PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Enhanced Care Management Claims Billing

Claims Resolution Coordinators

2026

ACCREDITED NCQA HEALTH PLAN

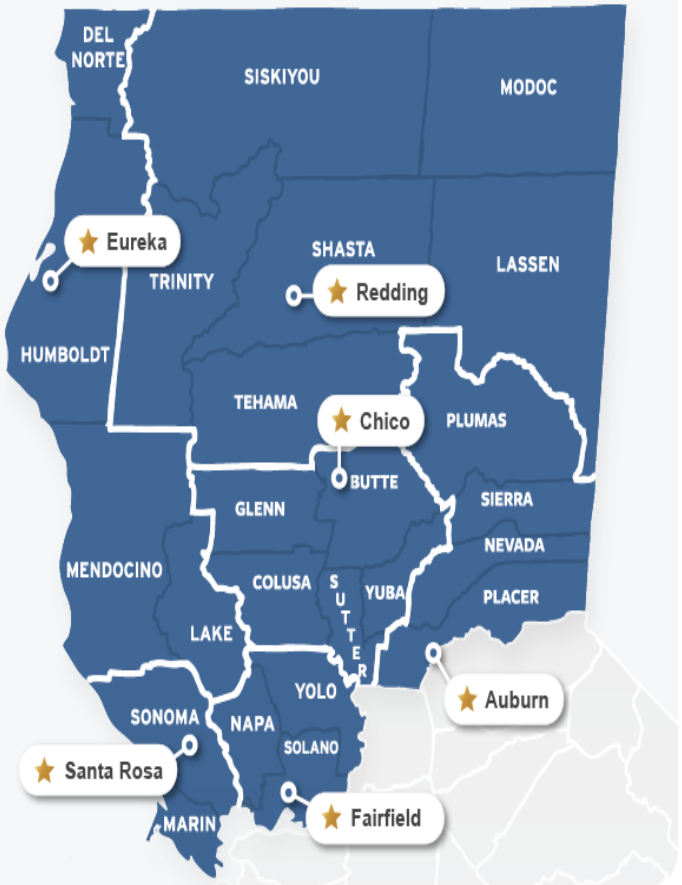
Welcome Everyone!

Please provide your name, organization and your e-mail in the chat

* The PowerPoint will be e-mailed to you after the training *

About Us

Regional Offices



Mission:

To help our members, and the communities we serve, be healthy.

Vision:

To be the most highly regarded managed care plan in California.

Overview

- What is a Claim?
- ECM Codes, Rates and Modifiers
- Place of Service codes & ICD-10 Codes
- Taxonomy Codes & NPI Registry
- 3 Ways to Submit Claims
  - Electronic billing
  - CMS 1500 Form
  - Office Ally
- Claim Corrections- submitting a PDR
- TAR Information
- Claim Billing Tips & Reminders
- EFT Information
- Contact Us

What is a Claim?

- A claim is a “bill” that health care providers submit to a member’s insurance provider.
- A provider submits a claim that includes all relevant codes and charges for that visit, including procedure code, diagnosis codes, and modifier.

What is a Clean Claim?

- A “clean claim” is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.
- Partnership has 30 days from the received date to process and finalize claims.

Billing Code Descriptions

PROCEDURE CODES

Procedure codes are standardized medical codes used to report medical, surgical, and diagnostic services.

- **CPT codes**: Five-digit numeric codes
- **HCPCS codes**: Five-digit alphanumeric codes

MODIFIERS

Modifiers are two-digit codes that provide additional information about a procedure code.

PLACE OF SERVICE

Place of Service codes identify the type of facility or entity where services were provided

ICD-10 CODES

ICD-10 codes are alphanumeric codes used to document and report a patient's diagnosis

ENHANCED CARE MANAGEMENT

Codes and Rates

Unsuccessful Outreach Attempts **Prior** to ECM Enrollment

- Up to 5 unsuccessful outreach attempts per member in a rolling 30-day period
- Bill one attempt per day; each billed as a single date of service
- Providers must verify members' eligibility before providing any service
- Confirm that members are not enrolled in an ECM program. If there is an approved TAR for ECM on file, unsuccessful outreach would be denied

Clinical	Mod 1	Mod 2	Frequency	Rate	Example
G9008	U8		Up to 5 per rolling 30-days	$5.00	G9008 –U8 X 1 unit = $5.00
G9008	U8	GQ	Up to 5 per rolling 30-days	$5.00	G9008-U8/GQ X 1 unit = $5.00
Non-Clinical	**Mod 1**	**Mod 2**	**Frequency**	**Rate**	**Example**
G9012	U8		Up to 5 per rolling 30-days	$5.00	G9012-U8 X 1 unit = $5.00
G9012	U8	GQ	Up to 5 per rolling 30-days	$5.00	G9012-U8/GQ X 1 unit = $5.00

Modifiers:
U8 = In-person
U8/GQ = Telephonic/electronic

*Telephonic/electronic methods can include text messaging or secure email individualized to the Member. Mass communications (e.g., mass mailings, distribution emails, and group text messages) do not count as outreach and should not be billed.

Non-Clinical & Clinical Codes

Non-Clinical	Mod 1	Mod 2	Frequency	Rate	Example
G9012	No modifier	No modifier	**S**uccessful Engagement. This is when the member agrees to enroll into ECM. This is allowed one time per provider.	$150.00	G9012 X 1 unit = $150
G9012	U2		Allowed once per month **in person**. The once-a-month meeting with the member. The care plan is reviewed, and goals are created for the month.	$400.00	G9012-U2 X 1 unit = $400.00
G9012	U2	GQ	Allowed once per month- **telephonic**	$400.00	G9012-U2-GQ X 1 unit = $400.00

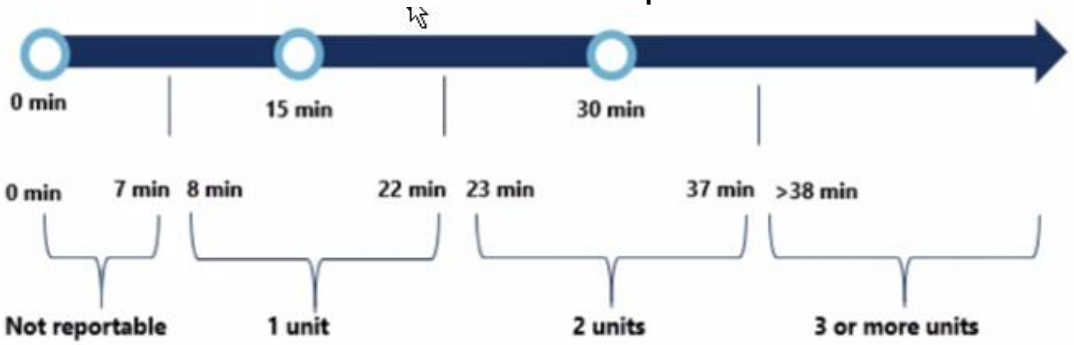
Clinical	Mod 1	Mod 2	Frequency	Rate	Example
G9008	U1		Allowed once per month **in person**. The once-a-month meeting with the member. The care plan is reviewed, and goals are created for the month.	$400.00	G9008 -U1 X 1 unit = $400.00
G9008	U1	GQ	Allowed once per month - **telephonic**	$400.00	G9008-U1-GQ X 1 unit = $400.00

- The once-a-month meeting with the member is allowed one time per member per month either in person or by telephone (not both).
- PHC will only reimburse either the clinical code G9008-U1 or the non-clinical G9012-U2 once per month, per member (not both).
- Do not bill a date span.

Multidisciplinary Team Conference Informational Services

Service code	Modifiers	Frequency	Billed amount	Example
G9007	No modifier	Optional~ 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	$0.01 or $1.00 this is not reimbursable. Billed in increments of 15 minutes.	G9007 X 4 units =$0.04

Efforts that are seven (7) minutes or less would not meet the "Rule of Eights" threshold and would not be reportable



Example: The case manager has spent 1 hour and 6 minutes with clinical staff discussing the members plan of care. This would be billed at 4 units of service.
G9007 X 4 units =$0.04

Place of Service codes

Place of Service (POS) codes are critical in medical billing to indicate where a healthcare service was provided. Providers must accurately identify the service location.

Why they're important:

They dictate reimbursement rates, influence claim processing, and ensure accurate payment for services rendered.

When billing telehealth POS codes, you must use modifier GQ in the secondary position

Place of Service Code	Description
02	Telehealth
04	Homeless Shelter
11	Office
12	Home
27	Outreach Site/Street

All POS codes must be 2 digits

You can find the complete list of POS codes along with their descriptions here:
https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

ICD-10 Codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.11	Inadequate housing, environmental temperature
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance and death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

DHCS has issued a list of 25 Priority SDOH Codes for providers to utilize when coding for SDOH to ensure correct coding and capture reliable data.

For additional ICD-10 Codes, please see IPN #431 on our website www.PartnershipHP.org

Taxonomy Codes

Taxonomy Codes are a 10-digit alpha numeric code set that designates Providers classifications and specializations

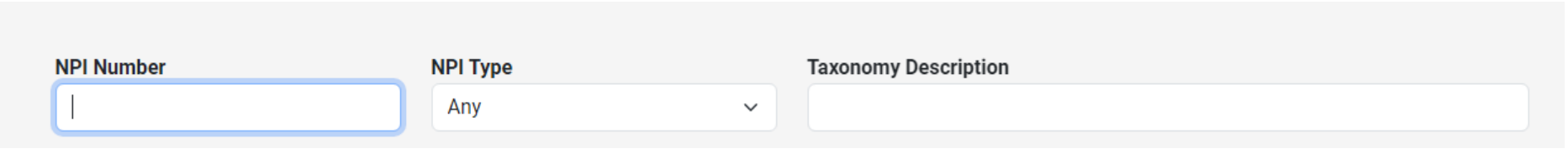
Attending Medical Provider Taxonomy Code – Taxonomy.nucc.org

NPI Registry

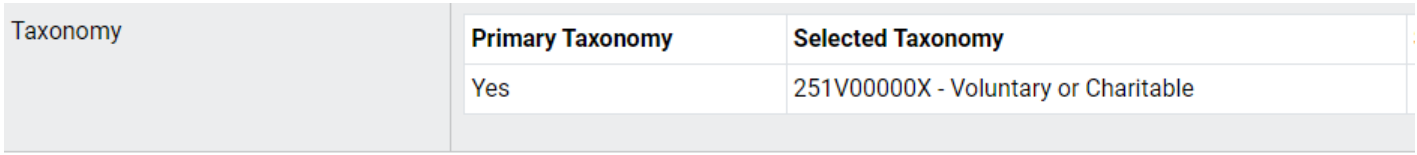
Searching for Taxonomy code with your NPI

NPI: https://npiregistry.cms.hhs.gov/search

Add NPI- click search- scroll to the bottom



Example



How to Submit Claims

Electronic Claims

Electronic Data Interchange (EDI)

- ✓**Now offering complementary electronic billing with Office Ally**
- ✓Submission of HIPAA-compliant 5010 version 837P File
- ✓Preferred submission method for faster reimbursement
- ✓Contact EDI Enrollment and Testing at:
  Phone: (707) 863-4527 or EDI-Enrollment-Testing@partnershiphp.org

Paper Claims

- ✓Submission of CMS-1500 format only
- ✓Send to: Partnership HealthPlan of California (Medi-Cal)
  P.O. Box 1368
  Suisun City, CA
  94585-1368

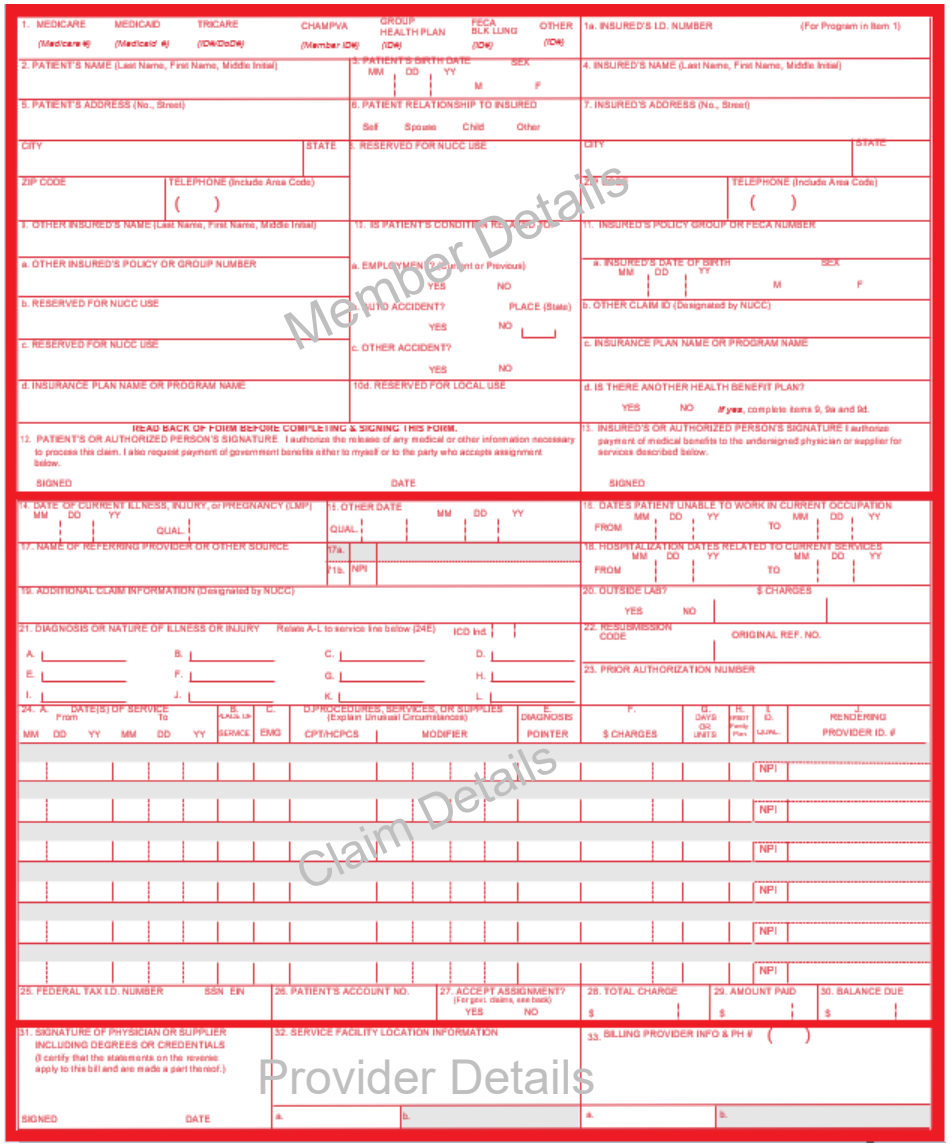
Invoice Billing Format

- ✓If invoice billing is the only option available for your organization to submit claims, please reach out to us.

CMS-1500

Member Details	
1a	CIN
2&4	Full Name
3	DOB & Gender
5&7	Address

Provider Details	
31	“Wet” Signature & Date
32	Physical Address/Providers Location
33	Billing Address
33a	NPI
33b	Billing Taxonomy Code

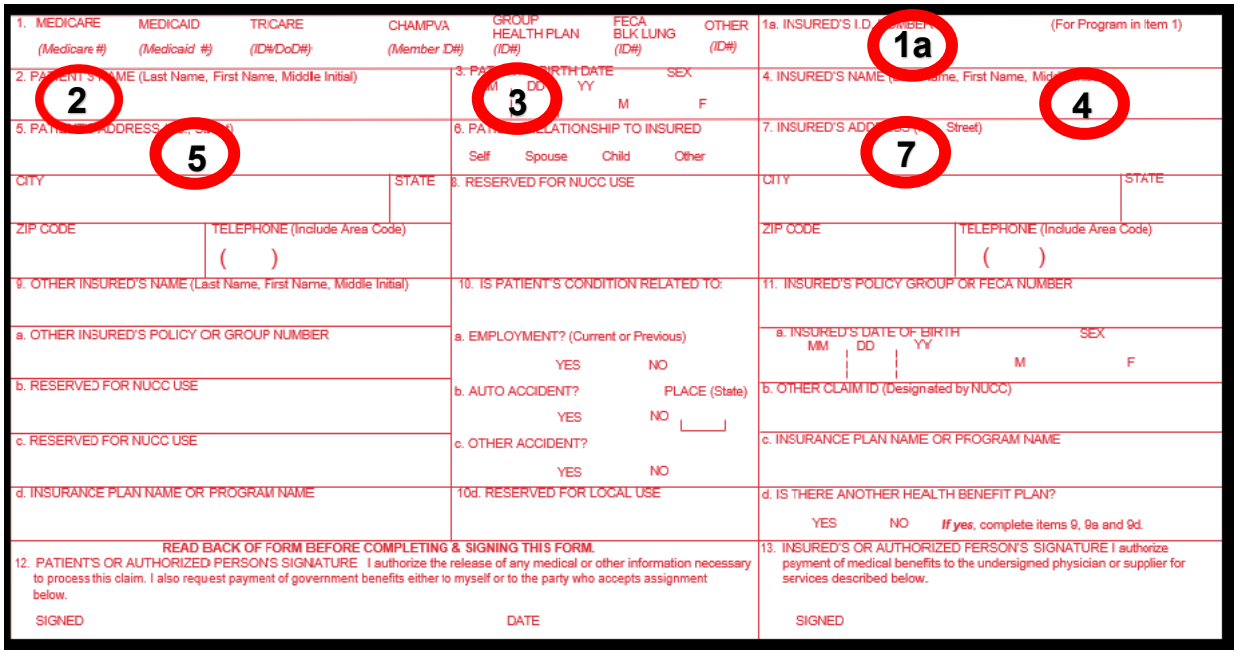


Claim Details	
21	Diagnosis: ICD-10 Indicator
24A	Date of Service
24B	Place of Service Code
24D	Procedure Code & Modifier
24E	Diagnosis Pointer
24F	Charges
24G	Units of service
24J	Shaded Area: Rendering Taxonomy Code
24J	Rendering Provider NPI

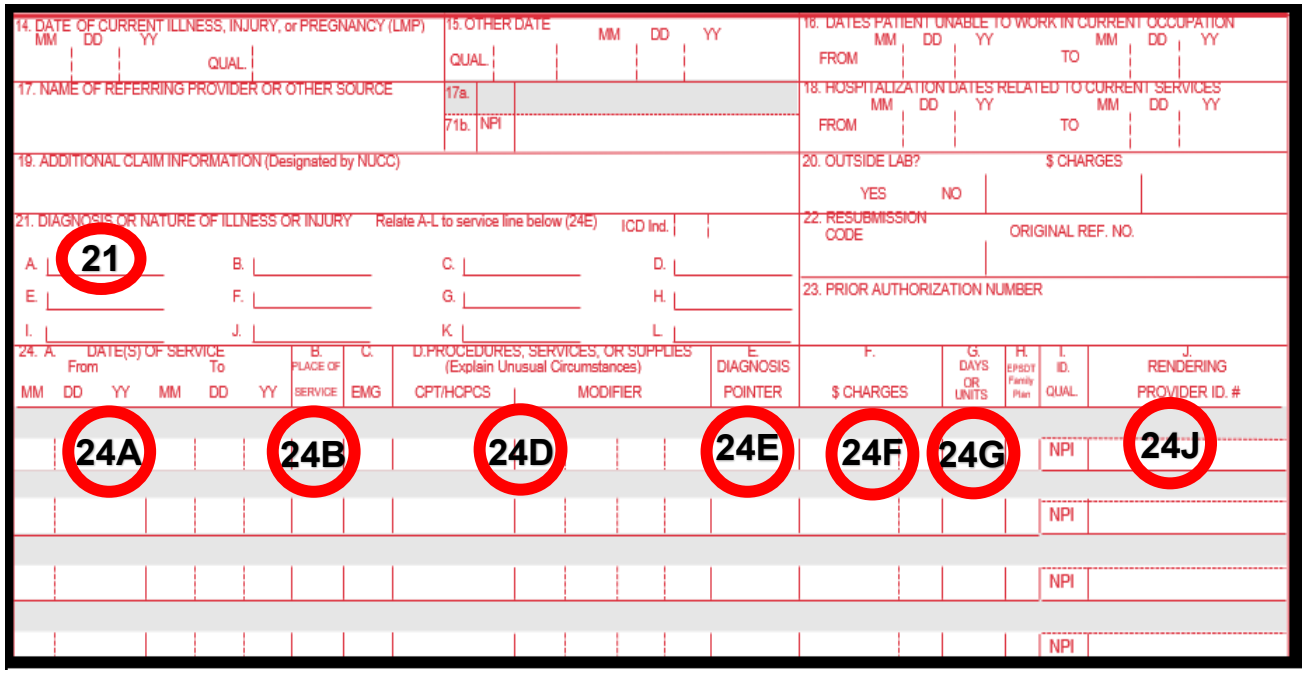
CMS-1500

MEMBER DETAIL

Field	Description
1a	Members CIN
2&4	Members full Name
3	Date of Birth and Gender
5&7	Members Address



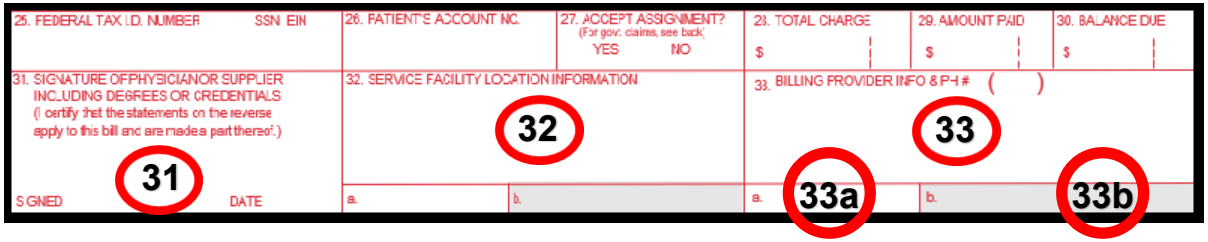
CMS-1500



CLAIM DETAIL

Field	Description
21	Diagnosis (ICD-10)
24A	Date of Service
24B	Place of Service
24D	Procedure & Modifier
24E	Diagnosis Pointer
24F	Charges
24G	Units of Service
24J	Rendering Provider Taxonomy & NPI

CMS-1500



PROVIDER DETAILS

Field	Description
31	Wet Signature & Date
32	Physical Address of Provider Location
33	Billing Address
33a	Billing NPI
33b	Billing Taxonomy Code

Getting Started with Office Ally

Payor Agreement

Complete your Payor Agreement and submit it to the EDI Team

- **Email:** EDIEnrollment@partnershiphp.org
- **Phone:** 707-863-4527

Office Ally Account

Set Up Your Organization's Administrator Account

- **https://www.officeally.com/sign-up/create-account**
- After the admin account is established, additional users can be added, each with their own unique login credentials

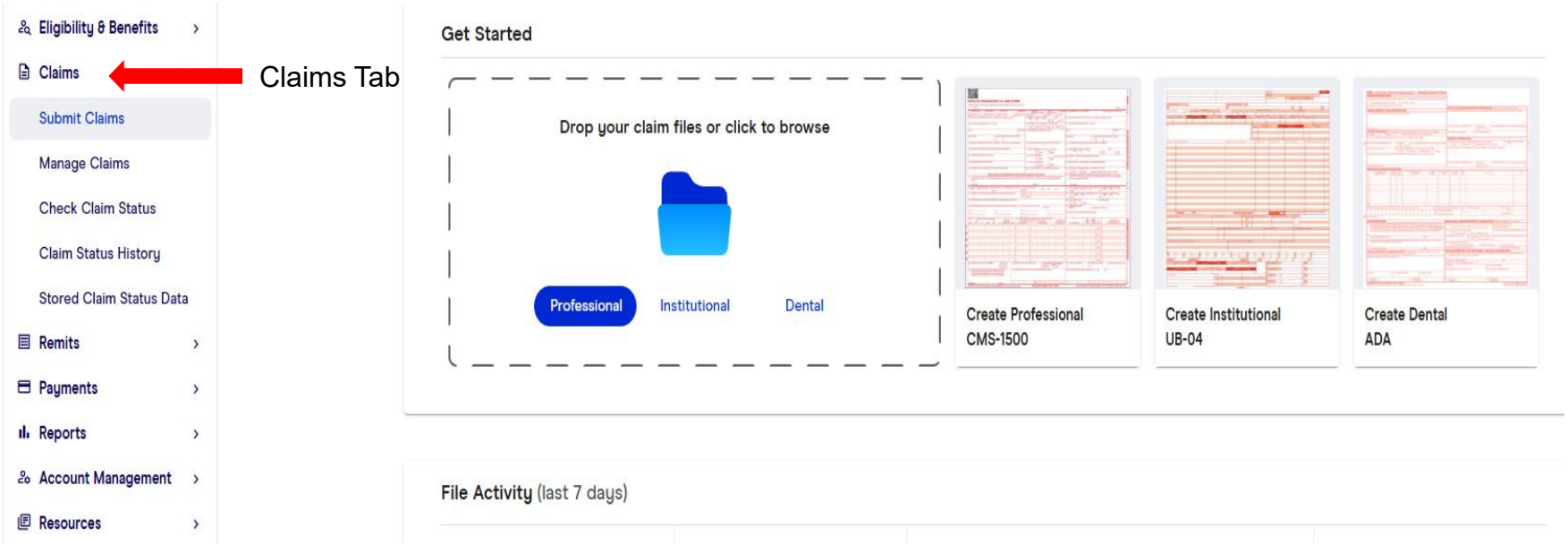
Payor ID

Partnership Payor ID: O9453

- This Payor ID should be used when submitting complimentary claims through Office Ally
- Please note this is the letter "O," not the number zero

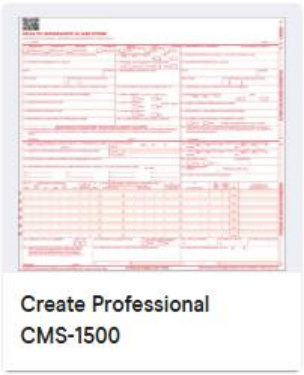
Office Ally Dashboard

The Claims tab is the primary area you'll use within your Office Ally dashboard

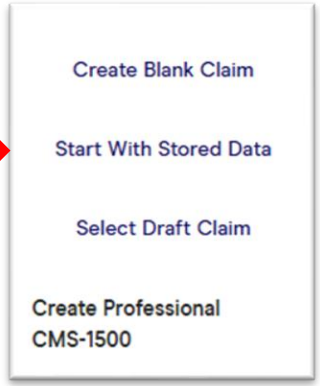


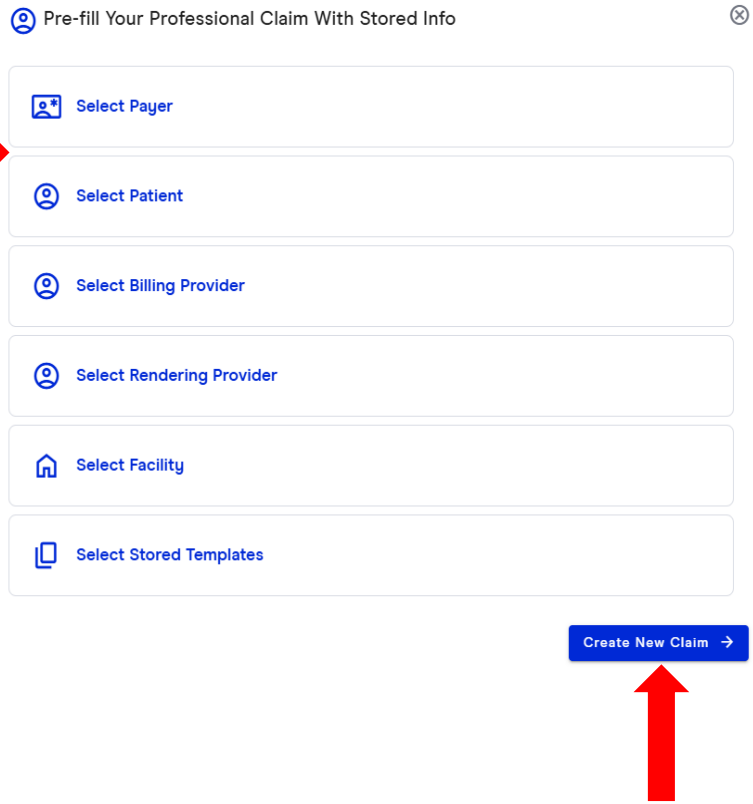
Here you can create, submit and manage your claims

Storing Data/Creating a claim



Create Professional
CMS-1500





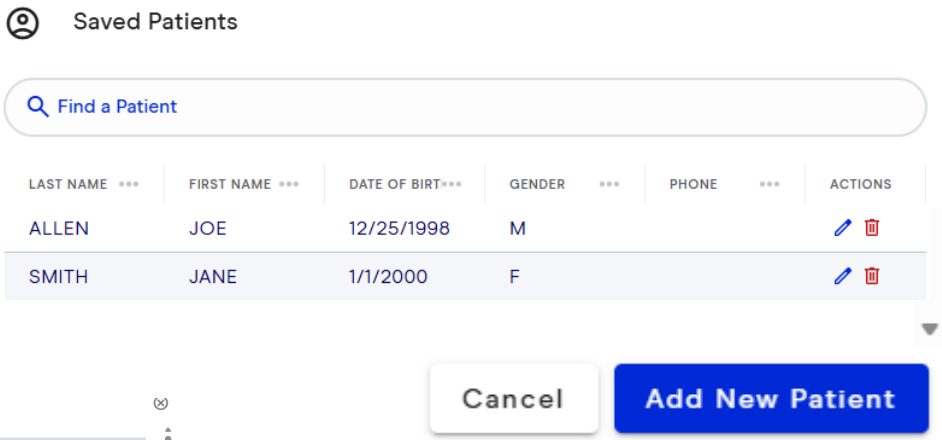
Stored Data Feature:

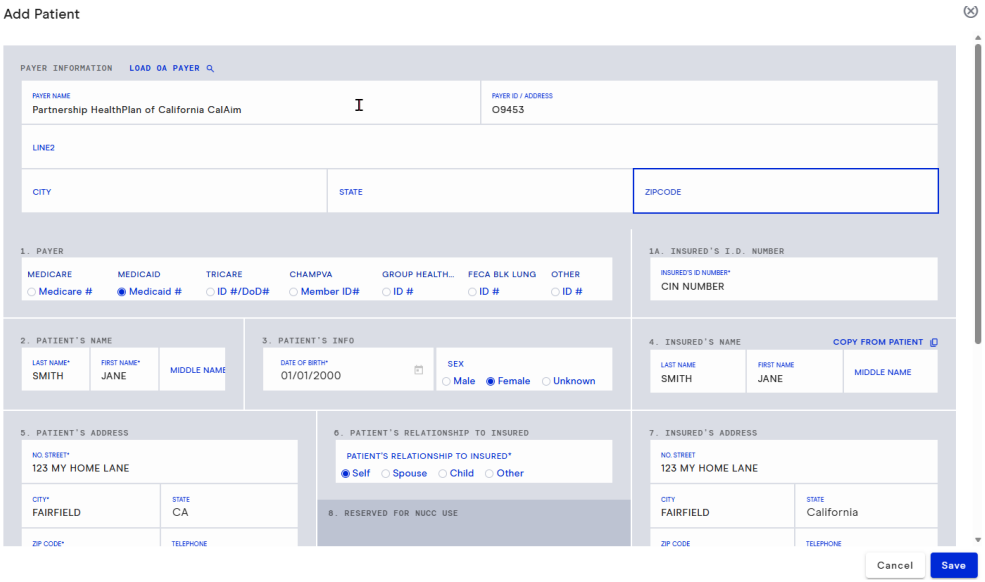
This option allows you to seamlessly access previously saved information and submit claims effortlessly

Generate a claim using saved information

Storing Data

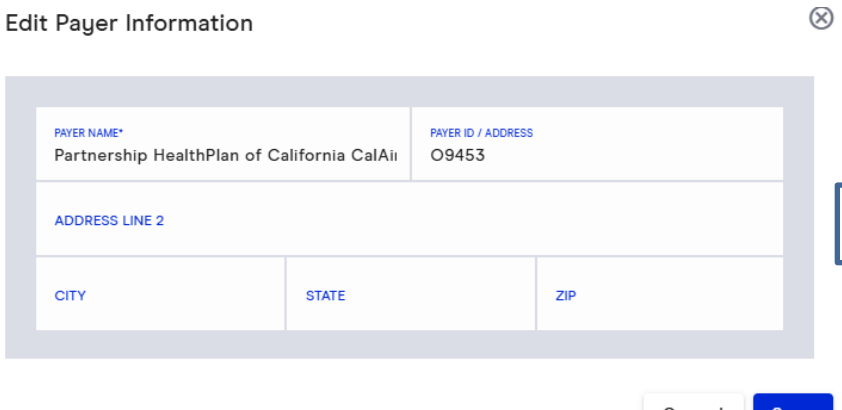
Add and store member details by selecting “Add New Patient”





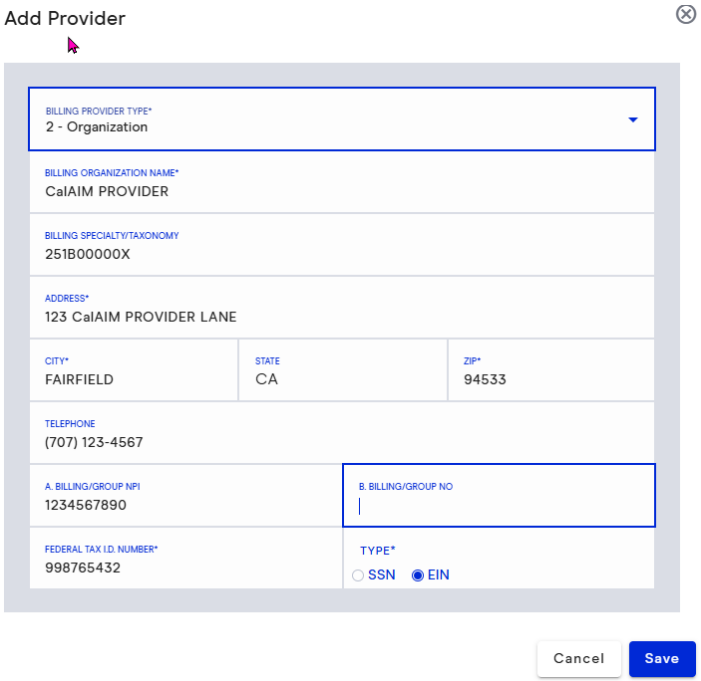
Search, edit, or delete member records within this section

Storing Data



Enter the payer name and payer ID O9453

Store your provider information for quick and easy future access



Templates

Saved Templates

Find a Template

NAME	ACTIONS
ECM - PMPM - TELEPHONIC	

Cancel | Add New Template

Create and store templates using procedure codes or member information

Edit Template

TEMPLATE NAME: ECM - PMPM - TELEPH

15. OTHER DATE: QUALI... | DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM DATE | TO DATE

17. NAME OF REFERRING PROVIDER: NAME | 17A. | 17B. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM DATE | TO DATE

19. ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC): ADDITIONAL CLAIM INFORMATION

20. OUTSIDE LAB?: OUTSIDE LAB? Yes / No | CHARGES 0

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

A.*	B.	C.	D.
Z5900			
E.	F.	G.	H.
I.	J.	K.	L.

22. RESUBMISSION: RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION: PRIOR AUTHORIZATION NUMBER

24.

	A. DATE(S) OF SERVICE FROM / TO DATE*	B. PLACE OF SERVICE*	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS*	MODIFIER A	B	C	D	E. DIAGNOSIS POINTER*	F. CHARGES*	G. DAYS OR UNITS*	H. EPSDT FAMILY PLAN	I. ID QUAL	J. RENDERING PROVIDER ID.
1	Note FROM TO	10		G9012	U2	GQ			A	$ 400	1		NPI	
2	Note FROM TO									$			NPI	
3	Note FROM TO									$			NPI	

+ Add line Items

25. FEDERAL TAX I.D. NUMBER: FEDERAL TAX I.D. NUMBER* 94369852 | TYPE* SSN / EIN

26. PATIENT'S ACCOUNT NUMBER: ACCOUNT NUMBER

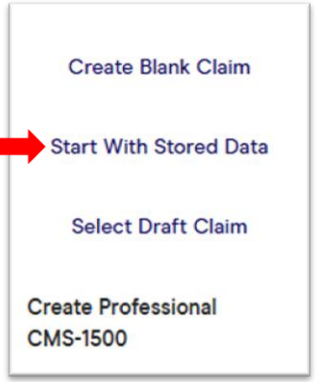
27. ACCEPT ASSIGNMENT?*: Yes / No

28. TOTAL CHARGE: $ 400.00

29. AMOUNT PAID: $ 0

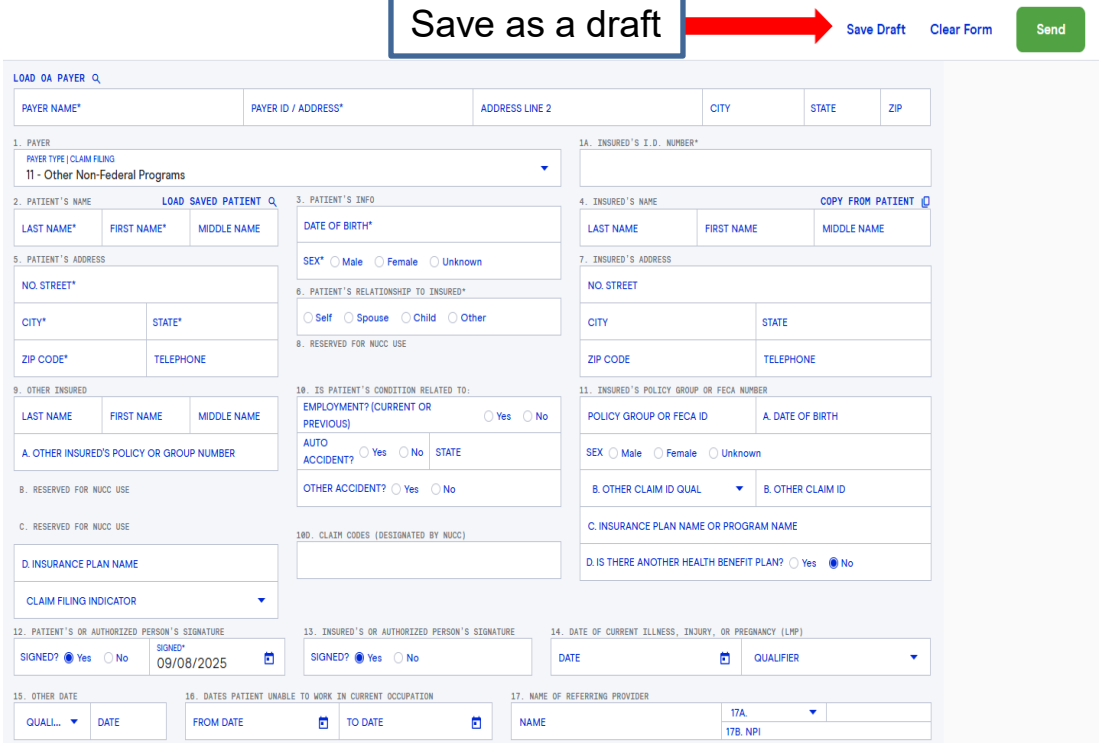
30. RSVD FOR NUCC USE

Creating a Claim

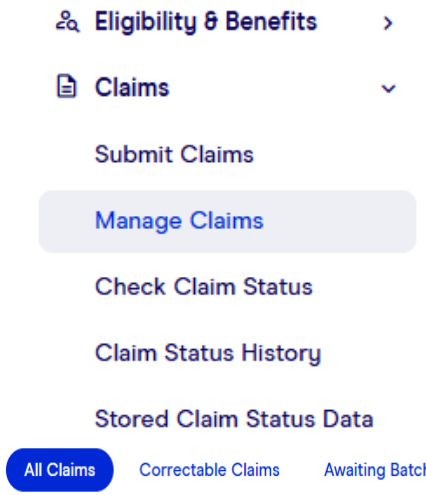


You can start with a blank claim, stored data or resume where you left off with a draft

Save as a draft

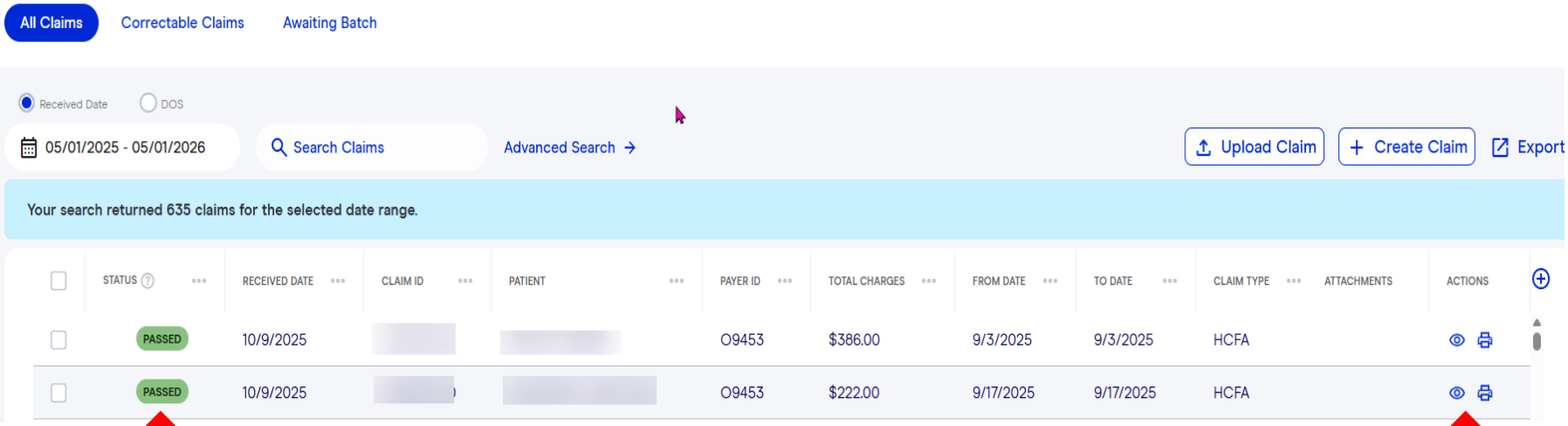


Managing Claims



Manage Claims Tab

- Easily track and manage your claims
- View all submitted claims in one place
- Make corrections to existing claims
- Monitor claims that are awaiting batching



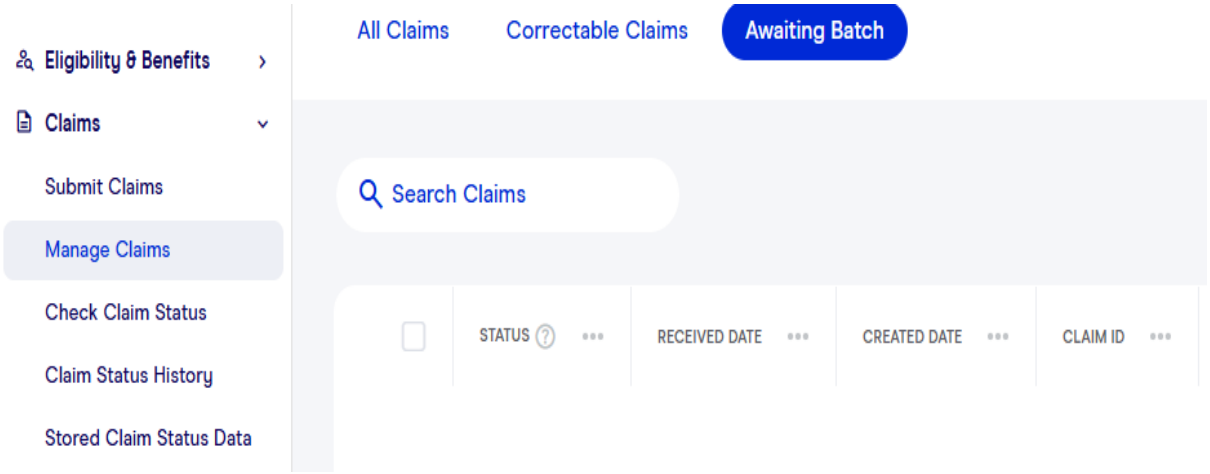
Claim Status

Easily track and manage your claims

View or print

Claims Awaiting Batch

Once the process of submitting the claim has been completed, it is sent to "Claims Awaiting Batch." Office Ally will pick up the claims for processing every three hours.

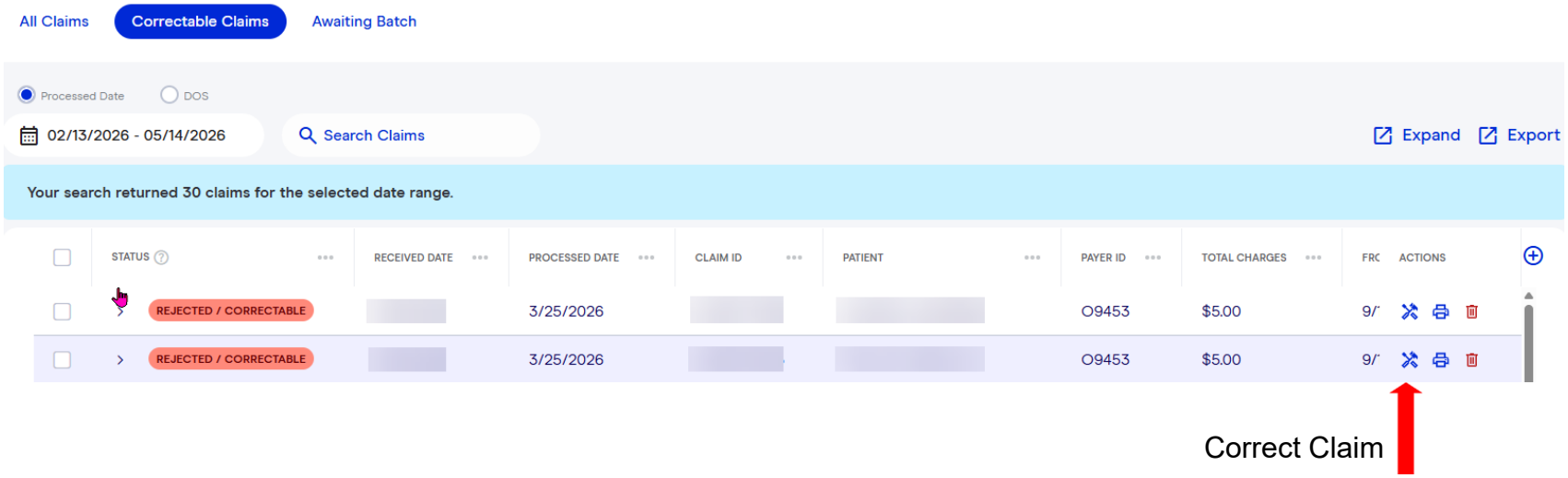


From this section you can **edit, print** or **delete** the claim before the claim is sent to the insurance company.

If a claim rejects, it is your responsibility to correct and resubmit the claim for processing

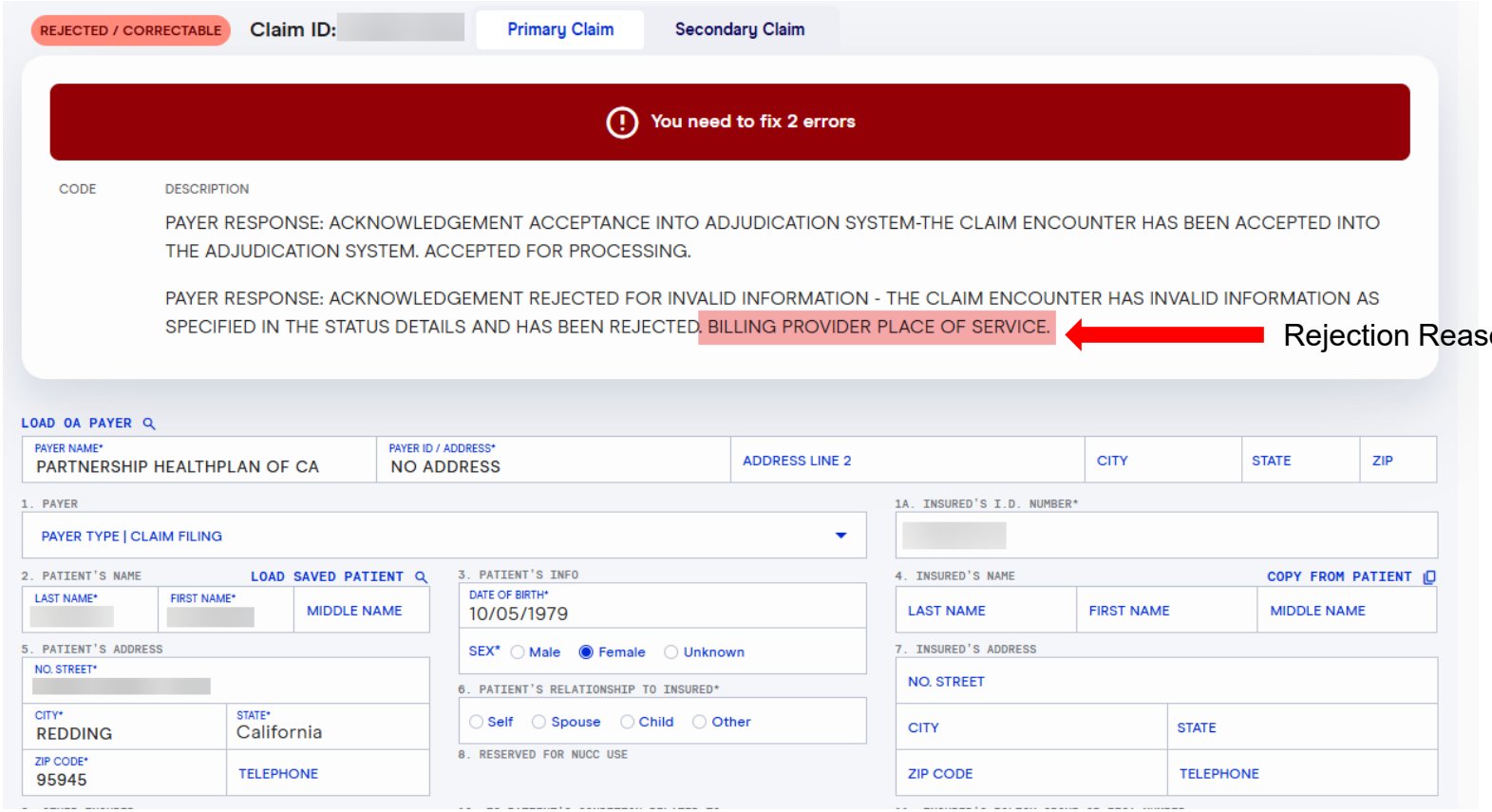
Claim Corrections in Office Ally

Claims that are rejected during pre-processing by Office Ally will be available for review in the “Correctable Claims” tab located within Manage Claims.



Click **correct claim** to the right of the claim line, this will bring up an editable claim image along with the claim rejection.

Claim Corrections in Office Ally



From this screen, you can review the reason for the claim rejection, make any necessary corrections, and resubmit the claim

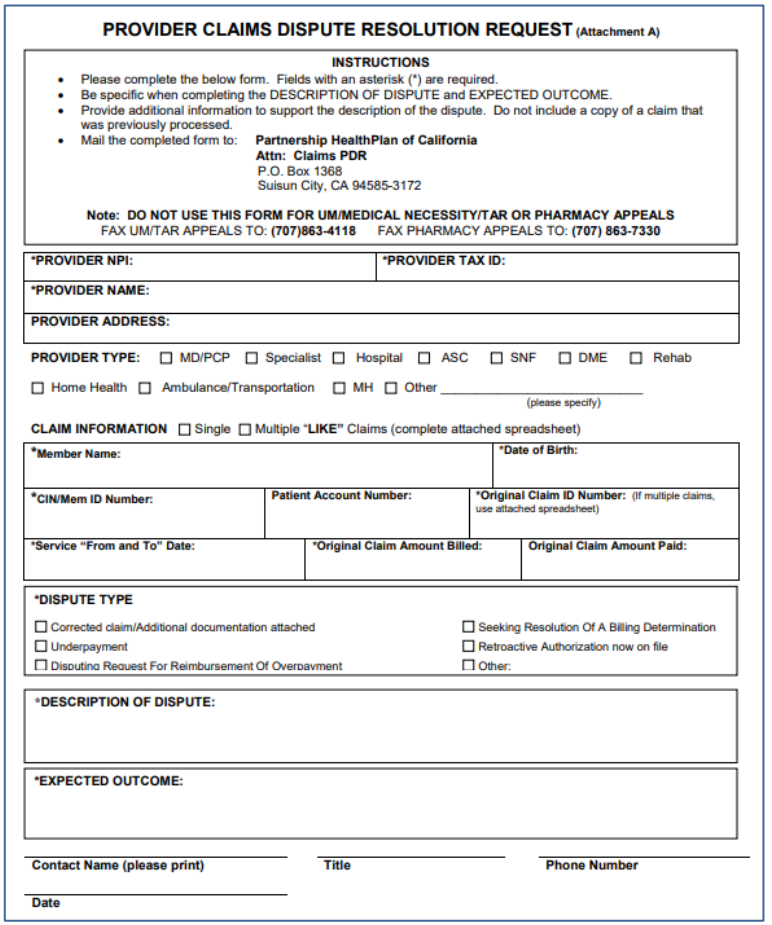
Claim Corrections in the Online Portal (PDR)

Providers have the right to submit a payment dispute if they disagree with a claim decision or compensation of a claim. Providers may submit disputes via Provider Online Services or by mail. **Disputes can be submitted within 365 days** (one year) from the original paid/denied date on the Partnership RA. Disputes received after one year are subject to automatic denial.

- Partnership will acknowledge receipt of the dispute immediately and will respond electronically indicating the outcome of the dispute review within 45 working days.

- When submitting a **PDR** to correct a claim for under payments, modifiers, units of service, or dates. There is now an option under **claim type** for **Community Supports claims.**

- Provider dispute form can be downloaded from the Partnership website.



PROVIDER CLAIMS DISPUTE RESOLUTION REQUEST (Attachment A)

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Mail the completed form to: **Partnership HealthPlan of California**
  Attn: Claims PDR
  P.O. Box 1368
  Suisun City, CA 94585-3172

Note: DO NOT USE THIS FORM FOR UM/MEDICAL NECESSITY/TAR OR PHARMACY APPEALS
FAX UM/TAR APPEALS TO: **(707)863-4118** FAX PHARMACY APPEALS TO: **(707) 863-7330**

*PROVIDER NPI:	*PROVIDER TAX ID:
*PROVIDER NAME:	
PROVIDER ADDRESS:	

PROVIDER TYPE: ☐ MD/PCP ☐ Specialist ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab
☐ Home Health ☐ Ambulance/Transportation ☐ MH ☐ Other _____ (please specify)

CLAIM INFORMATION ☐ Single ☐ Multiple "LIKE" Claims (complete attached spreadsheet)

*Member Name:		*Date of Birth:
*CIN/Mem ID Number:	Patient Account Number:	*Original Claim ID Number: (If multiple claims, use attached spreadsheet)
*Service "From and To" Date:	*Original Claim Amount Billed:	Original Claim Amount Paid:

*DISPUTE TYPE

☐ Corrected claim/Additional documentation attached
☐ Underpayment
☐ Disputing Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Retroactive Authorization now on file
☐ Other:

*DESCRIPTION OF DISPUTE:

*EXPECTED OUTCOME:

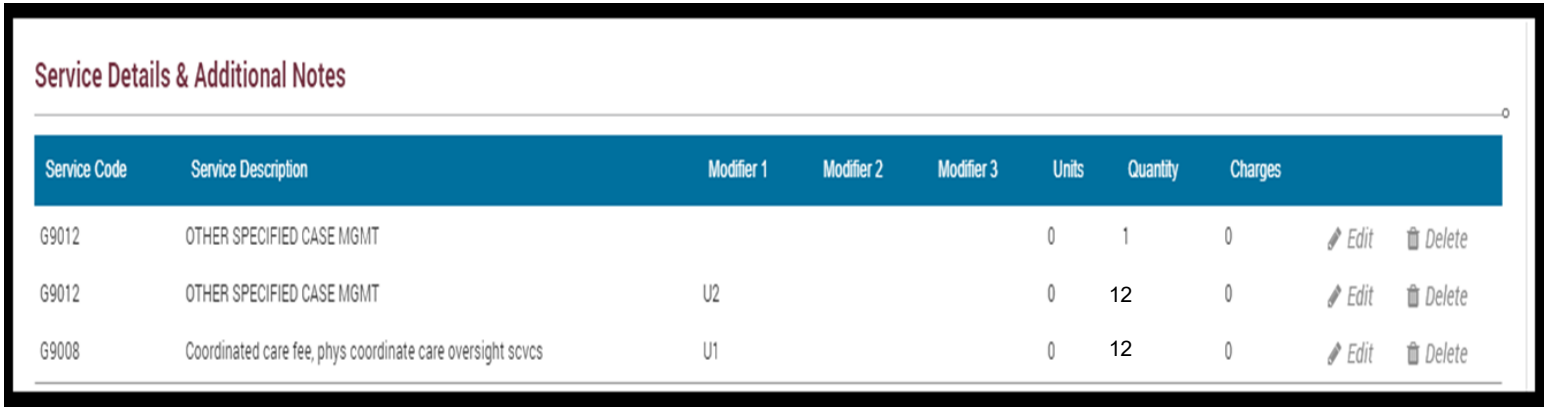
Contact Name (please print) | Title | Phone Number

Date

Initial TAR Submission

Services to be submitted on Initial TAR:

1. **Service line 1: G9012** (*Successful Engagement*)
   - No modifier
   - Quantity of **1**
   - 12-month authorization date span
2. **Service line 2: G9012** (*ECM services provided by non-clinical staff*)
   - Modifier U2
   - Quantity of **12**
   - 12-month authorization date span
3. **Service line 3: G9008** (*ECM services provided by clinical staff*)
   - Modifier U1
   - Quantity of **12**
   - 12-month authorization date span



Service Details & Additional Notes

Service Code	Service Description	Modifier 1	Modifier 2	Modifier 3	Units	Quantity	Charges		
G9012	OTHER SPECIFIED CASE MGMT				0	1	0	Edit	Delete
G9012	OTHER SPECIFIED CASE MGMT	U2			0	12	0	Edit	Delete
G9008	Coordinated care fee, phys coordinate care oversight scvcs	U1			0	12	0	Edit	Delete

TARs should not include modifier U8 or GQ

ECM TAR Reminders

- TARs are approved for one year (12 months). Re-authorizations may be approved for up to six months
- Verify that the TAR start date aligns with the date services begin
- Use 12 UOS in the Quantity field for G9008 and G9012, and add G9012 × 1 unit for the successful engagement
- ECM TARs should not include modifiers U8 or GQ

Billing Tips & Reminders

- Providers have 365 days from the date of service to submit claims to Partnership for payment consideration. Claims received on the 366th day from the date of service will be denied.
- Partnership has **30 days** from the receipt date of the claim to process and finalize ECM claims. Partnership will be the **primary** payer except for D-SNP.
- Verify Member's eligibility **every month**, preferably before each visit. Eligibility should be verified even when an approved TAR is on file.
- Verify the member's client ID/CIN is valid and complete on the invoice/claim. Do **NOT** use the member's social security number
- Providers can access claim status, generate and print remittance advice (RA), review check payment details, and submit claim corrections through the Partnership Provider Portal at www.partnershiphp.org.

Electronic Fund Transfer (EFT)

Electronic Fund Transfer(EFT) services (direct deposit) are provided by our third-party vender, FIS. Please contact FIS directly to get set up or if you have any questions

Monday – Friday, 5 a.m. – 3 p.m. (PT)	Phone: (877) 330-4950

Once you receive the first paper check and code, contact FIS to enroll

Partnership Contacts

Partnership HealthPlan of California	
Claims Helpdesk Please include your billing NPI when contacting the Helpdesk.	Claim/billing questions. Email: claimshelpdesk@partnershiphp.org
ECM Team	Reporting and/or TAR questions ECM@partnershiphp.org
Claims Resolution Unit	**1 (855) 798-8761**
Partnership EDI Enrollment	Phone: **(707) 863-4527** | Fax: **(707) 863-4390** Email: EDIEnrollment@partnershiphp.org
Partnership EDI Production Support (after enrollment)	Phone: **(707) 863-4520** | Fax: (**707) 863-4390** Email: EDISupport@partnershiphp.org

Office Ally Contacts

Office Ally	
Customer Service: Technical Support: Enrollments:	**(360) 975-7000 Option 1** **(360) 975-7000 Option 2** **(360) 975-7000 Option 3**
Live Chat (6 a.m. – 5 p.m. PST):	Support Suite | Office Ally
E-mail:	info@officeally.com or support@officeally.com

Thank you

Thank you for helping our members

Questions