NATIONAL ASSOCIATION OF Community Health Centers®

elevate

Together, our voices elevate all.

Elevate *Ask the Expert*

FQHC Care Management Billing and Coding

July 12, 2022

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

Bringing science, knowledge, and innovation to practice

Cheryl Modica

Director,
Quality Center

Cassie Lindholm

Deputy Director,
Quality Center

Oliver Conrad

Manager,
Learning & Instructional Design

Addison Gwinner

Specialist,
Quality Center

Panel of Experts

Lisa Messina
MPH, CPC
Messina Consulting

Gervean Williams
Director, Finance Training and Technical Assistance
NACHC

Ama Johnson
Manager, Health Center Finance
NACHC

CARE MANAGEMENT

PAYMENT

NATIONAL ASSOCIATION OF Community Health Centers®

What are the services that encompass care management in an FQHC?

CCM

Chronic Care Management

Multiple **(two or more) chronic conditions** expected to last at least 12 months or until the patient dies, or places the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.

CCCM

Complex Chronic Care Management

Multiple **(two or more) complex chronic conditions** expected to last at least 12 months or until the patient dies, or places the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.
Complex CCM patient is at a moderate or high MDM.

PCM

Principal Care Management

A qualifying condition that is expected to last at least 3 months and places the patient at **significant risk of hospitalization**, acute exacerbation/ decompensation, functional decline or death.
PCM patient is at a moderate or high MDM.

BHI

Behavioral Health Integration

Integrated behavioral health and primary care services that does not require, but may use, services of psychiatric consultation or designated behavioral health manager.

CoCM

Psychiatric Collaborative Care Model

Integrated behavioral health and primary care services but with two additional service components beyond general BHI: **a dedicated care manager and psychiatric consult**.

TCM

Transitional Care Management

Supports the transition and coordination of services from an inpatient/acute care setting to a community care setting by establishing a coordinated plan with the patient's PCP.
TCM patient is at a moderate of high MDM.

What services qualify as an initiating visit?

- ✓ Initial Preventive Physical Examination (IPPE)
- ✓ Annual Wellness Visit (AWV)
- ✓ Evaluation and Management service (E/M)
- ✓ The face-to-face visit included in Transitional Care Management (TCM)

Can the initiating visit be provided via telehealth?

During the COVID-19 PHE certain telehealth services may be furnished by FQHCs. The following initiating visit types may be furnished via telehealth:

- AWV: G0438, initial visit
- AWV: G0439, subsequent visit
- E/M Services: 99202-99205, 99212-99215, 99421-99423
- TCM: 99495 (moderate complexity) billed with G0467
- TCM: 99496 (high complexity) billed with G0467

A list of those services may be found here:
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Who are the Authorized Providers/Staff?

See Reimbursement Tips for additional details.

CCM

Chronic Care Management

Staff directed by a qualified health professional (QHP): MD, DO, NP, PA, & CNM.

CCCM

Complex Chronic Care Management

Staff directed by a QHP: MD, DO, NP, PA, & CNM.

PCM

Principal Care Management

Staff directed by a QHP: MD, DO, NP, PA, & CNM.

BHI

Behavioral Health Integration

QHP or clinical staff under the direct supervision of the billing practitioner ('incident to'): MD, DO, NP, PA, & CNM.

Other services by the care management team are permitted under general supervision (under billing practitioner direction and control but physical presence not required).

CoCM

Psychiatric Collaborative Care Model

QHP or staff under the direct supervision of the billing practitioner ('incident to'): MD, DO, NP, PA, & CNM.

Other services by the care management team are permitted under general supervision (under billing practitioner direction and control but physical presence not required).

TCM

Transitional Care Management

MD, DO, NP, PA, CNM

QHP or staff under the direct supervision of the billing practitioner ('incident to'): MD, DO, NP, PA, & CNM.

Other services by the care management team are permitted under general supervision.

FAQs: Authorized Providers

Who can furnish the initiating visit?

The FQHC practitioner (physician, NP, PA, CNM) qualified to furnish the E/M, or AWV, or IPPE, or TCM face-to-face visit. Care management services do not have to be discussed during this visit, especially when one considers that the need for them may not be known during this initiating visit. For BHI and CoCM, this initiating visit does not need to be a mental health encounter.

Who decides if a patient is eligible for care management services?

The FQHC practitioner (MD, DO, NP, PA, or CNM) must determine if the services are medically necessary and meets the criteria for the specific care management program. For BHI and CoCM, a social worker, clinical psychologist, or psychiatrist can recommend a patient for these services, but only the FQHC practitioner can determine eligibility.

Who can furnish care management services?

Care management services are comprised mainly of non-face-to-face services furnished in support of the care and coordination of the patient. Services are typically furnished by clinical staff working under state scope of practice and licensing regulations, under the supervision of the FQHC practitioner. The FQHC practitioner direct role in the patient's care varies based upon the requirements for furnishing and/or the overseeing the care management services.

FAQs: Supervision

Can consent for care management services furnished by FQHCs be obtained under general supervision during the PHE?

As a PHE flexibility, CMS has allowed for consent for care management services furnished to occur under general supervision.

https://www.cms.gov/files/document/fqhcs-pfs-faqs.pdf

Can consent for care management services furnished by FQHCs continue to be obtained under general supervision after the PHE?

CMS has not yet determined if there will be extensions to this PHE exception and has stated that it will continue to evaluate it for care management services.

What are the direct supervision requirements for care management services?

The direct supervision requirements for clinical staff have been waived for care management services. Services may be provided under the general supervision of the FQHC practitioner.
General supervision does not require the FQHC practitioner, who has overall all supervision for the care, to be in the same room or building. Clinical staff and auxiliary staff involved in the care of a patient must furnish services according to state law, payer policies, and scope of practice requirements.

Note: direct supervision requirement for the TCM face-to-face services has not been waived.

What are the Timeframe for Services?

See Reimbursement Tips for additional details.

CCM

Chronic Care Management

Non-complex CCM:
Minimum of **20** minutes.
20-minute add-ons up to 60 mins.

Provider only:
Minimum of 30 mins provided personally by a physician or qualified health professional.
New in 2022: 30 minute add-ons.

CCCM

Complex Chronic Care Management

Complex CCM:
Minimum of **60** minutes.
30-minute add-ons.

No provider only codes: If a physician or QHP furnishes any of the clinical staff services, that time may be counted toward total required clinical staff time.

PCM

Principal Care Management

Minimum of 30 minutes of clinical or staff time directed by, or personally provided by a physician or QHP.

All new codes in 2022:

BHI

Behavioral Health Integration

Minimum of 20 minutes.

CoCM

Psychiatric Collaborative Care Model

Initial:
Minimum of 70 minutes.

Subsequent:
Minimum of 60 minutes of services.
30-minute add-ons.

TCM

Transitional Care Management

Initial Interactive: within 2 business days post-discharge.

Moderate: Face-to-face within 7 days post-discharge.
High: Face-to-face within 14 days post-discharge.

Non-face-to-face: Throughout the 30-day post-discharge period.

Centers for Medicare and Medicaid Services (CMS) Care Management Services:
Reimbursement Opportunities

Care Management Services	FQHC Bills to Medicare	Reimbursement*
Chronic Care Management (CCM)	G0511	$79.25
Complex Chronic Care Management (CCCM)	G0511	$79.25
Principal Care Management (PCM)	G0511	$79.25
Transitional Care Management (TCM)	G0467 G2025 (telehealth)	$180.16 $97.24 (telehealth)
Psychiatric Collaborative Care Model (CoCM)	G0512	$151.23
General Behavioral Health Integration (BHI)	G0511	$79.25

*Above intended to provide a general picture of reimbursement potential using 2022 CMS reimbursement guidance. See Reimbursement Tips for more details.

FAQs: Coding and Billing

What diagnosis codes should be used for care management?

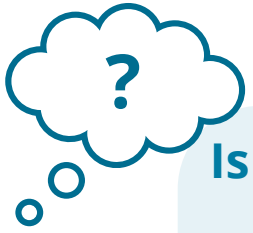
The most appropriate diagnosis code(s) should be submitted on the claim. The FQHC practitioner will determine patient eligibility for the services based upon the specific criteria for each program.

Are all care management services based upon the calendar month?

All care management services, except for TCM, are billed based upon the calendar month in which services are furnished. TCM services are furnished in a 30-day post-discharge period that may cross over consecutive months.

Can more than one practitioner provide and bill for care management services in one month?

No, only one practitioner can furnish and bill for services in one calendar month.



Is monthly contact with the patient required to bill for care management services?

Much of care management coordination and support does not require face-to-face contact with the patient. Monthly contact is not required to bill for these services so long as you document that the services you furnished are part of the care management care plan and all other requirements for the care management program are being met.

FAQs: Coding and Billing

What policy was finalized for CY 2022 for the billing of CCM and TCM services furnished in FQHCs?

Consistent with the changes made in the CY 2020 PFS final rule for care management services billed under the PFS, CMS finalized the proposal to allow FQHCs to bill for TCM and other care management services furnished for the same beneficiary during the same service period, provided all requirements for billing each code are met. https://www.cms.gov/files/document/fqhcs-pfs-faqs.pdf

Can BHI and Psychiatric CoCM services be billed in the same calendar month?

No, these services may not be reported during the same calendar month.

When does the counting for the service days for TCM begin?

Counting for TCM starts on the date of discharge and continues for the next 29 days.

- The initial interactive visit is to be completed within 2 business days of discharge.
- Face-to-face happens within 7 days post-discharge for a high complexity patient or within 14 days post-discharge for a moderate complexity patient. This portion of the visit is provided under direction supervision by the billing practitioner.
- Non-face-to-face services, furnished under general supervision, are furnished throughout the 30-day post-discharge period.

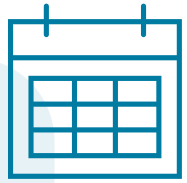
FAQs: Coding and Billing

Which care management services can be furnished via telehealth during the PHE?

- TCM: 99495 (moderate complexity) billed with G0467
- TCM: 99496 (high complexity) billed with G0467

During the PHE, can audio-only phone E/M visits (CPT codes 99441-99443) be billed in the same calendar month as CCM services?

Yes, when the time is not counted toward more than one service code.



Can a health center bill for a care management visit during the same period as a PPS qualifying visit?

Yes, a health center may submit a Medicare claims for a billable PPS “G” code visit and a care management service on a single claim. They will be reimbursed at 80% of the care management charges. Coinsurance does apply for care management services. TCM may be billed as a standalone service if not furnished on the same day as another PPS “G” code.

Reference Materials

Care Management Services
Coding & Billing

Care Management Service	FQHC Provider CPT Codes	What FQHC bills to CMS	What CMS Pays (PFS)
Chronic Care Management (CCM)	**99490** (First 20 mins, ***non-complex***; clinical staff) **+ 99439** (each add'l 20 mins; clinical staff. Only added to ***non-complex***/99490) **99491** (30 mins; **physician or QHP only** (*not to be reported in same month as above clinical staff codes*) **+99437 (New!)** (each add'l 30 mins; physician or QHP. Only added to 99491)	**G0511** *General care management, 20 minutes or more of clinical staff time, directed by FQHC practitioner, per calendar month*	**$79.25**
Complex Chronic Care Management (CCCM)	**99487** (60+ mins, **complex**; clinical staff) **+99489** (each add'l 30 mins; clinical staff. Only added to **complex**/99487)		
Principal Care Management (PCM)	**99424 (New!) (F**irst 30 mins; physician or QHP) **+99425 (New!)** (each add'l 30 mins; physician or QHP. Added to 99424) **99426 (New!)** (First 30 mins; clinical staff) **+99427 (New!)** (each add'l 30 mins; clinical staff; added to 99426)		

Behavioral Health Care Management Services
Coding & Billing

Care Management Service	FQHC Provider CPT Codes	What FQHC bills to CMS	What CMS Pays (PFS)
Behavioral Health Integration (BHI)	**CPT 99484** (20 minutes of clinical staff time directed by physician or QHP, per calendar month)	**G0511** *General care management, 20 minutes or more of clinical staff time, directed by FQHC practitioner, per calendar month*	**$79.25**
Psychiatric Collaborative Care Model (CoCM)	**CPT 99492** (Initial CoCM, first 70 mins of BHC manager activities; first calendar month; in consultation with psychiatric consultant; directed by treating physician or QHP) **CPT 99493** (Subsequent CoCM; 60 mins; plus as above elements) **+99494** (each add'l 30 mins of either of the above in a calendar month. Add on to either 99492 or 99493.	**G0512** *Psychiatric CoCM, 60 minutes or more of clinical staff time, directed by FQHC practitioner, including BHC manager in consultation with psychiatric consultant, per calendar month*	**$151.23**

Transitional Care Management
Coding & Billing

Care Management Service	FQHC Provider CPT Codes	What FQHC bills to CMS	What CMS Pays
Transitional Care Management (TCM	**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** **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**	**G0467**; established FQHC patient visit *TCM services are qualified visit codes under G0467*	**$180.16 (PPS)**
	If services are provided via Telehealth During PHE, G2025 rate trumps non-PHE telehealth rate.	**G2025**	**$97.24**

New! FQHCs may bill for TCM and care management services furnished "for the same beneficiary during the same service period, provided all requirements for each medically necessary service are separately met."

Virtual Communication Services
Coding & Billing

Care Management Service	FQHC Provider CPT Codes	What FQHC bills to CMS	What CMS Pays (PFS)
Virtual Communication Services	Visit is not related to E/M provided in previous 7 days and not leading to E/M within 24 hours or soonest avail. appt.: **G2010** (Remote evaluation of recorded video and/or images submitted by the patient, 24 hour follow-up by FQHC practitioner) **G2012** (Virtual check-in by FQHC practitioner; 5-10 minutes of medical discussion)	**G0071** *Communication technology-based services; 5 or more mins; non-face-to-face patient and FQHC practitioner; OR 5 or more mins or remote evaluation of recorded video and/or image by FQHC practitioner; in lieu of office visit.*	**$23.88**
Digital Assessment Services "E-Visits" (PHE Only)	Online digital E/M service, for an established patient for up to 7 days, cumulative time during the 7 days; **CPT 99421** (5-10 minutes) **CPT 99422** (11-20 minutes) **CPT 99423** (21 or more minutes)		

CMS/Medicare Care Management Services

Can Coinsurance be Slid?

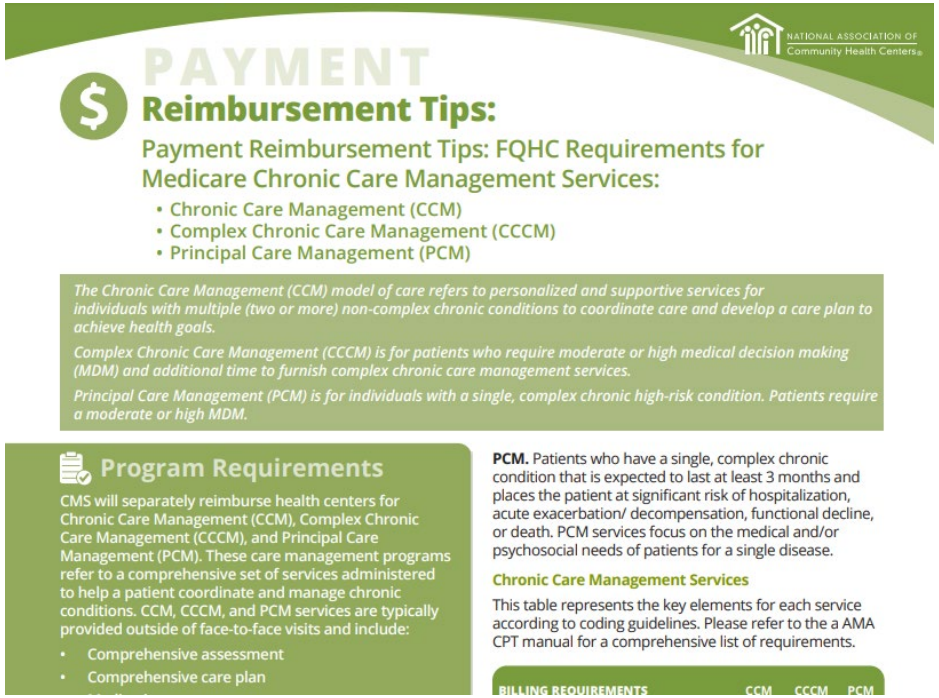
- While health centers are required to impose Medicare coinsurance for CMS/Medicare care management services, **the coinsurance may be "slid" commensurate with the sliding fee discount program (SFDP) policy of the health center**.

- 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

NACHC Reimbursement Tip Sheets


PAYMENT

Reimbursement Tips:

Payment Reimbursement Tips: FQHC Requirements for Medicare Chronic Care Management Services:

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)
- 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) non-complex chronic conditions to coordinate care and develop a care plan to achieve health goals.

Complex Chronic Care Management (CCCM) is for patients who require moderate or high medical decision making (MDM) and additional time to furnish complex chronic care management services.

Principal Care Management (PCM) is for individuals with a single, complex chronic high-risk condition. Patients require a moderate or high MDM.

Program Requirements

CMS will separately reimburse health centers for Chronic Care Management (CCM), Complex Chronic Care Management (CCCM), and Principal Care Management (PCM). These care management programs refer to a comprehensive set of services administered to help a patient coordinate and manage chronic conditions. CCM, CCCM, and PCM services are typically provided outside of face-to-face visits and include:

- Comprehensive assessment
- Comprehensive care plan

PCM. Patients who have a single, complex chronic condition that is expected to last at least 3 months and places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death. PCM services focus on the medical and/or psychosocial needs of patients for a single disease.

Chronic Care Management Services

This table represents the key elements for each service according to coding guidelines. Please refer to the a AMA CPT manual for a comprehensive list of requirements.

Newly updated to reflect 2022 guidance!

- ★ NACHC Reimbursement Tip Sheet - Behavioral Health Integration
- ★ NACHC Reimbursement Tip Sheet - CCM, CCCM, PCM
- ★ NACHC Reimbursement Tip Sheet - IPPE & AWV

NACHC Reimbursement Tip Sheet - Telehealth

- ★ NACHC Reimbursement Tip Sheet - Psych CoCM

NACHC Reimbursement Tip Sheet - RPM-SMBP

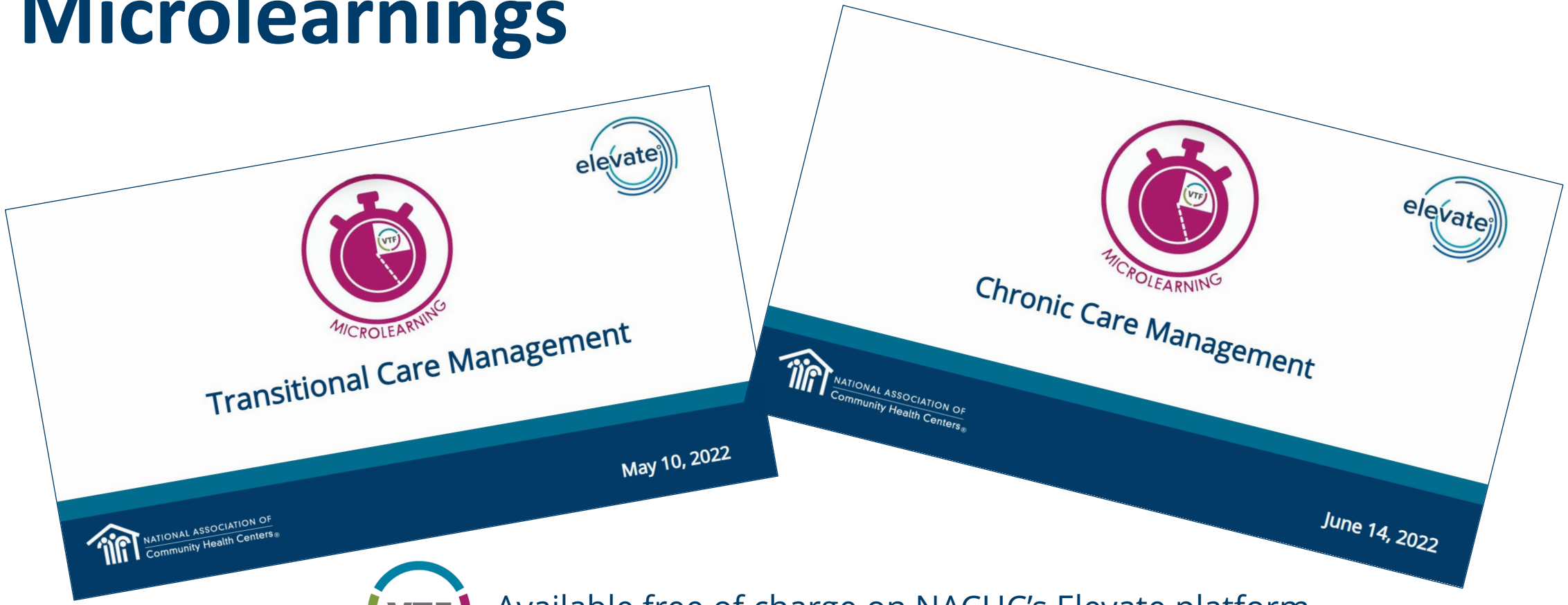
- ★ NACHC Reimbursement Tip Sheet - Tobacco Cessation
- ★ NACHC Reimbursement Tip Sheet - TCM
- ★ NACHC Reimbursement Tip Sheet - VCS

NACHC Guidance - Sliding Coinsurance for CMS Care Management

VTF

Available free of charge on NACHC's Elevate platform

NACHC Care Management Microlearnings



VTF Available free of charge on NACHC's Elevate platform

Elevate 2022 Participants:

QI Professional Development Opportunity

Institute *for* Healthcare Improvement

One year of free access to the IHI's full catalog of online courses including:

- More than 35 continuing education credits for nurses, physicians, and pharmacists
- Basic Certificate in Quality and Safety

VTF

Open to registered participants who complete the VTF assessment

Submit interest here: https://bit.ly/Elevate_IHI to be eligible for a scholarship

PCAs and HCCNs: did you know you can gift a scholarship to someone in a member health center? Follow this link for more info: bit.ly/Elevate_Gift

UPCOMING EVENTS

August 2022

SUN	MON	TUE	WED	THU	FRI	SAT
	Online learning platform re-design					

September 2022

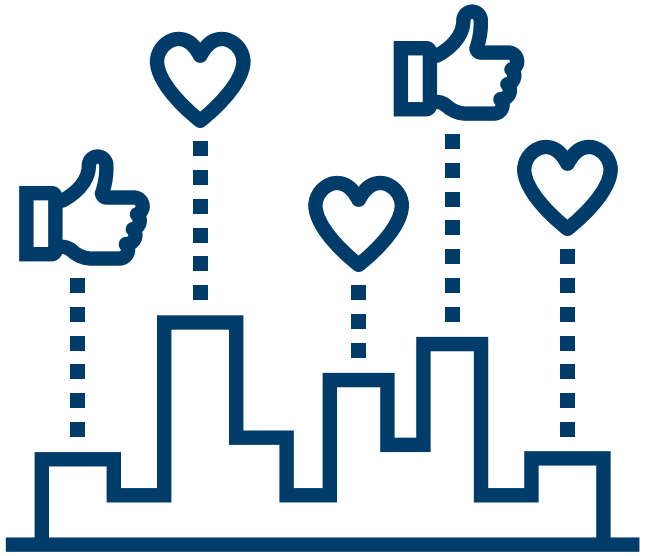
SUN	MON	TUE	WED	THU	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

August. No learning forum

Redesigned Elevate Platform!

September 13. Learning Forum: Evidence-Based Care

NATIONAL ASSOCIATION OF Community Health Centers®



Provide Us Feedback

FEEDBACK

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

FOR MORE INFORMATION CONTACT:

qualitycenter@nachc.org

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

August:

No monthly learning forum
Redesigned Elevate platform
New fall webinar series

Next Monthly Forum Call:

September 14, 2022
1-2 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

NATIONAL ASSOCIATION OF Community Health Centers®

elevate°

Together, our voices elevate° all.

The Quality Center Team

Cheryl Modica, Cassie Lindholm, Oliver Conrad, & Addison Gwinner

qualitycenter@nachc.org