labor or sexual exploitation in childhood
Z55.3	Underachievement in school	Z59.11	Inadequate housing environmental temperature	Z62.814	Personal history of financial abuse
Z55.4	Education maladjustment and discord with teachers and classmates	Z59.12	Inadequate housing utilities	Z62.815	Personal history of intimate partner abuse in childhood
Z55.5	Less than a high school diploma	Z59.19	Other inadequate housing	Z62.819	Personal history of unspecified abuse in childhood
Z55.6	Problems related to health literacy	Z59.2	Discord with neighbors, lodgers and landlord	Z62.819	Personal history of unspecified abusing childhood
Z55.8	Other problems related to education and literacy	Z59.3	Problems related To living in residential institution	Z62.820	Parent-biological child confect
Z55.9	Problems related to education and literacy, unspecified	Z59.41	Food insecurity	Z62.821	Parent-adopted child conflict
Z56.0	Unemployment, unspecified	Z59.48	Other specified lack of adequate food	Z62.822	Parent-foster child conflict
Z56.1	Change of job	Z59.5	Extreme poverty	Z62.890	Parent-child estrangement not elsewhere classified
Z56.2	Threat of job loss	Z59.6	Low income	Z62.891	Sibling rivalry
Z56.3	Stressful work schedule	Z59.71	Insufficient health insurance coverage	Z62.898	Other specified problems related to upbringing
Z56.4	Discord with boss and workmates	Z59.72	Insufficient wellfare support	Z62.9	Problem related to upbringing, unspecified
Z56.5	Uncongenial work environment	Z59.811	Housing instability, housed, with rise of homelessness	Z63.0	Problems in relationship with spouse or partner
Z56.6	Other physical and mental strain related to work	Z59.812	Housing instability, housed, with rise of homelessness in past 12 months	Z63.1	Problems in relationship with in-laws
Z56.81	Sexual harassment on the job	Z59.819	Housing instability, housed unspecified	Z63.31	Absence of family member due to military deployment
Z56.82	Military deployment status	Z59.82	Transportation insecurity	Z63.32	Other absence of family member
Z56.89	Other problems related to employments	Z59.86	Financial insecurity	Z63.4	Disappearance and death of family member
Z56.9	Unspecified problems related to employment	Z59.87	Material hardship due to limited financial resources, not elsewhere classified	Z63.5	Disruption of family by separation and divorce
Z57.0	Occupational exposure to noise	Z59.89	Other problems related to housing and economic circumstances	Z63.6	Dependent relative needing care at home
Z57.1	Occupational exposure to radiation	Z59.9	Problem related to housing and economic circumstances, unspecified	Z63.71	Stress on family due to return of family member from military deployment
Z57.2	Occupational exposure to dust	Z60.0	Problems of adjustment to life-cycle transitions	Z63.72	Alcoholism and drug addiction in family
Z57.31	Occupational exposure to environment tobacco smoke	Z60.2	Problems related to living alone	Z63.79	Other stressful life events affecting family and household
Z57.39	Occupational exposure to other air contaminants	Z60.3	Acculturation difficulty	Z63.8	Other specified problems related to primary support group
Z57.4	Occupational exposure to toxic agents in agriculture	Z60.4	Social exclusion and rejection	Z63.9	Problem related to primary support group, unspecified
Z57.5	Occupational exposure to toxic agents in other industries	Z60.5	Target of (perceived) adverse discrimination and persecution	Z64.0	Problems related to unwanted pregnancy
Z57.6	Occupational exposure to extreme temperature	Z60.8	Other problems related to social environment	Z64.1	Problems related to multiparity
Z57.7	Occupational exposure to vibration	Z60.9	Problem related to social environment, unspecified	Z64.4	Discord with councilors
Z57.8	Occupational exposure to other risk factors	Z62.0	Inadequate parental supervision and control	Z65.0	Conviction in civil and criminal proceedings without imprisonment
Z57.9	Occupational exposure to unspecified risk factors	Z62.1	Parental overprotection	Z65.1	Imprisonment and other incarceration
Z59.861	Financial insecurity , difficulty paying for utilities	Z62.21	Child in welfare custody	Z65.2	Problems related to release from prison
Z59.868	Other specified financial insecurity	Z62.22	Institutional upbringing	Z65.3	Problems related to other legal circumstances
Z59.869	Financial insecurity, unspecified	Z62.29	Other upbringing away from parents	Z65.4	Victim of crime and terrorism
Z58.81	Basic services unavailable in physical environment	Z62.3	Hostility towards and scapegoating of child	Z65.5	Exposure to disaster, war and other hostilities
Z58.89	Other problems related to physical environment	Z62.6	Inappropriate (excessive) parental pressure	Z65.8	Other specified problems related to psychosocial circumstances
Z59.00	Homelessness unspecified	Z62.810	Personal history of physical and sexual abuse in childhood	Z65.9	Problem related to unspecified psychosocial circumstances

SDOH Diagnosis Coding

- ECM/CS are meant to be submitted with SDOH codes
- Do not append diagnosis codes outside of SDOH categories for ECM/CS services even if you are treating the member for these reasons
- Based on your observations while working with the member

Place of Service Codes

Modifier GQ must be billed with POS 02

POS CODES	DESCRIPTION
02	Telehealth
03	School
04	Homeless Shelter
05	Indian Health Service Free - standing Facility
06	Indian Health Service Provider - based Facility
07	Tribal 638 Free - standing Facility
08	Tribal 638 Provider - based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit for preventative and diagnostic services
16	Temporary Lodging
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
49	Independent Clinic
50	Federally Qualified Health Center
52	Psychiatric Facility - Partial Hospitalization
53	Community Mental Health Center
71	Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

TELEHEALTH SERVICES

- Place of Service 02 is the only appropriate POS code for telehealth services
- Modifier GQ is required for telehealth services
- Place of Service 02 and Modifier GQ must be billed together, or claims will be denied

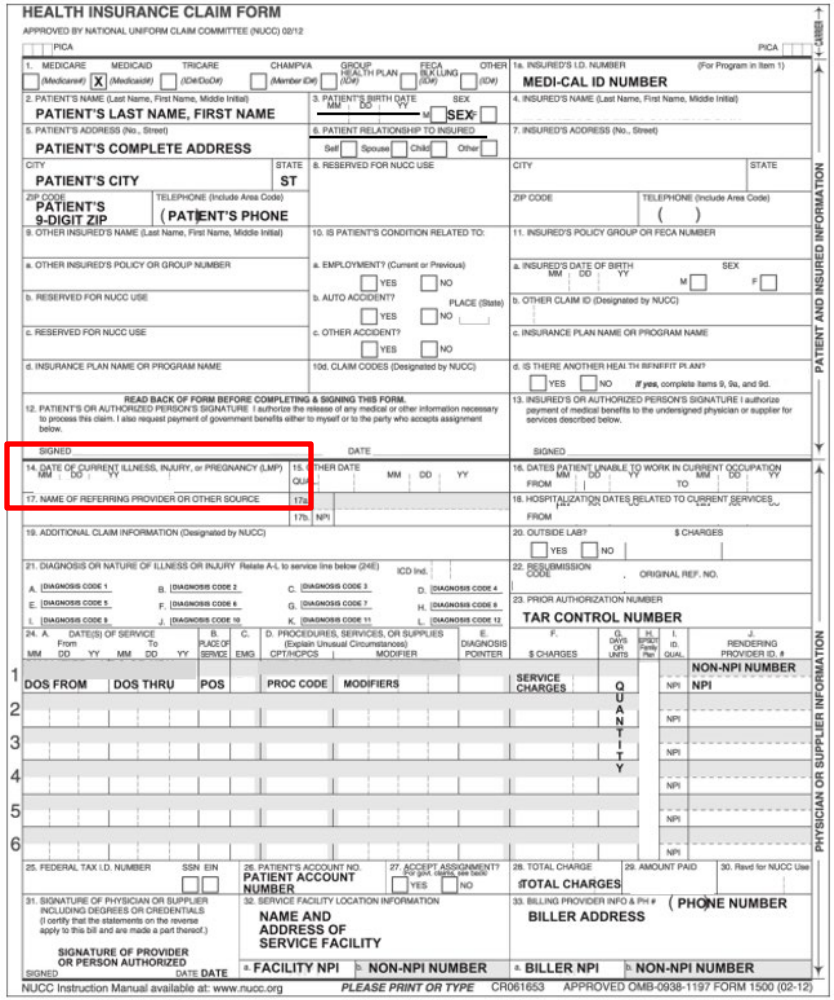
CMS 1500 Claim Form

- Submitted hard copy by mail or electronically thru a clearinghouse
- No charge w/Office Ally
- **Payer ID = CCA01**
- Must ensure **you do not** select OA's Invoice Template Process when signing up with OA (ECM Payer ID CCA10)
- Box 14 On Set date

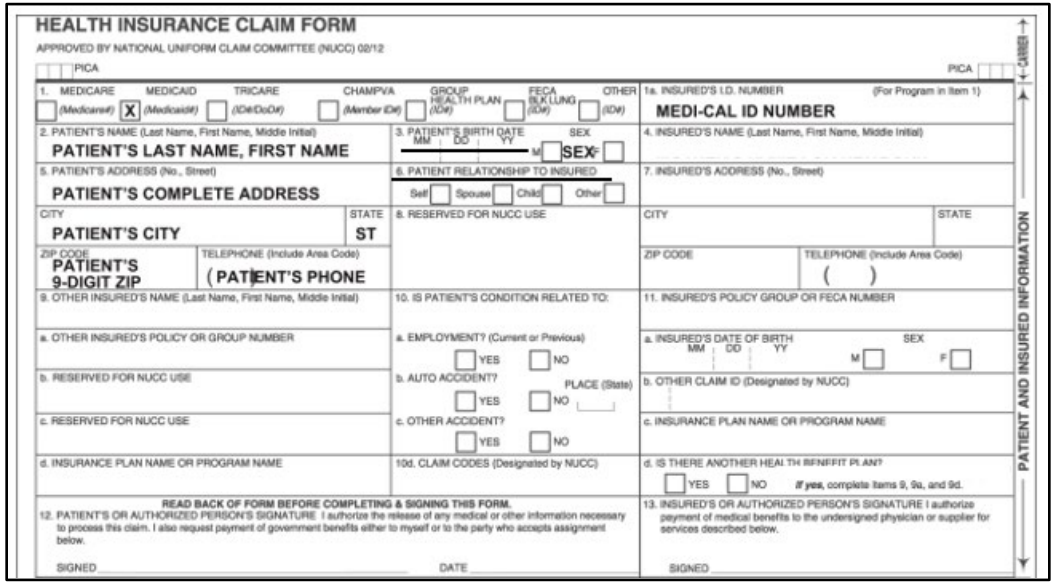
Office Ally's Payer List - [Search Results - Top 200 Records]

Payer Name | Starts With | central california allianc

Select	PayerID	PayerName
Select	CCA01	Central California Alliance for Health
Select	CCA10	Central California Alliance for Health ECM/CS



CMS 1500 Member Demographics



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) X | 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 SEX F

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 _____

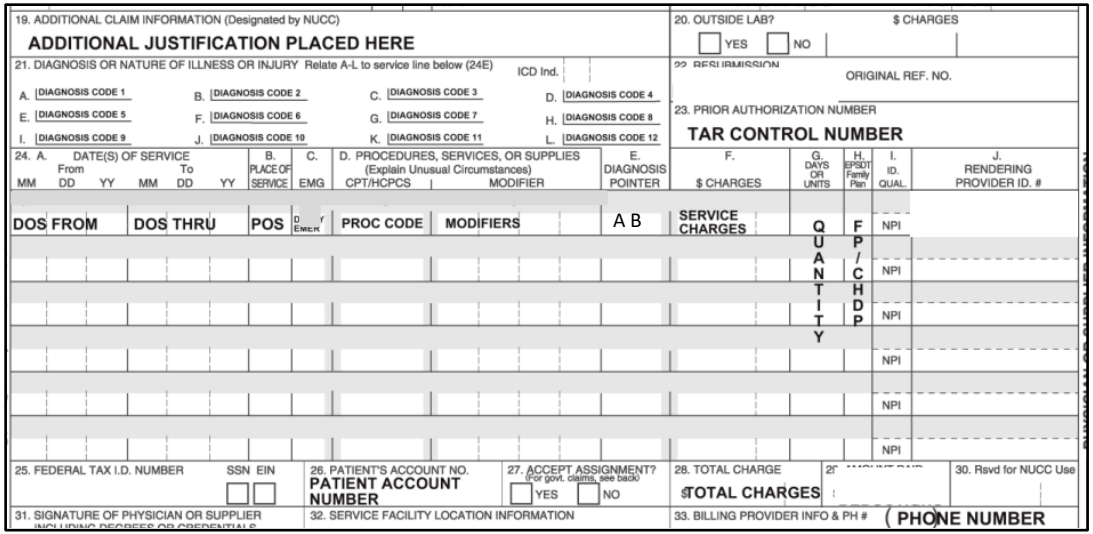
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

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

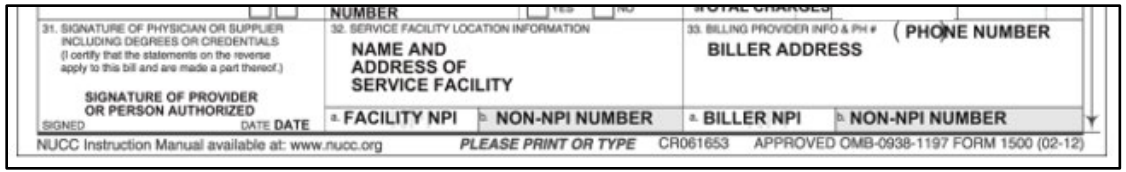
CMS 1500 Services Rendered


19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
ADDITIONAL JUSTIFICATION PLACED HERE
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 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. #
DOS FROM DOS THRU POS EMG PROC CODE MODIFIERS A B SERVICE CHARGES QUANTITY FP/CHDP 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 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # (PHONE NUMBER

- From - Thru dates are billed for overnight stays except for sobering centers which are limited to a quantity of 1
- Services should be billed with the date that they occurred
- May not bill for a date that is in the future

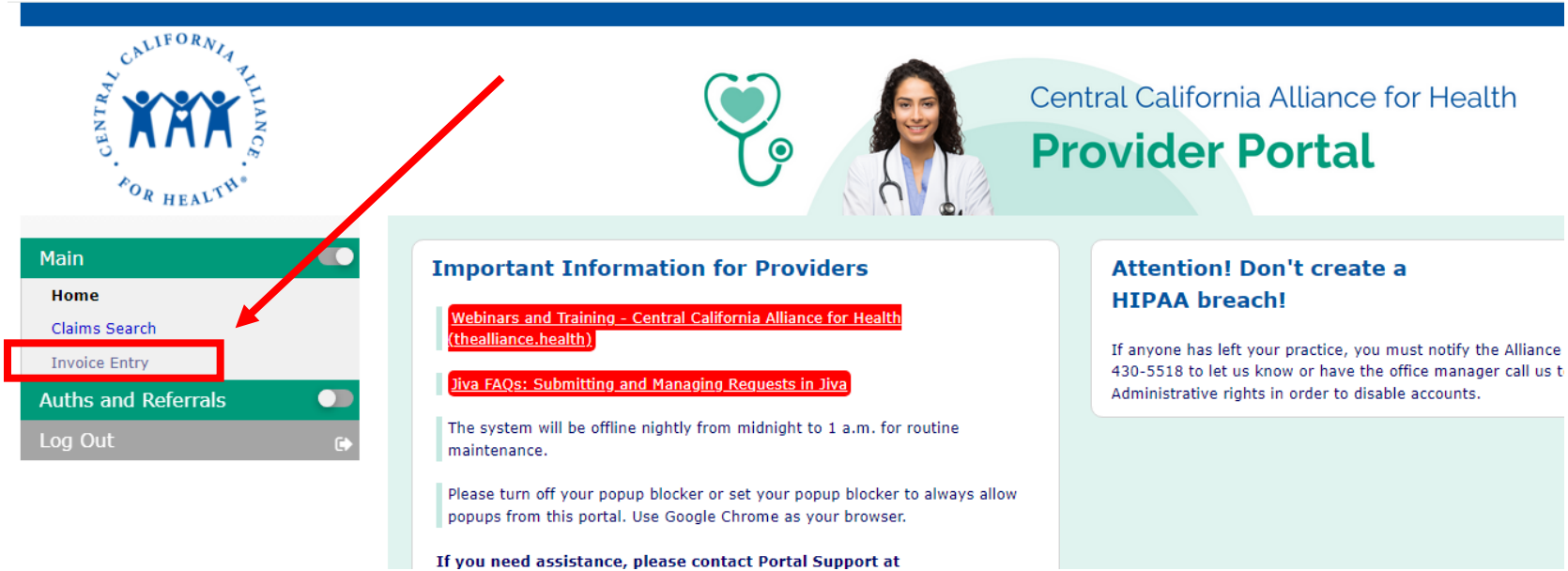
- 19 Additional Claim Information
- 21A-L Diagnosis Codes
- 23 Authorization Number
- 24A Dates of Service
- 24B Place of Service
- 24D Procedure Code & Modifiers
- 24F Billed Charges
- 24G Quantities/Units
- 25 Tax ID
- 26 Patient Account Number
- 27 YES
- 28 Total Billed Charges

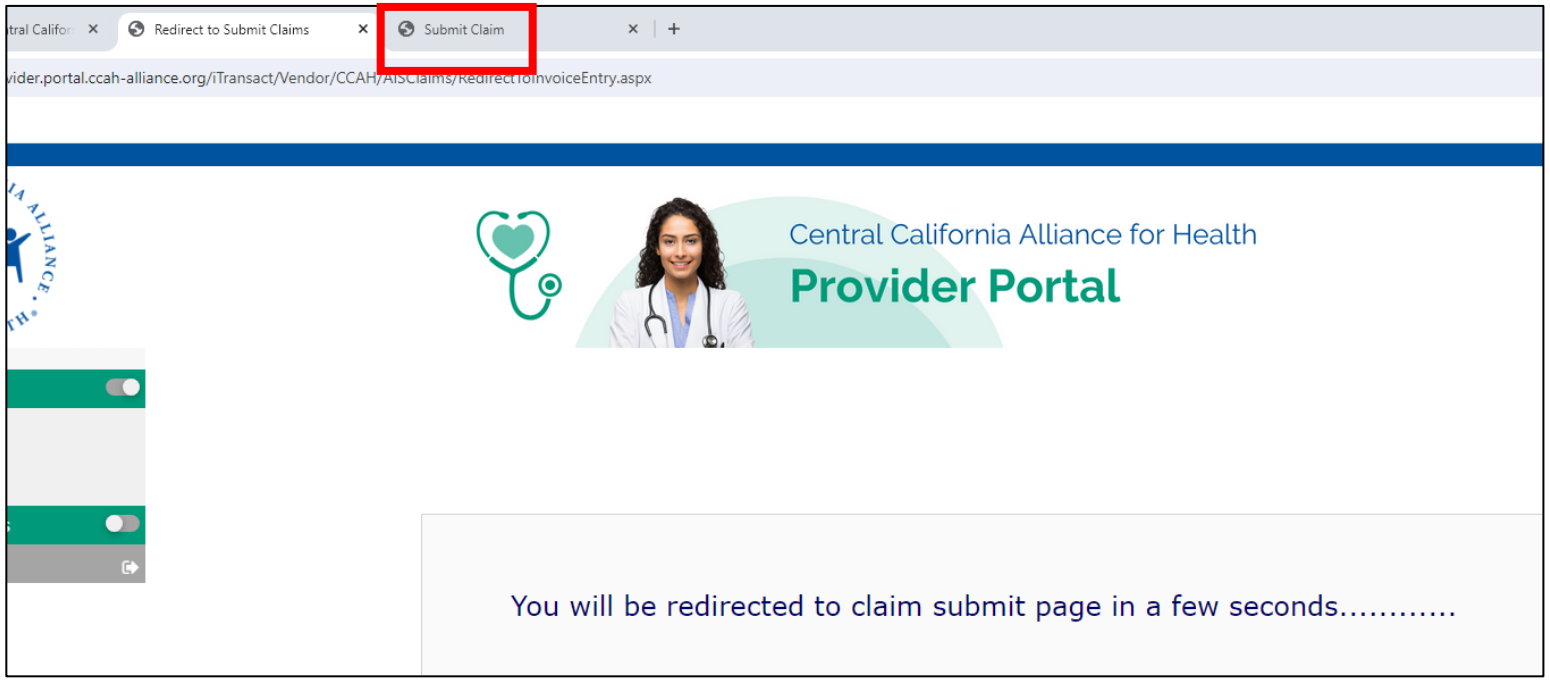
Provider Demographics



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

Provider Portal Claims Submission Platform





TIP: Turn off Pop up blockers to reveal the Submit Claim window

Provider Portal - Central Califor | Redirect to Submit Claims | Submit Claim

provider.portal.ccah-alliance.org/ClaimsResubmit/InvoiceEntry/SubmitClaim?userName="ccahkdeaton"&SessionKey=iZtz%2FSMYtkh0%2ByoT6EsHyxgNjK8vo9XxjZ1PBfrLW3FGqeDeS2EfZ3KO%2FX6LJBDO8da2xHTYDQZ0pkaKuMY3ZJg1PMi9...

New Claim Submit

Please fill out this form to submit your claim. All required fields are marked with a red asterisk *.

Provider Information

*Provider:

*NPI :

*Tax ID :

*Office Number :

Office Address :

Rendering NPI :

Rendering Provider Name :

Member Information

*Member #/ (CIN): Enter Full Member Number and select from the list.

*Member Last Name :

*Member First Name :

*Member Date of Birth :

*Patient Account Number :

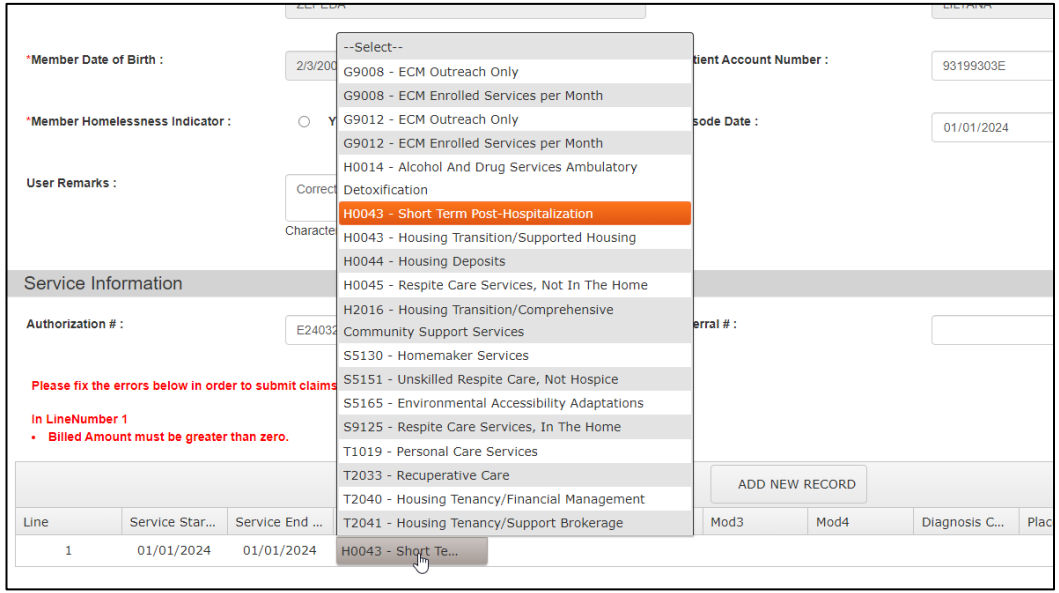
*Member Homelessness Indicator : YES NO

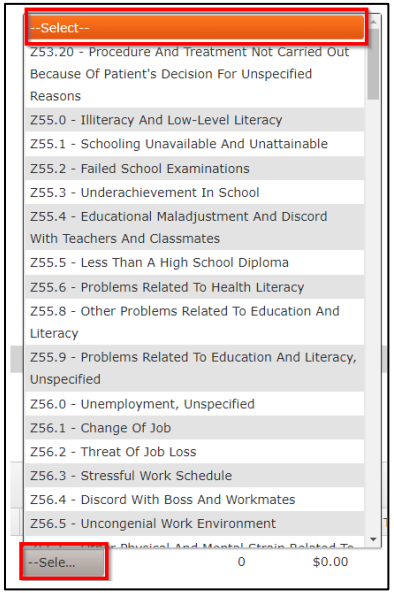
Episode Date : mm/dd/yyyy

User Remarks :

(max characters 80)

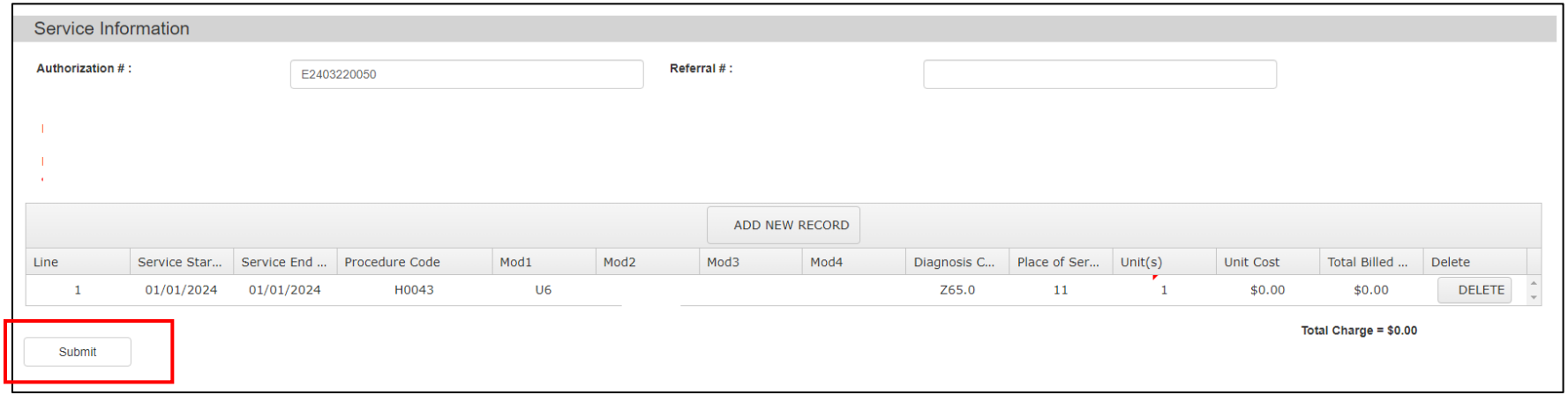
Service Information





- Prepopulated drop downs for Billing Code, Modifiers, Diagnoses, and Place of Service
- Reset Dx field by clicking on “Select” at Diagnosis and “Select” again on the orange tab
- 10 claims lines per claim
- Errors will be indicated if information is not correct

Submit

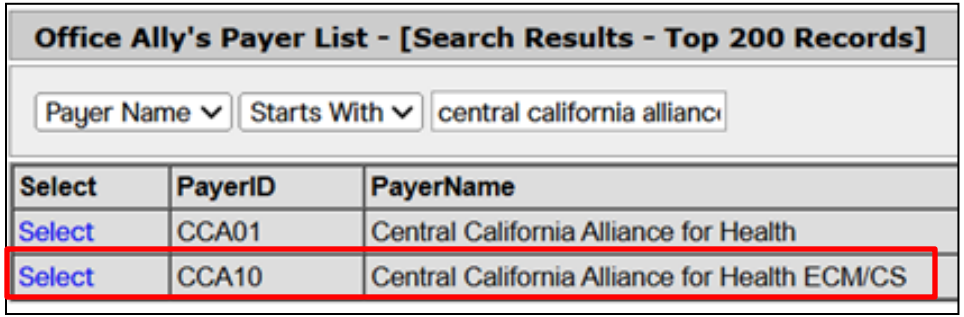


Claim will be in our system immediately

Note: This image is for portal step instruction only. All usual submission rules apply.

Office Ally Invoice Submission Process

- The invoice template has been developed based on mandates from DHCS
- The Alliance contracts with the clearinghouse Office Ally to ingest the file
- Providers upload the invoice template to Office Ally's platform
- An Office Ally account is required at no charge with easy set up
- **Payer ID CCA10**
- The Alliance will provide providers with the Invoice Template and supporting documents
- An EDI enrollment form is required for invoice template submission
- Opt out of claim printing when signing up with Office Ally to avoid hidden fees
- https://sc.officeally.com Support Experts

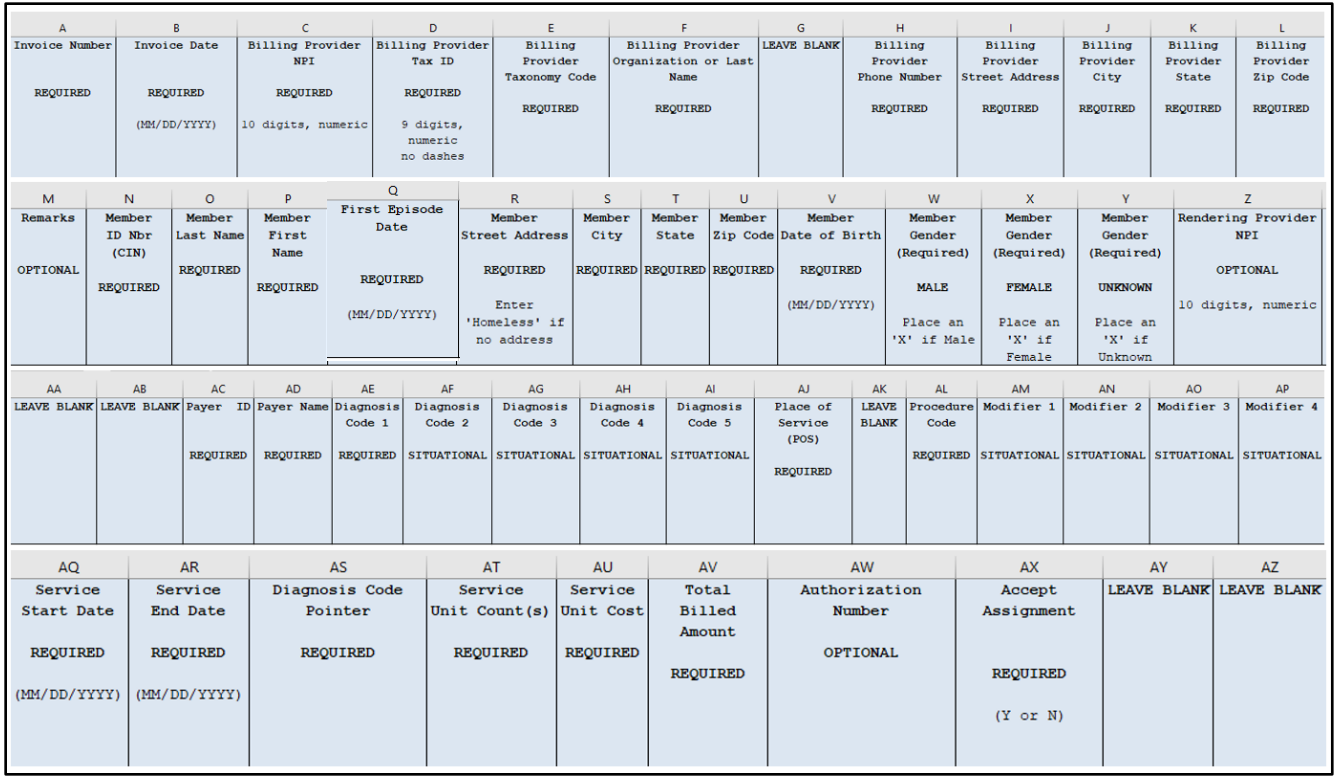


Office Ally's Payer List - [Search Results - Top 200 Records]

Payer Name | Starts With | central california allianc

Select	PayerID	PayerName
Select	CCA01	Central California Alliance for Health
Select	CCA10	Central California Alliance for Health ECM/CS

Invoice Template



A	B	C	D	E	F	G	H	I	J	K	L
Invoice Number REQUIRED	Invoice Date REQUIRED (MM/DD/YYYY)	Billing Provider NPI REQUIRED 10 digits, numeric	Billing Provider Tax ID REQUIRED 9 digits, numeric no dashes	Billing Provider Taxonomy Code REQUIRED	Billing Provider Organization or Last Name REQUIRED	LEAVE BLANK	Billing Provider Phone Number REQUIRED	Billing Provider Street Address REQUIRED	Billing Provider City REQUIRED	Billing Provider State REQUIRED	Billing Provider Zip Code REQUIRED

M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
Remarks OPTIONAL	Member ID Nbr (CIN) REQUIRED	Member Last Name REQUIRED	Member First Name REQUIRED	First Episode Date REQUIRED (MM/DD/YYYY)	Member Street Address REQUIRED Enter 'Homeless' if no address	Member City REQUIRED	Member State REQUIRED	Member Zip Code REQUIRED	Member Date of Birth REQUIRED (MM/DD/YYYY)	Member Gender (Required) MALE Place an 'X' if Male	Member Gender (Required) FEMALE Place an 'X' if Female	Member Gender (Required) UNKNOWN Place an 'X' if Unknown	Rendering Provider NPI OPTIONAL 10 digits, numeric

AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP
LEAVE BLANK	LEAVE BLANK	Payer ID REQUIRED	Payer Name REQUIRED	Diagnosis Code 1 REQUIRED	Diagnosis Code 2 SITUATIONAL	Diagnosis Code 3 SITUATIONAL	Diagnosis Code 4 SITUATIONAL	Diagnosis Code 5 SITUATIONAL	Place of Service (POS) REQUIRED	LEAVE BLANK	Procedure Code REQUIRED	Modifier 1 SITUATIONAL	Modifier 2 SITUATIONAL	Modifier 3 SITUATIONAL	Modifier 4 SITUATIONAL

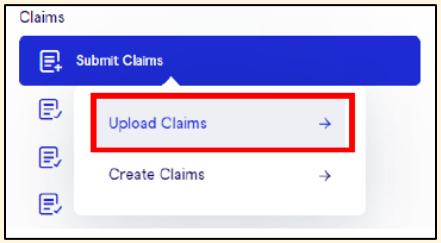
AQ	AR	AS	AT	AU	AV	AW	AX	AY	AZ
Service Start Date REQUIRED (MM/DD/YYYY)	Service End Date REQUIRED (MM/DD/YYYY)	Diagnosis Code Pointer REQUIRED	Service Unit Count(s) REQUIRED	Service Unit Cost REQUIRED	Total Billed Amount REQUIRED	Authorization Number OPTIONAL	Accept Assignment REQUIRED (Y or N)	LEAVE BLANK	LEAVE BLANK

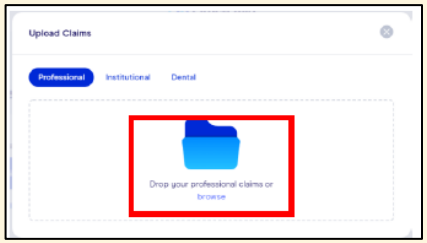
Invoice Template

- An excel spread sheet
- Must not be reformatted
- Hand outs with additional instructions
- Roll up billing required
- Corrected claim documentation column M
- Column Q has been added to report the ON SET DATE

Office Ally Interface for Invoice Template Submission

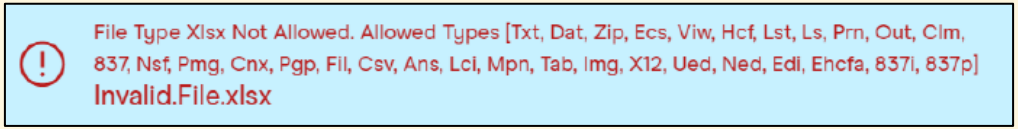
1. Log onto you Office Ally account at https://sc.officeally.com
2. Upload your claim file using the “Upload Claims” option





When the pop up appears, select the file type you are uploading. then click on “**Browse**” to browse your system for the file you would like to upload

3. Once the file is selected, if successful, it will be immediately uploaded to Office Ally. If the upload is not successful you will receive an error at the bottom of the screen



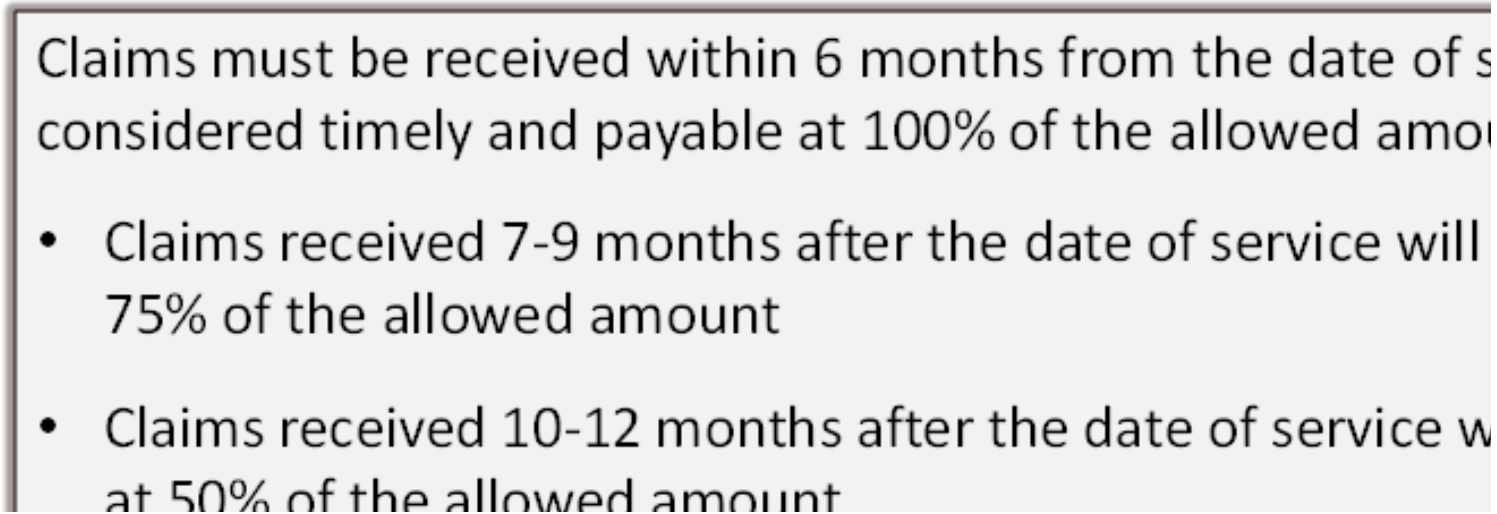
- You must be sure to upload a supported file type
- Office Ally will provide you with a User Guide with training information on this process
- There is the ability to do direct entry with stored data for items such as your provider information
- Hand outs will be provided with detailed instructions on how to maintain the integrity of the spread sheet

Field	Field Description	Required Flag	Instructions	Field	Field Description	Required Flag	Instructions
A	Invoice Number	Required	Provider generated	AA	Leave Blank		Leave Blank
B	Invoice Date MM/DD/YYYY	Required	Date of invoice submission	AB	Leave Blank		Leave Blank
C	Billing Provider NPI	Required	Provider's 10-digit numeric Billing NPI	AC	Payer ID	Required	CCA10
D	Billing Provider Tax ID	Required	Provider's 9-digit numeric code no dashes	AD	Payer Name	Required	Central California Alliance for Health
E	Billing Provider Taxonomy	Required	Provider's taxonomy code that is assigned with your NPI	AE	Diagnosis Code 1	Required	Homeless dx is required in addition to any other dx if homeless,*Diagnosis pointer 1
F	Billing Provider, Organization or Last Name	Required	Billing entity name	AF	Diagnosis Code 2	Situational	*Diagnosis pointer 2
G	Leave Blank		Leave Blank	AG	Diagnosis Code 3	Situational	*Diagnosis pointer 3
H	Billing Provider Phone Number	Required	Contact phone number	AH	Diagnosis Code 4	Situational	*Diagnosis pointer 4
I	Billing Provider Street Address	Required	Provider's billing address	AI	Diagnosis Code 5	Situational	*Diagnosis pointer 5
J	Billing Provider City	Required	Provider's billing address city	AJ	Place of Service	Required	The code that best defines where the service took place
K	Provider State	Required	Provider's billing address state	AK	Leave Blank		Leave Blank
L	Billing Provider Zip	Required	Provider's billing address zip code	AL	Procedure Code	Required	Billing code that represents the service performed
M	Remarks	Situational	Corrected claim/other info as required	AM	Modifier 1	Required	Primary modifier
N	Member ID	Required	Member's Medi-Cal ID number	AN	Modifier 2	Situational	Secondary modifier
O	Member Last Name	Required	Member Last Name	AO	Modifier 3	Situational	
P	Member First Name	Required	Member First Name	AP	Modifier 4	Situational	
Q	On Set Date	Optional	Used to report date of enrollment	AQ	Service Start Date MM/DD/YYYY	Required	Date service was rendered
R	Member Street Address	Required	Enter "Homeless" if member is homeless This is required by DHCS	AR	Service End Date MM/DD/YYYY	Required	Date service was rendered to same as above if not an overnight service
S	Member City	Required	Member's address city	AS	Diagnosis Pointer	Required	1 – 5 (see AE – AI)
T	Member Zip	Required	Member's address zip code	AT	Service Unit Count(s)	Required	Quantity of service units per day
U	Member State	Required	Members address state	AU	Service Unit Cost	Required	Charge per unit
V	Member DOB MM/DD/YYYY	Required	Member's date of birth	AV	Total Billed Amount	Required	Total billed charges on claim
W	Member Gender M	Required	Use if gender is male	AW	Authorization Number	Situational	
X	Member Gender F	Required	Use if gender is female	AX	Accept Assignment Y or N	Required	Yes
Y	Member Gender U	Required	Use if member's gender is unknown	AY	Leave Blank		Leave Blank
Z	Rendering Provider Billing NPI 10 digit numeric	Situational	Use only if reporting a rendering provider	AZ	Leave Blank		Leave Blank

Additional Information

- Homeless indication in member address must be accompanied by a SDOH code that reflects homelessness
- Corrected claims process must be followed for *paid* claims that require corrections and resubmission
- No claims submissions thru the SFTP file site
- The SFTP file site is for documentation sharing, examples include:
  - Member eligibility lists
  - Member Information files
  - Other documents as need
  - Documentation providers are required to share

Timely Filing



- Medi-Cal timely filing guidelines do not negate contract for ECM/CS services
- Contract states claims must be submitted withing 30 days of encounter

Differences between Alliance Portal vs Echo

Alliance 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

Echo

- Owned and maintained by the vendor Echo
- The site to view and pull RA's and check information
- Requires a log in given by Echo
- 888-983-5574
- Providerpayments.com

Resolving Denials

Contact the Claims Department

The Claims Customer service team is available from 8:30-4:30 Monday – Friday to answer your questions and help you resolve claims issues 831-430-5503. This line is closed from 11:30 – 12:30 for lunch

- Claim Number
- Member ID and Date of Service

Review your RA

Corrected Claims Use column M "Corrected Claim, claim number, What is being corrected"

Reading your Remittance Advice

Central California Alliance for Health
1600 Green Hills Rd Ste. 101

Provider Name
Address
City, State Zip

Your name, [redacted] [redacted], and Tax ID have been verified by the IRS.

Tax ID: [redacted] ***EPC Draft #:*** 115315(***Payment Week:*** 36 ***Payment Date:*** 09/10/2024 Page 1 of 3502

Service Date	Proc/Rev Code (Modifiers)	Units	Explanation Code(s)	Total Charge	Allowed Amount	Provider Discount	Other Plan Payment	Other Adjustments	Patient Obligation				Net Payment Amount
									Co-ins	CoPay	Deduct	Non-Cov	
Claim Number: 00472				**Group ID:**					**Reference Number:** CHC000				
Provider: [redacted]			, GROUP OF CA	**Patient Name:** ELIJAI					**Subscriber Name:** ELIJAI				
Network: CHC00(				**Patient Acct #:** 07011(					**Subscriber ID:** 932				
07/01/24	G9012 (U8) (GQ)	1	COB15	$44.00	$0.00	$44.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
			Claim Total:	$44.00	$0.00	$44.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

- a.k.a. Explication of Benefits (EOB)
- Payments on fee for service claims
- Issued by Echo
- https://thealliance.health/wp-content/uploads/RA_Guide.pdf

Note: 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. **We will need your NPI and your Tax ID at the time you make your request.** This does not apply if you currently receive payments from the Alliance.

Reading your Remittance Advice

Service Date	Proc/Rev Code (Modifiers)	Units	Explanation Code(s)	Total Charge	Allowed Amount	Provider Discount	Other Plan Payment	Other Adjustments	Patient Obligation				Net Payment Amount
									Co-ins	CoPay	Deduct	Non-Cov	
Claim Number: 00473				**Group ID:**					**Reference Number:** CHC0003				
Provider:				**Patient Name:**					**Subscriber Name:**				
Network: CHC00(				**Patient Acct #:**					**Subscriber ID:**				
08/02/24	G9012 (U8) (GQ)	1	COB15	$44.00	$0.00	$44.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
			Claim Total:	$44.00	$0.00	$44.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Statement Summary	Total Charge	Allowed Amount	Provider Discount	Other Plan Payment	Other Adjustments	Patient Obligation	Net Payment Amount
	$1,231,692.00	$36,740.00	$1,197,680.00	$0.00	$0.00	$0.00	$34,012.00

Document Total	
Net Payment Amount:	$34,012.00
Payment Adjustments:	$0.00
Total Payment:	$34,012.00

1) Claim Number
2) Patient Name
3) Subscriber name and ID
4) Date of Service, Billing Code, Units Billed, Explain Code
5) Net Payment Amount
6) Total Check Amount

Reading your Remittance Advice

Explanations

Codes	Description
CO16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
CO18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
CO27	Expenses incurred after coverage terminated.
CO272	Coverage/program guidelines were not met.
CO284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.
CO29	The time limit for filing has expired.
CO45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
COB15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
COB4	Late filing penalty.
N30	Patient ineligible for this service.
N329	Missing/incomplete/invalid patient birth date.

Questions?