Claims Guidance for Enhanced Care Management (ECM) and Community Supports (CS)

April 2025

Introduction

This document outlines the Kaiser Foundation Health Plan (Kaiser Permanente) claims and billing policy for Enhanced Care Management and Community Supports.

Enhanced Care Management (ECM) is a statewide Medi-Cal benefit available to select eligible members with complex needs. Enrolled members receive comprehensive care management from a single Lead Care Manager (LCM) who coordinates the member's health and health-related care, including physical, mental, dental care, and social services. ECM is a Medi-Cal benefit offered at no cost to eligible members.

Community Supports (CS) are a menu of services, which, at the option of a managed care plan and a member, can substitute for covered Medi-Cal services as cost-effective alternatives. CS services include the following: housing transition navigation services, housing deposits, housing tenancy and sustenance, 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/NF transition to a home, personal care and homemaker services, environmental accessibility adaptations (home modifications), meals/medically tailored meals, sobering centers, and asthma remediation.

The goals of this guide are to:

- Interpret DHCS **coding options** and **billing and invoicing** guidance.
- Provide preferred and alternate billing options.
- Facilitate and incentivize accurate and timely payments
- Collect a complete record of ECM/CS events to inform care coordination, program improvement, and future rate setting.

Scope

This guide is intended for CalAIM providers regardless of technical capacity. For providers submitting ANSI ASC X12N 837P or 837I claims, this document outlines the required data elements, file formats, transmission methods, submission timing, and adjudication processes Kaiser Permanente will use to accept and process invoices.

For providers not submitting institutional or professional claims through the 837 file format, this document outlines an alternative claim and invoice submission process that is compatible with **billing and invoicing** guidance. This alternative process includes clear instruction for submission.

National Lead Entities

Kaiser Permanente is responsible for administering both ECM and CS in collaboration with our network of community-based providers and Network Lead Entities (NLEs) as of January 1, 2024. Kaiser Permanente has contracted with the following NLEs for administering ECM and CS services:

- Independent Living Systems (ILS): ILSCAProviderRelations@ilshealth.com
- Full Circle Health Network: network@fullcirclehn.org
- Partners in Care Foundation: Hubinfo@picf.org

National Lead Entities, continued

NLEs will generate and submit claims/invoices to KP via paper or electronic data interchange transmission methods. NLEs will also determine the services and request KP to provide approval (via prior authorization) to deliver these services.

Claims Submission Options

Professional or institutional

There are two standards for claims submissions: *professional* and *institutional*. Except for the invoice process to submit claims, providers must choose one standard or the other. All NLEs have indicated that they would utilize the professional standard.

EDI

Kaiser Permanente urges providers to submit all claims via Electronic Data Interchange (EDI). Providers may submit EDI claims via 837I (Institutional) or 837P (Professional) transaction format, following all HIPAA standards and appropriate coding and regulatory requirements.

Benefits of Electronic Data Interchange (EDI) transmission include:

- Reduced Overhead Expenses
- Improved Data Accuracy
- Reduced Turnaround Time for Claims Processing
- Bypass U.S. Mail Delivery
- Go Green! Reduce paper, mail time and postal mail costs

Kaiser Permanente's EDI training partners for Northern California (NCAL) and Southern California (SCAL) are listed in the table below:

Clearinghouse	NCAL Payer ID	SCAL Payer ID
Office Ally	94135	94134
Relay Health	94135/RH009/KS003	94134/KS001
SSI	NKAISERCA	SKAISERCA

Paper Claims

Providers may elect to submit paper claims. Please keep in mind that the paper process is the least efficient claims submission method. Kaiser Permanente expects that ECM and CS providers billing for professional services submit professional claims on a *CMS-1500* form. Instructions for completing the *CMS-1500* can be found at **The National Uniform Claims Committee**.

Invoice

Kaiser Permanente has created an invoice template with the required fields necessary to successfully submit a claim. For a complete list of data elements and detailed requirements, please refer to **DHCS Billing and Invoicing Guidance**. Onboarding information may be obtained from the Kaiser Permanente contract manager.

Invoice, continued

Key data elements are listed as follows:

Table 1: Provider Information

Data Element	Required for ECM/CS Providers
Billing Provider National Provider Identifier (NPI)	*Yes*
Billing Provider Tax Identification Number (TIN)	*Yes*
Billing Provider Name	*Yes*
Billing Provider First Name	*Optional*
Billing Provider Last Name	*Optional*
Billing Provider Phone Number	*Yes*
Billing Provider Address	*Yes*
Billing Provider City	*Yes*
Billing Provider State	*Yes*
Billing Provider Zip Code	*Yes*
Rendering Provider National Provider Identifier (NPI)	*Optional*

Table 2: Member Information

Data Element	Required for ECM/CS Providers
Member Client Identification Number (CIN)	*Yes*
Medical Record Number (MRN)	*Optional*
Member First Name	*Yes*
Member Last Name	*Yes*
Member Homeless Indicator	*Yes*
Member Residential Address	*Yes*
Member Residential City	*Yes*
Member Residential Zip Code	*Yes*
Member Date of Birth (MM/DD/YYYY)	*Yes*

Table 3: Service and Billing Information

Data Element	Required for ECM/CS Providers
Primary Payer Identifier	*Yes*
Payer Name	*Yes*
Procedure Code(s)	*Yes*
Procedure Code Modifier(s)	*Yes*
Service Start Date	*Yes*
Service End Date	*Yes*
Service Name(s)	*Yes*
Service Unit Count(s)	*Yes*
Place of Services (POS)	*Yes*
Member Diagnosis Code(s)	*Yes*
Service Unit Cost(s)	*Yes*
Service Charge Amount(s)	*Yes*
Invoice Amount	*Yes*

Invoice, continued

Table 4: Administrative Information

Data Element	Required for ECM/CS Providers
Invoice Date (MM/DD/YYYY)	*Yes*
Invoice Number	*Yes*
Control Number	*Optional*
Authorization Number	*Optional*

Claims Submission Policy

The ECM/CS provider is required to submit claims and encounter data for the provision of services to Kaiser Permanente using the national standard specifications and code sets as defined by DHCS. Please see the **DHCS ECM and CS HCPCS Coding Options** for more information. This ensures that Kaiser Permanente can effectively monitor the volume and frequency of ECM/CS service provision and shows the actual cost of providing ECM/CS services to Kaiser Permanente and DHCS. Kaiser Permanente will pay 90% of all clean claims from practitioners who are individual or group practices or who practice in shared health facilities within 30 days of date of receipt and 99% of all clean claims within 90 days. Kaiser Permanente pathways for claims submission (in order of preference) are EDI, paper, and manual invoice. Find the latest Kaiser Permanente provider manuals, policies, and guidelines with additional claims guidance at **http://kp.org/providers**.

Clean Claims

Please use the following guidelines when submitting a claim.

- Submit clean claims, making sure that the correct and complete information is submitted on the correct form. A clean claim is a request for payment for a service rendered by a provider that:
    - Is submitted timely.
    - Is accurate.
    - Is submitted in a *HIPAA*-compliant format or using the standard claim form including a *UB-04*, *CMS-1450* or *CMS-1500* (02-12), or successor forms thereto, or the electronic equivalent of such claim form.
    - Requires no further information, adjustment, or alteration by the provider or by a third party to be processed and paid by Kaiser Permanente.
- Submit claims as soon as possible after providing service.
- Submit claims within the contract filing time limit. If Kaiser Permanente does not adjudicate the clean claim within 30 business days, all applicable interest as required by law will be paid. If Kaiser Permanente does not finalize a clean claim within 30 business days of receipt, interest will be due to the provider if the claim is payable. Providers are notified of the disposition of a claim with a remittance advice (RA) when the claim is finalized.

Unclean Claims

- Claims that are missing certain required fields or have invalid information may be rejected upfront. For paper claims, providers will receive a rejection letter stating the reason(s) why it could not be entered for processing. For EDI claims, providers will receive notification via the 277 EDI Claim Status transaction.
- Certain unclean claims may be denied during processing after claim entry. Providers will be notified of the rationale via the Evidence of Payment (EOP).
- A claim may also be considered unclean if additional information is required to make a payment decision. A written request will be sent to the provider through the Request for Information (RFI) process.

ECM and CS Coding Options

Providers must use the HCPCS codes listed in the tables below to report ECM/CS services. The specified HCPCS code and modifier combinations define the service as an ECM/CS service. As an example, HCPCS code H0043 by itself does not define the service as a Housing Transition/Navigation CS service. HCPCS code H0043 must be reported with modifier U6 for the supported housing services to be defined and categorized as a CS service. If an ECM/CS service is provided through telehealth, the additional modifier GQ must be used. GQ must be noted as a secondary modifier when applicable.

ECM Procedure Codes and Modifiers

HCPCS Code	Modifier	Service	Type of Service	Payable Billing Units
G9008	U8	ECM Outreach	ECM outreach in person, provided by clinical Rendering providers for the purpose of initiation into ECM. Other	1-unit per diem
G9008	U8, GQ	ECM Outreach	ECM outreach (telephonic/electronic)(1) provided by clinical Rendering providers for the purpose of initiation into ECM. Other specified case	1-unit per diem

ECM Procedure Codes and Modifiers, continued

HCPCS Code	Modifier[3]	Service	Type of Service	Payable Billing Units
G9012	U8	ECM Outreach	ECM outreach in person, provided by non-clinical Rendering providers. Other specified case management services	1-unit per diem
G9012	U8, GQ	ECM Outreach	ECM outreach by phone/telehealth[1], provided by non-clinical Rendering providers. Other specified case	1-unit per diem
G9008	U1	ECM Core Service	ECM in-person, provided by clinical rendering providers. Coordinated care fee, physician coordinated care	1-unit per diem
G9008	U1, GQ	ECM Core Service	ECM by phone/telehealth, provided by clinical rendering providers. Coordinated care fee, physician	1-unit per diem
G9012	U2	ECM Core Service	ECM in-person, provided by non-clinical rendering providers. Other specified case management service	1-unit per diem
G9012	U2, GQ	ECM Core Service	ECM by phone/telehealth, provided by non-clinical rendering providers. Other specified case management service	1-unit per diem
G9007	N/A[2]	Multidisciplinary Team Conference: Provided/Initiated by ECM Provider's Clinical Staff	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	1-unit per diem

(1) Telephonic/electronic methods include text messaging or secure email individualized to the member. However, mass communications (e.g., mass mailings, distribution emails, and text messages) do not count as outreach and should not be included.

(2) No modifier is required for the use of this code because it is assumed that these interactions will either be initiated by or involve participation of clinical staff.

CS Procedure Codes and Modifiers

HCPCS Code	Modifier[3]	Service	Type of Service	Payable Billing Units
T1002 T2033	U6	Recuperative Care	Residential care; per diem	1-unit per diem
H2016	U6	Housing Transition/ Navigation Service	Comprehensive community support services; per diem	1-unit per Member per month
H0043	U6	Housing Transition/ Navigation Service	Supported housing; per diem	1-unit per Member per month
T2040	U6	Housing Tenancy and Sustaining Services	Financial management, self- directed; per 15 minutes	1-unit per Member per month

CS Procedure Codes and Modifiers, cont.

HCPCS Code	Modifier[3]	Service	Type of Service	Payable Billing Units
T2041	U6	Housing Tenancy and Sustaining Services	Support brokerage, self-directed; per 15 minutes	1-unit per Member per month
H0044	U2	Housing Deposits	Supported housing, per month. Once in an individual's lifetime (must be in housing navigation)	Actual amount up to lifetime maximum
H0044	U3	Short Term Post-Hospitalization Housing	Supported housing, per month	1-unit per diem up to 6 months
T2038	U4	Nursing Facility Transition /Diversion to Assisted Living Facilities	Community transition; per service	1-unit per Member per month
T2038	U5	Community Transition Services/Nursing Facility Transition to a Home	Community transition; per service *(Care Management component only;* Home Modifications, Housing Deposits and/or Asthma Remediation are billed and paid as a separate service)	1-unit per Member per month up to lifetime maximum
S5165	U5	Asthma Remediation	Home modifications: per service	Billed amount(s) up to lifetime maximum
S5165	U6	Home Modifications	Home modifications; per service	Billed amount(s) up to lifetime maximum
S5170	U6	Medically-Supportive Food/Medically Tailored Meals	Home-delivered prepared meal	Per meal up to 12 weeks
S9470	U6	Medically-Supportive Food/Medically Tailored Meals	Nutritional counseling, diet	Per nutritional assessment
S9977	U6	Medically-Supportive Food/Medically Tailored Meals	Meals, per diem, not otherwise specified	Per weekly grocery box delivered
H0014	U6	Sobering Centers	Alcohol and/or drug services; ambulatory detoxification (up to 24 hours per instance)	1-unit per Member per day
T2012	U6	Day Habilitation Programs	Habilitation, educational	Per diem; Hourly

CS Procedure Codes and Modifiers, continued

HCPCS Code	Modifier(3)	Service	Type of Service	Payable Billing Units
T2014	U6	Day Habilitation Programs	Habilitation, prevocational	Per diem; Hourly
T2018	U6	Day Habilitation Programs	Habilitation, supported employment	Per diem; Hourly
T2020	U6	Day Habilitation Programs	Day habilitation	Per diem; Hourly
H2014	U6	Day Habilitation Programs	Skills training and development; per 15 minutes	Per diem; Hourly
H2024	U6	Day Habilitation Programs	Supported employment	Per diem; Hourly
H2026	U6	Day Habilitation Programs	Ongoing support to maintain employment	Per diem; Hourly
S5130	U6	Personal Care Services	Homemaker services; per 15 minutes	Hourly; Agency model
T1019	U6	Personal Care Services	Personal care services; per 15 minutes	Hourly; Agency model
H0045	U6	Respite Services	Respite care services, not in the home; per diem	Hourly; Agency model
S5151	U6	Respite Services	Unskilled respite care, not hospice; per diem	Hourly; Agency model
S9125	U6	Respite Services	Respite care, in the home; per diem	Hourly; Agency model

(3) If the Service is provided through telehealth, the additional modifier GQ must be used.

Reimbursement

The determination that a service, procedure, or item is covered under a member's benefit plan does not guarantee reimbursement for the provider. Services must adhere to authorization and medical necessity guidelines relevant to the procedure and diagnosis, as well as the member's county of residence. Providers must confirm member eligibility on the dates of service to avoid denials, clarify financial responsibility, and ensure appropriate care. Services rendered to patients without active Kaiser Permanente coverage on the date of service will be denied. Please follow proper billing and submission protocols using industry-standard, compliant codes on all claim submissions.

Kaiser Permanente reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by provider or state contract language, or by state or federal requirements or mandates. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Kaiser Permanente strives to minimize these variations.

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment include patient eligibility, benefits coverage, medical necessity, authorization requirements, or stipulations within a reimbursement policy. Neither payment rates nor methodology are conditions of payments.

ECM Outreach and Core Services

NLEs will be paid specific monthly rates for ECM outreach and core services. For members who receive both outreach and core services in the same month, NLEs will be paid the monthly core services rate only. Multiple attempts at an initial ECM outreach must be made by NLEs using different modalities (e.g., phone, text message) with in-person visits preferred. Outreach attempts should continue to be made for three months from the date the member was identified or confirmation of the member's agreement to participate in ECM, whichever occurs first.

For each service on the claim that is payable only once per month, the patient's claims history will be reviewed to determine if that service was previously paid for that month. If already paid, then the subsequent services for the same month will be denied. The remittance advice (RA) will include detailed rationale for any denied services.

The billing guidelines for ECM claims submitted for encounter capture are as follows:

- Outreach services only - billed/performed during a service month: The first instance is billed at the contract rate. All subsequent outreach services are billed at $.01.
- Core services only - billed/performed during a service month: The first instance is billed at the contract rate. All subsequent core services are billed at $.01.
- Both Core and Outreach services - billed/performed during a service month: The first core service is billed at the contract rate. All subsequent core and all outreach services are billed at $.01.

Electronic Payment and Remittance Advice Online Enrollment

Kaiser Permanente has partnered with Citi Payment Exchange to provide a portal for enrolling in Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA). With this partnership, Kaiser Permanente requests that all vendors pursuing EFT/ERA enrollments utilize the Payment Exchange portal for enrollment and changes to existing EFT/ERA. The portal is open 24 hours a day and 7 days a week for new enrollments or changes. Reduce turn-around-time for receipt of payments and remove overhead costs associated with handling paper correspondence by signing up for EFT/ERA today.

Each Kaiser Permanente region requires a separate enrollment. Please click the following links to create a new enrollment for EFT/ERA: **Southern California (SCAL)**, **Northern California (NCAL)**.

Provider Dispute Resolution Process

Kaiser Permanente actively encourages our contracted providers to utilize MSCC staff to resolve billing and payment issues. If unable to resolve provider billing and payment issues, Kaiser Permanente makes available to all providers a fast, fair, and cost-effective dispute resolution mechanism for disputes regarding invoices, billing determinations, or other contractual issues. This dispute resolution mechanism is managed in accordance with applicable law and in the contract. Please note that the process described in this section applies to disputes subject to the Knox-Keene Act. While Kaiser Permanente expects to use this process for other types of disputes, there is not a requirement to do so.

The following describes the most common types of disputes:

- Claims Payment Disputes: Challenging, appealing, or requesting reconsideration of a claim (or bundled group of claims) that has been denied, adjusted, or contested by Kaiser Permanente.
- Responding to Requests for Overpayment Reimbursements: Disputing a request initiated by Kaiser Permanente for reimbursement by you of a claim overpayment
- Other Disputes: Seeking resolution of a contract dispute (or bundled group of contract disputes) between you and Kaiser Permanente

Providers may submit payment disputes online via Online Affiliate or as a written notice to Kaiser Permanente by U.S. Mail or other physical delivery.

Please refer to the provider manual at **http://kp.org/providers** for detailed instructions.

Review Schedules and Updates

Kaiser Permanente reserves the right to review and revise its policies periodically when necessary. Reimbursement policies undergo reviews for updates to state, federal, or CMS contracts and/or requirements. Additionally, updates may be made at any time if Kaiser Permanente is notified of a mandate change or due to a Kaiser Permanente business decision. When there is an update, the most current policy will be published on the website provided at the beginning of this section.

Helpful Resources

Please see the below URLs for more information on specific claims-related topics:

- Video Overview of KP Online Tools
- Video Overview of Guest Access
- Video Overview of EOP Account Summary
- Video Overview of EOP Recoupment Detail Report

FAQ

1. **Who do providers contact to obtain claim status updates or ask claim submission questions?**
   Online Affiliate is Kaiser Permanente's self-service portal, which allows providers access to many features, such as:
   - Check the status of submitted claims and view claim details (service date, billed amount, allowed amount, patient responsibility)
   - Confirm payment information (check number, payment date, amount)

Online Affiliate is the most convenient and preferred method to access claims status; however, providers may also call (800) 390-3510 to speak with a Kaiser Permanente customer service representative.

2. **What are the rates providers should be using for claims?**
   Please refer to the provider's fully executed contract for rates.

3. **What modifier is required?**
   Please see the ECM and CS procedure codes and modifiers sections above. Providers may also reference the **DHCS ECM and Community Supports HCPCS Coding Options** for the list of HCPCS codes and corresponding modifiers.

4. **When using telehealth should another code be added?**
   If an ECM/CS service is provided through telehealth, the additional modifier GQ must be used.

5. **How do I submit claims for services rendered?**
   Claims submission options include submission through EDI, paper claim, or invoice. Please see the claims submission section above for further information about each of these options.

6. **What diagnosis code is required per CS claim?**
   ECM/CS providers should use the appropriate Z code(s) when submitting claims.