KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS **POLICY AND PROCEDURES**			
Policy Title	Enhanced Care Management Coding and Payment to Providers	**Policy #**	18.25-P
Policy Owner	Enhanced Care Management	**Original Effective Date**	01/01/2022
Revision Effective Date	04/01/2025	**Approval Date**	06/10/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

The purpose of this policy is to ensure that Enhanced Care Management (ECM) program providers are provided with proper coding and payment guidance and that they are properly reimbursed for ECM program provision.

II. POLICY

Kern Health Systems (KHS) ECM providers will use the Department of Healthcare Services (DHCS) provided Healthcare Common Procedure Coding System (HCPCS) codes and modifiers for ECM. This coding scheme uses Health Insurance Portability and Accountability Act (HIPAA) compliant HCPCS code and modifier combinations to identify clinical & non-clinical services, distinguish between in-person and telehealth visits, and identify ECM services. For the ECM program, KHS will submit encounter data to capture ECM as required by the DHCS.

III. DEFINITIONS

TERMS	DEFINITIONS
Clinical Staff	A clinical staff member is an individual who is qualified by licensure to perform ECM [e.g., licensed practical nurse (LPN), licensed vocational nurse (LVN), licensed clinical social worker (LCSW), registered nurse (RN), physician assistant (PA), nurse practitioner (NP), certified nurse specialist (CNS), licensed marriage family therapist (LMFT), etc.]
Non-Clinical Staff	A non-clinical staff member refers to anyone who does not meet the clinical definition above, who can perform or assist in the delivery of ECM (e.g., medical assistant (MA), community health worker (CHW), promotoras de

	salud, doulas). Please note a non-clinical staff member may be certified, but this does not equate to licensure.
In-Person	A Clinical or Non-Clinical ECM team member having an in-person or face-to-face interaction with the ECM member.
Phone/Telehealth	Interactions which occur via telephone or telehealth with a Non-Clinical or Clinical ECM team member.

IV.   PROCEDURES

A.   ECM– Coding Options for KHS

HCPCS codes will be used for ECM. The HCPCS code and modifier combined define the service as ECM. As an example, HCPCS code G9008 by itself does not define the service as an ECM care coordination service fee. HCPCS code G9008 must be reported with modifier U1 or U8 for the care coordination services to be defined and categorized as an ECM service. If a service is provided through telehealth, the additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy.

1. For ECM Outreach Services (for members not yet enrolled in the ECM program but have been authorized as eligible, excluding Streamlined (Presumptive) authorizations), to be billed, the following HCPCS code and modifier combinations should be utilized:

   a. G9008, U8 – ECM Outreach attempted and/or completed In-Person and provided by Clinical Staff.

   b. G9008, U8, GQ – ECM Outreach attempted and/or completed through Telehealth or Telephone by Clinical Staff.

   c. G9012, U8 – ECM Outreach attempted and/or completed In-Person and provided by Non-Clinical Staff.

   d. G9012, U8, GQ – ECM Outreach attempted and/or completed through Telehealth or Telephone by Non-Clinical Staff.

2. For ECM Enrollment and Engagement Services (for members being enrolled or already enrolled in the ECM program and who retain active authorizations for the ECM program) to be billed, the following HCPCS code and modifier combinations should be utilized:

a. G9008, U1 – ECM Enrollment and/or Engagement Services completed In-Person and provided by Clinical Staff.

b. G9008, U1, GQ – ECM Enrollment and/or Engagement Services completed through Telehealth or Telephone by Clinical Staff.

c. G9012, U2 – ECM Enrollment and/or Engagement Services completed through Telehealth or Telephone by Non-Clinical Staff

d. G9012, U2, GQ – ECM Enrollment and/or Engagement Services completed through Telehealth or Telephone by Non-Clinical Staff.

3. For members enrolled in ECM, HCPCS G9007 should be utilized for Multidisciplinary Team Conferences (MDTs). The ECM program provider's Clinical Staff should be present and this is used to indicate when a MDT occurs between the member's ECM Lead Care Manager (LCM) and one or more other providers involved in managing the member's care. No modifier is required for the use of this code as it is assumed that these interactions will either be initiated by or involve participation of clinical staff.

4. ECM services can only be billed and reimbursed to ECM program providers contracted with KHS to provide ECM services. No ECM services will be reimbursed to non-contracted providers.

For reimbursement, including rates and details of allowable claim submissions, billing and service frequency, etc., ECM program providers will refer to their established ECM contracts with KHS.

B. Payment of ECM Providers

1. KHS will pay ECM providers for the provision of authorized ECM to members in accordance with established contracts.

2. KHS shall pay 90% of all clean claims from ECM providers within thirty (30) days of the date of receipt and 99% of all clean claims within ninety (90) days. The date of receipt shall be the date KHS receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment. ECM providers will submit a claim for services rendered.

V.   ATTACHMENTS

N/A

VI.   REFERENCES

Reference Type	Specific Reference
Regulatory	ECM Billing and Invoicing Guidance ECM Billing and Invoicing Guidance
Regulatory	ECM and Community Supports HCPCS Coding Guidance HCPCS Coding Options for ECM and Community Supports (ca.gov)
Other KHS Policies	KHS Claims Submission and Reimbursement Policy 6.01

VII.   REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revised	04/2025	Annual Review of Policy by ECM Department Leadership. Revisions made to update current processes to ensure proper alignment with operational processes.	L.H.P Enhanced Care Management
Revised	04/01/24	Annual Review and Update	L.H.P Enhanced Care Management
Effective	01/01/22	Policy developed to outline processes regarding ECM coding and payment to providers.	Enhanced Care Management

VIII.   APPROVALS

Committees	Board (if applicable)	Date Reviewed	Date Approved
Choose an item.		

Regulatory Agencies (if applicable)	Date Reviewed	Date Approved
Choose an item.		

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Medical Officer		
Chief Operating Officer		
Chief Financial Officer		
Chief Compliance and Fraud Prevention Officer		
Chief Health Equity Officer		
Chief Legal and Human Resources Officer		
Deputy Chief Information Officer		
*Signatures are kept on file for reference but will not be on the published copy		

Kern Health Systems
18.25-P ECM Coding and Payment to Providers

Policy and Procedure Review

KHS Policy & Procedure: 18.25-P Enhanced Care Management Coding and Payment to Providers

Previous Implemented version: 2022-01

Reason for revision: Annual Review of Policy by ECM Department Leadership. Revisions made to update current processes to ensure proper alignment with operational processes.

Director Approval		
Title	**Signature**	**Date Approved**
Amisha Pannu Senior Director of Provider Network		
Robin Dow-Morales Senior Director of Claims		
Loni Hill Pirtle Director, Enhanced Care Management		

Date posted to public drive: _6/13/2025_

Date posted to website ("P" policies only): _6/13/2025___