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Enhanced Care Management (ECM) Billing Guide

How to Get Paid for Your Services

To get paid for services under Enhanced Care Management (ECM), providers must submit claims and/or invoices to the contracted Managed Care Plan (MCP) using certain standards. Following submission, providers must also understand MCP communications regarding claims adjudication to ensure correct payment takes place.

This Billing Guide walks providers through the steps to appropriately bill a MCP for ECM, questions to ask the contracted MCP, and considerations for other necessary decisions.

Prepare to Bill the MCP

- ✔ Decide how you will bill the MCP:
  - **Electronic Submission (837I) –** If an organization can submit electronically, this is the fastest way to receive payment and resubmit claims with errors. MCPs often use "clearinghouses" to prescreen and clean medical claims data, searching for errors and inaccuracies. If you engage with a clearinghouse, you may need to sign a separate data-sharing agreement. Speak with the MCP for more details on which clearinghouses they use.
  - **Paper Claim Form (CMS-1500) –** This standard form is used by providers to bill for supplies and services provided to Medi-Cal members. Providers are required to purchase CMS-1500 claim forms from a vendor. The claim forms ordered through vendors must include red "drop-out" ink to meet federal Centers for Medicare and Medicaid Services (CMS) standards.
  - **Invoice Submission –** If organizations cannot submit claims electronically or through paper forms, MCPs must accept invoices from ECM and Community Supports providers. This method can be cumbersome for providers and MCPs to use, sometimes delaying the payment process. Providers may submit invoices as an Excel-based workbook or web-based form or via a portal (e.g., provider payment portal). See the California Department of Health Care Services (DHCS) detailed document outlining required standards for submitting invoices.
- ✔ If submitting an electronic claim, review claims submission standards and engage the clearinghouse to understand clearinghouse processes.
- ✔ If submitting an invoice, review DHCS invoicing standards and develop your invoice template.
- ✔ Ensure that relevant staff are trained on coding and submission procedures.

Submit Claims/Invoices

- ✔ Submit claims or invoices on time. Claims and/or invoices for services must be submitted within a specific timeframe (i.e., 180 days from the date of service) to avoid late penalties or complete denial of payment. Check with your MCP to understand claims timeliness rules.
- ✔ Include all of the required fields. Check with your MCP for required fields. Some notable required fields include:
  - **National Provider Identifier (NPI) –** Make sure you are noting the Type 1 NPI (individual) or Type 2 NPI (organization) in the correct field. Ensure the NPIs match what has been used in the credentialing process. See the ACEs Aware "Medi-Cal Managed Care Explainer" document for more about NPIs.
  - **Place of Service Code –** Claims standards require that you also designate the place of service. These are standard codes. See the Centers for Medicare and Medicaid Services website for a list of Place of Service codes.
  - **Units of Service –** Some MCPs indicate defined units of service (e.g., 1 unit = 15 minutes). Some MCPs may require a certain number of service units are provided to satisfy requirements for payment.
  - **Diagnosis Code –** MCPs will also require that a diagnosis code be entered that is observable by the provider. Social Drivers of Health (SDOH), or "Z-codes", are allowable. See this DHCS All-Plan letter for a list of Z-codes that can be used for diagnosis.
- ✔ Include the correct ECM Service Code ***AND*** Modifier. See the DHCS HCPCs Coding Guidance for more details:

Code G9008 - ECM Services by CLINICAL Staff	
Modifier(s)	***Description***
U1	Services provided to an ECM enrolled member in-person
U1, GQ	Services provided to an ECM enrolled member via telehealth or telephone
U8	Pre-enrollment outreach ECM services provided to a member in-person
U8, GQ	Pre-enrollment ECM outreach services provided to a member via telehealth or telephone – can include individualized text messages or secure email

Code G9012 - ECM Services by NON-CLINICAL staff	
Modifier(s)	***Description***
U2	Services provided to an ECM enrolled member in-person
U2, GQ	Services provided to an ECM enrolled member via telehealth or telephone
U8	Pre-enrollment outreach ECM services provided to a member in-person
U8, GQ	Pre-enrollment ECM outreach services provided to a member via telehealth or telephone – can include individualized text messages or secure email

Code G9007: Multidisciplinary team meeting between the ECM Lead Care Manager and one or more other Providers involved with the Member (can be CLINICAL or NON-CLINICAL).

Claims Decision and Payment

- Check for immediate *rejections* from the clearinghouse or MCP. If the claim or invoice is submitted incorrectly, you should receive a quick rejection from the clearinghouse for electronic claims. Rejections from MCPs for incorrect invoice submissions will take longer. This gives you the opportunity to correct some basic errors before the claim is moved along to the MCP for more substantive review. *Rejection* is often the term used for claims containing these more basic errors.
- Receive and REVIEW the Remittance Advice (RA). An RA will list the claim submitted and its decision status. *It is important to review this information to understand how many claims have been denied and for what reason.* Denials could significantly impact how much your organization is paid and MCPs do make mistakes. First, review the RA to understand how many of your claims were denied and for what reason.
- Understand claims denial codes. When reviewing RAs, the MCP will often not describe the denial reason, but will simply list a denial code. *Make sure you understand each MCP's denial codes – these will be different across MCPs.*

- Correct and resubmit claims to address any rejections or inappropriate denials. Providers can correct any errors that may have led to the result and resubmit the claim. *It is important that providers not submit a new claim for the service, as this will result in yet another denial due to "duplicate claims" in the MCP's system.* Instead, be sure to understand the MCP and clearinghouse process for resubmissions and correct the existing claim for adjudication.
- If necessary, submit a Provider Dispute Resolution (PDR) request. When a provider believes that one or more claims denials are inappropriate, they can submit a PDR request to have that claim reviewed again. If a provider is experiencing a significant volume of PDRs resolved in their favor, it may indicate other systems challenges or otherwise originating at the MCP.
- Review your revenue cycle regularly. Regularly reviewing which claims are paid and which are outstanding will help make providers aware of any issues, including overdue payments from the MCP, opportunities for staff training, and systemic problems with claims decision-making.

Helpful Resources and Links

- **DHCS ECM and Community Supports HCPCS Coding Guidance (Updated June 2024)**
  https://www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf
- **DHCS CalAIM Data Guidance: Billing and Invoicing between ECM/Community Supports Providers and MCPs (Updated: April 2023)**
  https://www.dhcs.ca.gov/Documents/MCQMD/ECM-and-Community-Supports-Billing-and-Invoicing-Guidance.pdf