NATIONAL ASSOCIATION OF
Community Health Centers®

Care Management & Care Coordination

Part 2: Coding, Billing, & Reimbursement

August 10, 2021

Packaging and implementing evidence-based transformational strategies for safety-net providers

Bringing science, knowledge, and innovation to practice

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THE NACHC MISSION

America’s Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NATIONAL ASSOCIATION OF
Community Health Centers®

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Attendee:

Camila Silva (NACHC)
Me

Raise your hand button

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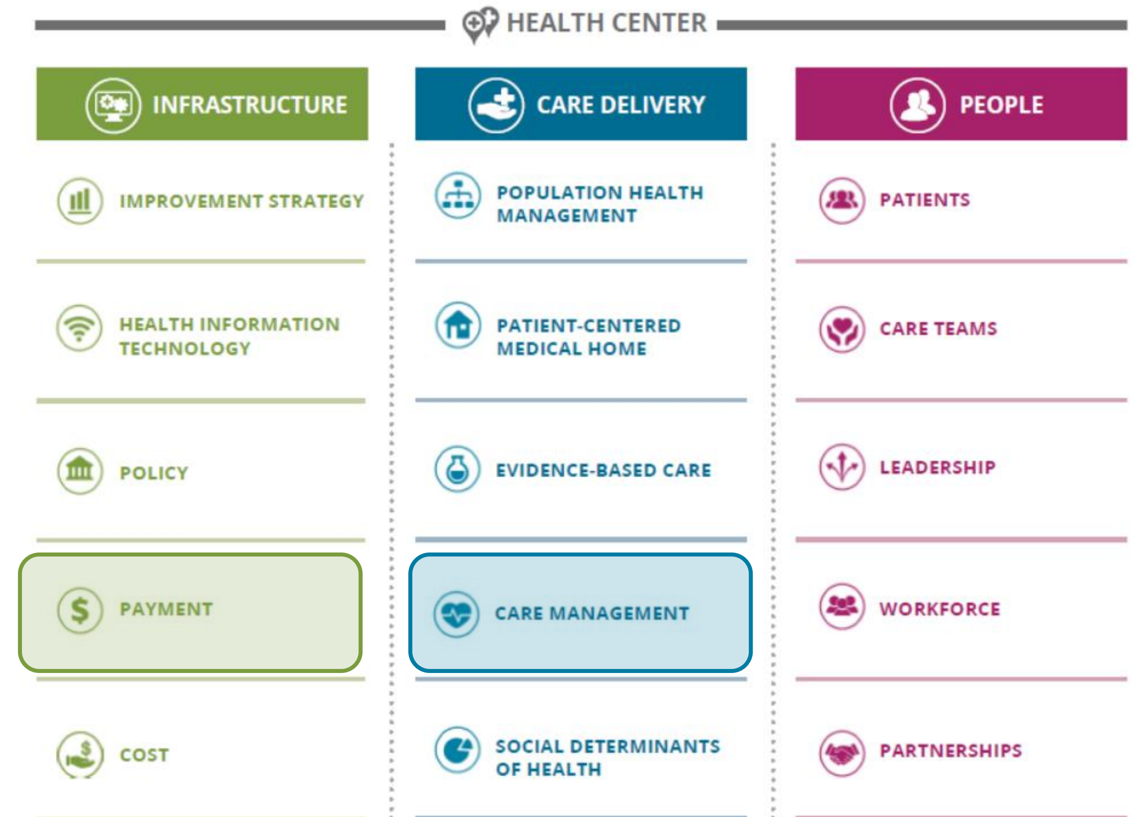
Value Transformation Framework



https://www.nachc.org/clinical-matters/value-transformation-framework/

Today's Objective:

- Outline reimbursement opportunities available for care management services under Medicare
- Answer questions from the field regarding coding and billing for Medicare care management services
- Offer health center perspectives on Medicare reimbursement strategies

NACHC's Diabetes Opportunity

Request for Proposals:

Attention: PCAs/HCCNs/Health Centers/Others

NACHC Diabetes Prevention and Management Program: A National Virtual Model for Delivering the National Diabetes Prevention Program to Individual with/at-risk for Diabetes.

Family Focus

Managing diabetes and prediabetes using a whole-person, whole-family perspective

More than Prevention

A program that focuses not only on preventing, but also managing diabetes.

Patient Kits

Patient Kits to all patients to help them manage chronic diseases and encourage participation.

Deadline: August 15, 2021

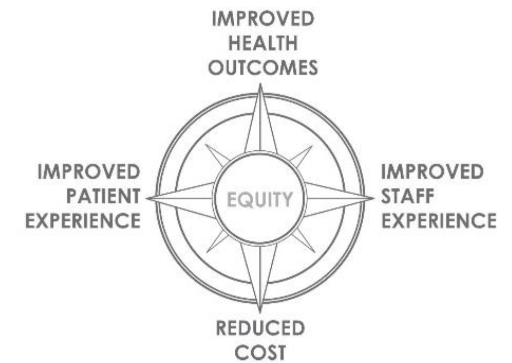
https://www.nachc.org/about/current-rfps/

CARE MANAGEMENT

Facilitate the delivery and coordination of care and manage high-risk and other subgroups of patients with more targeted services, when and how they need it.

https://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Care-Management-AG_November-2019.pdf

Return on Investment (ROI):
Know the Reimbursement Opportunities



Care Management Services	Reimbursement*
Chronic Care Management (CCM)	$65.25
Principal Care Management (PCM)	$65.25
Transitional Care Management (TCM)	$207.96 (moderate) / $281.59 (high complexity) $99.45 (telehealth)
Psychiatric Collaborative Care Model (CoCM)	$154.23
General Behavioral Health Integration (BHI)	$65.25
Virtual Communication Services	$24.76+

*Above intended to provide a general picture of reimbursement potential using 2021 CMS reimbursement guidance. See Reimbursement Tips for more details.
+For the duration of the COVID-19 public health emergency, will be paid at a rate of $24.76 rather than the 2021 PFS rate of $23.73.

PAYMENT

Utilize value-based and sustainable payment methods and models to facilitate care transformation.

https://www.nachc.org/wp-content/uploads/2020/04/Payment-Action-Guide-April-2021.pdf

Payment Action Guide

A compendium of care management tools is available free of charge on NACHC's Elevate platform

NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

INFRASTRUCTURE | CARE DELIVERY | PEOPLE

PAYMENT
CARE MANAGEMENT & VIRTUAL COMMUNICATION SERVICES

WHY
structure care management services to meet CMS reimbursement requirements?

Care management services are an essential population health activity under value-based care. Health centers are in a position to offer care management services to a wide range of people who have higher risks for some of the most common chronic conditions. Many of these patients clinically qualify for, and would benefit from, care management (See the Value Transformation Framework's Care Management Action Guide).

Health centers have the opportunity to obtain revenue above and beyond their federally-qualified all-inclusive flat rate when they offer, document, and bill for allowable care management services. This additional revenue has the potential to help fund systems change as health centers transition from a volume to value-based payment model.

CMS allows for the billing of care management services and virtual communication services (not a care management service) by Federally Qualified Health Centers (FQHC) including:

- Chronic Care Management (CCM)
- Principal Care Management (PCM)
- Transitional Care Management (TCM)
- General Behavioral Health Integration (BHI)
- Psychiatric Collaborative Care Model (CoCM)
- Virtual Communication Services (VCS)

To obtain revenue for care management services that benefit high risk patients, health center staff must establish systems to identify those in need of care management services, and establish processes to provide, document, and bill for these services. This action guide, and companion set of *Reimbursement Tips*, are designed to support health centers in this process of establishing and obtaining reimbursement for care management and virtual communication services.

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- Payment Reimbursement Tips: Chronic Care Management
- Payment Reimbursement Tips: Transitional Care Management
- Payment Reimbursement Tips: Behavioral Health Integration
- Payment Reimbursement Tips: Psychiatric Collaborative Care Model
- Payment Reimbursement Tips: Initial Preventive Physical Exam
- Payment Reimbursement Tips: Virtual Communications Services
- Payment Reimbursement Tips: Medicare Telehealth Services during the COVID-19 Public Health Emergency
- Guidance: Sliding Coinsurance for CMS/Medicare Care Management Services

Ray Jorgensen Consulting

Ray Jorgensen, MS

Lisa Messina, MPH, CPC

Chronic Care Management (CCM) & Principal Care Management (PCM)

PAYMENT

Reimbursement Tips:

FQHC Requirements for Medicare Chronic Care Management (CCM) and Principal Care Management (PCM)

The Chronic Care Management (CCM) model of care refers to personalized and supportive services for individuals with multiple (two or more) chronic conditions to coordinate care and develop a care plan to achieve health goals. Principal Care Management (PCM) is for individuals with a single, high-risk condition.

Program Requirements

In addition to Chronic Care Management (CCM), effective January 1, 2021, CMS will reimbursement for two new codes under a service called Principal Care Management (PCM). Both care management options refer to a comprehensive set of services administered to help a patient coordinate and manage chronic conditions. CCM and PCM services are typically provided outside of face-to-face visits and include:

- Comprehensive assessment
- Comprehensive care plan
- Medication management
- Preventive care
- Care plan sharing
- Care coordination
- Continuity of care
- Care transition management
- 24/7 access
- Resources
- Electronic communication options
- Electronic health record documentation

Patient Eligibility & Consent

Patients eligible for **CCM** include those who have multiple (two or more) chronic conditions expected to last at least 12 months or until the patient dies, or that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.

Patients eligible for **PCM** include those who have a qualifying condition that is expected to last between 3 months and 1 year, or until the death of the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. CMS anticipates these services will be billed by specialists focused on managing patients with a single complex condition requiring substantial care management.

A FQHC provider (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. With general supervision, the billing practitioner provides overall direction and control, but their physical presence is not required during the provision of services. **PCM** may be furnished by a physician or qualified health provider (QHP), or by clinical staff supervised a physician or QHP.

The patient must provide consent prior to initiating services but during the COVID-19 Public Health Emergency (PHE), consent may be obtained at the same time services are provided. Patient consent may be written or verbal but must be documented in the medical record. The billing provider must inform the beneficiary that cost sharing applies (i.e., s/he will be responsible for co-insurance).

Timeframe & Services

CMS/Medicare covers several types of chronic care management services. These include CCM and complex CCM. These services vary in the amount of clinical staff time provided, the level of involvement of the billing practitioner, and the extent of care planning performed. CCM services include:

Non-complex (CPT 99490) *New!*	First 20 mins of CCM clinical staff time directed, or personally provided, by a physician or QHP.
Non-complex additional time (CPT 99439) *New!*	Each add'l 20 mins of clinical staff time directed by physician or QHP; added to 99490 (clinical staff time). Up to 60 mins in a calendar month.
Complex (CPT 99487)	60 mins of CCM clinical staff time direction by a physician or QHP.
Complex additional time (CPT 99489)	Each add'l 30 mins of clinical staff time directed by physician or QHP; added to 99487.
Provider only (CPT +99491)	30 mins or more of CCM services in a month provided personally by a physician or QHP.

*Codes 99490, 99439, 99487, and 99489 are reported only once per calendar month. Code 99491 are reported no more than twice per calendar month.

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https://bit.ly/VTF_Payment_CCM

Chronic Care Management (CCM) Principal Care Management (PCM)

Comprehensive set of services for coordination and management of chronic care conditions

Provided outside of face-to-face visits, includes:

- Comprehensive assessment
- Comprehensive care plan (shared with outside providers)
- Medication management
- Preventive care
- Care plan sharing
- Care coordination
- Continuity of care
- Communication with patient (all methods)

- Services by clinical staff may be provided via general supervision

CCM & PCM Eligibility

CCM Eligibility

- Two or more chronic conditions
- Conditions expected to last at least 1 year or until death, or
- Places patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Complex CCM patients have a greater intensity of care and coordination needs as seen by number and diversity of services, ADL limitations, psychiatric or medical comorbidities, and/or social support to access care.

PCM Eligibility

- One chronic condition
- Condition expected to last between 2 months and a 1 year or until death, or
- Places patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- New service codes issued in 2020

Eligibility is determined by a FQHC practitioner (MD, DO, NP, PA, or CNM)

Chronic Care Management
Coding & Billing

FQHC Provider Codes (maps to G codes)	What FQHC bills to CMS	What CMS Pays (Physician Fee Schedule)	Non-PPS FFS (e.g., Medicare Advantage, Managed Medicaid, Commercial)
99490 (First 20 mins, ***non-complex***; clinical staff) + 99439 (New code in 2021 replacing G2058) (each add'l 20 mins; clinical staff. Only added to ***non-complex***/99490)	G0511 *General care management, 20 minutes or more of clinical staff time, directed by FQHC practitioner, per calendar month*	$65.25	99490: $ 41.27 +99439: $ 37.68
99487 (60+ mins, **complex**; clinical staff) +99489 (each add'l 30 mins; clinical staff. Only added to **complex**/99487)	G0511	$65.25	99487: $ 91.77 +99489: $ 43.97
99491 (30 mins; **physician or QHP only** (*not to be reported in same month as above clinical staff codes*)	G0511	$65.25	99491: $ 82.35

Principal Care Management
Coding & Billing

FQHC Provider Codes (maps to G codes)	What FQHC bills to CMS	What CMS Pays (Physician Fee Schedule)	Non-PPS FFS (e.g., Medicare Advantage, Managed Medicaid, Commercial)
G2064 (30 mins, physician or QHP, single high-risk disease	G0511	$65.25	G2064 = $ 90.37
G2065 (30 mins, clinical staff directed by a physician)	G0511	$65.25	G2065 = $ 38.73

The 2021 payment rate for HCPCS G0511 is the average of the national non-facility PFS payment rate for FQHC care management and general behavioral health codes (CPT codes 99490, 99487, 99484, and 99491) and the Principal Care Management codes (G2064 and G2065).

CCM/PCM Coding & Billing

What you need to know

- Services vary in the amount of clinical staff time provided, the level of involvement of the billing FQHC practitioner, and the extent of the planning performed.
- Only one practitioner can provide and bill for these services per calendar month.
- Monthly contact is not required to bill for care management services as not all services directly involve patient.
- Coinsurance applies
- A FQHC may submit a Medicare claim for a billable CMS PPS "G" code visit and a care management service on a single claim. They will be reimbursed separately.
- If billing for CCM/PCM 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 plus 80% of the charges for CCM/ PCM.
- 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.

Primary Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Behavioral Health Management (BHI)

Reimbursement Tips

PAYMENT

Reimbursement Tips:

FQHC Requirements for Medicare Behavioral Health Integration (BHI)

The general Behavioral Health Integration (BHI) model of care refers to the integration of physical and behavioral health services similar to core services offered under the Psychiatric Collaborative Care Model (CoCM), but without several additional components.

Program Requirements

General Behavioral Health Integration (BHI) covers models of care that focus on integrative treatment for patients with mental or behavioral health conditions that do not require, though they may use, the services of a behavioral health care manager or psychiatric consultant as required under the Psychiatric Collaborative Care Model (CoCM).

Patient Eligibility & Consent

Eligible patients are those requiring integrated behavioral health and primary care services, but not a psychiatric consultation or designated behavioral health manager. The patient must provide consent prior to initiating services. Consent may be verbal but must be documented in the medical record. The billing provider must inform the beneficiary that cost sharing (e.g., co-insurance) applies.

Timeframe & Services

Start-up An initiating visit with the billing provider (separately billable) is required for new patients or patients not seen within one year prior to the start of BHI services.

Subsequent Months Minimum of 20 minutes of behavioral health services.

BHI services are billed based on the calendar month rather than per 30 days. Reporting can occur any time in the calendar month after the 20-minute time threshold is met. Face-to-face services are not required during the calendar month. Patients should periodically be reminded that BHI services are performed by authorized staff (via phone, online, or other means of communication and coordination), even if the patient does not come to the FQHC for a visit.

Initiating Visit

A comprehensive initiating visit (e.g., IPPE, AWV, or E/M) within the past 12 months is required before the start of BHI services. The initiating visit is not part of BHI services and is billed separately. BHI services do not have to be discussed during the initiating visit, but this visit must occur during the year (12 months) prior to the start of BHI.

At FQHCs under **Medicare**, a new patient is someone who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service. Dental service would not count as dental is not covered by Medicare. This definition differs from the traditional CPT definition of a new patient. FQHCs are encouraged to educate staff of the variance and may choose to use a single definition.

Authorized Provider/Staff

Only one practitioner/facility can furnish and be paid for BHI during a calendar month, though it involves a team-approach led by the primary care provider.

Treating (Billing) Provider				Behavioral Health Care Manager*	Psychiatric Consultant*
Physicians (MD or DO)	Non-Physician Practitioners				
	NP	PA	CNM		
x	x	x	x		

- *Medical Doctor (MD) or Doctor Osteopathy (DO)*
- *Non-Physician Practitioners include Nurse Practitioners (NP), Physician Assistants (PA), and Certified Nurse Midwives (CNM)*
- *Behavioral Health Care Manager: Designated individual with formal/specialized training in behavioral health (i.e., social work, nursing, psychology) and at least a bachelor's degree, working under the oversight and direction of the billing practitioner*
- *Psychiatric Consultant: Medical professional trained in psychiatry and qualified to prescribe the full range of medications*
- **Not required as part of the BHI model although such personnel may provide general behavioral health services*

Services not provided personally by the billing practitioner are provided by other authorized staff under the direct supervision of the billing practitioner (i.e., "incident to" or "within shouting distance" oversight by the billing provider). Other services by the care management team are permitted under general supervision (the billing practitioner provides overall direction and control, but their direct physical presence is not required during provision of services). All services and supervision requirements (regardless of CMS/Medicare policy)

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https://bit.ly/VTF_Payment_BHI

Behavioral Health Integration

Integration of physical and behavioral health, similar to, but without the additional components of Psychiatric Collaborative Care Management (CoCM)

BHI

- May use services of psychiatric consultation or behavioral health manager.
- Minimum of 20 minutes of clinical staff services per calendar month.
- Care management services primarily offered by clinical staff under general supervision.

Services can be recommended by social worker, psychiatrist, or clinical psychologist; however, eligibility is determined only by a FQHC practitioner (i.e., MD, DO, NP, PA, or CNM)

CoCM

- Uses a dedicated behavioral health care manager and psychiatric consultant as key service providers.
- Minimum of 70 minutes for initial visit and then 60 minutes for subsequent services with 30 minutes of add-ons possible.
- Services provided by physician, behavioral health care manager, and psychiatric consultant in a collaborative care model.

BHI Documentation

- Time-based and requires proper medical record documentation.
- Once the patient has consented to services, initiating visit criteria must be met (E/M, IPPE, AWV) by FQHC practitioner.
- If patient is switched to Psychiatric CoCM, a separate consent is required.
- Treatment Plan – simple, not requiring all functions of CCM
- Services (Face-to-Face or Non-Face-to-Face) that count towards the 20-minute BHI threshold include:
    - Initial assessment and ongoing monitoring using validated clinical rating scales
    - Behavioral health care planning in relation to behavioral/psychiatric health problems, including time spent modifying plans for patients who are not progressing or whose status changes
    - Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation
    - Continuity of care with a designated member of the care team

BHI Coding & Billing

FQHC Provider Codes (maps to G codes)	What FQHC bills to CMS	What CMS Pays (Physician Fee Schedule)	Non-PPS FFS (e.g., Medicare Advantage, Managed Medicaid, Commercial)
CPT 99484 (20 minutes of clinical staff time directed by physician or QHP, per calendar month, and includes required elements from previous slide)	G0511	$65.25	99484: $46.76

The payment rate for HCPCS G0511 is the average of the national non-facility PFS payment rate for FQHC care management and general behavioral health codes (CPT codes 99490, 99487, 99484, and 99491) and the new Principal Care Management codes (G2064 and G2065).

BHI Coding & Billing

What you need to know

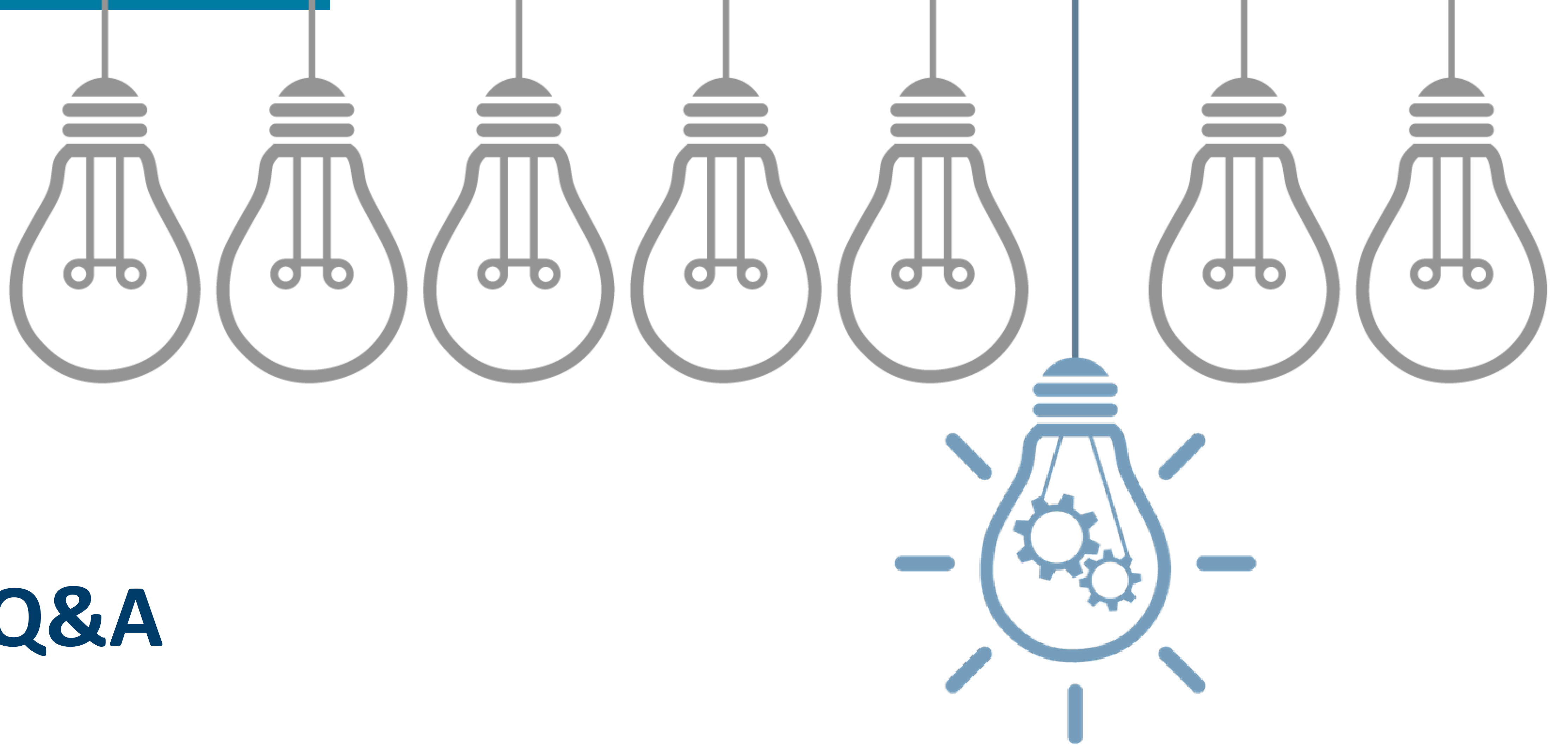
- Initiating visit (E/M, IPPE, AWV) by FQHC practitioner can be face-to-face or, during PHE, furnished via telehealth and billed for using G2025.
- Only one practitioner can provide and bill for these services per calendar month.
- Monthly contact is not required to bill for care management service as not all service directly involve patient.
- BHI cannot be reported in the same calendar month as Psychiatric CoCM.
- 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 calendar month.
- Clinical staff time spent coordination care with the ED may be reported using 99484, but not for inpatient or OBV services.
- Coinsurance applies.

CCM/PCM/BHI

Q: **Is the initiating visit separately billable?**
A: Yes, the E/M, AWV, IPPE is separately billed and paid.

Q: **Can BHI be billed during the same month as CCM services?**
A: Possibly "yes" if billing to FFS, but "no" to Medicare.

Q: **During the PHE, can audio-only phone E/M visits (CPT codes 99411-99443) be billed in the same calendar month as CCM services?**
A: Yes, when the time is not counted toward more than one service code.



Q&A

WELCOME

Reimbursement for Chronic Care Management Services

Judith Gaudet
Systems of Care Director

GENERATIONS
FAMILY HEALTH CENTER

Operating Under a Hybrid Model for Chronic Care Management

2019 – GFHC opted for a hybrid model to enroll and follow patients for Chronic Care Management.

- In-house staff and providers will discuss CCM with the patient and enroll those who are interested.
- Care Programs in EHR will designate eligibility, enrollment, declined or opt out of CCM.
- CCM enrollment will automatically trigger a contracted company to begin contact with patient for live 24-hour access to a health coach.
- Enrollment was low, Systems of Care completed a PDSA for targeted telephonic enrollment in November 2019 with a record 214 patients activated that month.

Activations + Billable Lives MTD : Generations Family Health Center

Updated at 1/10/2020 4:01:54 AM

Site Code: GFHC

Practice Name: All

	Current Month Activations	Current Month Deactivations	Net Activations	Running Total Active Patients
October 2019	0	4	(4)	121
November 2019	214	15	199	320
December 2019	14	24	(10)	310

2020 – Systems of Care began a performance improvement project to increase the number of enrolled CCM patients.

- Year end goal 750 enrolled patients.

Activations + Billable Lives MTD : Generations Family Health Center

Updated at 1/8/2021 4:04:09 AM

Site Code: GFHC

Practice Name: All

	Current Month Activations	Current Month Deactivations	Net Activations	Running Total Active Patients
October 2020	67	21	46	806
November 2020	4	19	(15)	796
December 2020	1	13	(12)	786

- Telephonic enrollment is done by a care coordinator or care facilitator using a prepared script.
- Patients notified that PCP recommends CCM services.
- Program explained with information regarding services and care between provider visits.
- Patient notified of access to health coach 24 hours a day.
- Made aware of Medicare co-pays if applicable. (Dual eligible patients incur no charges out of pocket.)
- Notified that enrollment requires patient consent.

CCM Enrollment Consent

Contact:

☐ Y Telephonic Enrollment Consent

☐ Y Patient Declines Chronic Care Management or Care Coordination Services.

Interpretation Required

- Click boxes built into Care Coordination form in EHR with preset documentation. When boxes are checked, documentation as below appears in document in patient's chart.

- **If patient consents:**

DISCUSSED

• Patient engagement: Identified through risk stratification and based on multiple chronic conditions that place the patient at significant risk for morbidity and mortality, this patient is eligible for and would benefit from the Medicare covered benefit for comprehensive care management services and care coordination, including but not limited to: Chronic Care Management (CCM), Behavioral Health Integration (BHI), and Complex Chronic Care Management (Complex CCM). These services may include but will not be limited to creation and monitoring of a comprehensive care plan, medication reconciliation, prescription refills, appointment scheduling, assistance with transportation to or from provider appointments, nutritional guidance, escalation of care for specific symptoms, and disease specific guidance including preventive measures. Program information was discussed with the patient and financial obligation/cost-sharing were explained to the patient. The patient was informed that only one practitioner can furnish CCM services and be paid per calendar month and the patient was informed that they have the right to stop CCM services at any time. The patient has consented verbally via telephone to enrollment in the CCM programs

- **If patient declines:**

DISCUSSED

• Refusing intervention Patient has declined Chronic Care Management Services. Informational resource to be mailed.

Care program and risk leve are documented in chart

☐ CCM-DECLINED Patient declined CCM Services
☑ CCM-ENROLLED Patient Enrolled in CCM Services
☐ CCM-ELIGIBLE Patient is Eligible for CCM Services
☐ CCM-CHECK Patient is Eligible for CCM Services
☐ CCM-OPT OUT Patient Opted Out of CCM Services

Patient Risk Level 1 2 3 4 5 6

OK Cancel

Visible to all when opening chart

Test, 21 (June)
11/02/1948 72y M
Chart

Reminders
Problems
Meds

SSN: --
Patient: 82359
Phone: (860) 860-8600
Chart:
Mobile: (860) 860-8600
More
Email: lbee@yahoo,com

PORTAL
Access Not Granted
Send Invite

CARE PROGRAM
CCM-ENROLLED 6

Task	Type / Status
Care Coordination Due: 07/29/2021	CARE C Completed
Care Coordination Due: 07/29/2021	CARE C Completed
Care Coordination Due: 07/29/2021	CARE C Completed
Med Related Due: 07/29/2021	MED Completed
Follow-up Appt Due: 07/29/2021	F-UP Completed
ER Notes Due: 07/27/2021	IMAGE Open
CareCoord: Follow Up ED Utilizati... Due: 07/26/2021	ORDREQ Completed
! Med Related Due: 07/09/2021	MED Completed

- **It is important to clearly document tasks completed for medication refills care coordination to include social determinants of health, review of hospital discharge summaries, monthly care plan review and so forth as these may assist to meet billing requirements.**
- **Urgent patient issues are clearly identified via task sent from contracted company with monthly reports provided**
- **Evidence of care documents are tasked to providers monthly to outline # minutes health coach or other designated clinical staff have worked with the patient under CCM services. Attached to this document is the updated care plan.**

Task	Type / Status
! Patient Escalation Notification: B... Due: 06/22/2021	ESC Completed
! Available for review: Deborah Ba... Due: 06/11/2021	CCM D Completed

Escalation Report : Generations Family Health Center

Range : All
Updated at 7/9/2021 4:18:37 AM

Escalation Type	April 2021	May 2021	June 2021	Grand Total
Hospitalization Review	3	2	4	9
Patient Escalation: Accident, Injury or Pain	3		4	7
Patient Escalation: Cardiac	2	1		3
Patient Escalation: GI (gastrointestinal)	1			1
Patient Escalation: Medication			1	1
Patient Escalation: Miscellaneous	1	1		2
Patient Escalation: Neurological		1		1
Patient Escalation: Provider Follow-up		1	4	5
Patient Escalation: Respiratory	2		2	4
Prescription Request	2	1	2	5
Grand Total	14	7	17	38

Patient Evidence of Care

Patient Name:
Patient Date of Birth:
Patient MRN:
Services Enrolled: CCM
Synced Devices:

Account: Generations Family Health Center
Ordering Provider: Aurora Teresa Leon Conde
Prepared: July 08, 2021 by MDR
Care Delivered: June 2021

Summary

Tasks *All call, follow up, and escalation tasks*	0 Calls	0 Follow-ups	0 Escalations
Vital Tracking *Count of vitals provided by the patient either online or over the phone*	0 Provided by patient		
Engagement Score *Best score out of 5 that a patient can complete either over the phone or online*	0 Current month	0 Last 3 months	
Messaging *Count of messages between a patient and his/her care team*	10 From Care Team to Patient	0 From Patient to Care Team	

Total Time Spent			
Sum of minutes spent on care of patient	14 Total Minutes	14 CCM Minutes 10 minutes of direct messaging, 4 minutes of clinical care and analysis.	0 RPM Minutes

Alerts		
Triggered when a patient logs a vital	0 Standard	0 Out of Range

Task Summary

Tasks	Status	Type	Scheduled Date
New Patient Onboarding Call	PARTIAL on 06/18/2021	call	

Notes and related tasks

New Patient Onboarding Call	**PARTIAL**		**Created at: 09/14/2020**	**Updated at: 06/18/2021**
Related Notes	Date		Description	
Nayeli, Martinez, CMA	06/18/2021	0 minutes	Called patient per RevUp welcome call protocol. Wrong number.	
Nayeli, Martinez, CMA	06/18/2021	4 minutes	Completed monthly pre-call review of chronic conditions, associated goals, medication management review and reconciliation. Reviewed demographics, problems and diagnoses, allergies, prognosis and expected outcomes, planned interventions and goals and care coordination	

Next Steps

- Renew focus on telephonic enrollments.
- Develop RN protocols for Wellness Visits, CCM and TCM
- Use Population Health to identify Gaps in Care and improve health outcomes along with value-based revenue streams.
- Track in-house care coordination efforts for CCM enrolled patients to supplement the CCM billing when contracted services do not reach 20 min threshold each month.

MD REVOLUTION

CCM MONTHLY BILLING SUMMARY

Account Name: Generations Family Health Center

Billing Month: June 2021

Total Accounts: 785

Total Qualified CCM: 385

<table>
<tr><th>Last Name</th><th>First Name</th><th>Medical Record Number</th><th>Billing Code</th><th>Date Of Birth</th><th>CCM Ordering Provider</th><th>Activated Date</th><th>Deactivated Date</th><th>MDR RevUp CCM Problem Codes</th><th>Total Minutes</th></tr>
<tr><td></td><td></td><td></td><td>G051</td><td>05/24/1953</td><td>Molly Moran</td><td>02/20/2020</td><td></td><td>E78.5 | J44.9 | E66.9 | K21.9 | N52.9 | N40.0</td><td>49.</td></tr>
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<tr><td></td><td></td><td></td><td>G051</td><td>06/16/1947</td><td>Carina Holmgren</td><td>10/02/2020</td><td></td><td>I10 | E78.5 | E11.9 | M54.30 | E66.9</td><td>20.</td></tr>
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<tr><td></td><td></td><td></td><td>G0511</td><td>01/09/1978</td><td>Allissa Joseph</td><td>05/14/2019</td><td></td><td>I10 | J45.909 | M19.90 | E66.9 | F17.200 | M54.5 | M13.80</td><td>14.</td></tr>
<tr><td></td><td></td><td></td><td>G0511</td><td>08/02/1949</td><td>Jennifer Bernache</td><td>02/18/2020</td><td></td><td>I10 | E78.5 | E56.9 | M85.80 | E66.9 | G47.00 | K21.9 | F33.9 | M13.80</td><td>14.</td></tr>
</table>

Identifying Success and Return on Investment

- 2020, the pandemic required a great deal of attention.
- Enrollments occurred but at a much slower pace.
- 74% of patients contacted enrolled in CCM.
- 32% of enrolled patients opted out leaving a 68% enrollment retention.

Selected Item	Pat Person Nbr
Calculation	Count Distinct
TOTAL CCM CONTACTED	1547
CCM-DECLINED	375
CCM-POSTPONE	28
TOTAL CCM ENROLLED	1144
CCM-OPT OUT	364
CURRENT CCM-ENROLLED	780

- Despite the pandemic and reduced enrollments, FY 2021 boasts a revenue stream of almost ¾ of a million dollars.

❖ $ 674,840.19 in receipts

❖ $ 29,000 in pending payments

Fiscal Year 21 (7/1/2020-6/30/2021)		
Site	Receipts	# of visits
DN	$ 103,603.12	102
Nor	$ 268,757.55	299
Put	$ 105,378.62	104
WM	$ 197,100.90	223
Totals	$ 674,840.19	728
Pending Payments	$ 29,000.00	
Total Revenue Stream	$ 703,840.19	

Suggestions for Other Health Centers

- **Identify organizational strengths to determine in-house, hybrid or fully contracted CCM enrollment and services.**
- **Use performance improvement projects to drive your successes with CCM.**
- **Get feedback from patients to determine if changes in the CCM program need to occur.**
- **Evaluate health outcomes and revenue stream regularly.**
- **Supplement billing with documented in-house care management services when applicable.**
- **Determine if end goal is to provide CCM services in house long term and set improvement projects in line with that goal.**

Thank You!

Judith Gaudet, Systems of Care Director
jgaudet@genhealth.org

GENERATIONS
FAMILY HEALTH CENTER

Coastal Family Health Center

Stacey Curry,
Director of Clinical Quality Management
scurry@coastalfamilyhealth.org

Evolution of CCM at CFHC

2015	BEHAVIORAL HEALTH INTEGRATION INTO PRIMARY CARE MODEL
2017	SUSTAINABILITY PLAN FOR BHI TO INCLUDE CCM
2018	TEMPLATES BUILT, TRAINING COMPLETED, UNABLE TO GET THE TRACTION
2019	RESEARCH FOR CCM RESOURCES
2020	SIGNED WITH 3RD PARTY CCM VENDOR

Evolution of CCM at CFHC

CCM Enrollment Process

- 3rd Party vendor and CFHC work together to ensure patients selected for enrollment qualify for the CCM program.
- 3rd party vendor contacts the patient for enrollment. Each patient enrolled is consented.

CCM Workflow Process

- Patients contacted monthly by 3rd party vendor. The vendor reviews chronic care needs, medications, appointments, care gaps and other patient needs during the call.
- CFHC Care Coordination team logs into 3rd party portal to collect messages from the patient contact. These messages are routed to the appropriate care team members via EHR communications.
- Care plan is imported into the patient's chart via an open API.
- A clinical line is also available for 24-hour patient triage.

CCM Billing Process

- ChartSpan uploads changes to the portal, which is interfaced with NextGen via the open API.
- CFHC A/R staff can submit one charge or all charges for the month through the rapid bill process to the NextGen EPM system.
- Charges are billed through NextGen.

2021 CCM Goals and Outcomes

CCM Enrollment Goal:
300 Patients

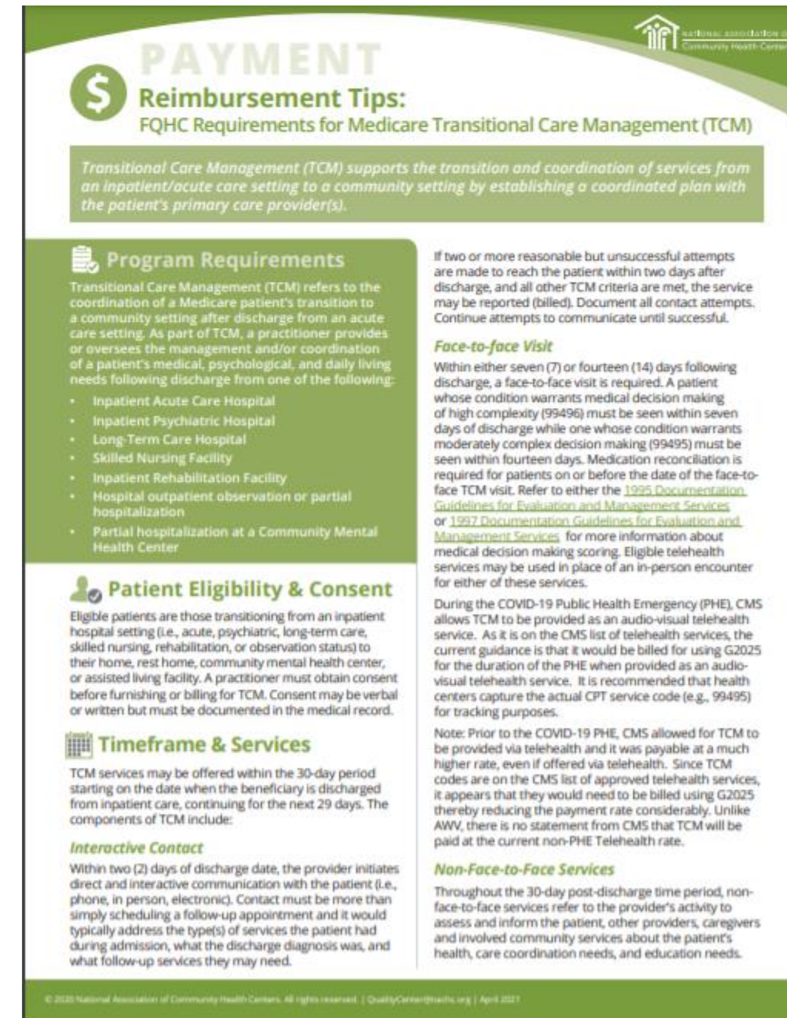
CCM Actual Enrollment:
805 Patients

2021: YTD Charges and Payments:
Total Charges $580K+
Payments received: $342K

2021 CCM Patient Satisfaction:
80%

Transitional Care Management (TCM)

Reimbursement Tips



PAYMENT

Reimbursement Tips:
FQHC Requirements for Medicare Transitional Care Management (TCM)

Transitional Care Management (TCM) supports the transition and coordination of services from an inpatient/acute care setting to a community setting by establishing a coordinated plan with the patient's primary care provider(s).

Program Requirements

Transitional Care Management (TCM) refers to the coordination of a Medicare patient's transition to a community setting after discharge from an acute care setting. As part of TCM, a practitioner provides or oversees the management and/or coordination of a patient's medical, psychological, and daily living needs following discharge from one of the following:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long-Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center

Patient Eligibility & Consent

Eligible patients are those transitioning from an inpatient hospital setting (i.e., acute, psychiatric, long-term care, skilled nursing, rehabilitation, or observation status) to their home, rest home, community mental health center, or assisted living facility. A practitioner must obtain consent before furnishing or billing for TCM. Consent may be verbal or written but must be documented in the medical record.

Timeframe & Services

TCM services may be offered within the 30-day period starting on the date when the beneficiary is discharged from inpatient care, continuing for the next 29 days. The components of TCM include:

Interactive Contact

Within two (2) days of discharge date, the provider initiates direct and interactive communication with the patient (i.e., phone, in person, electronic). Contact must be more than simply scheduling a follow-up appointment and it would typically address the type(s) of services the patient had during admission, what the discharge diagnosis was, and what follow-up services they may need.

If two or more reasonable but unsuccessful attempts are made to reach the patient within two days after discharge, and all other TCM criteria are met, the service may be reported (billed). Document all contact attempts. Continue attempts to communicate until successful.

Face-to-face Visit

Within either seven (7) or fourteen (14) days following discharge, a face-to-face visit is required. A patient whose condition warrants medical decision making of high complexity (99496) must be seen within seven days of discharge while one whose condition warrants moderately complex decision making (99495) must be seen within fourteen days. Medication reconciliation is required for patients on or before the date of the face-to-face TCM visit. Refer to either the 1995 Documentation Guidelines for Evaluation and Management Services or 1997 Documentation Guidelines for Evaluation and Management Services for more information about medical decision making scoring. Eligible telehealth services may be used in place of an in-person encounter for either of these services.

During the COVID-19 Public Health Emergency (PHE), CMS allows TCM to be provided as an audio-visual telehealth service. As it is on the CMS list of telehealth services, the current guidance is that it would be billed for using G2025 for the duration of the PHE when provided as an audio-visual telehealth service. It is recommended that health centers capture the actual CPT service code (e.g., 99495) for tracking purposes.

Note: Prior to the COVID-19 PHE, CMS allowed for TCM to be provided via telehealth and it was payable at a much higher rate, even if offered via telehealth. Since TCM codes are on the CMS list of approved telehealth services, it appears that they would need to be billed using G2025 thereby reducing the payment rate considerably. Unlike AWV, there is no statement from CMS that TCM will be paid at the current non-PHE Telehealth rate.

Non-Face-to-Face Services

Throughout the 30-day post-discharge time period, non-face-to-face services refer to the provider's activity to assess and inform the patient, other providers, caregivers and involved community services about the patient's health, care coordination needs, and education needs.

https://bit.ly/VTF_Payment_TCM

Transitional Care Management (TCM)

Coordination of a Medicare patient's transition to a community setting after discharge from acute care.

Eligibility and Consent

- Offered within 30 days post-discharge
- Patient consent must be obtaining prior to initiating services
  - Verbal or written, documented
  - Informed that cost share applies
- New or established patient
- Medical and/or psychosocial problems require moderate to high MDM during transition
- Comprised of one face-to-face visit in combination with non-face-to-face services performed by FQHC practitioner and or/licensed clinical staff under his/her direction.

Eligibility is determined by a FQHC practitioner (MD, DO, NP, PA, or CNM)

TCM Requirements

Three components in 30 days: Initial Contact, Face-to-Face services, Non-Face-to-Face Services

Initial Interactive Contact

- Provider initiates direct and interactive communication (i.e., in person, phone, electronic) within **2 days of discharge**. (M-F)
- Addresses the services patient had during admission, what the discharge diagnosis was, and necessary follow-up

Face-to-Face Visits

- Face-to-face visit is required
  - within 7 days post-discharge if MDM is of high complexity (99496) **or**
  - within 14 days post-discharge if MDM is of moderate complexity (99495).
- Medication reconciliation is required on or before visit
- Furnished under minimum **direct** supervision by billing practitioner

Non-face-to-face services:

- Provider's activity, throughout 30-day post-discharge period, to assess and inform the patient, other providers, caregivers and involve community services about patient's:
  - Health
  - Care coordination needs
  - Education
  - Care resources
- Furnished under **general** supervision of billing practitioner (overall direction and control, direct presence not required)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/fqhcfactsheet.pdf

TCM

Non-Face-to-Face Service Examples

Physician or other QHP:

- Obtaining and reviewing d/c information
- Reviewing need for or follow-up on tests and treatments
- Interacting with QHP involved in care services
- Educating patient/family/ caregiver
- Assisting with community provider/services scheduling

Refer to the CPT Manual for more examples

Clinical staff :

Communicating with patient/family/caregiver/other providers re: aspects of care

- Communicating with community service providers
- Educating patient/family/caregiver to support self-management, independent living, and ADLs
- Identifying community resources and providers
- Assessing and supporting treatment and medication reconciliation

TCM Documentation

- All services delivered in the 30-day post-discharge period
- Discharge date
- Interactive contact date with patient/caregiver
- Date of face-to-face visit
- Complexity of MDM (moderate or high)

Documentation Examples:

- Obtaining and reviewing discharge information
- Labs/tests (code separately)
- DME ordered or discontinued
- Referrals made to other providers
- If visit was conducted via telehealth
- Education
- Interactions with other providers
- Assistance provided

TCM Coding & Billing

FQHC Provider Codes (maps to G codes)	What FQHC bills to CMS	What CMS Pays (Physician Fee Schedule)	Non-PPS FFS (e.g., Medicare Advantage, Managed Medicaid, Commercial)
99495 (Moderate Complexity) Communication with patient and/or caregiver within 2 days of discharge; Moderate MDM ; Face-to-face visit, within 14 calendar days of discharge	CPT 99495	$ 207.96 or FQHC visit rate?	99495: $ 207.96
99496 (High Complexity) Communication with patient and/or caregiver within 2 days of discharge; High MDM; Face-to-face visit, within 7 calendar days of discharge	CPT 99496	$ 281.59 or FQHC visit rate?	99496: $ 281.59
If services are provided via Telehealth During PHE, G2025 rate trumps non-PHE telehealth rate.	**G2025**	**$99.45**	**Varies**

TCM Coding & Billing

What you need to know

- Only one qualified clinical provider may report TCM services for each patient following a discharge.
- TCM codes are for new or established patients
- State law, licensure, and scope of practice
- TCM may be billed alone or with other payable services.
- May be billed as a standalone services if not furnished on the same day as another Medicare PPS G code.
- Do not separately report or with:
  - 93792: Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring
  - 93793: Anticoagulant management
  - 99487-99489/**G0511: Any Chronic Care Management during the TCM period**
- Beneficiary cost-share applies

TCM

Q: Can TCM be separately reported or with any CCM (G0511) service in the same period?
A: No, TCM may not be billed during the same service period as CCM services.

Note: CMS is proposing, for 2022, that billing for TCM and other CCM services furnished during the same period, for the same beneficiary, be allowed. All other requirements for billing each service would still need to be met.

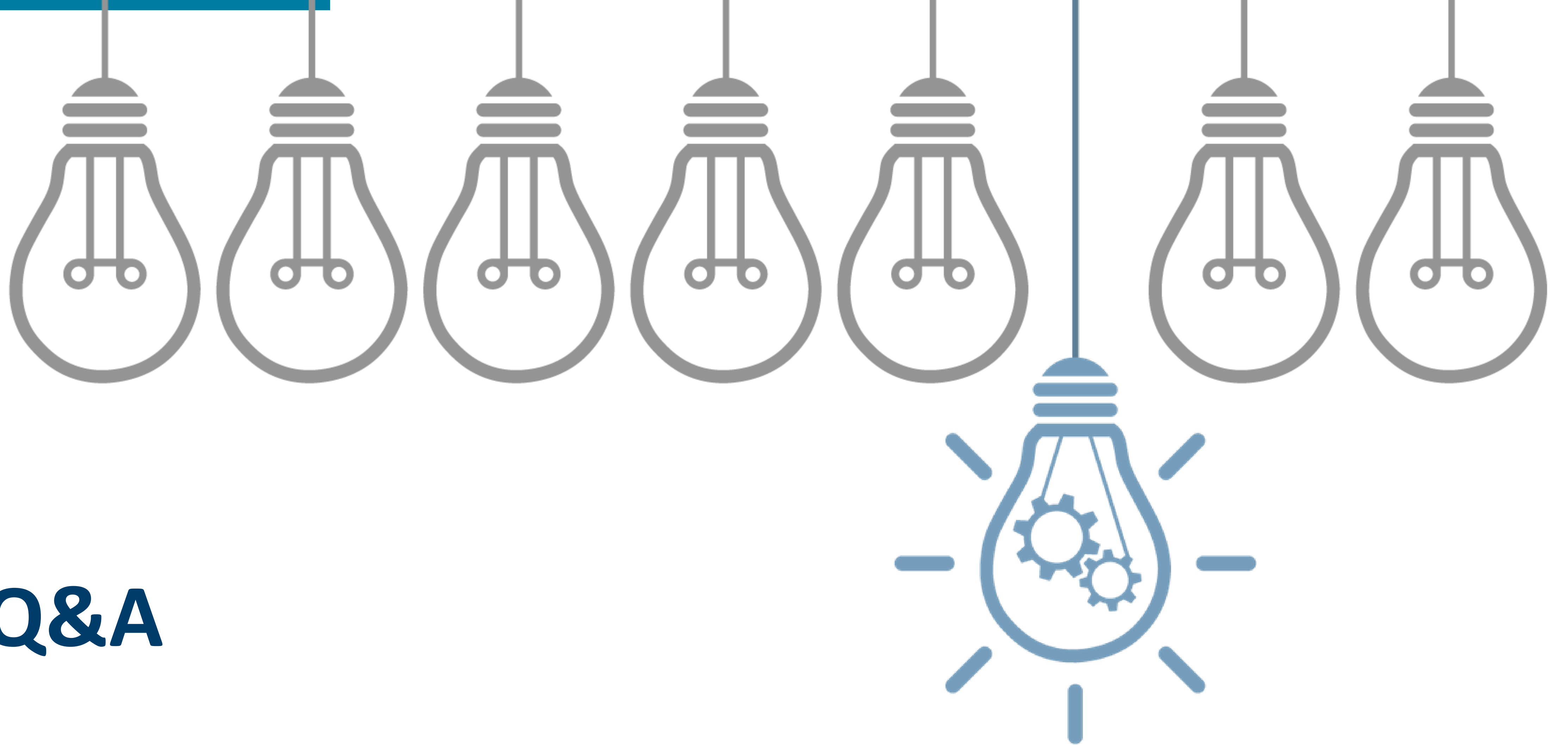
Q: Can the same provider who discharged the patient report TCM services?
A: Yes, but the required face-to-face visit cannot take place on the same day as the actual discharge.

Q: What date of service should we use on the claim?
A: Use the date of the required face-to-face visit. Claims can be submitted once this visit occurs rather than holding it until the end of the 30-day period.

FQHC & Care Management Resources

- CMS CY 2021 Medicare Final Rule 1737: https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf
- CMS CY 2017 Medicare Final Rule 1654: https://www.govinfo.gov/content/pkg/FR-2016-11-15/pdf/2016-26668.pdf
- CMS MLN FQHC Fact sheet – everything you need to know: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/fqhcfactsheet.pdf
- CMS FQHC Payment Codes: https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf
- FAQs FQHC Medicare PPS Services: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-FAQs.pdf
- CMS Benefit Policy Manual, Chapter 13, for FQHCs: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf
- Medicare Claims Processing Manual, Chapter 9, for FQHCs: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf
- Care Management CMS list noting general supervision not waived for TCM: https://www.cms.gov/files/zip/cy-2021-pfs-final-rule-list-designated-care-management-services.zip
- CMS Benefit Policy Manual Chapter 13 2019 Update: https://www.cms.gov/files/document/R263BP.pdf
- CMS FQHC Update page: https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center
- COVID 19 CMS FAQs (FQHCs page 64): https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
- CMS 2021 Telehealth Service Codes: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- CMS MLN Matters SE20016 PHE FQHC flexibilities: https://www.cms.gov/files/document/se20016.pdf
- CMS MLN Matters SE2011 PHE FQHC Cost-Share waiver, etc: https://www.cms.gov/files/document/SE20011.pdf

Compiled by: Lisa Messina, MPH, CPC, August 2021



Q&A

CMS/Medicare Care Management Services

Can Coinsurance be Slid?

- While health centers are required to impose Medicare coinsurance for CMS/Medicare care management services, **the coinsurance may be "slid" commensurate with the sliding fee discount program (SFDP) policy of the health center**.
- Federal anti-kickback statutes and beneficiary inducement prohibitions include exceptions allowing health centers to discount coinsurance for patients who are eligible for the health center's sliding fee discount program without violating Medicare rules.
- HRSA's guidance (Compliance Manual, Chapter 9, Element K) **allows health centers to discount coinsurance for their SFDP eligible patients** to an amount no more than what the patient would have paid under his/her applicable SFDS payment level.

Guidance per Feldesman Tucker Leifer Fidell LLP, April 2020

CMS/Medicare Care Management Services

Coinsurance for Patients with annual income ≤ 100% FPL*

- **Under both Medicare rules and HRSA requirements, health centers can slide the coinsurance for patients who are eligible for the sliding fee discount program (SFDP). Health centers can slide the coinsurance to $0 for the patients earning annual incomes at or below 100% of the FPL.**
  - Under the health center regulations, patients who are eligible for the nominal fee should be provided care at "full discount" (i.e., $0) but can be charged a nominal fee where "imposition of such fees is consistent with project goals." (42 CFR 51c.303(f)). This latter phrase is generally interpreted to allow nominal fees, provided that the fees do not create a barrier to care.
  - If the health center determines that imposition of a nominal fee for these services would create a barrier to care, it can establish a $0 charge for eligible patients (patients earning annual incomes at or below 100% of the FPL) for this service.
  - Note that a Medicare beneficiary with income at or below the poverty level would almost always be a Medicare-Medicaid dual eligible beneficiary, and so Medicaid as secondary payor would typically cover the coinsurance – although health centers should check with their Medicaid state plans regarding individuals who are "full benefit dual eligible" but not meet the "qualified Medicare beneficiary" definition.

**FPL = Federal Poverty Line*

Guidance per Feldesman Tucker Leifer Fidell LLP, April 2020

CMS/Medicare Care Management Services
Coinsurance for Patients with annual income > 100% and ≤ 200% FPL*

Under both Medicare rules and HRSA requirements, health centers can discount the coinsurance:

- **based on the patient's payment level prior to billing the patient; or**
- **can discount based on payment level, or can waive/reduce payment.**

  - Patients who are eligible for the sliding fee discount rather than the nominal fee (i.e., patients earning annual incomes above 100% of the FPL and up to and including 200% of the FPL) cannot be slid to $0 under the sliding fee discount rules.
  - Patients eligible for the sliding fee discount can have their coinsurance waived under the provision in Chapter 16 (element h) of the Compliance Manual that requires health centers to have a board-approved policy and related operating procedures "that include the specific circumstances when the health center will waive or reduce fees or payments required by the center due to any patient's inability to pay." HRSA considers such waivers would be determined on a patient-to-patient basis (rather than setting the fee for all such patients at $0), based on individualized determinations of financial hardship.
  - Health centers can establish an attestation for patients to sign that includes a brief description of why the coinsurance charge would be a barrier to care for purposes of fulfilling the case-by-case waiver (sample available on Elevate platform).

**FPL = Federal Poverty Line*

Guidance per Feldesman Tucker Leifer Fidell LLP, April 2020

UPCOMING EVENTS

September 2021

SUN	MON	TUE	WED	THU	FRI	SAT
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

14. Monthly Forum

New webinars coming soon…

Scan QR code to register

FOR MORE INFORMATION CONTACT:

qualitycenter@nachc.org

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Director, Quality Center
National Association of Community Health Centers
cmodica@nachc.org
301.310.2250

Next Monthly Forum Call:

September 14th, 2021
1 -2 pm ET

FEEDBACK

Don't forget! Let us know what you thought about today's session.

NATIONAL ASSOCIATION OF Community Health Centers®

Together, our voices elevate° all.

The Quality Center Team
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qualitycenter@nachc.org