ECM/CS Invoice FAQ

What is capitation (CAP)?
Capitation is a fixed amount that providers are paid per enrolled member per month.

What is fee for service (FFS)?
Fee for service is when providers are paid a fee for each service rendered. An invoice must be submitted to the Alliance for providers to receive payment.

Which services are capitated or fee for service?
View the Coding and Payment Guide at the end of this document to see which codes are capitated and which are paid fee for service.

How often should I be submitting invoices?
The Alliance suggests that providers submit invoices a minimum of once per month.

I didn't interact with a member face-to-face, should I still submit an invoice?
It is expected that an invoice is received for each member enrolled in a capitated ECM or CS service. The benefit description for many ECM and CS capitated services includes time spent on the member's behalf. If a service was provided via telehealth include the GQ modifier when billing.

What counts as an outreach attempt for ECM?
Outreach attempts are defined as individualized communication with a prospective ECM enrollee who is provided with the opportunity to respond directly. Individualized communication can occur through in-person, email, text, phone call, or other electronic method. An outreach attempt counts whether or not successful contact was made with the enrollee and whether or not the outreach results in ECM enrollment.

Do billing limits apply?
Yes. The Alliance follows Medi-Cal timeliness guidelines. Please see the Medi-Cal Provider Manual for more information. For capitated services, providers have one calendar year to submit invoices, but are strongly encouraged to bill more frequently. The recommended frequency is at least once per month.

Is roll-up billing allowed on invoice submissions?
Yes. Roll-up billing is encouraged. Providers should roll-up invoice lines for services that meet these requirements:

- Same Member
- Same Procedure Code and Modifier
- Same POS
- Same DOS

When roll-up billing, enter the total number of units for the single invoice line. Do not bill multiple lines.

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When should I disenroll a member from a capitated service?

Providers should submit a Provider Change Request (PCR) for any member when:

- Services are no longer needed
- The member needs alternate services from the currently enrolled benefit
- The member "graduates" from the program
- Or any other circumstances not listed here

Providers are encouraged to make any changes in a timely manner.

How many units should I bill?

Please refer to the Coding and Payment Guide below to help you determine the correct number of units to bill. Note: only whole units may be submitted on claims, in other words, bill in whole numbers only, not decimals.

References

Links:

DHCS Enhanced Care Management and Community Supports Website
DHCS ECM and CS FAQ
Medi-Cal Community Supports Explainer
ECM Outreach Toolkit
ECM Provider Toolkit

Coding and Payment Guide

Enhanced Case Management

HCPCS	Modifier	Description	Auth Code	Billing	Payment
G9008	U1 U1, GQ	ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services. ECM Phone/Telehealth: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	ECM02	Bill in 15-minute increments. 1 unit= 15 minutes	Capitation
G9008	U8 U8, GQ	ECM Outreach In Person: Provided by Clinical Staff. Other specified case management service not elsewhere classified. ECM Outreach Telephonic/Electronic:	ECM01	Bill in 15-minute increments. 1 unit= 15 minutes	FFS

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		Provided by Clinical Staff. Other specified case management service not elsewhere classified.			
G9012	U2 U2, GQ	ECM In-Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified. ECM Phone/Telehealth: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	ECM02	Bill in 15-minute increments. 1 unit= 15 minutes	Capitation
G9012	U8 U8, GQ	ECM Outreach In Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified. ECM Outreach Telephonic/Electronic: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	ECM01	Bill in 15-minute increments. 1 unit= 15 minutes	FFS

Community Supports

HCPCS	Modifier	Description	Auth Code	Billing	Payment
H0014	U6	Alcohol and/or drug services; ambulatory detoxification	H0014	Per diem. 1 unit=1 day	FFS
H0043	U6	Housing transition/navigation services per month. Supported housing.	CS02	Bill in 15-minute increments. 1 unit= 15 minutes	Capitation
H0044	U2	Housing Deposits	CS03	Bill once within the 6-month authorized period for the amount noted in the housing support plan	FFS – one-time payment
H2016	U6	Housing transition/navigation services per month. Comprehensive community support services.	CS02	Bill in 15-minute increments. 1 unit= 15 minutes	Capitation
T2040	U6	Housing tenancy and sustaining services.	CS01	Bill in 15-minute increments.	Capitation

		Financial management		1 unit= 15 minutes	
T2041	U6	Housing tenancy and sustaining services. Support brokerage	CS01	Bill in 15-minute increments. 1 unit= 15 minutes	Capitation