Molina Healthcare of California

Enhanced Care Management (ECM) and Community Supports (CS) Billing Guide

Overview

ECM and CS are Medi-Cal benefits and services under the CalAIM initiative that help members with complex health and social needs. ECM focuses on comprehensive care management, while CS offers optional services, such as housing supports, meals, and respite care, that are provided in lieu of other covered Medi-Cal benefits. This guide outlines Molina Healthcare of California's billing, coding, and documentation standards for both ECM and CS to ensure accurate claims and compliance.

ECM Billing

1. Billing Expectations

Providers must submit ECM claims or encounters using national electronic standards (e.g., ANSI ASC X12N 837P/I).

Claims and encounters should include:

- Accurate date(s) of service
- Appropriate staff type (clinical vs. non-clinical)
- The correct HCPCS code-modifier combination

ECM services are defined by the specific pairing of a HCPCS code with the appropriate modifier(s). For example, G9008 must be billed with modifier U8 for ECM outreach (pre-enrollment), and telehealth ECM services must also include modifier GQ. A breakdown of all applicable ECM and CS HCPCS codes and required modifiers are included in the tables below.

Claims: Providers may bill ECM Outreach services through **Availity Essentials** or through their standard claims submission process.

Encounters:

- **CCA Users**: Providers who are utilizing Molina's Care Management platform, Clinical Care Advance (CCA), do not need to submit encounters separately. The system will generate an encounters file that is submitted to DHCS on your organization's behalf, based on the documentation entered. Proper documentation guidelines as specified in the ECM Provider Manual and during ECM training sessions must be followed to ensure accurate capitation payment and encounter submission through this process. Providers have 30 days from the date of service to enter the required documentation in CCA. Members must have valid contacts every month to sustain capitation. Molina reserves the right to recoup funds when ECM documentation processes are not followed and/or when there is no record of service delivery in CCA.

- **Non-CCA Users:** Providers who are not utilizing CCA must submit Encounters, not claims, for capitated services. Providers must follow the Encounter guidelines as specified in the Provider Manual. Electronic Encounter Reporting is Subject to the Following Requirements:
  - Data must be submitted in the HIPAA-compliant 837 format (ASC X12N 837)
  - DHCS-mandated values must be used when appropriate (e.g., procedure code modifiers)
  - Electronic Encounter Data must be received no later than 60 days from the Date of Services.
  - Only encounter records that pass Molina's edits will be included in the records evaluated for compliance.
  - Encounters that fail Molina edits will be rejected, and responses be supplied back utilizing the standard 999 acknowledgement and 277CA response files.
  - Rejected encounters must be corrected and resubmitted within 60 days from the Date of Services to be included in the performance standards.
  - In no event will incomplete, inaccurate data be accepted.
  - All Providers are required to submit encounters via EDI and have the ability to submit adjustments, voids/reversal transactions.
  - If a Clearinghouse is used to process your electronic encounter or Claims to Molina, please ensure that your contracted Clearinghouse uses the correct Payer ID for the type of EDI transactions (FFS Claims vs. Encounter):
    - **FFS Claims Payer ID: 38333**
    - **Encounters Payer ID: 33373**

Please refer to the **CA Medi-Cal Provider Manual** for more details regarding Encounters.

2. Member Eligibility Requirements

Reimbursement is available only when:

- The member is actively enrolled with Molina Medi-Cal on the date of service (DOS).
- The member is not enrolled with another ECM provider (Verify via **Availity**).
- For referrals outside of the Member Information File (MIF), a valid ECM referral must be submitted and on file with Molina before outreach attempts can be billed.

Once a member is enrolled in ECM:

- Providers receive monthly capitation,
- Submit Encounters, either through a clearinghouse or through the CCA process, and
- No additional outreach FFS claims may be submitted.

3. ECM Outreach (Fee-For-Service) Codes

ECM Outreach refers to the efforts made before a member is enrolled in ECM. These activities are reimbursable **up to five (5) attempts per member**, regardless of whether outreach is successful.

Valid outreach includes:

- In-person attempts
- Phone calls
- Secure individualized electronic communication (text or email)

Not considered outreach:

- Mass mailings
- Generic text blasts
- Impersonalized outreach campaigns

Providers must document each attempt, including date, method, and outcome.

HCPCS Level II Code	HCPCS Description	Modifiers	Modifier Description
ECM Provided by Clinical Staff			
G9008	**ECM Outreach In Person:** Provided by Clinical Staff. Other specified case management service not elsewhere classified.	U8	Used with HCPCS code G9008 to indicate a single in-person ECM outreach attempt for an individual member, for the purpose of initiation into ECM. (Updated January 2024) Can be used to indicate both successful & unsuccessful outreach attempts.
G9008	**ECM Outreach Telephonic/ Electronic:** Provided by Clinical Staff. Other specified case management service not elsewhere classified.	U8, GQ	Used with HCPCS code G9008 to indicate 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. (Updated January 2024) Can be used for both successful & unsuccessful outreach attempts.
ECM Provided by Non-Clinical Staff			
G9012	**ECM Outreach In Person**: Provided by Non- Clinical Staff. Other specified case management service not elsewhere classified.	U8	Used with HCPCS code G9012 to indicate a single in –person ECM outreach attempt for an individual member, for the purpose of initiation into ECM. (Updated January 2024) Can be used for both successful & unsuccessful outreach attempts.
G9012	**ECM Outreach Telephonic/ Electronic:** Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U8, GQ	Used with HCPCS code G9012 to indicate 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. (Updated January 2024) Can be used for both successful & unsuccessful outreach attempts.

4. Capitated ECM Services and Codes

Once a member is engaged and enrolled in ECM, providers cannot bill additional outreach attempts. All ongoing ECM activities, including care coordination, assessments, monitoring, home or community visits, and care plan updates are reimbursed through a monthly capitated payment rather than individual claims. Providers must either document in CCA or submit encounters separately though a clearinghouse. Provider should not bill FFS claims for enrolled ECM members.

HCPCS Level II Code	HCPCS Description	Modifiers	Modifier Description
ECM Provided by Clinical Staff			
G9008	**ECM In-Person:** Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1	Used with HCPCS code G9008 to indicate ECM services.
G9008	**ECM Phone/Telehealth:** Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1, GQ	Used with HCPCS code G9008 to indicate ECM services.
ECM Provided by Non-Clinical Staff			
G9012	**ECM In-Person:** Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2	Used with HCPCS code G9012 to indicate ECM services.
G9012	**ECM Phone/Telehealth:** Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U2, GQ	Used with HCPCS code G9012 to indicate ECM services.

5. Non-Reimbursable Activities and Codes

Some ECM activities are essential to care coordination but not separately reimbursable. For example:

- Multidisciplinary team conferences
- Internal care team meetings
- Administrative tasks not directly tied to outreach or billable encounters

HCPCS Level II Code	HCPCS Description	Modifiers	Modifier Description
ECM Provided by Multidisciplinary Team			
G9007 *(Added January 2024)*	**Multidisciplinary Team Conference:** Provided/Initiated by ECM Provider's Clinical Staff	No modifiers	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. 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 Billing

6. How CS Services are Billed

CS services are separate Medi-Cal services designed to address social needs such as housing, meals, and respite care. While CS services often complement ECM, they are **not included in ECM's monthly capitated payment**. CS services are reimbursed on a fee-for-service (FFS) basis and must be billed using the correct HCPCS code and modifier combination. Each CS service type has its own designated code and unit. Common unit types include:

- Per diem – Billed for each day the service is provided (e.g., housing, respite care).
- Per 15 minutes – Billed in 15-minute increments for time-based services (e.g., personal care, tenancy support).
- Per service – Billed for a single completed service (e.g., home modifications, housing deposits).
- Per month – Billed for services delivered over a monthly period (e.g., certain housing supports).

Accurate coding ensures timely payment and compliance with DHCS requirements. Always verify the appropriate code-modifier pairing and units before submitting claims to avoid denials.

7. CS Codes and Modifiers

Below is the full coding list per the **DHCS CS Policy Guide**. Please note that you must bill according to the codes that are included in your CS contract **and** in accordance with the approved authorization.

Community Supports	Codes	Modifiers	Descriptions
Housing Transition/ Navigation Services	H0043	U6	Supported housing; per diem
	H2016	U6	Comprehensive community support services; per diem
Housing Deposits	H0044	U2	Supported housing, per month. Requires deposit amounts to be reported on the encounter. Modifier used to differentiate housing deposits from Short-Term Post-Hospitalization Housing.
Housing Tenancy and Sustaining Services	T2040	U6	Financial management, self-directed; per 15 minutes
	T2050	U6	Financial management, self-directed; per diem
	T2041	U6	Support brokerage, self-directed; per 15 minutes
	T2051	U6	Support brokerage, self-directed; per diem
Short-Term Post-Hospitalization Housing	H0043	U3	Supported housing, per diem. Modifier used to differentiate Short-Term Post-Hospitalization Housing from Housing Transition/Navigation Services.
	H0044	U3	Supported housing, per month. Modifier used to differentiate Short-Term Post-Hospitalization Housing from Housing Deposits.
Recuperative Care (Medical Respite)	T2033	U6	Residential care, not otherwise specified (NOS), waiver; per diem

Community Supports	Codes	Modifiers	Descriptions
Respite Services	H0045	U6	Respite care services, not in the home; per diem
	S5151	U6	Unskilled respite care, not hospice; per diem
	S9125	U6	Respite care, in the home, per diem
Day Habilitation Programs	T2012	U6	Habilitation, educational; per diem
	T2014	U6	Habilitation, prevocational; per diem
	T2018	U6	Habilitation, supported employment; per diem
	T2020	U6	Day habilitation; per diem
	H2014	U6	Skills training and development; per 15 minutes
	H2038	U6	Skills training and development; per diem
	H2024	U6	Supported employment; per diem
	H2026	U6	Ongoing support to maintain employment; per diem
Assisted Living Facility (ALF) Transition	T2038	U4	Community transition; per service. Requires billed amount(s) to be reported on the encounter.
	H2022	U5	Community wrap-around services, assisted living services, per diem. Requires billed amount(s) to be reported on the encounter.
Community or Home Transitions	T2038	U5	Community transition; per service. Requires billed amount(s) to be reported on the encounter. Modifier used to differentiate from Nursing Facility Transition/Diversion to Assisted Living Facilities.
	H0044	U5	Supported housing; per month. Nonrecurring Set-Up Expenses. Modifier used to differentiate from Housing Deposits and Short-Term Post-Hospitalization Housing.
Personal Care/ Homemaker Services	S5130	U6	Homemaker services; per 15 minutes
	T1019	U6	Personal care services; per 15 minutes
Environmental Accessibility Adaptations (Home Modifications)	S5165	U6	Home modifications, per service. Requires billed amount(s) to be reported on the encounter.
Medically Tailored Meals/ Medically-Supportive Food	S5170	U6	Home delivered prepared meal. Used with HCPCS code S5170 to indicate Community Supports MTM/MSF: Medically Tailored Meals (Per Meal)
	S9452	U5	Nutrition classes, non-physician provider; Nutrition Education - Individual Session (Per 15 Minutes)
	S9452	U6	Nutrition classes, non-physician provider; Nutrition Education - Group Session (Per 15 Minutes)
	S9470	U6	Nutritional counseling, diet. Nutritional Assessment (Per 15 Minutes)
	S9977	U4	Meals; per diem, not otherwise specified. Produce Prescription – Box (Per Week)
	S9977	U5	Meals; per diem, not otherwise specified. Produce Prescription – Retail (Per Week)
	S9977	U6	Meals: per diem, not otherwise specified. Medically Tailored Groceries (Per Week)

Community Supports	Codes	Modifiers	Descriptions
	S9977	U7	Meals; per diem, not otherwise specified. Medically Supportive Groceries (Per Week)
	S9977	U8	Meals; per diem, not otherwise specified. Food Pharmacy (Per Session)
	S9977	U9	Meals; per diem, not otherwise specified. Healthy Food Vouchers (Per Month)
Sobering Centers	H0014	U6	Alcohol and/or drug services; ambulatory detoxification
Asthma Remediation	S5165	U5	Home modifications; per service
Transitional Rent	H0044	U6	Supported housing, per month Permanent settings (e.g., apartments, single family homes, etc.)
	H0043	U2	Supported housing, per diem Interim settings (e.g., non-congregate shelters, hotel/motel rooms, etc.)
CS Outreach	T1016	U8	Community Supports In-Person Outreach per 15 minutes for the following services: - Housing Transition and Navigation - Housing Deposits - Housing Tenancy and Sustaining Services
	T1016	U8, GQ	Community Supports Telephonic/Electronic Outreach per 15 minutes for the following services: - Housing Transition and Navigation - Housing Deposits - Housing Tenancy and Sustaining Services

Please note: CS Outreach codes for the Housing Trio are not separately reimbursable, but providers are encouraged to include these codes in their claim submissions for reporting purposes.

8. Common Billing Errors to Avoid

Providers can reduce denials by avoiding frequent mistakes such as:

- **Incorrect or missing modifiers.**
  Example: Using the capitated ECM modifier (U2) instead of the outreach modifier (U8) for ECM outreach claims.
- **Do not bill capitated modifiers for ECM Outreach.**
- **Do not bill for capitated services.**
- **Modifier placement.**
  The modifiers should be billed in the correct order; the U-modifier is considered primary and should be billed first. Any additional modifiers (i.e., GQ) should be included after the primary modifier (U-).
- **Billing outreach after the member is already enrolled.**
  Outreach is only reimbursable before ECM enrollment.

- **Billing more than five outreach attempts.**
  Only five (5) outreach attempts per member are reimbursable.
- **Submitting services for ineligible members.**
  The member must have active Molina Medi-Cal eligibility on the date of service (DOS).
- **Billing without a prior referral (for non-MIF members).**
  Non-MIF outreach is only reimbursable when Molina has approved the referral.
- **Billing for services prior to the authorization start date.**
  Example: Authorization begins 1/12/26 but the claim is billed for DOS 1/10/26.
- **Billing codes that are not included in the contract.**
  Example: Submitting claim for T2012 w/ U6 modifier, but the contract only specifies H2014 w/ U4 modifier.
- **Billing codes that are not included in the authorization.**
  Example: Submitting claim for H0044 w/U3 modifier instead of H0043 w/ U3 modifier as listed in the authorization.
- **Billing after the member has termed or has active eligibility restrictions.**
  These will appear in Availity or AEVS.
- **Incorrect date ranges for per-diem CS services.**
  Example: Billing T2033 U6 x 30 units with DOS 1/1/26–1/31/26 incorrectly reflects 31 days; correct range is 1/1/26–1/30/26

Tip: Always verify ECM enrollment, eligibility, and authorization dates in **Availity Essentials** before submitting claims.

9. Additional Resources & Support

For more information, please refer to the **ECM Provider Manual** or the **CS Provider Toolkit** available on the Molina provider website.

- ECM Team: **MHC_ECM@MolinaHealthcare.com**
- ECM Referrals: **MHC_ECMReferrals@MolinaHealthCare.Com**
- CS Team: **MHC_CS@MolinaHealthCare.Com**
- Provider Relations: **Contact List**
- Availity Essentials: **availity.com/providers/**