Enhanced Care Management (ECM) CMS 1500 PDF Encounter Submittal Requirements

ECM Encounters Start Date

Enhance Care Management Encounters are applicable on and after January 1st, 2022. Encounters with DOS (Date of Service) on or after January 1st, 2022, must be submitted as ECM Encounters.

Migration and Run Out for WPC

Trading Partners who previously submitted WPC Encounters will have the ability to continue sending WPC Encounters with DOS December 2021, through March 6th, 2022.

Original Encounter Submittal Time Requirement

You can submit files weekly or monthly, however, all files must be received by the 6th of each month to be processed for payment that month. Encounters submitted are to have service dates in the previous month(s). Bill only services for the same member, for the same DOS (date of Service) in one encounter.

Service Date	Cut-off Date for Replacement Submittals				
January	April 6th				
February	May 6th				
March	June 6th				
April	July 6th				
May	August 6th				
June	September 6th				
July	October 6th				
August	November 6th				
September	December 6th				
October	January 6th				
November	February 6th				
December	March 6th				

Replacement Encounter Submittal Time Requirements

PDF Encounter File Naming Convention Example

Example: ECAC_ECM20220206_001.pdf (Spaces not allowed)

E = encounter file

3 letter-acronym = Identifies the Trading Partner (Assigned by AAH)

_ = underscore

ECM = denotes program

YYYY= submission year

MM = submission month

DD = submission day

00# = sequence identification number, using 001 for the first file submitted in a day, incrementing for each additional file submitted that day. Send in pdf format only (.pdf)

Types of Encounters

- Original Outreach Encounters for Pre-Enrolled Members Require: Relevant Diagnosis Code, Procedure Code G9008 or G9012, Modifier(s) = U8, and GQ if applicable, and <u>Must have a Tier value between 1 and 3.</u> Valid Outreach Procedure code/modifier combinations: G9008-U8 G9008-U8-GQ G9012-U8 G9012-U8-GQ
- Original Encounters for Enrolled Members Require: Relevant Diagnosis Code, Procedure Code G9008 or G9012, Modifier(s) = U1 or U2, and GQ if applicable, and <u>Must Not have a Tier (Just send 'ECM')</u> G9008-U1 G9008-U1-GQ G9012-U2 G9012-U2-GQ
- <u>Replacement/Void Encounters for either Outreach/Pre-Enrolled or Enrolled Members Require</u>
 Fix data in Error, and in Field 22, send Resubmission Code = 7 indicating replacement, and the Original Claim Number. Send the entire claim again as a replacement and not just the Service that was denied.
 Send a new unique Claim ID in Box 26 (or in 11 b if that is where you are sending this ID). See example:



 <u>Encounters with Service Line modifier 2 = 77, prevent duplicate services from being denied Require:</u> To ensure your claims are accepted by the Alliance. Multiple services (touches) on the same date (DOS), with the same modifier, for the same member, must be sent with an additional Modifier of = 77. Example:

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Outbound Encounter Accept/Deny Reports

AAH provides Excel ECM Monthly Encounter Summary Reports on approx. the 22nd of each month. The report is placed in the Trading Partner's SFTP 'Correspondence' folder. Only high-level acceptance/denial information is available, and only the first denial reason identified for any given claim is captured. Contact AAH for detail.

Trading Partner Testing and Certification

Encounters must be submitted by use of a CMS1500_Fillable_Form_That_Prints_on_Blank-White. Ask for a form if needed. <u>Multiple claims submitted in a single pdf file are allowed and are preferred</u>.

<u>Multiple page claims are allowed</u>. Follow the CMS standard for how providers must prepare the CMS-1500 paper claims as outlined below:

- a. The pages of a multipage claim must be in sequential order i.e. .page 1, page 2, ... and be consecutive within the.pdf file (no gaps).
- b. Box 28 of the last page must have the total charges for all pages (claim total).

c. All other/not-last pages must have either 0, or blank or 'continued' in box 28. DO NOT PUT THE PAGE TOTAL

<u>Testing will involve submittal of a minimum of 3 encounters per each type listed below:</u> Original Outreach Encounters for Pre-Enrolled Members Original Encounters for Enrolled Members Replacement Encounters for either Outreach/Pre-Enrolled or Enrolled Members Encounters with Service Line modifier 2 = 77 which prevents duplicate services from being denied <u>Test File Drop Location</u>: To be provided by AAH <u>Production File Drop Location</u>: To be provided by AAH Upon completion of EDI Certification, ECM Provider may start sending in production data

CMS 1500 ECM Example

Member ID must be 9 digits, pad with leading Zero's if needed

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If Field 31 (First and Last Name of Rendering Provider) or Field 24J (Rendering Provider NPI) is present, then the other field needs to be present

CMS 1500 Encounter Form Requirements

Field#	Claim Field Name	ECM Value Requirements
1	Type of Health Insurance	Default 'Medicaid' - Required
1a	Insured's ID Number	Alameda Alliance Member ID - Please send a Full 9-digit ID (Pad with leading zeroes if Necessary) - Required
2	Patient Last Name Patient First Name	Valid Last Name and First Name are both required.
	Patient Middle Initial	
3	Patient's Birth Date	Valid DOB and Gender code Required.
4	Insured's Name	Required
5	Patient's Address	Required
6	Patient's Relationship to Insured	Default Self - Required
7	Insured's Address	Required
11a	Insured's Date of Birth, Sex	Required
11b	Other Claim ID	Conditional Use:
		Use box 11b only if Box 26 can't support a Unique Provider Claim ID. The Unique Claim ID must start with a fixed 3-character acronym provided to you by AAH followed by a '9' and then sequential numbering (example EBI700001, EBI7000002, EBI7000003) Do not send anything in this box if Box 26 can support the Unique Provider Claim ID noted above. THIS NUMBER MUST BE UNIQUE per Claim, even when sending in corrections to a claim, this number must never be a duplicate.
12	Patient's or Authorized Person's Signature	Default to Signature on File - Required
13	Insured's or Authorized Person's Signature	Default to Signature on File - Required
19	Additional Claim Information	Required
		Post Enrollment (Outreach) send only: <u>'ECM'</u>
		Pre-Enrollment send one of these values:
		Send 'ECM; Tier 1'
		For Street Outreach
		• Face-to-face
		In person only
		No Telehealth
		Must be bi-directional
		• Paid for each street outreach; maximum total outreach attempts is 5

		• Reimbursement is limited to one outreach attempt per tier per day
		• The 5 attempts must be within a 90-day period from the first outreach attempt
		Send 'ECM; Tier 2'
		For Non-Street Outreach
		Face-to-face
		• In person
		 Telehealth during public health emergency Must be bi-directional
		 Paid for each non-street outreach; maximum total outreach
		attempts is 5
		Reimbursement is limited to one outreach attempt per tier per
		day
		• The 5 attempts must be within a 90-day period from the first outreach attempt
		Send 'ECM; Tier 3'
		• For Outreach types = phone call, email, text, unsuccessful Street
		and Non-Street Outreach (face-to-face)
		One direction
		Maximum attempts is 20
		• Reimbursement is limited to one outreach attempt per tier per day
		 Attempts must be within a 90-day period from the first outreach attempt
21	Diagnosis or Nature of Illness	Send Relevant ICD 10 code per Business Rules
	or Injury	and Default value of '0' in upper right top of field – Required
22	Claim Resubmission	Conditional Use
	(Correction)	
		SEND data in this field only when sending in a Corrected Claim
		Send with Resubmission code = '7', and send in Original Claim
244		Number
24A	Dates of Service: (Range)	Required
24B	Place of Service	Required
		Note: For Tier 3 Outreach send 02 (TeleVideo)
24D	Procedure Codes and Modifiers	Required - Refer to page 7 Reference Guide.
		Valid Outreach/Pre-Enrollment Combinations:
		G9008/U8
		G9008/U8/GQ
		G9012/U8 G9012/U8/GQ
		Valid Enrolled Member Combinations:

		G9008/U1 G9008/U1/GQ G9012/U2 G9012/U2/GQ And
		Conditionally Send Modifier 77 for valid same services (to prevent Duplicate Rejections) Example: G9012/U2/GQ/77
24E	Diagnosis Pointer	Default to 'A' - Required
24F	Charges	Default to '0.00' - Required
24G	Days or Units	Required Default to 0 unless Multiple same services in one day. If same service date, Tier, Proc Code and Modifier, send a single Service Line and correct unit qty. An example would be three phone calls in a day, then the unit would be = 3
241	ID Qualifier	Default to NPI - Required
24J	Rendering Provider ID. (NPI) #	Conditional Use
		Send if Applicable, else leave blank
		If either box 31 or 24j has data, the other must
		have data.
25	Federal Tax ID Number	Billing Provider's Tax ID - Required
26	Patient's Account Number (also referred to as Claim # for ECM Use)	Required Must be Unique and Sequential Send with Acronym followed by a 7, and then sequential numbering (Example: EBI700001). This number must not be duplicated, even when sending in corrected claims
27	Accept Assignment?	Default to YES - Required
28	Total Charge	Default to '0.00' - Required
29	Amount Paid	Default to '0.00' - Required
31	Rendering Physician First and Last Name	Conditional Use Send if Applicable, else leave blank If either box 31 or 24j has data, the other must have data.
32	Service Facility Location Information	Conditional Use Address, City, State, and Zip code Required only if different than Billing Location
32a	Service Facility NPI#	Conditional Use Valid NPI code Required only if different than Billing Location
33	Billing Provider	Required Phone Number Valid Address, City, State, and Zip code Required and send a 9-digit zip code

33a	Billing Provider NPI#	Required - Valid Billing NPI
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Document Version Edits

Date	Description	Author	Version
11.22.21	Creation date	C. Rogers	Version 1.0
2.25.22	Updated Valid Tiers, changed the available date for Outbound Encounter Accept/Deny Reports, Clarified Procedure Code/Modifier Valid Combinations	C. Rogers	Version 1.1

Helpful Links and Information

https://www.dhcs.ca.gov/provgovpart/Pages/ECM_ILOS.aspx Email:<u>EDISupport@alamedaalliance.org</u> P: 1.510.373.5757

Per ECM and Community Supports Coding Options November 2021.pdf -

MCPs must use the Healthcare Common Procedure Coding System (HCPCS) codes listed in the table to report ECM services. The HCPCS code and modifier combined define the service as ECM. As an example, HCPCS code G9008 by itself does not define the service as an ECM service. HCPCS code G9008 must be reported with modifier U1 for the care coordination service to be defined and categorized as an ECM service. MCPs may utilize alternative payment approaches with ECM Providers, but must use the below HCPCS codes and modifiers for reporting applicable encounters to DHCS. If an ECM service is provided through telehealth, an additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy.¹

HCPCS Level II Code	HCPCS Description	Modifiers	Modifier Description
G9008	ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1	Used by Managed Care with HCPCS code G9008 to indicate Enhanced Care Management services
G9008	ECM Phone/Telehealth: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1, GQ	Used by Managed Care with HCPCS code G9008 to indicate Enhanced Care Management services.
(New) G9008	ECM Outreach In Person: Provided by Clinical Staff. Other specified case management service not elsewhere classified.	U8	Used by Managed Care with HCPCS code G9008 to indicate a single in -person Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management.

(New)	ECM Outreach Telephonic/Electronic: Provided by Clinical Staff. Other specified case management service not elsewhere classified.		Used by Managed Care with HCPCS code G9008 to indicate a single telephonic/electronic Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management.
G9008		U8, GQ	Telephonic/electronic methods can include text messaging or secure email individualized to the Member. However, mass communications (e.g., mass mailings, distribution emails, and text messages) do not count as outreach and should not be included.

G9012	ECM In-Person: Provided by Non- Clinical Staff. Other specified case management service not elsewhere classified.	U2	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services
G9012	ECM Phone/Telehealth: Provided by Non- Clinical Staff. Other specified case management service not elsewhere classified.	U2, GQ	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services.

(New) G9012	ECM Outreach In Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U8	Used by Managed Care with HCPCS code G9012 to indicate a single in –person Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into Enhanced Care Management.
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