Medi-Cal Health Homes Program (HHP and AC3)

Community Based Care Management Entities (CB-CMEs) - 837P Data Requirements -

CB-CME's Member's Pre and Post Enrollment Requirements

AAH Member's Pre-Enrollment Status requires Tier level and default data as noted below in matrix.
AAH Member's Post-Enrollment requires a standard 837P be sent with relevant Diagnosis, Modifiers, and Procedure Codes. Reference: HHP Program Guide - Final_12-20-18.pdf

Bill services with the same Date of Service for same member in one Encounter. Multiple service dates within one Encounter is not allowed.

Multiple services (touches) on the same date (DOS) with the same modifier (U1 – U7) with Modifier 77

CBCME's are expected to bill separate claims for every touch with the patients. To ensure your claims are accepted by the Alliance, CBCME's should use Modifier 77 so that it by passes our duplicate check. We request CBCME's to use U1-U7 modifiers in the first box followed with modifier 77 if applicable.

Example:

Charge Line Information (Box 24)

	24. A. DATE(S) OF SERVICE FROM MM	DD	YY	TO MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES,SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS/ UNITS	H. EPSDT Fam Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	07	08	2019				22		G9008	U3	77			1	02	2		NPI	
2																		NPI	
3																		NPI	

CB-CME's 837P Testing

Testing will include both Member's Pre and Post Enrollment Status

Original, Void and Replacement 837P data will be tested. For every encounter submission, trading partners will receive AAH ICN (Internal Control Number) in 277CA or proprietary report. Encounters previously denied by AAH shall be submitted as replacements. Reference Appendix B – Void and Replacement Scenarios in our standard companion guide: AAH_837P_CG_V.1.0.

Test File Drop Location: To be provided by AAH
Upon completion of EDI Certification, CB-CME's may start sending in production data

CB-CME's 837P File Naming Convention

Example: ECHC_HHAC320190323_001.TXT **(Do not send any spaces)
E = encounter file
AAA = Trading partner designation assigned by the Alliance
_ = Underscore
HHAC3 = Denotes Program(s)
YYYY= submission Year
MM = Submission Month

DD = Submission Day
00# = Sequence identification number, using 001 for first file submitted in a day, incrementing for each additional file submitted that day.

CB-CME's Production Data Submittal Time Requirements

Data may be sent weekly or monthly. Pay period monthly cut off receipt date for CMS 1500 pdf encounter files is the 6th of each month to allow for processing. Pay period monthly cut off receipt date for 837P EDI encounter files is the 10th of each month.

Sending Corrected Replacement Encounters in 837P

Loop ID	Reference	Name	Codes	Notes/Comments
2300	CLM05-3	Claim Frequency Type Code	7 - Replacement 8 - Void	
2300	REF	Original Claim Reference Number	F8	Send back the ICN (internal control number in the 277 Denial

Sending Corrected Replacement Encounters in CMS 1500

Enter the missing or corrected data to fix the issue

Enter Code 7 in Box 22 and Enter the Original Claim ID

Send Only for Corrections

Enter a 7 and the Original Claim ID here

Send new Claim ID in Box 26 (or in 11 b if that is where you are sending this ID)

Send New Unique Claim ID here

Replacement Submittal Time Requirements

HHP/AC3	CMS 1500 PDF Encounter Format	EDI 837P Encounter Format
Service Date	Cut-off Date for Replacement Submittals	Cut-off Date for Replacement Submittals
January	April 6th	April 10th
February	May 6th	May 10th
March	June 6th	June 10th
April	July 6th	July 10th
May	August 6th	August 10th
June	September 6th	September 10th
July	October 6th	October 10th
August	November 6th	November 10th
September	December 6th	December 10th
October	January 6th	January 10th
November	February 6th	February 10th
December	March 6th	March 10th

Document Version Edits

Date	Description	Author	Version
4.25.19	Creation date	C. Rogers	Version 1.0
5.28.19	NTE02 - Changed Tier informational text per Business HI01-02 – Removed Default Diagnosis Code Status	C. Rogers	Version 1.1
7.16.19	CLM01 (Claim/Patient Control Number) - Requirements for 'Paper' Claim Submittals	C. Rogers	Version 1.2
7.16.19	HI01-02 Diagnosis Codes Examples for Pre-Enrollment	C. Rogers	Version 1.2
7.16.19	Removed Loop 2430 Line Adjudication Information	C. Rogers	Version 1.2
7.16.19	Removed Amount Segment in EDI 837P requirements	C. Rogers	Version 1.2
7.16.19	Added CMS 1500 Example/Reference	C. Rogers	Version 1.2
7.19.19	Added 11b Unique Provider Claim ID	C. Rogers	Version 1.3
7.29.19	CMS1500 Noted 32a and 32b conditional requirement	C. Rogers	Version 1.3
7.29.19	CMS1500 Noted Box 19 requirements	C. Rogers	Version 1.3
7.31.19	CMS1500 Noted Box 24J and Box 31 requirements	C. Rogers	Version 1.4
8.14.19	CMS1500 sending multiple encounters per file	C. Rogers	Version 1.5
8.16.19	Diagnosis code can't have a '.' In 837P files	C. Rogers	Version 1.5
8.26.19	Added NTE02 – Tier 4 for non-Face-to-Face encounters	C. Rogers	Version 1.6
10.4.19	Added Enforced data validations, clarification on Multiple services (touches) on the same date (DOS) with the same modifier (U1 – U7) with Modifier 77	C. Rogers	Version 1.7
10.9.19	Request date to receive PDF Encounters 6th of every month and 10th of every month for EDI Files	C. Rogers	Version 1.7
10.15.19	Subscriber ID/ Member ID must be 9 digits	C. Rogers	Version 1.8
11.6.19	Included Submittal/Replacement Cut-off Date chart	C. Rogers	Version 1.9
11.8.19	Included Encounter Replacement Requirements	C. Rogers	Version 1.9
11.25.19	Removed Other Subscriber Loop in EDI 837P	C. Rogers	Version 2.0
11.25.19	Added requirements of only one service date per Encounter	C. Rogers	Version 2.0
12.6.19	DHCS updated revenue codes and ICD-10 codes	C. Rogers	Version 2.1
1.10.20	EDI files should contain multiple encounters	C. Rogers	Version 2.2
1.14.20	EDI file must be DOS Format, one ISA/IEA, one GS/GE witch up to 5000 ST/SE's allowed	C. Rogers	Version 2.2

EDI 837P FORMAT

EDI 837P Files should contain multiple encounters. One encounter per EEDI file is not allowed.

EDI files must be sent in DOS Format and should have one ISA/IEA, one GS/GE, and can have up to 5000 ST/SE's

EDI 837P Data Requirements for Pre and Post Member Enrollment

Element	Name	PPH Pre-Enrollment Data Requirements	PPH Post-Enrollment Data Requirements
ISA05/ISA06	Interchange ID Qualifier and ID **of Sender – AAH will advise on what should be sent**	Example formats: ZZ*EAHSHHAC3 or 30*123123123	Example formats: ZZ*EAHSHHAC3 or 30*123123123
Heading		Beginning of Hierarchical Transaction	
BHT06	Transaction Type Code	Default RP	Default RP
Detail	2000B	Subscriber Information	
SBR03	Reference Identification	Default MCAL	Default MCAL
SBR09	Claim Filling Indicator Code	Default MC	Default MC
Detail	2010BA	Subscriber Information	
NM109	Subscriber / Member ID	Send 9 digit Member ID, add leading zero's if necessary	Send 9 digit Member ID, add leading zero's if necessary
Detail	2300	Claim Information	
CLM01	Claim/Patient Control Number	Unique and Sequential *(For CBCME's submitting Paper Claims , send with Acronym and sequential numbering EBI00000001)	Unique and Sequential *(For CBCME's submitting Paper Claims , send with Acronym and sequential numbering EBI00000002)
CLM02	Monetary Amount	Default '0' Zero Amount	Default '0' Zero Amount
CN101	Contract Type Code	Default '05' Capitated	Default '05' Capitated
NTE01	Claim Note Type Identifier	Default 'ADD'	Default 'ADD'
NTE02	Claim Note	Default Examples: 'HHP/AC3; Tier 1' which indicates face-to-face encounter 'Homeless Outreach on the street' 'HHP/AC3; Tier 2' which indicates face-to-face encounter 'outreach to home, hospitals and other facilities outside of the CB-CME organization 'HHP/AC3; Tier 3' which	Default 'HHP/AC3'

		indicates face-to-face encounter 'outreach made within the CB-CME organization) ' 'HHP/AC3; Tier 4' All Non-Face to Face Encounters such as phone calls	
HI01-01	Code List Qualifier Code	Default 'ABK'	Default 'ABK'
HI01-02	Health Care Diagnosis Code	Diagnosis Code must be a valid ICD-10 Code. DO NOT SEND A 'PERIOD/DOT' in code Examples include, but are not limited to the following: Z7189 = Other specified counseling	Send valid code - refer to Diagnosis Reference: Appendix H – HHP Eligible Condition Diagnosis Codes - page 73 in: HHP Program Guide - Final_12-20-18.pdf DO NOT SEND A 'PERIOD/DOT' in code
Detail	2400	Service Line Number	
SV101-01	Product /Service ID Qualifier	Default 'HC'	Default 'HC'
SV101-02	Product /Service ID	Default to ' G9008' And mod U7	Refer to Appendix E – G Modifiers - Service Codes for the Health Homes Program- Page 59 in: HHP Program Guide - Final_12-20-18.pdf
SV101-3	Modifier 1	Send Modifier U7	Send Modifier within U1 – U6 range
SV101-4	Modifier2	Conditional Use – Send 77 for Multiple services (touches) on the same date (DOS) with the same modifier (U1 – U7)	Conditional Use – Send 77 for Multiple services (touches) on the same date (DOS) with the same modifier (U1 – U7)
SV102	Monetary Amount	Default '0' Zero	Default '0' Zero
SV104	Quantity	Default '1'	Refer to 837P 5010 Standard use

HHP Member Pre Enrollment EDI 837P Data Example

ISA*00* *00* *30*471950819 *30*943216947 *180904*1706*^*00501*001028480*1*T*:~
GS*HC*471950819*943216947*20180904*1706*1028480*X*005010X222A1~
ST*837*1028480*005010X222A1~
BHT*0019*00*1028480*20180904*1706*RP~
NM1*41*2*CBCME NAME*****46*471950819~

PER*IC*CBCME EDI CONTACT NAME*TE*5101112222*FX*5101113333~ Send only 1 occurrence of Per Segment
NM1*40*2*ALAMEDA ALLIANCE FOR HEALTH*****46*943216947~
HL*1**20*1~
NM1*85*2*BILLING PROVIDER NAME*****XX*1234567890~
N3*BILLING PROVIDER STREET~
N4*CITY*CA*945781009~ ……..Send full 9 digits
REF*EI*111222333~
HL*2*1*22*0~
SBR*S*18*MCAL******MC~
NM1*IL*1*ROGERS*OLLIE****MI*566555666~ ID must be 9 Digits, Pad with leading Zero's if Necessary
N3*99 HOPER LANE~
N4*PLEASANT HILL*CA*94538~
DMG*D8*20100801*M~
NM1*PR*2*AAH MANAGED CARE*****PI*943216947~
N3*PO BOX 2460~
N4*ALAMEDA*CA*94502~
CLM***EBI00000001***0***11:B:1*Y*A*Y*Y~
CN1*05~
REF*D9*62075552~
NTE*ADD***HHP/AC3; Tier 1~**
HI*ABK**: Z7189 ~**
NM1*77*2*SERVICE LOCATION NAME*****XX*1224447770~
N3*6066 CIVIC TERRACE AVENUE~
N4*NEWARK*CA*945603746~
LX*1~
SV1*HC***:G9008:U7****0*UN*1***1~
DTP*472*RD8*20180830-20180830~
REF*6R*1620755521-1~
SE*32*1028480~
GE*1*1028480~
IEA*1*001028480~

HHP Member Post Enrollment EDI 837P Data Example

ISA*00* *00* *30*471950819 *30*943216947 *180904*1706*^*00501*001028480*1*P*:~
GS*HC*471950819*943216947*20180904*1706*1028480*X*005010X222A1~
ST*837*1028480*005010X222A1~
BHT*0019*00*1028480*20180904*1706*RP~
NM1*41*2*CBCME NAME*****46*471950819~ ……Loop 1000A Submitter / NPI
PER*IC*CBCME EDI CONTACT NAME*TE*5101112222*FX*5101113333~
NM1*40*2*ALAMEDA ALLIANCE FOR HEALTH*****46*943216947~ ……Loop 1000B Receiver
HL*1**20*1~
NM1*85*2*BILLING PROVIDER NAME*****XX*1234567890~ ……..Loop 2000A Billing Provider / NPI
N3*BILLING PROVIDER STREET~
N4*CITY*CA*945781009~ ……..Send full 9 digits
REF*EI*111222333~ …… Billing Provider Tax ID
HL*2*1*22*0~ …… Loop 2000B Subscriber Information
SBR*S*18*MCAL******MC~ ……Payer Responsibility Identifier (S = Secondary)
NM1*IL*1*ROGERS*OLLIE****MI*566555666~ ……\ Loop 2010BA Subscriber / 9 Digit Subscriber ID

N3*99 HOPER LANE~
N4*PLEASANT HILL*CA*94538~
DMG*D8*20100801*M~ ……. Subscriber Date of Birth
NM1*PR*2*AAH MANAGED CARE*****PI*943216947~ …… Loop 2010BB Payer/ Tax ID
N3*PO BOX 2460~
N4*ALAMEDA*CA*94502~
CLM***EBI00000002***0***11:B:1*Y*A*Y*Y~…… Loop 2300 Claim/PCN Unique and Sequential, ('1' =Original)
REF*D9*62075552~ …… Situational - Original Claim ID when sending Replacements or Voids
NTE*ADD***HHP/AC3~** ……..Denotes Program
HI*ABK: **E0821** ~ ……. Diagnosis Code
NM1*77*2*SERVICE LOCATION NAME*****XX*1224447770~ …… Loop 2310C Service Facility / NPI
N3*6066 CIVIC TERRACE AVENUE~
N4*NEWARK*CA*945603746~
LX*1~
SV1*HC**:G9008:U3*****0*UN*1***1~……..Loop 2400 Service Code, Modifier, Amount, Qty
DTP*472*RD8*20180830-20180830~…….. Service Date Range
REF*6R*1620755521-1~ ……..Provider Control Number (Optional)
SE*32*1028480~
GE*1*1028480~
IEA*1*001028480~

CMS 1500 FORMAT

(For Paper Scan/Conversion to 837P format by Third Party)
*PDF Form's must be <u>on blank/white form only</u> for scanning purposes

Reference requirements in right column. Please send all Test Forms in pdf (Blank/white) format to AAH for review. Both Pre and Post Enrollment Paper Claims will be required. Original and Replacement/Correction claims will also need to be certified as compliant prior to sending in production environment.

<u>Requirements when/if sending multiple claims per pdf file:</u>

- The pages of a multipage claim must be in sequential order page 1, page 2, … and be consecutive within the .pdf file
- Box 28 of the last page must have the total charges for all pages (claim total).
- All other/not-last pages must have either 0, or blank or 'continued' in box 28. DO NOT PUT THE PAGE TOTAL.
- If all requirements can't be met, send 1 encounter per 1 pdf file

Item #	Paper CMS 1500 Claim Field Name	Alameda Alliance AC3-HHP CMS 1500 Requirements
1	Type of Health Insurance	Default Medicaid - Required

1a	Insured's ID Number	Alameda Alliance Member ID - Please send Full 9 digit ID – Pad with leading Zero's is Necessary
2	Patient Last Name Patient First Name Patient Middle Initial	Valid LN, FN required.
3	Patient's Birth Date Sex	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	Use box 11b only if Box 26 can't support Unique Provider Claim ID which must start with fixed 3 character acronym (example RTS000001, RTS000002, RTS000003) Do not send anything in this box if Box 26 supports described Unique Provider Claim ID 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	**Pre-Enrollment send one of these:;** 'HHP/AC3; Tier 1' which indicates 'Homeless Outreach on the street' 'HHP/AC3; Tier 2' which indicates 'outreach to home, hospitals and other facilities outside of the CB-CME organization' 'HHP/AC3; Tier 3' which indicates ' outreach made within the CB-CME organization) per face-to-face encounter ' 'HHP/AC3; Tier 4' All Non- Face to Face Encounters such as phone calls Post Enrollment send: 'HHP/AC3'
21	Diagnosis or Nature of Illness or Injury	Valid ICD 10 code with ICD Ind Default to '0' – Required Please reference Appendix E below.

		Diagnosis Reference: Appendix H – HHP Eligible Condition Diagnosis Codes - page 73 in: HHP Program Guide - Final_12-20-18.pdf
22	Medicaid Resubmission	SEND only when sending in a Corrected Claim Resubmission code = '7', and Original Ref # (ICN) to be provided by AAH
24A	Dates of Service: From To	Required – and if same service date , Tier, Proc Code and Modifier only send in a single Claim. Example would be three phone calls in a day, then the unit would be = 3
24B	Place of Service	Required
24D	Procedures, Services, or Supplies: CPT/HCPCS Modifier	Pre-Enrollment: Default to ' G9008' And mod1 = U7 Conditional Use for both Pre and Post Encounters – Send Mod2 as 77 for Multiple services (touches) on the same date (DOS) with the same modifier (U1 – U7) Post-Enrollment: Refer to Appendix E – G Modifiers - Service Codes for the Health Homes Program- Page 59 in: HHP Program Guide - Final_12-20-18.pdf
24E	Diagnosis Pointer	Default to 'A' - Required
24F	Charges	Default to '0.00' - Required
24G	Days or Units	Required - Required –and if same service date, Tier, Proc Code and Modifier only send in a single Claim. Example would be three phone calls in a day, then the unit would be = 3
24I	ID Qualifier NPI	Default to NPI - Required
24J	Rendering Provider ID. (NPI) #	Rendering Physician NPI -Provider can leave box 24j and 31 empty. -Box 31 should not be empty if 24j must have NPI -24J should not be empty when Box 31 has first/ last name.

25	Federal Tax ID Numb	Billing Provider's Tax ID - Required
26	Patient's Account Number	Unique and Sequential Send with Acronym and sequential numbering EBI00000001). 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	Signature of Physician or Supplier	Rendering Physician First and Last Name --Provider can leave box 24j and 31 empty. -Box 31 should not be empty if 24j must have NPI -24J should not be empty when Box 31 has first/ last name.
32	Service Facility Location Information	Valid Address, City, State and Zip code Conditional - Required only if different than Billing Location
32a	Service Facility NPI#	Valid NPI code Conditional - Required only if different than Billing Location
33	Billing Provider	Valid Address, City, State and Zip code Required --Send full 9 digit zipcode
33a	Billing Provider NPI#	Valid NPI Required

HEALTH INSURANCE CLAIM FORM

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

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

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) / X (Medicaid#) / (ID#/DoD#) / (Member ID#) / (ID#) / (ID#) / (ID#)	566555666
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ROGERS, OLLIE	3. PATIENT'S BIRTH DATE MM DD YY: 08 01 2010 — SEX: M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): ROGERS, OLLIE	
5. PATIENT'S ADDRESS (No., Street): 99 HOPER LANE	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street): 99 HOPER LANE	
CITY: PLEASANT HILL — STATE: CA	8. RESERVED FOR NUCC USE
CITY: PLEASANT HILL — STATE: CA	
ZIP CODE: 94538 — TELEPHONE (Include Area Code): ( )	
ZIP CODE: 94538 — 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: 08 01 2010 — SEX: M X 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: SIGNATURE ON FILE — Verified by PDFfiller 07/16/2019 — DATE: 08/30/2018

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: SIGNATURE ON FILE — Verified by PDFfiller 07/16/2019

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY — QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): HHP/AC3; Tier 1	20. OUTSIDE LAB? YES NO — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind. 0	22. RESUBMISSION CODE: 7 — ORIGINAL REF. NO.: Get ICN from AAH
A. Z7189 B. C. D. / E. F. G. H. / I. J. K. L.	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	08 30 18	08 30 18	11		G9008	U7	A	0.00	1		NPI Require if applicable
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
111222333	EIN X	EBI00000001	X YES NO	$ 0.00	$ 0.00	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED / DATE	Service Location (Req. if different than Biller) Address, City, State Zipf	BILLING PROVIDER NAME BILLING PROVIDER STREET, City State, Zip
	a. Serv Loc NPI b.	a. Bill NPI b.

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

PATIENT AND INSURED INFORMATION / PHYSICIAN OR SUPPLIER INFORMATION

Send only if required PCN unique value can't be supported in Box 26

Send Only for Corrections

Send Full 9 digit Zip

If either Box 31 (First and Last Name of Rendering Provider) or 24J (Rendering Provider NPI) is present then the other needs to be sent

Appendix E – G Modifiers - Service Codes for the Health Homes Program- Page 59 in: HHP Program Guide - Final_12-20-18.pdf

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
In-Person: Provided by Clinical Staff	G9008	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G9008	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G9008	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G9008	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G9008	U5	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Non-Clinical Staff	G9008	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	G9008	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Pre-Enrollment Diagnosis Code Reference: (Do not send period/dot in code)
Examples could include, but are not limited to the following:
Z029 = Administrative examinations, unspecified
Z7189 = Other specified counseling
Z719 = Counseling, unspecified
Diagnosis Code must be a valid ICD-10 Code.
Please use the diagnosis code, with the highest level of specificity.
While we know that patients will have multiple diagnoses, it is not necessary to enter more than one diagnosis code for the purpose of claim submission.
However, at least one diagnosis code is required or else the claim will reject.

Post-Enrollment Diagnosis Code Reference: Appendix H – HHP Eligible Condition Diagnosis Codes - page 73 in: HHP Program Guide - Final_12-20-18.pdf

DHCS updated codes December 2019
Codes listed in the table below will be reflected in the upcoming release of the TEL.
These updates have resulted in a minor increase of potential eligibles for the HHP across all counties that are offering HHP.

Criteria	Codes	Code Type
Inpatient Stay – Acuity Criteria	H2013	HCPCS

ED Visit – Acuity Criteria	S9484, H2011, H0018	HCPCS
Hospice Exclusion	0650, 0659, 0552	Medi-Cal Revenue
CHF – Chronic Condition Criteria	I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83 I50.84, I50.89	ICD-10
Diabetes - Chronic Condition Criteria	E08.3.3211, E08.3.3212, E08.3.3213, E08.3.3219, E08.3.3291, E08.3.3292, E08.3.3293, E08.3.3299, E08.3.3311, E08.3.3312, E08.3.3313, E08.3.3319, E08.3.3391, E08.3.3392, E08.3.3393, E08.3.3399, E08.3.3411, E08.3.3412, E08.3.3413, E08.3.3419, E08.3.3491, E08.3.3492, E08.3.3493, E08.3.3499, E08.3.3511, E08.3.3512, E08.3.3513, E08.3.3519, E08.3.3521, E08.3.3522, E08.3.3523, E08.3.3529, E08.3.3531, E08.3.3532, E08.3.3533, E08.3.3539, E08.3.3541, E08.3.3542, E08.3.3543, E08.3.3549, E08.3.3551, E08.3.3552, E08.3.3553, E08.3.3559, E08.3.3591, E08.3.3592, E08.3.3593, E08.3.3599, E08.37X1, E08.37X2, E08.37X3, E08.37X9, E09.3211, E09.3212, E09.3213, E09.3219, E09.3291, E09.3292, E09.3293, E09.3299, E09.3311, E09.3312, E09.3313, E09.3319, E09.3391, E09.3392, E09.3393, E09.3399, E09.3411, E09.3412, E09.3413, E09.3419, E09.3491, E09.3492, E09.3493, E09.3499, E09.3511, E09.3512, E09.3513, E09.3519, E09.3521, E09.3522, E09.3523, E09.3529, E09.3531, E09.3532, E09.3533, E09.3539, E09.3541, E09.3542, E09.3543, E09.3549, E09.3551, E09.3552, E09.3553, E09.3559, E09.3591, E09.3592, E09.3593, E09.3599, E09.37X1, E09.37X2, E09.37X3, E09.37X9, E10.3211, E10.3212, E10.3213, E10.3219, E10.3291, E10.3292, E10.3293, E10.3299, E10.3311, E10.3312, E10.3313, E10.3319, E10.3391, E10.3392, E10.3393, E10.3399, E10.3411, E10.3412, E10.3413, E10.3419, E10.3491, E10.3492, E10.3493, E10.3499, E10.3511, E10.3512, E10.3513, E10.3519,	ICD-10

	E10.3521, E10.3522, E10.3523, E10.3529, E10.3531, E10.3532, E10.3533, E10.3539, E10.3541, E10.3542, E10.3543, E10.3549, E10.3551, E10.3552, E10.3553, E10.3559, E10.3591, E10.3592, E10.3593, E10.3599, E10.37X1, E10.37X2, E10.37X3, E10.37X9, E11.3211, E11.3212, E11.3213, E11.3219, E11.3291, E11.3292, E11.3293, E11.3299, E11.3311, E11.3312, E11.3313, E11.3319, E11.3391, E11.3392, E11.3393, E11.3399, E11.3411, E11.3412, E11.3413, E11.3419, E11.3491, E11.3492, E11.3493, E11.3499, E11.3511, E11.3512, E11.3513, E11.3519, E11.3521, E11.3522, E11.3523, E11.3529, E11.3531, E11.3532, E11.3533, E11.3539, E11.3541, E11.3542, E11.3543, E11.3549, E11.3551, E11.3552, E11.3553, E11.3559, E11.3591, E11.3592, E11.3593, E11.3599, E11.37X2, E11.37X3, E11.37X9, E11.3X11, E11.10, E11.11, E13.3211, E13.3212, E13.3213, E13.3219, E13.3291, E13.3292, E13.3293, E13.3299, E13.3311, E13.3312, E13.3313, E13.3319, E13.3391, E13.3392, E13.3393, E13.3399, E13.3411, E13.3412, E13.3413, E13.3419, E13.3491, E13.3492, E13.3493, E13.3499, E13.3511, E13.3512, E13.3513, E13.3519, E13.3521, E13.3522, E13.3523, E13.3529, E13.3531, E13.3532, E13.3533, E13.3539, E13.3541, E13.3542, E13.3543, E13.3549, E13.3551, E13.3552, E13.3553, E13.3559, E13.3591, E13.3592, E13.3593, E13.3599, E13.37X1, E13.37X2, E13.37X3, E13.37X9.	
Hypertension - Chronic Condition Criteria	I16.0, I16.1, I16.9	ICD-10
Major Depressive Disorder - Chronic Condition Criteria	F32.81, F32.89, F34.81, F34.89	ICD-10
Substance Related - Chronic Condition Criteria	F12.23, F12.93	ICD-10