CenCal HEALTH®
Local. Quality. Healthcare.

# Enhanced Care Management Provider Reference Guide

## Eligibility, Authorizations, Billing, Payment and more!

This document is for training purposes only, and does not replace or change contractual obligations between Providers and CenCal Health.

More details are available in the **CenCal Health Provider Manual** online at www.cencalhealth.org/providers/forms-manuals-policies/provider-manual/ or **CalAIM Provider** website page at www.cencalhealth.org/providers/calaim/

Should you find any discrepancies between this document and the Provider Manual, please follow the Provider Manual's specifications. CenCal Health also has specific policies and procedures for each subject highlighted in this document.

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# CenCal Health Member Eligibility and Verification

## ECM Member Assignment

CenCal Health eligible Members presumed eligible for ECM benefit will be assigned to a contracted ECM Provider based on several factors that include the ECM Provider's ability to serve the Member's specific Population of focus (POF), the location of the Member, the Member's preference, and/or if the Member has an established relationship with the ECM Provider.

Every month, CenCal Health will provide each ECM Provider with a list of prospective ECM Members via the Member Information File for the ECM Provider to review and begin outreach. This Member Information File will be transmitted to the ECM Provider through a secure file transfer protocol (SFTP).

Members with Medi-Cal and Other Health Coverage such as Medicare who meet the ECM eligibility criteria are eligible to receive ECM.

## CenCal Health Member Eligibility and continuation of services

A member's eligibility with CenCal Health can change. It is important to verify eligibility before every patient visit. All providers are urged to verify member eligibility and PCP assignment (or Special Class status) prior to rendering services.

This will serve to:

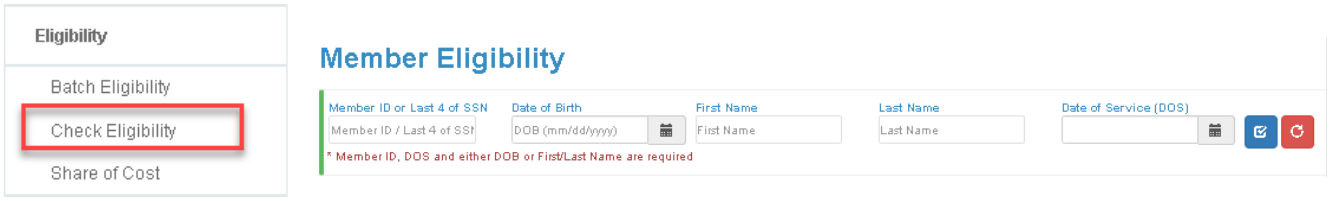
- Reinforce case management
- Avoid possible referral/authorization/claims problems
- Identify instances of member misrepresentation

CenCal Health members receive a CenCal Health Identification Card. The group listed indicates the program under which the member is covered. Other information printed on the card includes member name, ID number, PCP name and PCP phone number. These cards are issued only once, and are reissued only when information on the card changes or if a member requests a copy via the Member Portal memberportal.cencalhealth.org.


**These cards are intended to be a means of identification only. They are not considered proof of eligibility** and all contracted providers should verify eligibility prior to rendering services every month by logging into the Provider Portal at web.cencalhealth.org.

## Checking Eligibility on the Provider Portal

This system only looks within CenCal Health's member/subscriber database for the eligibility. CenCal Health does NOT determine eligibility and a member's eligibility with CenCal Health can change. Please follow these quick easy steps when referencing a members eligibility status at the beginning of each month or prior to service.

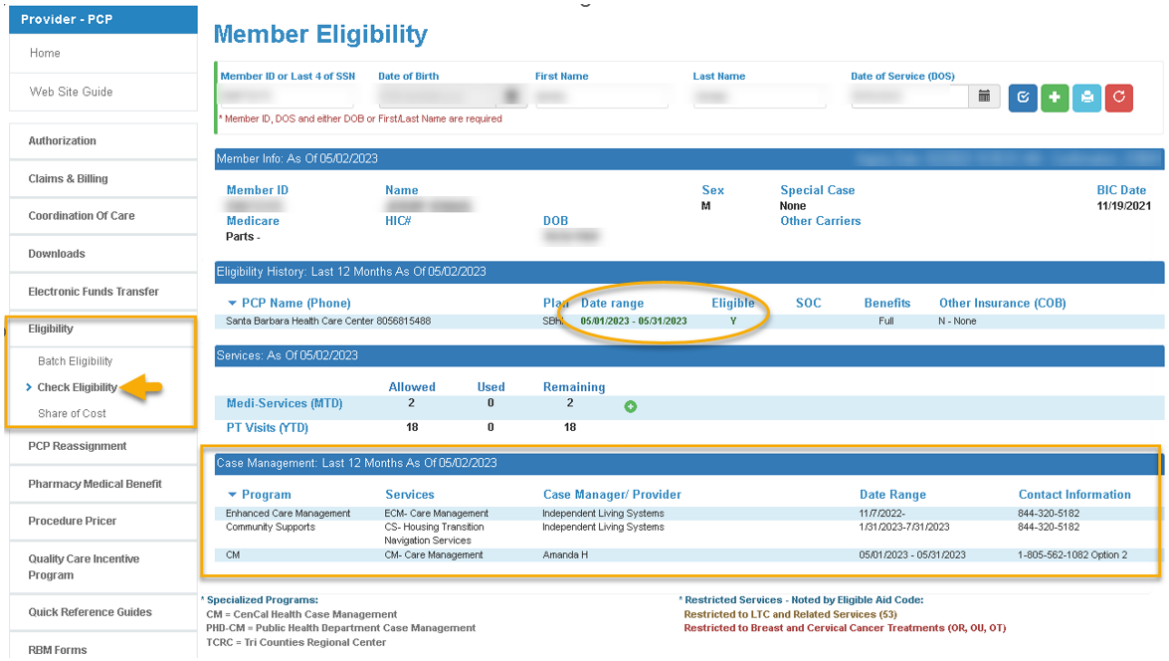



**Required Filters**

1. Enter the Member's nine (9) digit ID Number **or** Last four (4) numbers of Member's social security number (SSN)
2. Enter Date of Birth **or** Member's First Name/ Last Name
3. Enter Date of Service (DOS) current or past date in the format mm/dd/yyyy
4. Click 'Check Eligibility' icon
   - ❖ Tip: Click the 'reset' icon to refresh your search

This is a screen example of a member that is eligible with CenCal Health with the '**Y**' indicator within the Date range. The screen will also identify Other Carriers and Medicare Parts ABCD as their primary health carrier (Medi-Cal is always second payer if they have a primary insurance plan), and identify if the member has a Share of Cost associated to their Medi-Cal benefit.

If the eligible screen has a 'N' indicator within the Date range entered, that means the member is no longer eligible to receive Medi-Cal services at that time. Please check again the following month, or prior to seeing the member again.



# Enhanced Care Management (ECM) Outreach Services & Approved Authorizations

Authorization for **ECM Outreach** will be automatically approved for each CenCal Health Member that is assigned to your organization. The authorization number will start with the letter 'A' followed by 7-digits (e.g., A1234567)

Each unique **Outreach** Authorization number (e.g., A1234567) will be submitted with every "Outreach" Services claim(s) billed to CenCal Health.

- Each Auto-Approved **Outreach** Authorization is communicated to the Provider via Member Information File (MIF) at the beginning of each month, and weekly as needed for newly assigned Members
- Each **Outreach** Authorization is approved for six (6) weeks
- **Outreach** Authorization is approved for 10 units to outreach to Member
- One (1) **Outreach** Unit = 15 minutes (1 minute up to 15 minutes)
- Provider must make at least 4 attempts to Outreach to Member, with the intent to offer/enroll CCH Members ECM Services
- Once Member accepts enrollment into ECM Services, each ECM Provider will need to acquire an ECM Services Authorization

## Enhanced Care Management (ECM) Services

Authorization for **ECM Services** is required by requesting a "**Services**" authorization on a 50-1 Form. CenCal Health contracted ECM Providers can request an 50-1 authorization via the Provider Portal at web.cencalhealth.org.

Each unique ECM **Services** Authorization number requested through the Provider Portal begins with a 'W' followed by seven (7) unique digits (e.g., W7654321). Each **Services** Authorization number will be submitted with every "**ECM Services**" claim(s) billed to CenCal Health.

- A **Services** Authorization should be requested for no less than a quantity of 144
  - See example next page of a typical ECM Service Authorization
- Each Services Authorization is approved for twelve (12) months
- One (1) **Services** Unit = 15 minutes (1 minute up to 15 minutes)
- ALL ECM Services should be billed to CCH, for both direct and indirect ECM services provided to our Member. (e.g., calls/work when Member not present)

If additional time is needed to render outreach ECM services, please submit a new authorization request, or call CenCal Health's ECM Team at (805) 562-1698. Please contact us at least 10 days prior to the end of the prior approved authorization to request an authorization extension.

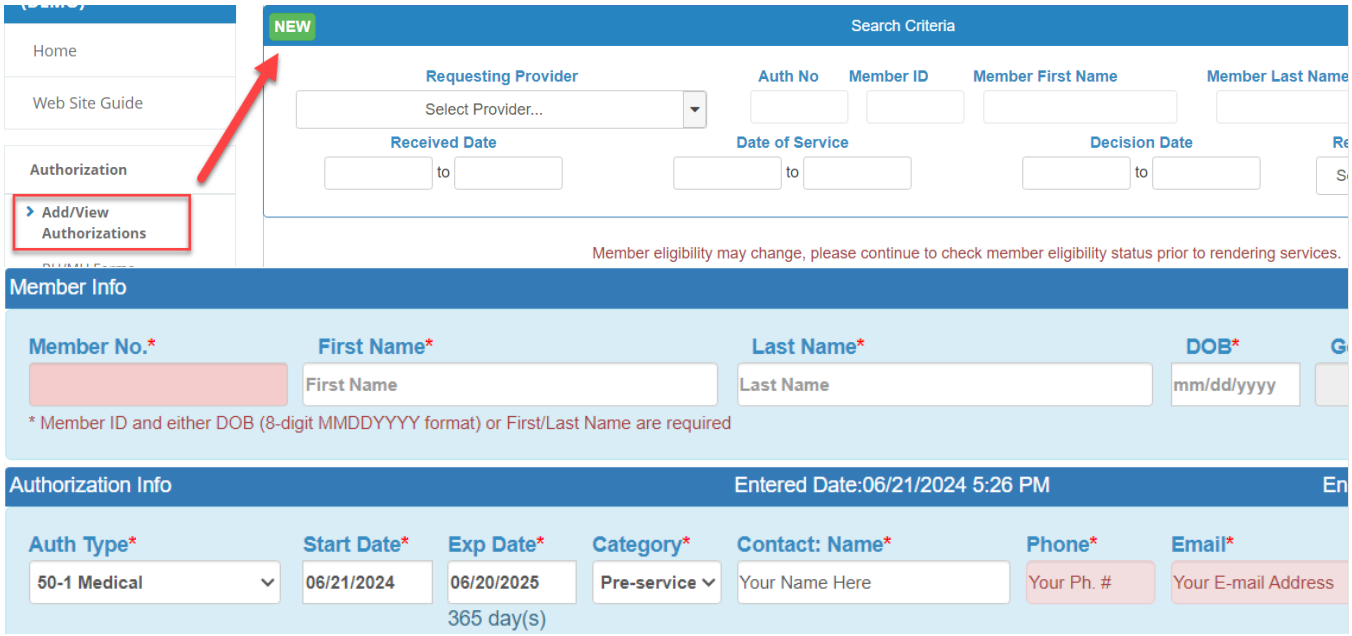
CenCal Health will review ECM Authorization requests within 1-5 business days or 72 hours for Urgent Requests.

For additional information on Documentation required for ECM authorizations please reference ecm-authorization-information-and-checklist-form-a20221230.pdf (cencalhealth.org)

## Requesting a 50-1 Authorization Request

CenCal Health contracted ECM Providers can request a 50-1 authorization via the Provider Portal at web.cencalhealth.org. **ECM Services** Authorizations are approved for 12 months.

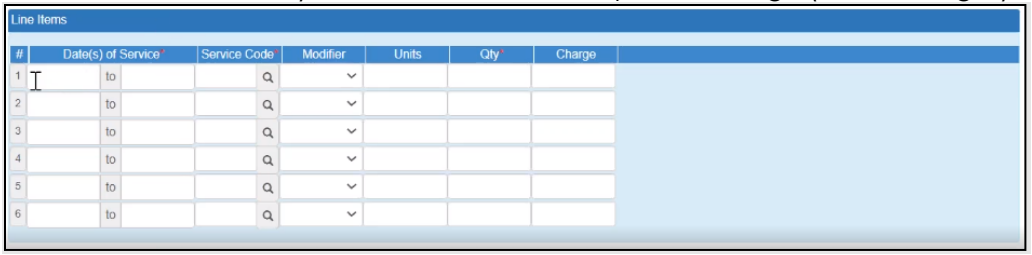
Once logged into the restricted site, click on 'Authorization' located within the left banner, then 'Add/View Authorizations'. The main screen will provide you with a list of submitted authorizations within your organization. Click the NEW icon to submit a Medical TAR (50-1).




When submitting a new authorization, **the form will require member verification by entering the Member ID#, First/Last Name, or Date of Birth (DOB)**. The form will then provide the user with the Member's PCP Group Name, PCP Group NPI#, PCP phone number, PCP fax number, and the member's eligibility effective dates.

**Diagnosis code** is required in the first Dx1 box, with additional diagnosis code(s) as needed. ECM providers are not diagnosing for services; kindly enter a SDOH code (available list located on last page).


**Line Items** will populate for the 50-1 Medical TAR form which requires Date(s) of Service, Service Code (procedure code or CPT code), Modifier, Units, Quantity, and Charge (billed charges).



Please use procedure codes G9008-U1 and G9012-U2 to request ECM services and modifier combination:

- G9008 must be requested with U1 modifier
- G9012 must be requested with U2 modifier
- NOT necessary to request GQ modifier for telehealth services

Request at least 144 total quantity (Qty) for ECM **Services** for 12 authorized months

- One (1) Services Unit = 1 to 15 minutes of ECM Services
  - Four (4) units = 1 hour of ECM Services
  - Quantity of 144 (Qty) = 36 hours of ECM Services for **EACH** procedure code
  - 36 hours for BOTH G9008 (Clinical) and G9012 (Non-Clinical)
    - 144 approved hours in 12 months = 12 hours of ECM Services/month
    - If 12 hours of ECM Services/month per Member is not enough, request more than a quantity (Qty) of 144 for every 12-month authorization requested for both G9008 and/or G9012 (No ceiling).

| # | Date(s) of Service* | | | ProcCode* | Modifier(s) | | Req Serv Category* | Units | Qty* |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 06/01/2024 | to | 06/20/2025 | G9008 | U1 | | | 4 | 144 |
| 2 | 06/01/2024 | to | 06/20/2025 | G9012 | U2 | | | 4 | 144 |

Units = How much of each Service/Procedure code is needed (blank default to "1")
Qty (Quantity) = How many encounters or frequency of services are needed.

For additional authorization questions please contact the CenCal Health ECM & CS Referral team at (805) 562-1698 or email ecmcsreferrals@cencalhealth.org.

## Billing CenCal Health for ECM Services

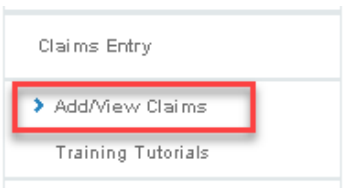
Once a provider receives confirmation of their effective date with CenCal Health, and approved authorizations are in place, payment is payable at the contracted rate.

"Clean" claims will be reimbursed within 45 working days of receipt. Clean claims are claims that include all the necessary, accurate and valid data for adjudication.

CenCal Health offers (3) three easy and convenient ways to bill:

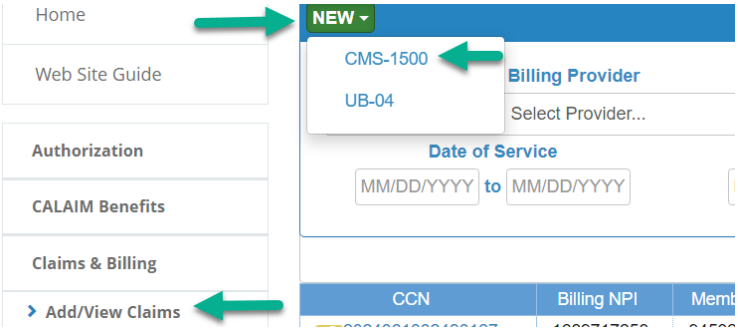
1. CenCal Health Provider Portal
2. Electronic via EDI Team edi@cencalhealth.org
3. Paper Mailing to: CenCal Health
   PO Box 948
   Goleta, CA 93116-0948

### Provider Portal Claims Entry




There are two different types of claim forms that are supported on the Website: CMS-1500, and UB-04 Form. Once you submit your claim you will receive a **Claim Control Number (CCN)**. Every CCN is a unique 16-digit identifier for each claim submitted to CenCal Health.

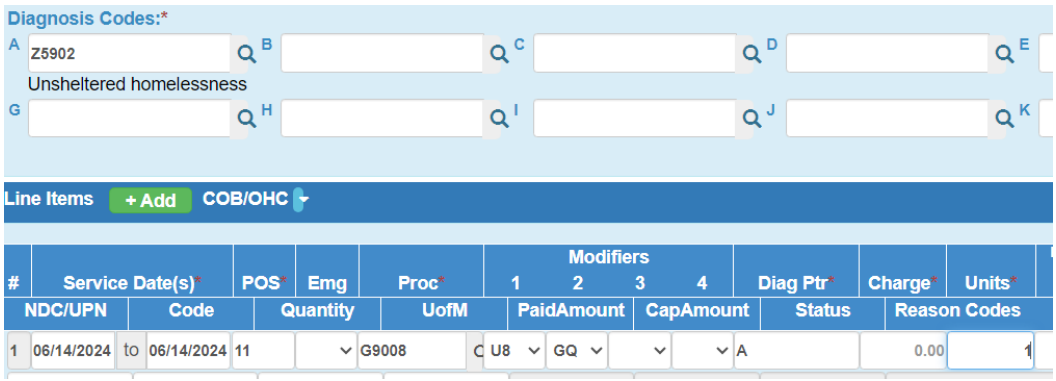
Click the NEW icon from the main dashboard to submit a CMS1500 claim form. You will then be taken to Health Insuracnce Claim Form – Professional.




Similar to the authorization form, please enter the Member ID# and either the Date of Birth (DOB) or the First/Last Name of the member. The Name and gender will auto populate.

## Claim Information & Line Items

ECM "Outreach" procedure codes are defined by the "U8" modifier, and the "GQ" modifier if the outreach is via a telephonic/electronic method.




"Clean" claims will be reimbursed within 45 working days of receipt of the billed claim. Clean claims are claims that include all the necessary, accurate and valid data for adjudication.

## ECM Outreach Billing & Payment Table

| Procedure Code | Description | Required Modifier(s) | Authorization |
|---|---|---|---|
| G9008 | ECM Outreach In-Person, provided by Clinical Staff | U8 | Auto-Assigned as "A" Auth; sent with MIF Excel file |
| G9008 | ECM Outreach Telephonic, provided by Clinical Staff | U8, GQ | |
| G9012 | ECM Outreach In-Person, provided by Non-Clinical Staff | U8 | |
| G9012 | ECM Outreach Telephonic, provided by Non-Clinical Staff | U8, GQ | |

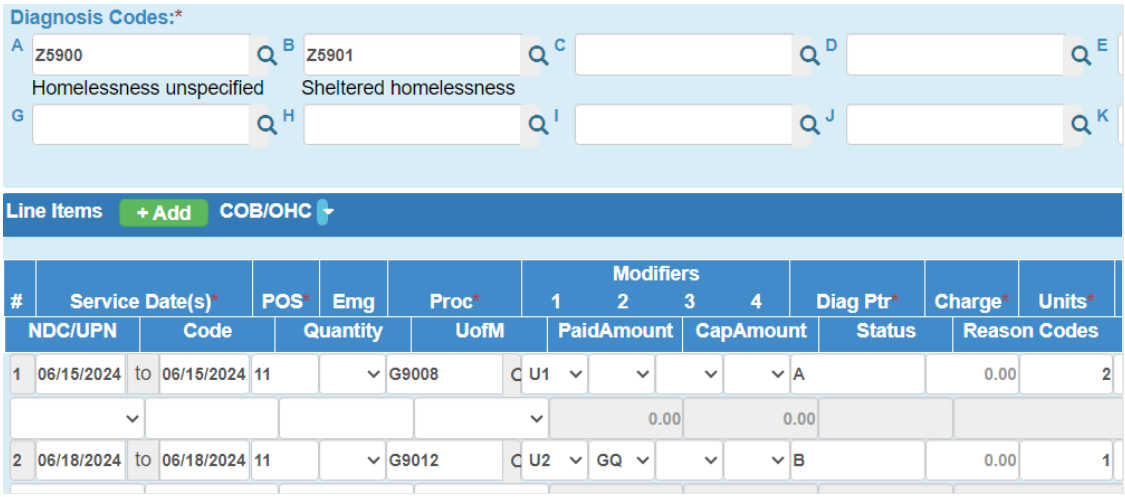
- **Outreach** Case Rate reimbursement is a **one-time only** payable case rate per Member per Outreach authorization.
- ECM **Outreach** attempts/successes are to be billed for In-Person and Telephonic services with G9008 & G9012 with modifier "U8" and "U8, GQ" only
- G9008 is the procedure code for "Clinical" staff **Outreach**/initiation

- G9012 is the procedure code for "Non-Clinical" staff **Outreach**/initiation
- BOTH G9008 & G9012 MUST be billed with modifier "U8" for **Outreach**/initiation
    - Telehealth modifier "GQ" can **NOT** be billed without "U8" modifier
- ALL **Outreach** attempts/successes must be billed to CCH for encounter data

## ECM Services Billing & Payment Table

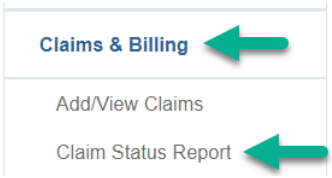
| Procedure Code | Description | Required Modifier(s) | Authorization |
|---|---|---|---|
| G9008 | ECM In-Person, provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services. | U1 | Requested through Provider Portal as "W" or Web authorization |
| G9008 | ECM Phone/Telehealth, provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services. | U1, GQ | |
| G9012 | ECM In-Person, provided by Non-Clinical Staff. Other specified case management service not elsewhere classified. | U2 | |
| G9012 | ECM Phone/Telehealth, provided by Non-Clinical Staff. Other specified case management service not elsewhere classified. | U2, GQ | |
| G9007 | COORDINATED CARE FEE, SCHEDULE TEAM CONFERENCE | N/A | Authorization not required |

- ECM **Services** Case Rate reimbursement is Per Calendar Month for each authorized month
- G9008 with modifier "U1" is billed when "Clinical" staff renders ECM **Services**
    - G9008-U1 & G9008-U1, GQ is correct pairing for "Clinical" ECM Services
- G9012 with modifier "U2" is billed when "Non-Clinical" staff renders **Services**
    - G9012-U2 & G9012-U2, GQ is correct pairing for "Non-Clinical" **Services**
- If **Services** are rendered telephonically (call, email, etc.), modifier "GQ" MUST be added to the procedure code and modifier combination
    - Modifier "GQ" billed **without** modifiers "U1" or "U2" is not reimbursable
- Procedure code G9007 is now available to be billed when a multidisciplinary team (MDT) conference/meeting occurs with the member's ECM lead case manager and one or more Providers involved with managing the member's care. This may include contact with the Primary Care Provider, Behavioral Health, a Providing Specialist, a former ECM Provider or CenCal Health's Care Management team for transition of care efforts, or Community Supports Providers engaged in the member's Care Plan Goals. At this time the billing of G9007 is inclusive in the ECM Services calendar month reimbursement and is recorded as an encounter.

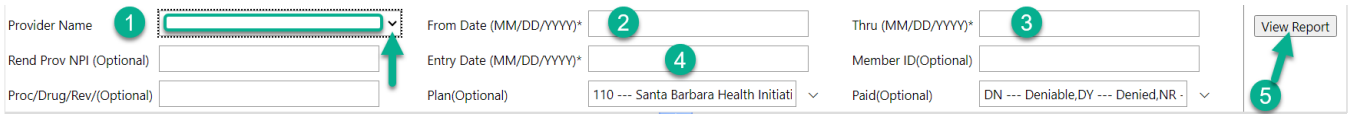


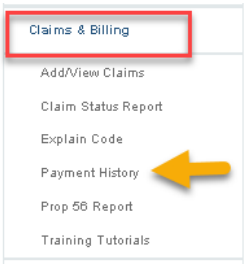

## Viewing 'Claim Status Report' & 'Payment History' in Provider Portal

Once logged into the Provider Portal, click on left banner 'Claims & Billing' then scroll down to "Claims Status Report"



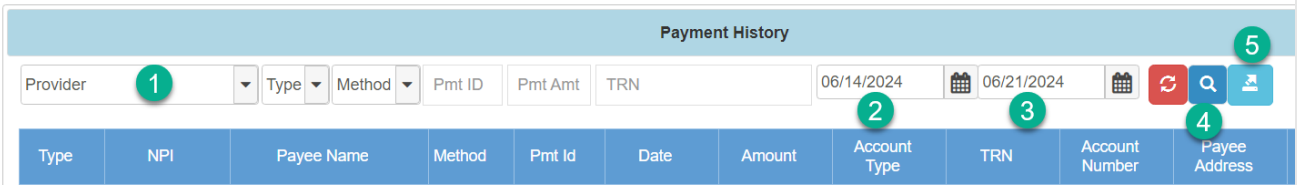

1. Select your provider name
2. Select "From" date for desired report start date
3. Select "Thru" date for desired report end date
4. Select current date of requested report
5. Click on tile "View Report" to complete the process




For a claims 'Payment History'

1.Select Billing NPI # for requested payment history
2.Select "start" date for desired report
3.Select "end" date for desired report
4.Click the tile to run requested payment history
5.Click the tile to export the "Payment History" report to Excel




For additional claims & billing questions please contact CenCal Health's Claims department at (805) 562-1083.

## Social Determinants of Health (SDOH) Diagnosis Billing Z-Codes

CenCal Health has a list of SDOH Codes based on International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) to ensure correct coding and capture of reliable data.

Consistent and reliable collection of SDOH data is **vital** to identify ways to support our members. There are several health-related social factors that can be improved through the analysis of the member characteristics, health, social, and risk needs. Our providers are key to identify the health disparities, and their root causes, that are negatively impacting our members' health.

For CenCal Health contracted ECM Providers, kindly use no less than one (1) of the following SDOH Codes when billing for all ECM Services.

***NOTE – Do NOT use a period when billing Z-codes (e.g., Z59.00 = Z5900 submitted)**

SDOH diagnosis Z-codes can be accessed on CenCal Health's website at cencalhealth.org/providers/social-determinants-of-health/