July 12th NACHC Elevate Learning Forum
Ask the Expert: FQHC Care Management Billing & Coding

Questions & Answers

Topics

See Learning Forum slide deck for additional Q&A

Billing

Q: Can you bill for a subsequent AWV if you never billed for an IPPE?
A: If a beneficiary did not receive IPPE services at your health center or through a provider outside of your health center, you may furnish an Initial AWV if the beneficiary is no longer within 12 months or enrollment.

Q: Can FQHCs bill for Remote Patient Monitoring services (RPM) using CPT codes 99453, 99454, 99457, and 99457?
A: FQHCs are not eligible to bill Medicare for RPM services. During the PHE, services furnished under CPT 99473 and provided via telehealth, may be bill using G2025. CMS does not otherwise permit these services to be bill outside of the PPS methodology. Please check with your other payers to determine if their policies will allow you to furnish and bill for these services.

Q: Does the health center have to be certified for eligibility to bill for care management services.
A: There are no certification requirements to furnish and bill for care management services.

Q: As the Pandemic took hold, many patients who were older or challenged with physical disabilities, and too vulnerable to come in for care, were being care for with CCM, CCCM, etc. Care was delivered at their home. Can these be billed as home care?

A: FQHCs cannot bill for care management services during the same period they are being furnished by other providers, including home care service providers. If your health center furnished care management services in the home environment, the specific payment policies of your MAC should be referred to in order to determine the definition of a qualified home visit.

Coding

Q: If TCM is done via telehealth then does this get reported as G2025 instead to align with telehealth billing
A: Yes

Q: Do we need to bill both the TCM codes 99495 plus G0467? Is that only for Medicare or Medicaid?
A: The PPS G code is required for Medicare and any plans that may require it. Please refer to your Medicaid program policy for specific requirements.

Q: Is the G0467 for TCM reimbursed at the PPS/Encounter rate or fee for service?
A: G0467 is reimbursed at the lesser of 80% of your local PPS rate or your charges.

Q: Are G2010 or G2012 code or G0071 billable by FQHCs?
A: Refer to NACHC's Virtual Communication Services (VCS) Reimbursement Tips.

Q: How do we determine whether G0071 services are separately billable or should count toward care management plans?
A: Refer to NACHC's Virtual Communication Services (VCS) Reimbursement Tips.

Q: For more than 20 minutes of CCM, do you quantity bill G0511 for each 20 minutes (up to 60 minutes)?
A: G0511 can be billed only once in a calendar month. The CPT codes on the claim will include fees for additional service time through the applicable add-on codes. Each base CPT code has a range of time that is applied before an add-on code can be used. Please refer to your CPT manual for each code definition.

Q: Does the G codes also need to be on the claim form? Along with CPT?
A: Yes, Medicare requires the qualifying visit codes along with the applicable PPS G code to be entered on the claim form. Please refer to the Medicare Claims Processing Manual for instructions. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf

Staff

Q: Do community health workers count as "clinical staff"?

A: Medicare defers to the AMA's definition of clinical staff which may be found in the CPT Manual under "Instructions for Use of the CPT Codebook". "A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by, law, regulation, and facility policy to perform or assist in the performance of a specified professional service…" Health centers needs to understand State scope of practice limitations and licensing regulations in order to determine if a clinical staff member can perform certain services. Additionally, the supervising practitioner (MD, DO. NP, PA, CSW) must determine that the individual staff member has the training and competencies to perform the activities of those services.

Cost Share

Q: Is there still a co pay for care management services?

A: FQHCs will be paid at the lesser of 80% of the care management charges plus 80% and the beneficiary is responsible for the 20% coinsurance. And while coinsurance does apply to care management services, health centers can slide it according to the sliding fee discount program for eligible patients.

Payers

Q: Do any of the managed care programs cover care management?

A: Health centers need to review the payer contracts and policies in order to determine whether they cover care management services.

2023 Medicare Final Rule

Q: Is CMS proposing a new Physician Fee Schedule for 2023 with some cuts in their fees, will this affect the FQHC PPS rates?

A: The conversion factor set forth by CMS as part of the PFS is applied to the PPS and FFS rates of an FQHC. If there are reductions in fees, those reductions may impact health centers; however, the final policy with the adjusted FQHC PPS rate will provide the official decision.