|  |  |  |
| --- | --- | --- |
| https://nachccom-5.sharepoint.microsoftonline.com/Communications%20Publishing%20Guide%20and%20Templates/NACHC_LOGO.jpg |  |  |

**Billing for Care Management Services**

 (CMS) Chronic Care Management (CCM) Services

|  |  |  |
| --- | --- | --- |
| **Checklist/Requirements to Bill for CCM** | Completed‘***Yes***’ | Missing‘***No***’ |
| **Initiating Visit**. An Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a FQHC employed MD, DO, NP, PA, or CNM occurring not more than one-year prior to commencing care coordination services.[[1]](#endnote-1)  |  |  |
| **Beneficiary Consent**. Obtained during or after the initiating visit and before provision of care coordination services by clinical staff; consent can be written or verbal, but must be documented in the medical record and include: * Availability of care coordination services and applicable cost-sharing
* Advise that only one practitioner can furnish and be paid for care coordination services during a calendar month
* Communicate patient right to stop care coordination services at any time (effective at the end of the calendar month)
* Patient permission to consult with relevant specialists.
 |  |  |
| **Patient Eligibility.** Presence of multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and/or place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. |  |  |
| **Care Coordination Services**. Documentation of 20 or more minutes of care coordination services furnished in the calendar month (a) under the direction of the FQHC employed practitioner (i.e., MD, DO, NP, PA, or CNM), and (b) by an FQHC practitioner, or by clinical personnel under general supervision. State law, licensure, and scope of practice definitions must be considered for non-primary care service providers. |  |  |
| **Electronic Health Record Documentation**. Structured recording of patient health information using Certified EHR Technology; includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care |  |  |
| **24/7 Access**. Patient has 24/7 access to physicians or other qualified health care professionals or clinical staff and means to contact health care professionals in the practice to address urgent needs regardless of the time of day or day of week. |  |  |
| **Continuity of Care**. Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments. |  |  |
| **Comprehensive Assessment**. Comprehensive care management including systematic assessment of the patient’s medical, functional, and psychosocial needs. |  |  |
| **Preventive Care**. System-based approaches to ensure timely receipt of all recommended preventive care services |  |  |

|  |  |  |
| --- | --- | --- |
| **Checklist of FQHC Requirements to Bill CMS for CCM** *(page 2 of 2)* | Completed‘***Yes***’ | Missing‘***No***’ |
| **Medication management**. Medication reconciliation with review of adherence and potential interactions; oversight of patient self-management of medications. |  |  |
| **Comprehensive Care Plan**. Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment; and a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed |  |  |
| **Resources and Support**. An inventory of resources and supports for patients. |  |  |
| **Care Plan Sharing**. Care plan information made available electronically (including fax) in a timely manner within and outside the FQHC as appropriate and a copy of the care plan given to the patient and/or caregiver |  |  |
| **Care Transition Management**. Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; follow-up after hospital discharges from hospitals, skilled nursing facilities, or other health care facilities; and timely creation and exchange/transmission of continuity of care document(s) with other practitioners and providers |  |  |
| **Coordination of Care**. Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient’s psychosocial needs and functional deficits in the patient’s medical record |  |  |
| **Electronic Communication Options**. Enhanced opportunities for the patient and caregiver to communicate with the practitioner regarding the patient’s care through not only telephone access, but also through secure messaging, internet, or other asynchronous non-face-to-face consultation methods. |  |  |
| **Coding & Billing**. Documentation to support using G0511 for General Care Management. Payment for G0511 code may only be billed once per month per beneficiary and cannot be billed if other care management services are billed for the same time period. |  |  |

***FQHC Chronic Care Management Services***

***Additional Billing and Coding Guidelines per excerpts from Centers for Medicare and Medicaid Services (CMS) Care Management Services FAQs*** [[2]](#footnote-1)

Chronic Care Management (CCM) services are billed using code G0511 for 20 minutes or more of clinical staff time spent on non-complex chronic care management per calendar month. Code G0511 may only be billed once per month per beneficiary and cannot be billed if other care management services are billed within the same time period. Here are a few quick reminders:

* CMS PFS 2020 CCM rate is $66.77.
* A FQHC practitioner (i.e., MD, DO, NP, PA, or CNM) determines if the patient meets the criteria for care management services and if they are likely to benefit from care management services.
* CCM may be furnished by auxiliary personnel under general supervision of the FQHC practitioner. General supervision does not require the FQHC practitioner to be in the same building or immediately available, but it does require the services to be furnished under the FQHC practitioner’s overall supervision and control.
* An initiating visit with a qualified FQHC practitioner is required within one year before beginning care management services.
* Consent must be obtained prior to the commencement of care management services. Consent may be verbal (written consent is not required) but must be documented in the medical record and remains in effect unless/until revoked by the patient.
* Monthly contact with the patient is not necessary to bill for care management services.
* Coinsurance applies to all care management services in FQHCs and cannot be waived. However, the HRSA sliding fee discount scale may be applied to all co-payments, co-insurance, and deductibles.
* A FQHC may submit a Medicare claim for a billable, CMS PPS “G” code visit and a care management service on a single claim.
* If billing for CCM AND a CMS PPS “G” code on the same claim, payment for the PPS “G” code will be the lesser of its charges or the fully adjusted PPS rate for the billable visit AND 80% of the charges for CCM.
* The date of service (DOS) used on the claim may be the date when the requirements to bill for the service have been met for that month or any date before the last day of the month.
* The 20 minutes of CCM must be furnished and totaled within each calendar month, not during a 30-day period that overlaps a start and end of consecutive months.
* ICD codes are required for CCM and FQHC practitioners should select the most appropriate ICD based on chronic conditions managed.
* CCM should only be furnished on an as-needed basis. There are no specific requirements for updating the care plan. It should be reviewed and updated as appropriate for the patient’s care.
* Care management costs such as software or management oversight can be included on the cost report. Any cost incurred as a result of the provision of FQHC services, including care management, is a reportable cost and must be included in the Medicare cost report.
* CCM should be reported on 837-I with revenue code 052x and corresponding HCPCS (e.g., CPT) code.
1. CMS defines a new patient as a patient covered by Medicare that has not been seen by a provider, or other provider of the same health center, in the last three years. This definition of a new patient differs from the traditional CPT definition of new patient so it is important all FQHC staff use the same definition. [↑](#endnote-ref-1)
2. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf>. [↑](#footnote-ref-1)