Enhanced Care Management and Fee for Service Billing

Health Net* reimburses providers for Enhanced Care Management (ECM) services using a Fee for Service (FFS) reimbursement model. In the FFS model, providers are reimbursed based on the number of units of eligible service they provide.**One hour of service equals one unit of service.**

Members who are eligible for ECM are among the most vulnerable and highest-need Plan members. It is critical for ECM Providers to establish strong relationships with these members (and their support systems, if applicable), and this occurs most effectively through regular in-person interactions in locations most convenient for the member. The FFS model allows providers to be reimbursed for the actual time spent delivering this high-touch, person-centered care.

Billing Practices

- Providers can bill for every hour of service that impacts care directly with or on behalf of a client.
- Provider contracts include procedure codes and modifiers for in-person and telephonic services delivered by either clinical or non-clinical staff.
- Record the time spent working with a client and document the amount of time by code.
  - One hour equals one unit.
  - Bill for full units during the billing period, rounding up if necessary. It is important to bill as close to one hour for each unit as possible.
  - Do not carry over partial hours to future billing periods. A member's eligibility can change from month to month.
- If you are planning and delivering care as a team, record the time for each staff member.
- Bill one unit for pre-enrollment outreach to a member regardless of the outcome.
  - Use outreach codes in your contract (and listed on the next page).
  - Providers may bill following the first outreach attempt to enroll a member, but all required outreach attempts must still be made prior to reporting a member as unable to reach.

Keep it simple!

- Bill for every hour of service that impacts care directly with or on behalf of a member.
- Services will be in person or telephonic and delivered by clinical or non-clinical staff. Use the corresponding codes and modifiers.
- One hour = one unit. Calculate hours and round up partial hours at the end of the billing period to determine the number of units.

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Reimbursable Component Activities

ECM component activities that directly impact member care either with or on behalf of a member/client can be billed. This includes planning for care even if the member is not participating.

The core components of ECM that are universal for all populations of focus include:

1. Outreach and engagement.
2. Comprehensive assessment and care management plan.
3. Enhanced coordination of care.
4. Health promotion.
5. Comprehensive transitional care.
6. Member and family supports.
7. Coordination of and referral to community and social support services.

Examples of reimbursable activities

- Meeting with a member in the hospital when the member is hospitalized.
- Conducting needs assessments and creating care plans.
- Case conferencing with care team (with or without the member present).
- Helping clients apply for benefits and prepare budgets.
- Arranging transportation to appointments.
- Assisting with basic needs and referring to Community Supports.
- Conferencing with hospital case managers when a client is discharged from the emergency department (ED).
- Travel time for member visits/outreach.
- Documenting case notes and updating recordkeeping systems.
- Telephone calls (including hold time).
- Appointment reminders and attending appointments with the member.
- Following up with member's primary care physician (PCP).
- Referrals to a mental health provider or substance use disorder (SUD) program.
- Coordinating with the member's support system (caregivers, parents).
- Follow up to ensure the member received referred services.
- Enrolling in activities and health and exercise programs.
- Medication and medical equipment education.
- Health Education – diabetes, nutrition, prenatal, smoking cessation, oral care, etc.

Activities that cannot be reimbursed

- Administrative overhead costs.
- Billing/claims submission costs.
- Services covered under another contract.

(continued)

ECM Procedure Codes and Modifiers

HCPCS Level II Code	Modifier	Description
G9008	U1	ECM in-person: provided by clinical staff.
G9008	U1, GQ	ECM telephone/telehealth: provided by clinical staff.
G9008	U8	ECM outreach in person: provided by clinical staff. Indicates a single in person ECM outreach attempt for an individual member, for the purpose of initiation into ECM.
G9008	U8, GQ	ECM outreach telephonic/electronic: provided by clinical staff. Indicates a single telephonic/electronic ECM outreach attempt for an individual member, for the purpose of initiation into ECM*.
G9012	U2	ECM in person: provided by non-clinical staff.
G9012	U2, GQ	ECM telephone/telehealth: provided by non-clinical staff.
G9012	U8	ECM outreach in person: provided by non-clinical staff. Indicates a single in person Enhanced Care Management outreach attempt for an individual member, for the purpose of initiation into ECM.
G9012	U8, GQ	ECM outreach telephonic/electronic: provided by non-clinical staff. Indicates a single telephonic/electronic ECM outreach attempt for an individual member, for the purpose of initiation into ECM*.

*Telephonic/electronic methods can 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.