blue california

Promise Health Plan

How to use the Blue Shield claims process for ECM and CS services

March 2025

Why we are here

For dates of service beginning April 1, 2025, Blue Shield of California Promise Health Plan will no longer accept Enhanced Care Management (ECM) or Community Supports (CS) encounters submissions using the prior process.

- Instead, ECM and CS providers will submit encounters for your Blue Shield Promise Medi-Cal members through our standard Blue Shield Promise claims submission processes.
- The purpose of this webinar is to give you the information you need to meet this requirement.

Dates of service prior to April 1, 2025	Dates of service on or after April 1, 2025
• Submit using existing encounter submission processes, through our Care Connect portal (ECM) or manual spreadsheets (CS).	• Submit using the standard claims submission processes (electronically, by mail, or by SympliSend.)

Benefits to you of this change

- Transitioning ECM and CS encounters to our standard claims processes will create a more accurate and efficient claims submission and processing experience for everyone.
- Payments will be automated, to allow for a more streamlined and timely payment process.

Agenda

- Claim submission overview
- ECM & CS billing instructions
- Q&A
- Claims payment
- Provider disputes
- Resources
- Q&A

Claims submission overview

General claim tips

A clean claim has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment.

- The CMS-1500 form is preferred for claims submission vs. the UB-04 as Blue Shield Promise considers ECM/CS services to be professional services.
- Include the rate charged for the service in the submitted claim(s).
- A service (rendering, attending, etc.) location should only be submitted if services are provided at a location other than the billing provider address. Otherwise, leave blank.
- Always submit with an NPI for the billing provider and any additional providers that are part of the claim.

Two ways to submit claims*

1. Paper claims

- Use the current CMS-1500 form.†
- For help, see: CMS-1500 completion instructions.
- Send paper claims via either:
  - **Mail:** Blue Shield Promise Health Plan, P.O. Box 272660, Chico, CA 95927-2660
  - **Digitally:** SympliSend after logging in to Provider Connection.
    - Go to *Claims* > *How to submit claims* > *Submit Via SympliSend*. See user guide for instructions.

2. Electronic claims

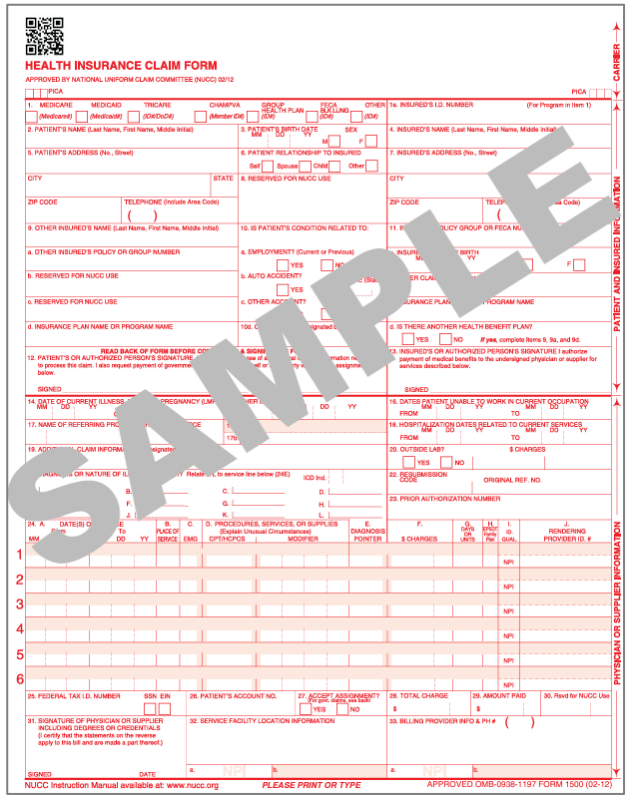
- Register with the Office Ally™ Clearinghouse to submit claims electronically. Use Payer ID: C1SCA.
- Electronic Clean Claim Data Elements:
  - Control segments
  - Header
  - Billing provider details
  - Subscriber details
  - Patient details
  - Service line detail
- For help, see: Blue Shield of California 5010 Companion Guide.

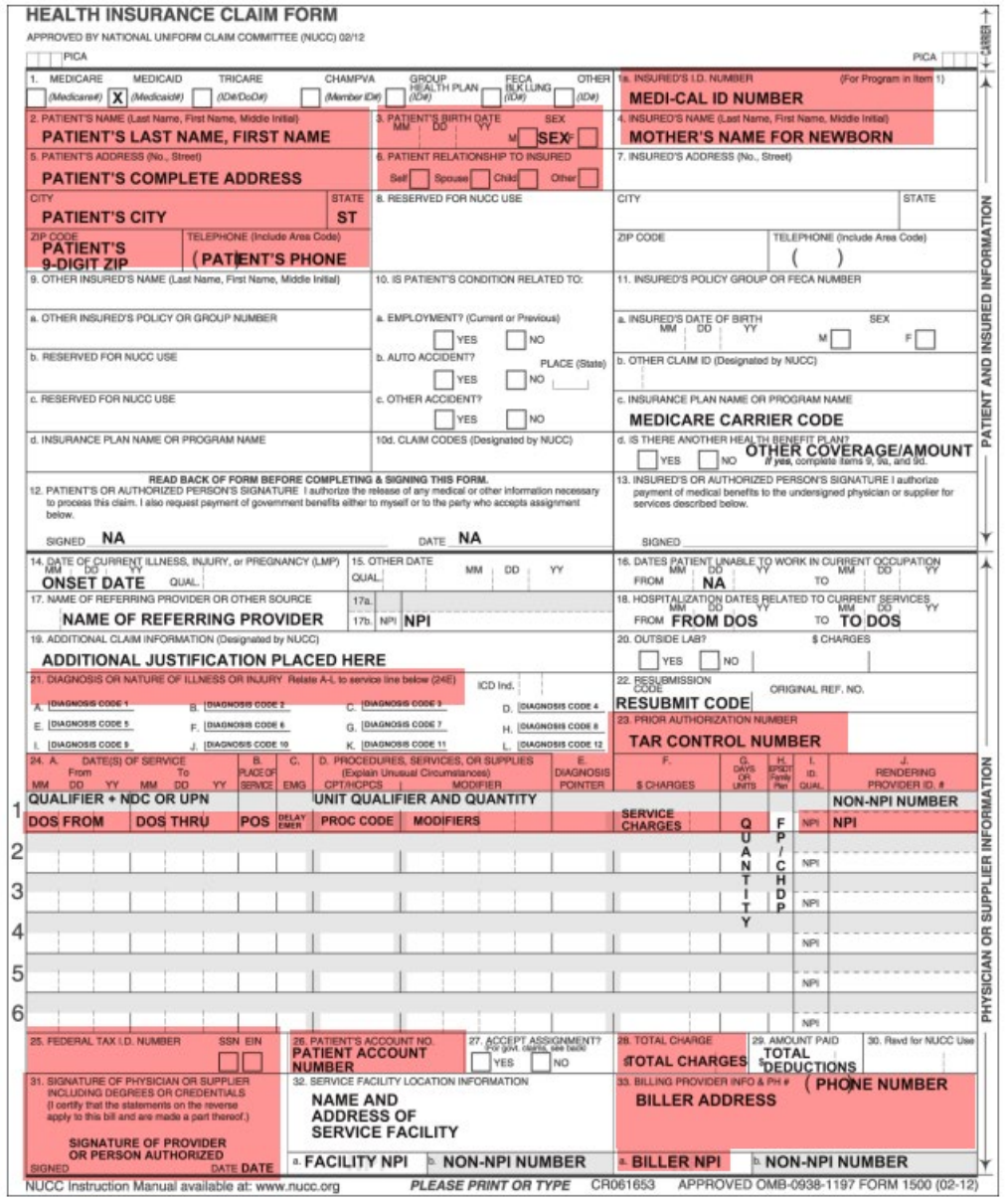
* For additional information on claims, visit the Claims overview page on Provider Connection – no login required.

† While CMS-1500 is preferred, the UB-04 will be accepted for facility service claims. For help, see UB-04 general instructions.

CMS-1500 form key sections

The CMS-1500 claim form is printed in red ink (specifically "Flint OCR Red J6983") to facilitate use of Optical Character Recognition (OCR) technology during scanning and processing of paper claims.



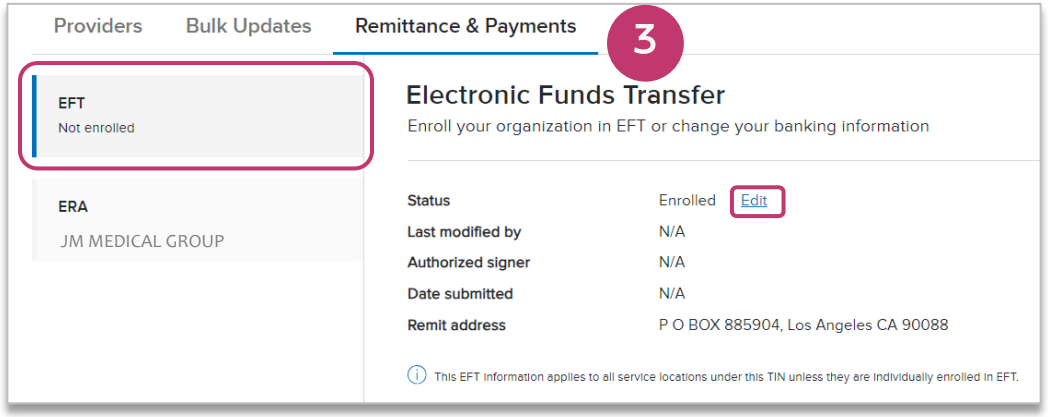


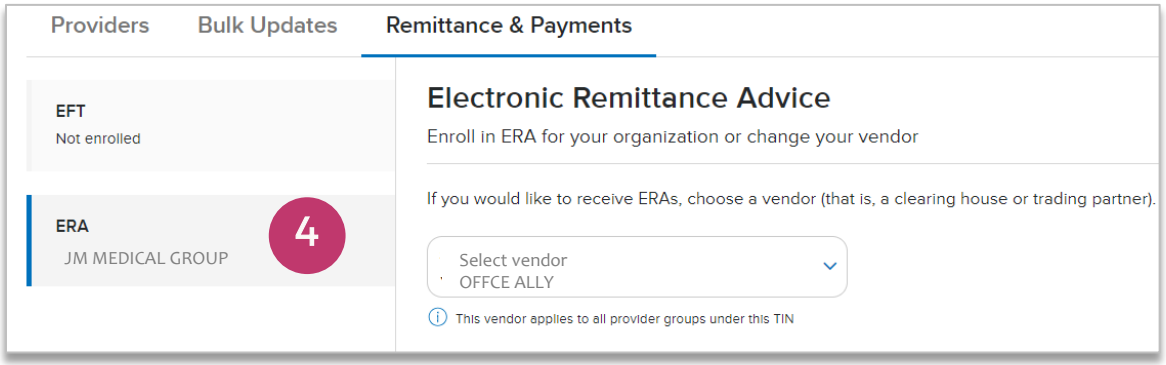
Enroll in ERA and EFT instructions

If you are a Provider Connection Account Manager, you can enroll or update ERA and/or EFT online. If you do not have a Provider Connection account, enroll in ERA/EFT by fax using the ePayments Provider Authorization Form.

To enroll online:

1. Click **Account Management** > **Provider & practitioner profiles.**
2. Select the correct TIN from the drop-down menu and click **Search** to refresh the screen.
3. Click the **Remittance & Payments** tab. The screen will open on the EFT information for that TIN. Click **Edit** to enroll or to change your EFT enrollment information.
4. To view/edit ERA , click ERA in the left navigation. Use the drop-down menu to choose a vendor (i.e., clearinghouse or trading partner). The vendor you choose applies to all providers under the selected Tax ID. Changes take up to three (3) business days.





* Electronic funds transfer (EFT): is an electronic form of payment. Electronic Remittance Advice (ERA): is an electronic version of an explanation of medical payment in HIPAA-complaint files. For additional information on claims, visit the EDI, ERA/EFT FAQ on Provider Connection – no login required.

Three ways to verify claims status

You can verify the status of claims within 15 days of submission to Blue Shield Promise by one of the following ways:

1. Via the *Check Claim Status* tool on Provider Connection after log in

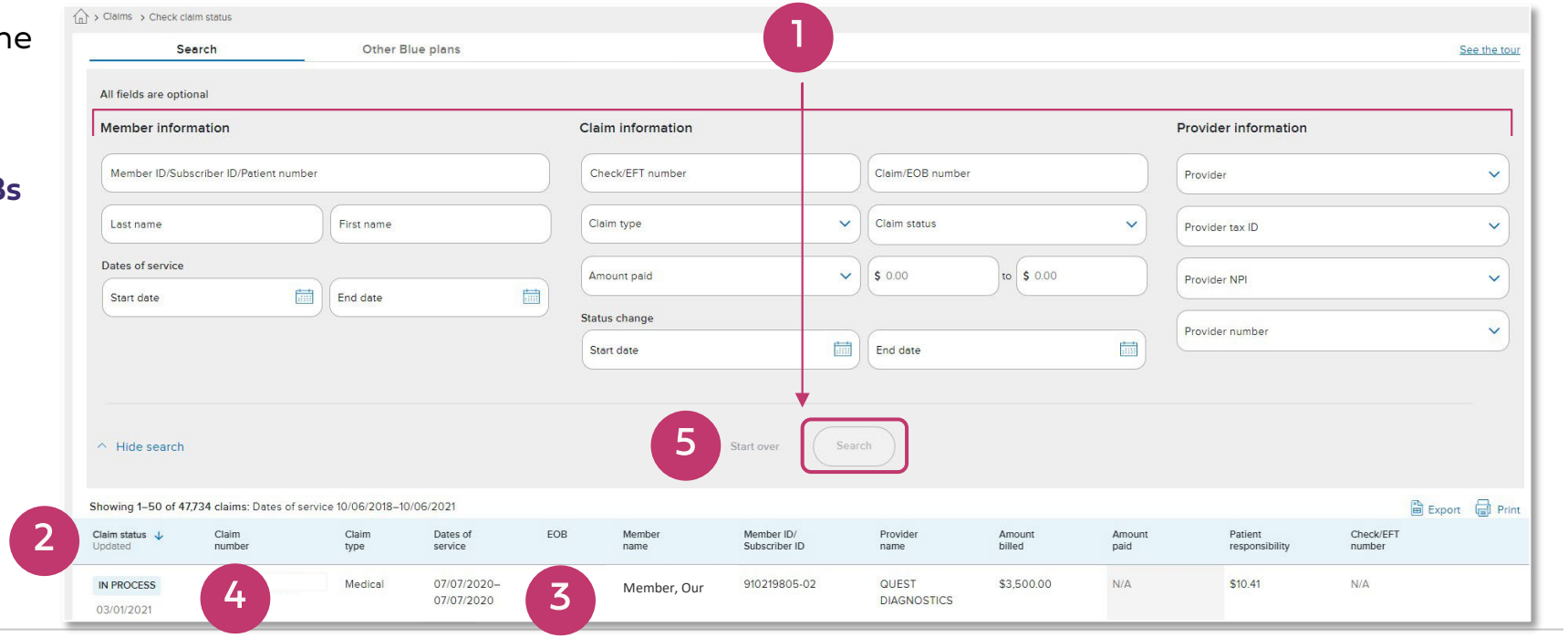
2. By using online chat available on every page of Provider Connection after log in

3. By calling Provider Customer Service 24/7: **(800) 468-9935 ext. 3**

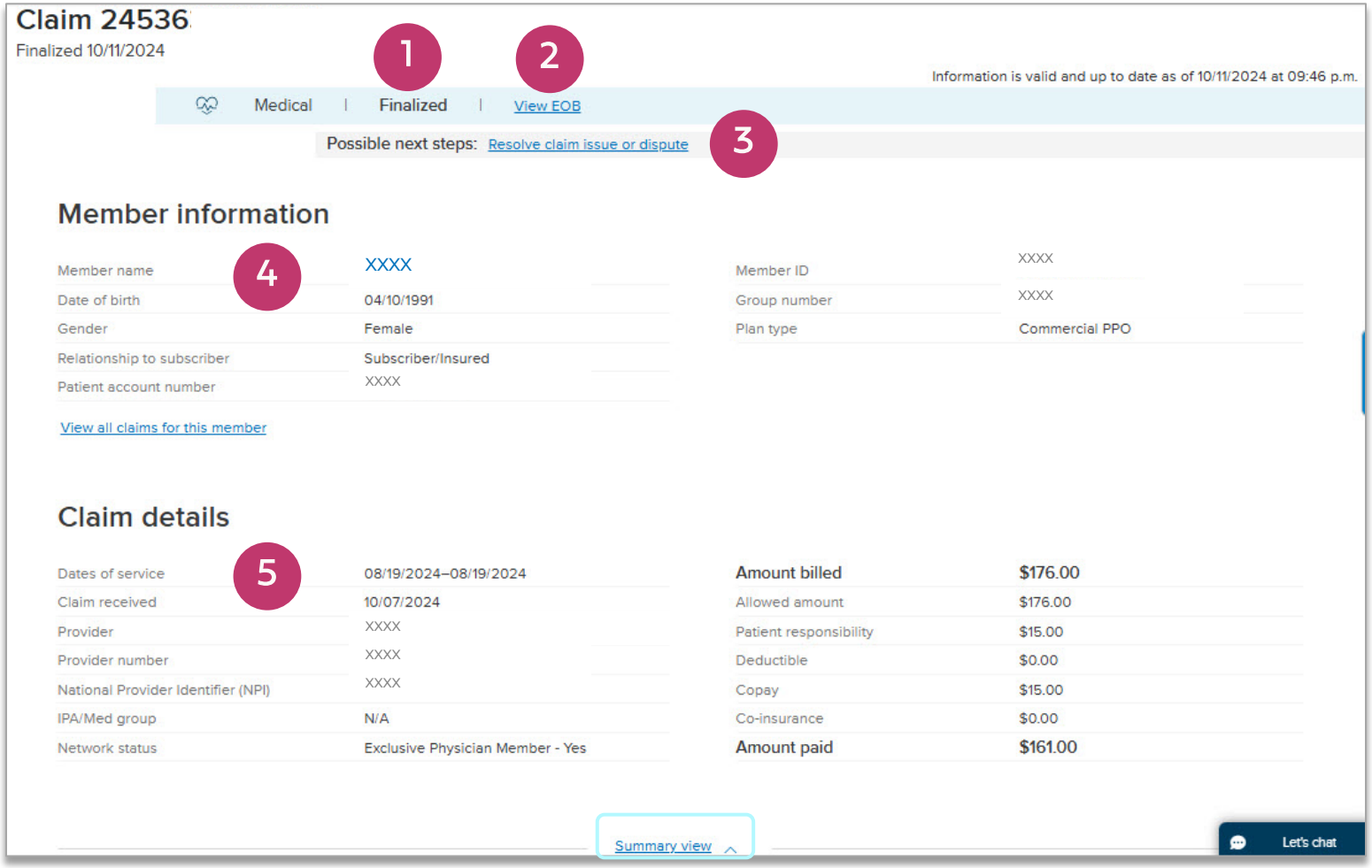
Check claims status on Provider Connection (log in required)

Check claims status is available from the home page and from the *Claims* section after log in. All claims connected to your username and login will display if you are the Account Manager or have been granted access by your Account Manager. Use to locate claims and related EOBs. It will display claims from the last three years with most recent at the top.

1. Enter data into one or more search fields: Member, Claim, and/or Provider Information. Click **Search**.
2. Results will display in the table below the blue header. To sort results in alphabetical or ascending/descending order by column, click the desired column header and the up/down arrow once it presents.
3. EOBs are downloadable once the claim is finalized.
4. Click the claim number to see more detailed information. **EOBs are also available from this link.**
5. To conduct a new search, click Start over to clear the search fields.



Claim details screen: Clicking the claim number from the search results opens the *Claims detail screen* and provides access to the following information.



Summary view

1. Claim status
2. EOB for finalized claim
3. Option to file a dispute
    - You will also see a link to add additional documentation to a finalized claim if Blue Shield has requested it.
4. Member information
    - Link to view all claims for the member
5. Claim details

Full view – contains all the above +

- Payment details
- Service & procedure details
- Claim message
- Claim notes

ECM & CS billing instructions

Increment billing

Daily meals

- Provider can bill 1 unit per meal up to the provider's contracted maximum.
  - **Example:** Mama's Kitchen has a maximum daily rate of $28.50 and any claims received after will deny.
    - Provider can bill 1 unit per meal up to 3 unit maximum (3 meals a day $9.50 per meal = $28.50).

Personal care services

- Provider can bill 1 unit per 15 minutes or 4 units per hour up to provider contracted maximum.
  - **Example:** 24-hour home care and Libertana rate is $35 per hour. The maximum per day is 24 hours or 96 units (4 units x 24 hours) with a total of $840 per day.

Increment billing continued..

Respite Services / Personal Care Services PMPM

- The first claim received for the month either Respite or Personal care, is considered for $25 PMPM payment. If Blue Shield Promise receives two claims, one respite and one personal, $25 PMPM is applied on the first claim.
  - **Note**: It is advisable for the provider to bill at least $25 on the claim since Blue Shield Promise's FACET system cannot pay more than the billed charges.

- For respite, the provider can bill 1 unit per 15 minutes or 4 units per hour, up to the provider-contracted maximum.
  - **Example:** Partners in Care Foundation (PICF) rate is $35 per hour. For the first 8 hours, provider is required to bill 32 units (4 units x 8 hours) for service per day. Anything above 32 units is overtime. Overtime and holiday pay is 24 hours, or 96 units (4 units x 24 hours) is the maximum PMPM $25 on either respite or personal care services

ECM coding provided by clinical staff

Providers must include informational codes with zero dollars on the claims form to comply with billing regulations.

HCPCS Level II Code	HCPCS Description	Modifiers	Modifier Description
G9008	ECM in-person: Provided by clinical staff • Coordinated care fee, physician coordinated care oversight services	U1	Used with **HCPCS code G9008** to indicate ECM services
G9008	ECM phone/telehealth: Provided by clinical staff • Coordinated care fee, physician coordinated care oversight services	**U1, GQ**	Used with **HCPCS code G9008** to indicate ECM services

ECM coding provided by non-clinical staff

- Non-clinical staff, including medical assistants and community health workers, play a vital role in delivering ECM services.
- **HCPCS code G9012** is essential for documenting various types of ECM services provided by non-clinical staff to facilitate proper billing.
- Modifiers such as **U2, GQ,** and **U8** enhance the specificity of ECM service types when using **HCPCS code G9012**.
- ECM services can be delivered in various formats, including in-person meetings, phone calls, telehealth sessions, and outreach efforts.

ECM coding provided by multidisciplinary team

HCPCS Level II Code	HCPCS Description	Modifiers	Modifier Description
G9007 (Added Jan 2024)	Multidisciplinary Team Conference: • Provided/initiated by ECM provider's clinical staff	**None**	• Used to indicate when a multidisciplinary team conference occurs between the member's ECM lead care manager and one or more other providers involved with managing a member's care. • No modifier is required for use of this code because it is assumed that these interactions will either be initiated by or involve participation of clinical staff.

Community Supports: Claims coding guidance

Community Support (CS) providers can bill for the services below. A full list of HCPCS and modifiers are in the ECM and Community Supports HCPCS Coding Guidance.

- Housing transition/Navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Short-term post-hospitalization housing
- Recuperative care (medical respite)
- Respite services
- Day habilitation programs
- Nursing facility transition/Diversion to assisted living facilities
- Community transition services/Nursing facility transition to a home
- Personal care/Homemaker services
- Environmental accessibility adaptations (home modifications)
- Medically tailored meals/Medically-supportive food
- Sobering centers
- Asthma remediation

Claims payment

Overview: Claims payment

Payment terms

- Blue Shield Promise ensures timely payments to contracted ECM providers based on established contract terms.
- Blue Shield Promise commits to paying 90% of clean claims within 30 days and 99% within 90 days.

Timely filing

- Providers must submit claims within a strict timeline of 180 calendar days to prevent denials.
- Timely filing of claims is crucial to avoid untimely filing denials that may impact providers financially.

No balance billing

- Practitioners participating in Medi-Cal and/or Medicare are prohibited from balance billing any Blue Shield Promise member eligible for Medi-Cal and/or Medicare.
- Network practitioners who engage in balance billing are in breach of their contract with Blue Shield Promise.
- Practitioners who engage in balance billing may be subject to sanctions by Blue Shield Promise, CMS, DHCS and other industry regulators.

Provider disputes

Claim disputes overview*

Four types of disputes

1. Challenging or appealing a claim or a group of claims to reach a resolution.
2. Seeking resolution on benefit determinations, which are critical for understanding entitlements.
3. Arising from denial of claims or timely filing denials, impacting claims processing.
4. Seeking resolution for contract disputes is essential for maintaining agreements and financial transactions.

Dispute requirements

- Must be submitted in writing with proper documentation through Provider Connection or by postal mail.
- A claim number(s) is essential for filing disputes.
- Initial disputes must be filed within 365 days from the service or action date.
- Providers who disagree with the initial determination can submit a final dispute within 45 working days of the initial determination.

Dispute submission

- Can be submitted online through the Blue Shield Provider Connection website (after log in) or by mail.
- By mail, send to: Provider Dispute Resolution Request / Blue Shield Promise / ATTN: FirstSource – BSCPHP PDR / PO Box 8309 / Chico, CA 95927-8309

* See dispute fundamentals to learn more about the dispute process. For step-by-step instructions with screenshots, see Submit claims disputes online and view status.

Helpful resources

Establishing a Provider Connection account

- **Identify a Provider Connection Account Manager**
  - The person executing the initial Provider Connection registration is considered an Account Manager. When the maximum allowed number of Account Managers are registered, Provider Connection will display a message. Most organizations can have at least two Account Managers.

- **Determine your account type and have the following information on hand:**

Click these links for step-by-step instruction.

Account type	Required for registration
1. Provider	• One Tax ID (TIN) or Social Security Number (SSN). • Claims data* for the TIN/SSN you are registering under.
2. MSO	• MSO's TIN and one TIN/SSN for provider you are representing/registering with. • Claims data* for the provider you are representing/registering with. • Business Associate Agreement (BAA) date for each provider's TIN you are registering. ◦ BAA date = date the provider signed the contract.
3. Billing Service	• TIN(s) of the providers for whom you will bill. • BAA date for each provider's TIN/SSN you are registering.

* A check/EFT amount AND either the 1) check/EFT number or 2) claim number or 3) Member ID for one claim paid in the last three months under the TIN/SSN being registered. If there are no claims within the last three months, the system will ask for the subscriber ID and birth date of an eligible Blue Shield/Blue Shield Promise member.

Resources to support you

Action	Support
Provider Connection Support – no log in required	• Provider Connection Reference Guide • Provider Connection website registration instructions for Provider, MSO and Billing accounts and additional tutorials • Online text-based website help available from every page – no log in required.
Blue Shield Promise Provider Customer Service at **(800) 468-9935** Live chat from Provider Connection – log in required.	• General help with website if you can't find answers in the resources above. • Removal or disabling of an Account Manager for your organization. • Provider and Tax ID association for one of your claims.

- Claims overview page on Provider Connection – no login required.
- Register with the Office Ally™ Clearinghouse to submit claims electronically. Use Payer ID: C1SCA.
- Submitting claims electronically, visit the EDI, ERA/EFT FAQ on Provider Connection – no login required.
- Blue Shield of California 5010 Companion Guide.
- ECM and Community Supports HCPCS Coding Guidance.
- Enroll in ERA/EFT by fax using the ePayments Provider Authorization Form.
- CMS-1500 completion instructions.
- UB-04 general instructions.
- See user guide for how to submit claims in SympliSend.
- See dispute fundamentals and how to submit claims disputes online and view status.

Blue Shield Promise ECM/CS office hours

- We invite you to join one or more of the office hours listed below if you have questions about how to use the Blue Shield claims process for ECM and CS services:

Bi–weekly on Wednesdays	Time	To join a session
April 23	1-2:00pm Pacific	Click: Join the meeting now • Meeting ID: 251 270 310 290 • Passcode: ru72k3qT By phone only: • 1-628-225-1779 • ID: 15137657#
May 7		
May 21		
June 4