



Promise Health Plan

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

November 2025



ECM/CS process change

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 presentation 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.



Claims submission overview

General claim tips

A clean claim has no defect, impropriety or special circumstance, including incomplete documentation that can lead to processing delays and payment denials.

- The CMS-1500 form is preferred for claims submission over 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 the location field blank.
- The NPI used for billing should match the NPI associated with your ECM and/or CS provider agreement.
- The taxonomy code submitted should also match your enrollment and your ECM and/or CS agreement.
- Verify a member's status before billing. Do not submit a PMPM code for members in pending status; only bill the PMPM code once the member's status is updated to "engaged."

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. [Learn more about CMS-1500](#)

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

☐ PICA

1. MEDICARE ☒ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA ☐ OTHER ☐

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
PATIENT'S LAST NAME, FIRST NAME

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
MEDI-CAL ID NUMBER

5. PATIENT'S ADDRESS (No., Street)
PATIENT'S COMPLETE ADDRESS

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)
MOTHER'S NAME FOR NEWBORN

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. RESERVED FOR NUCC USE
c. RESERVED FOR NUCC USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

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 NA DATE NA

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)
ONSET DATE QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
FROM NA TO NA

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
NAME OF REFERRING PROVIDER

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
FROM FROM DOS TO TO DOS

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? \$ CHARGES
☐ YES ☐ NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))
A. [DIAGNOSIS CODE 1] B. [DIAGNOSIS CODE 2] C. [DIAGNOSIS CODE 3] D. [DIAGNOSIS CODE 4]
E. [DIAGNOSIS CODE 5] F. [DIAGNOSIS CODE 6] G. [DIAGNOSIS CODE 7] H. [DIAGNOSIS CODE 8]
I. [DIAGNOSIS CODE 9] J. [DIAGNOSIS CODE 10] K. [DIAGNOSIS CODE 11] L. [DIAGNOSIS CODE 12]

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM TO B. PLACE OF SERVICE EMG C. D. PROCEDURE(S), SERVICE(S), OR SUPPLIES (Explain Unusual Circumstances) E. F. G. DAYS OF SERVICE H. I. J. RENDERING PROVIDER ID. #
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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.

ProvidersBulk UpdatesRemittance & Payments

EFT
Not enrolled

ERA
JM MEDICAL GROUP

Electronic Funds Transfer

Enroll your organization in EFT or change your banking information

Status

Enrolled

Edit

Last modified by

N/A

Authorized signer

N/A

Date submitted

N/A

Remit address

P O BOX 885904, Los Angeles CA 90088

This EFT information applies to all service locations under this TIN unless they are individually enrolled in EFT.

ProvidersBulk UpdatesRemittance & Payments

EFT
Not enrolled

ERA
JM MEDICAL GROUP

Electronic Remittance Advice

Enroll in ERA for your organization or change your vendor

If you would like to receive ERAs, choose a vendor (that is, a clearing house or trading partner).

Select vendor

OFFCE ALLY

This vendor applies to all provider groups under this TIN

* 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, including EOBs.
5. To conduct a new search, click **Start over** to clear the search fields.

The screenshot shows the 'Check claim status' page. At the top, there's a 'Search' tab and a 'See the tour' link. Below is a search form with three main sections: 'Member information', 'Claim information', and 'Provider information'. A red box labeled '1' highlights the search form. Below the search form is a 'Start over' button and a 'Search' button. A red box labeled '5' highlights the 'Start over' button. Below the search form is a table of results. A red box labeled '2' highlights the table header. A red box labeled '4' highlights a claim number in the table. A red box labeled '3' highlights the 'EOB' column header. The table shows 1-50 of 47,734 claims. The first row shows a claim in 'IN PROCESS' status, dated 03/01/2021, with a claim number, medical claim type, dates of service, member name, member ID, provider name, amount billed, amount paid, patient responsibility, and check/EFT number.

Claim status	Claim number	Claim type	Dates of service	EOB	Member name	Member ID/Subscriber ID	Provider name	Amount billed	Amount paid	Patient responsibility	Check/EFT number
IN PROCESS 03/01/2021		Medical	07/07/2020–07/07/2020		Member, Our	910219805-02	QUEST DIAGNOSTICS	\$3,500.00	N/A	\$10.41	N/A

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

Claim 24536

Finalized 10/11/2024

1

2

Information is valid and up to date as of 10/11/2024 at 09:46 p.m.

Medical | Finalized | [View EOB](#)

Possible next steps: [Resolve claim issue or dispute](#)

3

Member information

Member name

XXXX

4

Date of birth

04/10/1991

Gender

Female

Relationship to subscriber

Subscriber/Insured

Patient account number

XXXX

Member ID

XXXX

Group number

XXXX

Plan type

Commercial PPO

[View all claims for this member](#)

Claim details

Dates of service

08/19/2024–08/19/2024

5

Claim received

10/07/2024

Provider

XXXX

Provider number

XXXX

National Provider Identifier (NPI)

XXXX

IPA/Med group

N/A

Network status

Exclusive Physician Member - Yes

Amount billed

\$176.00

Allowed amount

\$176.00

Patient responsibility

\$15.00

Deductible

\$0.00

Copay

\$15.00

Co-insurance

\$0.00

Amount paid

\$161.00

Summary view

Let's chat

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:** Provider can bill 1 unit per meal up to 3 unit maximum (3 meals a day at contracted rate per meal).
- For accurate processing, enter a separate line item for each day on the claims form.

Personal care services

- Provider can bill 1 unit per 15 minutes or 4 units per hour up to provider contracted maximum.
 - **Example:** If your rate is \$15 per hour and the maximum per day is 24 hours or 96 units (4 units x 24 hours), your total would be \$360 per day.
- For accurate processing, enter a separate line item for each day on the claims form.

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 first 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:** Suppose your 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

Informational codes must be entered on the claims form with a charge amount of \$0.00.

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](#). For all informational codes, remember to note \$0.00 as the claim amount.

- 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 90 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 of California Promise Health Plan is an independent licensee of the Blue Shield Association