ECM
Webinar Fridays:

ECM Claims Guidance

March 25, 2022

Presented by:

L.A. Care Health Plan | Health Net
Anthem Blue Cross | Blue Shield Promise Health Plan | Molina

Housekeeping

- This webinar is being recorded
- Attendance will be tracked via log-in
- Please submit all questions to **all Panelists**
- Questions will be managed through the Chat
- Send a message to the host if you cannot hear or see the slides

Webinar Overview

Topic	Time
Welcome & Introductions	5 minutes
Claims Submission Guidance	30 minutes
Common FAQs	15 minutes
Q & A	10 minutes

- Please submit all questions to all Panelists
- Send a message to the host if you cannot hear or see the slides
- *We will not be discussing payment or payment recovery processes today; specific questions about these topics should be routed to the respective MCP.*

ECM Claims Guidance

Guest Speakers:

Mary Zavala, LCSW, MPP, MA
Director, Enhanced Care Management
L.A. Care Health Plan

Anuj Patel
Clinical Data Analyst, Enhanced Care Management
L.A. Care Health Plan

Michael Vasquez
Manager, Safety Net Initiatives Support Services
L.A. Care Health Plan

Polling Question:
ECM Care Team Members on Today's Webinar

Understanding Our Audience

Please let us know your role on the ECM Care Team:

- Lead Care Manager
- ECM Director
- ECM Clinical Consultant
- Billing / Claims Team Member
- Other

Why are Claims Important?

How do MCPs use ECM claims?

- Representative of interventions provided to support members
- Supports regulatory reporting
- Supports future SDR for rate setting
- Drives payment reconciliation and recovery
- Allows MCP oversight of ECM provider activities

Enhanced Care Management Claims Data Elements

DHCS has identified 2 HCPCS codes for ECM Services:

- **G9008** for ECM services provided by a clinical staff person
- **G9012** for ECM services provided by a non-clinical staff person

HCPC Code	Modifier	Description
G9008	U1	In Person, Clinical Staff
G9008	U1, GQ	Phone/Telehealth, Clinical Staff
G9008	U8	Outreach In Person, Clinical Staff (Pre-Enrollment ONLY)
G9008	U8, GQ	Outreach Telephonic/Electronic, Clinical Staff (Pre-Enrollment ONLY)
G9012	U2	In Person, Non-Clinical Staff
G9012	U2, GQ	Phone/Telehealth, Non-Clinical Staff
G9012	U8	Outreach In Person, Non-Clinical Staff (Pre-Enrollment ONLY)
G9012	U8, GQ	Outreach Telephonic/Electronic, Non-Clinical Staff (Pre-Enrollment ONLY)

ECM Provider Type to HCPC Code Crosswalk

ECM HCPC Code	Appropriate Enhanced Care Management Program Multidisciplinary Team Members
G9008	ECM Services provided by a clinical member of the Multidisciplinary ECM Team, such as: • MD / DO • NP / PA • RN • LCSW • LMFT • RD • PsyD • PharmD • Other staff member with clinical licensure(s)
G9012	ECM Services provided by a non-clinical member of the Multidisciplinary Team, such as: • Trained paraprofessional Care coordinator • Community Health Worker • Other non-licensed staff
G9008 U8 &/or U8, GQ or G90012, U8 &/or U8, GQ = ECM Engagement Services	Any member of the Multidisciplinary Team

HCPCs & Modifier Review – G9008 Member Services by Clinical Staff

ECM Modifiers for ECM CPT Code: G9008	Example Enhanced Care Management Activity for each Modifier
U1 = ECM In-person service provided by Clinical Staff	• Nurse Care Coordinator, Social Worker, or other Clinical ECM staff meets with member in-person at ECM Provider office, other Provider office, home, or in the field to discuss care plan, goals, recent transitions, etc. • Clinical ECM staff accompaniment to medical, behavioral health, social service, or other relevant appointments. Always occurs on/after the date of Enhanced Care Management enrollment.
U1, GQ = ECM Phone / Telehealth provided by Clinical Staff	• Nurse Care Coordinator, Social Worker, or other clinical ECM staff speaks with member by phone or telehealth, to check in on referrals, care transitions, changes in health status, etc. Always occurs on/after the date of Enhanced Care Management enrollment.

HCPCs & Modifier Review – G9012 Member Services by Non-Clinical Staff

ECM Modifiers for ECM CPT Code: G9012	Example Enhanced Care Management Activity for each Modifier
U2 = ECM In-person service provided by Non-Clinical Staff	• Non-Clinical ECM staff meets with member in-person at ECM Provider office, other Provider office, home, or in the field to discuss care plan, goals, recent transitions, etc. ○ This can include Non-Clinical ECM staff accompaniment to medical, behavioral health, social service, or other relevant appointments. Always occurs on/after the date of Enhanced Care Management enrollment.
U2, GQ = ECM Phone / Telehealth service provided by Non-Clinical Staff	• Non-Clinical ECM staff speaks with member by phone or telehealth, to check in on referrals, care transitions, changes in health status, etc. ○ Member participates in the activity by telephone or telehealth. Always occurs on/after the date of Enhanced Care Management enrollment.

HCPCs & Modifier Review
Outreach by a Clinical Staff Person

ECM Modifiers for ECM CPT Code: G9008	Example Enhanced Care Management Activity for each Modifier
U8 = ECM Engagement Services, in-person, provided by Clinical Staff	Pre-enrollment in-person outreach attempt by Clinical Staff to an Enhanced Care Management Eligible member. Always occurs prior to the date of Enhanced Care Management enrollment.
U8, GQ = ECM Engagement Services, telephonic/electronic, provided by Clinical Staff	Pre-enrollment telephonic or electronic outreach attempt by Clinical Staff to an Enhanced Care Management Eligible member. Always occurs prior to the date of Enhanced Care Management enrollment.

HCPCs & Modifier Review
Outreach by a Non-Clinical Staff Person

ECM Modifiers for ECM CPT Code: G9012	Example Enhanced Care Management Activity for each Modifier
U8 = ECM Engagement Services, in-person, provided by Non-Clinical Staff	Pre-enrollment in-person outreach attempt by Non-Clinical staff to an Enhanced Care Management Eligible member. Always occurs prior to the date of Enhanced Care Management enrollment.
U8, GQ = ECM Engagement Services, telephonic/electronic, provided by Non-Clinical Staff	Pre-enrollment telephonic or electronic outreach attempt by non-clinical staff to an Enhanced Care Management Eligible member. Always occurs prior to the date of Enhanced Care Management enrollment.

Outreach Claims & Payment Reconciliation

- Please note, while DHCS requires the documentation of outreach attempts, the outreach modifier ***shall not*** be considered an ECM covered service.

- This means that payment reconciliation, performed by L.A. Care via submitted claims, will not take U8s into consideration as a covered service when applying guidelines for capitation payment.
  - Payment reconciliation requires that “Enhanced Care Management Enrolled Members received an ECM covered service (U1 / U1, GQ or U2 / U2, GQ) in the service month, and a claim must be present for those activities.

- For L.A. Care contracted ECM providers, payments for outreach will be made separately from ECM capitation payments, and details are included in the ECM Outreach Incentive description.

- ***ECM outreach activities must also be reported on the OTF (Outreach Tracker File).***

DHCS Update: Accounting for Care Coordination when Member is not Present

- DHCS recently decided not to include HCPCs codes or modifiers to distinguish these activities from member-facing ECM activities

- DHCS has identified they may consider adding these codes in the future

ECM Claims – Important Data Elements

Data	Description
Diagnosis Code	Diagnosis Code must be a valid ICD-10 Code. Please use the diagnosis code, with the highest level of specificity. Examples could include, but not limited to the following: - Z02.9 = Administrative examinations, unspecified - Z71.89 = Other specified counseling - Z71.9 = Counseling, unspecified
Unit of Service	Bill 1 Unit of Service for ECM per encounter – time components are captured in ECM claims
NPI	ECM Claims should be billed via an Organizational or Type 2 NPI - Rendering - Billing - Service Facility
Date(s) of Service	Required, will reject if blank or invalid date.
Place of Service Code	Required, will reject if blank. Common Codes may include: 04 – homeless shelter 11- medical office 12 – patient home 50 – Federally Qualified Health Center 53 – community health center 99 – other place of service not identified above

L.A. Care Claims Guidance

- How Can ECM Providers Submit Claims to L.A. Care
  - EDI
  - Paper

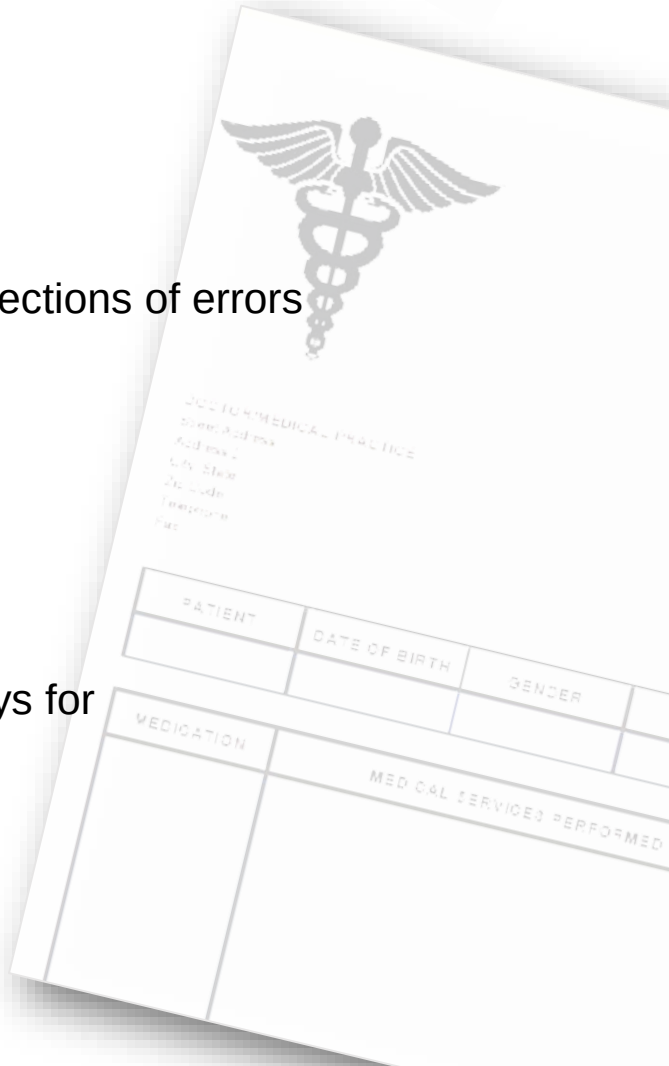
- What is Electronic Data Interchange (EDI)?

EDI is the electronic interchange of business information using a standardize format; a process which allows one company to send information to another company electronically rather than on paper

Benefits of EDI Billing

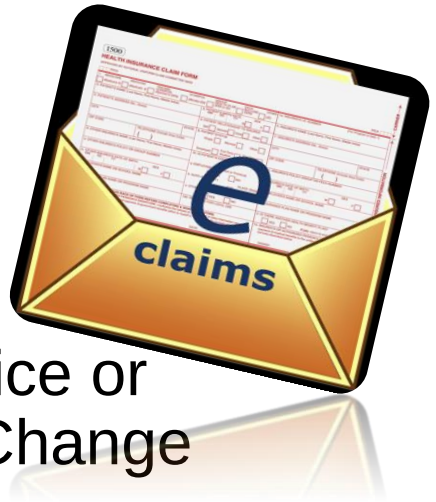
Why Bill Electronically?

- Improve Data Quality
  - Eliminating Illegible Handwriting Errors
  - Keying and Re-Keying Errors
- Real-Time Visibility Into Transaction Status
  - Error Reports from Clearinghouse Enables Corrections of errors
- Reduced Administration Expenses
  - No More Purchasing Claims Forms
  - No Printing Necessary
  - Postage and Handling Cost Eliminated
- Expedited Claims Adjudication & Payment
  - Exchange Transaction in Minutes Instead of Days for Postal Service
  - Payment Floor for Paper Claims = 20 Days
  - Payment Floor for **EDI Claims = 10 Days**



How Do You Submit EDI Claims?

Billing Claims Electronically Over a Secured Clearinghouse is a Safe and Secure Method of Submitting Your Claims to L.A. Care



- Change Healthcare
- You May Also Use A 3rd Party Billing Service or Clearinghouse that Bills Directly Through Change Healthcare
- Reference L.A. Care's Payer ID: **"LACAR"**

EDI Submissions Through Change Healthcare

- Billing Software Solution at a Cost to the Provider
- All Claim Types Accepted (**Including** Attachments)
- Visit Change Healthcare at:
  - www.changehealthcare.com
  - Customer Support: (877) 363-3666

CHANGE HEALTHCARE

More information is available at:
https://www.lacare.org/providers/claims-edi/submitting-claim

L.A. Care ECM Claims Guidance

Topic	Electronic / EDI (Strongly Preferred)	Paper
Format	**837 P** ECM is specific to Professional Services only. Therefore, an 837 I format **will not be accepted.**	**CMS 1500 Form** ECM is specific to Professional Services only. Therefore, the UB 04 Form **will not be accepted.**
Acknowledgement of Claims	L.A. Care shall identify and acknowledge the receipt of each claim, whether or not complete, and disclose the recorded date of receipt to the billing practitioner: • Within 2 working days of the date of receipt of claim.	L.A. Care shall identify and acknowledge the receipt of each claim, whether or not complete, and disclose the recorded date of receipt to the billing practitioner: • Within 15 working days of postmarked envelope
Submit to	All Claims are required to go through a Clearing House: - Change Healthcare	**L.A. Care Health Plan** Attention: Claims Department P.O. Box 811580 Los Angeles, CA 90081

L.A. Care ECM Claims Guidelines

Topic	Electronic / EDI (Strongly Preferred)	Paper
Claims Payment	N/A ECM Claims will be adjudicated to Pay at Zero, as ECM Providers will be receiving a monthly capitation rate. However, claims submissions are critical, as they will be used to document rendered services and utilization, which will serve as the primary driver for ECM payment reconciliation.	N/A ECM Claims will be adjudicated to Pay at Zero, as ECM Providers will be receiving a monthly capitation rate. However, claims submissions are critical, as they will be used to document rendered services and utilization, which will serve as the primary driver for ECM payment reconciliation.
Remittance Advice	All adjudicated ECM Claims, with a "Paid" Status will generate a $0 pay amount with the below language: "Charge exceeds fee schedule / maximum allowable or contracted / legislated fee arrangement." ECM claims may be denied if the member is not currently enrolled in ECM, for incorrect CPT codes or modifiers, or for other reasons. Please consult remittance advice and resubmit accordingly.	All adjudicated ECM Claims, with a "Paid" Status will generate a $0 pay amount with the below language: "Charge exceeds fee schedule / maximum allowable or contracted / legislated fee arrangement." ECM claims may be denied if the member is not currently enrolled in ECM, for incorrect CPT codes or modifiers, or for other reasons. Please consult remittance advice and resubmit accordingly.
Claims Timeliness	Within 60 days following the end of the service month. i.e. submit claims for ECM services rendered in March 2022 by May 31, 2022.	Within 60 days following the end of the service month. i.e. submit claims for ECM services rendered in March 2022 by May 31, 2022.

Remittance Advice

The Remittance Advice is a tool that can be used to detail a source of different information related to Claims. Data includes:

- **Check Date** - **Check Number** - **Pay To Provider (Name)** - **Address**	- **Claim ID** - **Claim Status (PAID / DENIED)** - **Adjustment Codes & Description** - **Remit Codes & Description** - **Allowable Amount**

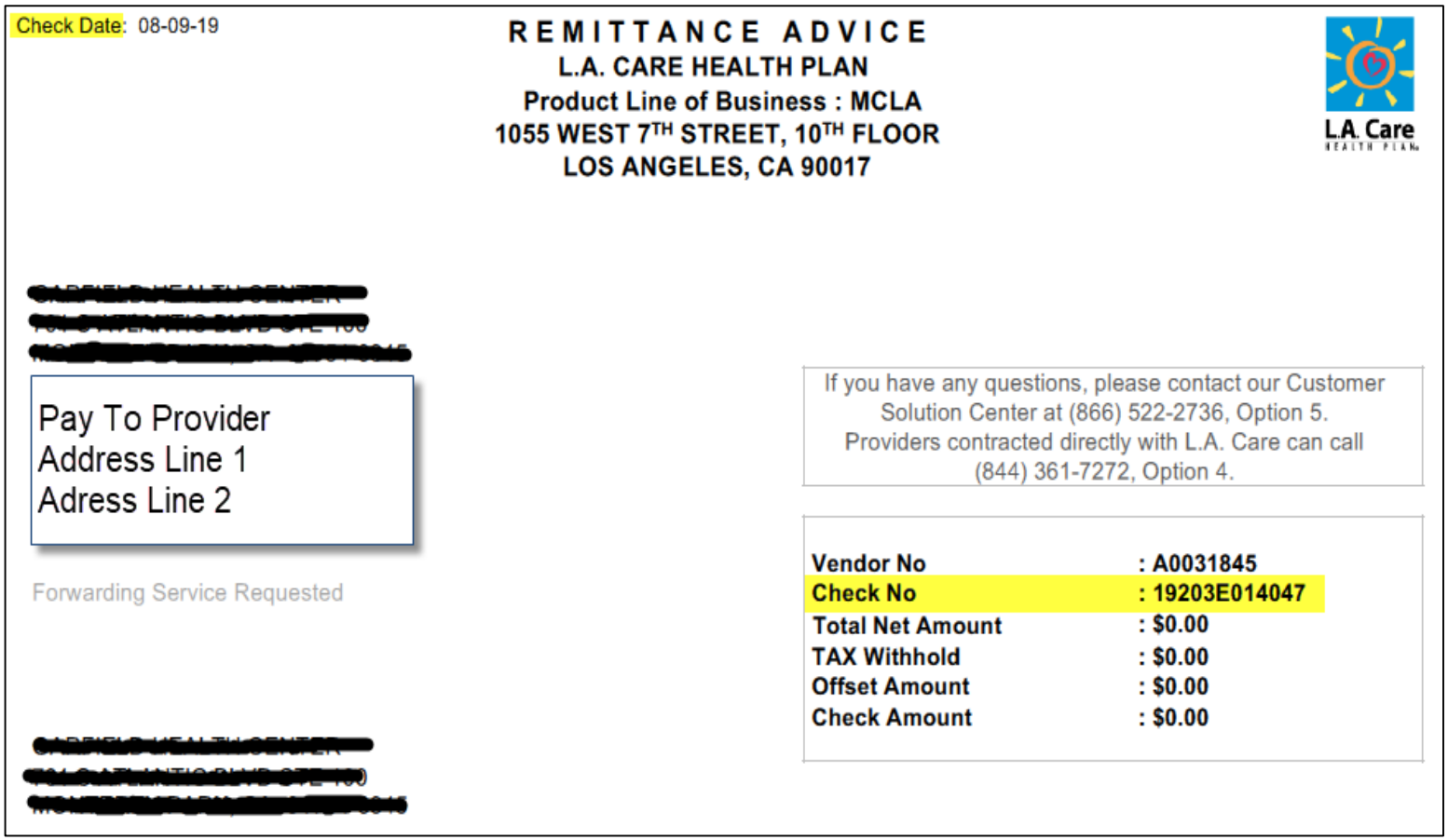
Please note, L.A. Care Health Plan, for the Enhanced Care Management Program, will pay ECM Providers a contracted monthly capitation rate for ECM members who are enrolled and served. ***Therefore, claims will be adjudicated to pay at $0 dollars as seen in the Allowable Amount section of the Remittance Advice.***

Also, L.A. Care will send a Remittance Advice for every claim that is submitted and adjudicated by L.A. Care.

Note, if a claim errors out via our Clearing House, Change Healthcare, this means L.A. Care did not receive the claim and did not adjudicate thus would not send an Remittance Advice.

Sample Remittance Advice

Screenshots below display where information can be found on the Remittance Advice



Check Date: 08-09-19

REMITTANCE ADVICE
L.A. CARE HEALTH PLAN
Product Line of Business : MCLA
1055 WEST 7TH STREET, 10TH FLOOR
LOS ANGELES, CA 90017

L.A. Care HEALTH PLAN

[redacted]

Pay To Provider
Address Line 1
Adress Line 2

Forwarding Service Requested

[redacted]

If you have any questions, please contact our Customer Solution Center at (866) 522-2736, Option 5.
Providers contracted directly with L.A. Care can call (844) 361-7272, Option 4.

Vendor No	**: A0031845**
Check No	**: 19203E014047**
Total Net Amount	**: $0.00**
TAX Withhold	**: $0.00**
Offset Amount	**: $0.00**
Check Amount	**: $0.00**

Sample Remittance Advice

Screenshots below display where information can be found on the Remittance Advice

Check Date: 08-09-19

REMITTANCE ADVICE
L.A. CARE HEALTH PLAN
Product Line of Business : MCLA
1055 WEST 7TH STREET, 10TH FLOOR
LOS ANGELES, CA 90017

L.A. Care HEALTH PLAN

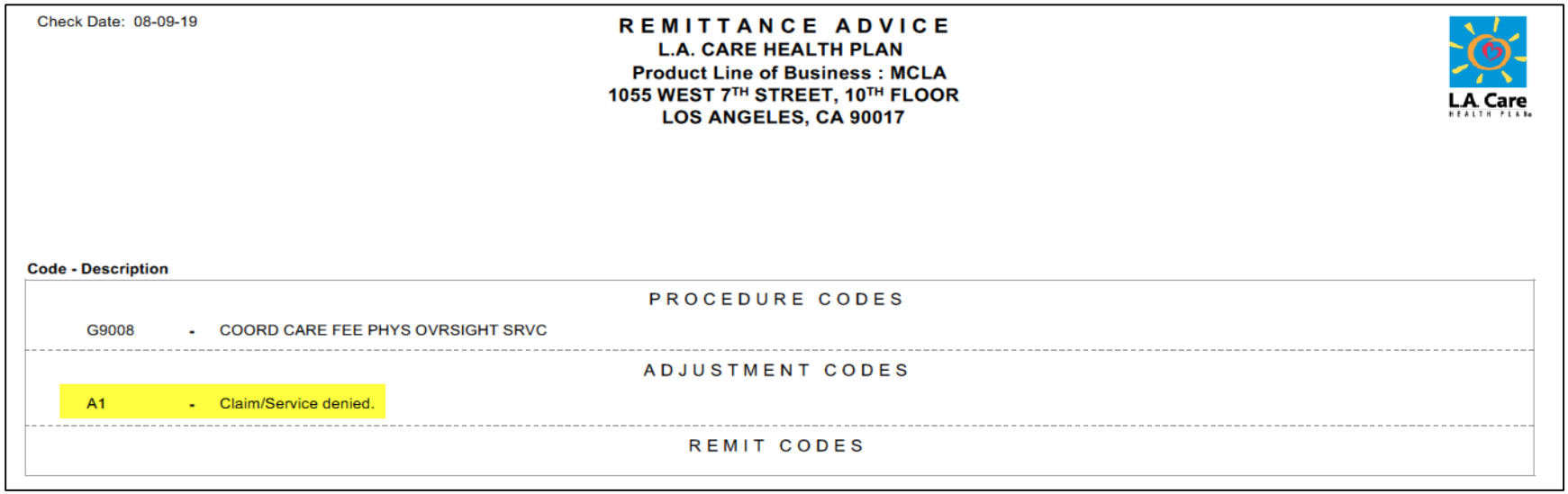
Vendor Name: [redacted]
FFS / CAP: FFS
TIN: 760733752
Benefit Plan: MCLA Medi-Cal Benefit Plan
Vendor No: A0031845

Patient : [redacted]
Member ID : [redacted]
Date of Birth : [redacted]
Member Responsibility : $0.00
Patient Control #: 100000261993
Authorization ID :
Provider : CHEN, DAVID
Claim Level Adj :
Claim Status : PAID
Claim ID : 19203E014047
COB Adjustment : $0.00
Claim Level Remit :

Line#	DOS From DT	DOS Thru DT	Serv Code	Mod Code	Rev Code	Units	Billed Amount	Allowable Amount	Adj Codes	Remit Code	Deductible	Co-Ins	Co-Pay	Interest / Other Adjustments	Net Amount
1	07-08-19	07-08-19	G9008	U7		1	$150.00	$0.00	A1		$0.00	$0.00	$0.00	$0.00	$0.00
CLAIM MESSAGES :					Total Net Amount :		$150.00	$0.00			$0.00	$0.00	$0.00	$0.00	$0.00

Claim Status: Please ensure to leverage ***Claims Status as the official indicator*** to determine Claim Status, even if the Adjustment Code / Description paint a different picture. ***Remember, Claim Status is the "Source of Truth."***

Sample Remittance Advice



Check Date: 08-09-19

REMITTANCE ADVICE
L.A. CARE HEALTH PLAN
Product Line of Business : MCLA
1055 WEST 7TH STREET, 10TH FLOOR
LOS ANGELES, CA 90017

L.A. Care HEALTH PLAN

Code - Description

PROCEDURE CODES

G9008 - COORD CARE FEE PHYS OVRSIGHT SRVC

ADJUSTMENT CODES

A1 - Claim/Service denied.

REMIT CODES

Claim Status: Please ensure to leverage ***Claims Status as the official indicator*** to determine Claim Status, even if the Adjustment Code / Description paint a different picture. Remember, ***Claim Status is the "Source of Truth."***

Common Denial Codes

CLAIM STATUS	ADJUSTMENT CODE	ADJUSTMENT DESCRIPTION	REMIT CODE	REMIT DESCRIPTION	NOTES / DESCRIPTION
DENIED	16	Claim/service lacks information or has submission/billing error(s).	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service / Provider.	•The most common reason for this Claim Denial Adjustment Code is that an Individual's NPI is used as Rendering Provider. •Other reasons that we have seen are related to either an invalid Places of Service or Diagnosis Code. ***Rendering Provider NPI = Billing Provider NPI*** **Action: ECM Provider to Re-Bill**

Common Denial Codes

CLAIM STATUS	ADJUSTMENT CODE	ADJUSTMENT DESCRIPTION	REMIT CODE	REMIT DESCRIPTION	NOTES / DESCRIPTION
DENIED	18	Exact duplicate claim/service.	N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	•The Claim received was deemed a Duplicate and therefore was Denied. **Action: No action required by ECM Provider.**

Common Denial Codes

CLAIM STATUS	ADJUSTMENT CODE	ADJUSTMENT DESCRIPTION	REMIT CODE	REMIT DESCRIPTION	NOTES / DESCRIPTION
DENIED	26	Expense incurred prior to coverage.	N30	Patient ineligible for this service.	•**The Claim was Denied due to an Enrollment / Eligibility Issue.** •Most common example, member is active with a Line of Business other than Medi-Cal. **<u>Action: ECM Provider to review and determine whether or not a resubmission is required.</u>**

ECM Claims Submission – Best Practices

- Always review your Remittance Advice
- Submit ECM claims in a timely manner – including time for possible resubmission
- Check the NPIs being used for claims submission:
  - Use Type 2 NPIs
  - Billing and rendering NPIs must match
  - Ensure claims are submitted with the NPIs provided to L.A. Care in the ECM contracting process
- Ensure ECM member enrollments are reported to L.A. Care timely

Key ECM Claims FAQs

- **Question**: Since the Provider is both the member's Provider and part of the ECM member's care team, would a ECM claim also need to be submitted to demonstrate the engagement/activity with this member? Or is this code only used for care coordination activities?
  - G9008 and G9012 are the only acceptable HCPCS/CPT codes for the ECM Program. Should clinical services be provided as part of a PCP or other visit please document separately and aside from the ECM Claim.
  - If the member saw his/her ECM Care Coordination or other team members to receive an ECM service (such as care management) at the same time, the ECM Care Team member would submit a claims for G9008 or G9012 with the appropriate modifier. This would not replace any separate billing for non-ECM clinical services (a physician visit or psychotherapy).

- **Question**: The description for HCPC Code G9008 specifies Nurse Care Coordinator, Social Worker, or other Clinical ECM staff as the qualifying clinical staff to utilize these modifiers. G9012 identifies Non-Clinical Coordinator or Community Health Worker staff as the qualifying staff to use these specific modifiers. Is my understanding correct then that if a Lead Care Manager is not a clinically licensed professional, they are only to use G9012?
  - Correct.

Key ECM Claims FAQs

- **Question**: Which claim(s) would we submit if a ECM member meets with his/her PCP to discuss a recent hospital admission (ECM transitional services) and also completes an examination?
  - Bill as for a PCP visit. The G9008 or G9012 + appropriate modifier could be billed by the care coordinator if he/she met with the member to also discuss the recent hospital admission.
  - PCP visits should be kept / documented separately from ECM services. Given that a majority of our ECM Providers will also be the clinic of where the member is assigned, it is important to note that the clinic is already receiving capitation from their contracted medical group for PCP services. Therefore, we would expect to see an encounter for the PCP visit and a Claim for the ECM service with the appropriate HCPC code and modifier(s).
  - The PCP visit itself and the encompassing details (CPT Codes / Diagnosis Codes / etc.) should not be included on the ECM claim.

- **Question**: Would an email conversation between LCM and member be billable (i.e., LCM sends resources and member responds with questions)?
  - Yes, the email conversation should be added to the chart and a claim should be submitted. However, it is also expected that members receive ECM services either in-person or telephonically / via telehealth; email alone is not a sufficient form of member interaction for ECM services.

Key ECM Claims FAQs

- **Question**: Do text messages sent to a member pre-enrollment count as an outreach attempt?
  - Yes, text messages directed toward an ***individual*** member count as an outreach attempt and an outreach claim should be submitted.
  - Mass text messaging, directed to multiple recipients at the same time, does not qualify as an outreach attempt for ECM.

- **Question**: When outreaching to a member who is not yet enrolled in ECM, should I submit a claim if the outreach attempt was unsuccessful (i.e. the member was not reached)?
  - Yes, a claim for the appropriate HCPC code based on the type of staff person (clinical vs. non-clinical) conducting the outreach, with the appropriate modifier (U8 for in-person attempt; U8, GQ for telephonic or electronic attempt), should be submitted.
  - It is important to track all efforts made to outreach to and engage a member. ECM Providers are required to identify if outreach attempts/activity to their assigned members were successful or unsuccessful through their monthly reporting in the Outreach Tracker File (OTF).

Key ECM Claims FAQs

- **Question**: We would like clarification on billing. Can you clarify about how to quantify the time spent with a member during a specific encounter?
  - L.A. Care Response: Enhanced Care Management does not track services in increments of time. One (1) unit is equal to one service encounter, regardless of time spent.
  - ECM Providers are expected and required to track and report time spent conducting outreach activity to member prior to their enrollment to ECM. However, the time spent conducting outreach is not identified in the claims/encounter submissions to L.A. Care.
  - The time spent conducting outreach is part of ECM provider monthly reporting via the Outreach Tracker File (OTF).

- **Question**: How can we test our claims coding and submission with LA Care to make sure the billing for outreach is captured and processes correctly. Is there someone we can work with?
  - Should ECM Providers choose to leverage EDI, please note that all claims must first be sent to a Clearinghouse (Change Healthcare). Therefore, testing should be conducted with your selected clearinghouse to ensure your submission can be accepted.
  - If ECM Providers have any questions regarding Change Healthcare, you may reach out to Change Healthcare Support at 800-527-8133 (option 1) or email EDI_Shared_Services@lacare.org.

Key ECM Claims FAQs

- **Question**: If a member received more than one ECM service on the same day, how can we submit claims for those services in a way that they do not appear to be duplicates?
  - If you find a scenario where you would need to bill for an additional service (i.e., outreach attempt) on the same day (DOS), modifier, etc., there are a select few modifiers (59, 76, 77) that would override the duplicate validation logic.
  - Please note, the use of these modifiers will be strictly monitored as we do not anticipate this being the norm for the program.
  - Furthermore, when processing a claim for a beneficiary has enrolled into ECM as a result of the team's outreach, it is L.A. Care's expectation to see the appropriate code with an accompanying modifier of U1 or U1, GQ; or U2 or U2, GQ in addition to the U8 or U8, GQ.

Additional Resources

- L.A. Care Health Plan Change Healthcare Information: https://www.lacare.org/providers/claims-edi/submitting-claim

- DHCS ECM & Community Support Coding Options: https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf

- DHCS ECM & Community Supports Billing and Invoicing Guidance: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-and-Community-Supports-Billing-and-Invoicing-Guidance.pdf

- Clean Claim Billing Requirements – CMS 1500

  http://www.lacare.org/sites/default/files/universal/Clean%20Claim%20Billing%20Requirements%20CMS%201500%20PDF.pdf

- National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual – Version 6.07/18 1500 Instruction Manual

  http://www.nucc.org/index.php/1500-claim-form-mainmenu-35/1500-instructions-mainmenu-42

Questions? Comments?

From all of us …..