Reimbursement Tips: FQHC Requirements for Medicare CCM, CCCM, and PCM

Program Requirements to bill for CCM, CCCM, and PCM	Completed Yes	Missing No
Initiating Visit. An Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit has been furnished by a FQHC employed MD, DO, NP, PA, or CNM. This is required for patients not seen within one year of the start of care management services, or new patients (not seen within the last three years by a FQHC provider covered by Medicare). The face-to-face visit included in transitional care management (TCM) services (CPT codes 99495 and 99496) also qualifies as a "comprehensive" visit for CCM, CCCM, PCM, General Behavioral Health, or Psychiatric CoCM service initiation.		
Beneficiary Consent. Consent is obtained during or after the initiating visit and before provision of care coordination services by clinical staff. During the COVID-19 PHE, consent may be obtained at the same time services are provided. Consent can be written or verbal but must be documented in the medical record and: • Include the availability of care coordination services and applicable cost-sharing. • Inform the patient that only one practitioner can furnish and be paid for care coordination services during a calendar month. • Communicate the patient's right to stop care coordination services at any time (effective at the end of the calendar month). • Provide the patient with permission to consult with relevant specialists.		
Patient Eligibility. **CCM:** A patient with 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:** A patient with 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. MDM of moderate or high complexity and more care management service time needed. **PCM:** A patient with 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.		
Care Coordination Services. Clinical staff time is directed by a physician or qualified health provider (i.e., MD, DO, NP, PA, or CNM) or personally by the provider. State law, licensure, and scope of practice definitions must be considered for non-primary care service providers.		
Electronic Health Record Documentation. The patient's health information has been structurally recorded with Certified EHR Technology, including: demographics, problems, medications and medication allergies that inform the care plan, care coordination, and ongoing clinical care.		
24/7 Access. The patient has 24/7 access to physicians or other qualified health care professionals or clinical staff and the 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. The patient is offered continuity of care with a designated member of the care team with whom the patient can schedule successive routine appointments.		
Comprehensive Assessment. Comprehensive care management is offered, including a systematic assessment of the patient's medical, functional, and psychosocial needs.		
Preventive Care. System-based approaches are applied to ensure the patient receives all recommended preventive care services in a timely manner.		
Medication Management. Medication reconciliation includes the review of adherence, potential interactions, and oversight of the patient's self-management.		
Comprehensive Care Plan. A comprehensive care plan is created, including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment. The comprehensive care plan covers all health issues with particular focus on the chronic conditions being managed. To be reviewed annually, this plan includes, but is not limited to, the following elements: • Problem list • Expected outcome and prognosis • Cognitive and functional assessments • Measurable treatment goals • Symptom management • Planned interventions, including responsible individuals • Medication management • Caregiver assessment • Summary of advance directives • Community/social services ordered • A description of how outside services/agencies are directed/coordinated • Schedule for periodic review and, where appropriate, revision of the care plan		

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Program Requirements to bill for CCM, CCCM, and PCM	Completed Yes	Missing No
Resources and Support. An inventory of resources and supports are provided to the patient.		
Care Plan Sharing. Care plan information is made available electronically (including by fax) in a timely manner for internal FQHC staff and external stakeholders, as appropriate. A copy of the care plan is given to the patient and/or caregiver.		
Care Transition Management. Care transitions between and among health care providers and settings are managed, including referrals to other clinicians. Follow-up is provided after an emergency department visit, a hospital discharge, or with skilled nursing facilities and other health care facilities being utilized. The creation and exchange/transmission of continuity of care document(s) is shared with other practitioners and providers in a timely manner. Effective January 1, 2022, FQHCs are now permitted to 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. See the Reimbursement Tips for Transitional Care Management for more details.		
Coordination of Care. Care is coordinated with home- and community-based clinical service providers, and communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits is documented in the patient's medical record.		
Electronic Communication Options. Enhanced opportunities are available for the patient and caregiver to communicate with the practitioner regarding the patient's care through telephone access, secure messaging, internet, and/or other asynchronous non-face-to-face consultation methods.		
Coding & Billing. Documentation has been made 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, except for TCM, are billed for the same time period.		

References

- CMS. Benefits Policy Manual, Chapter 13. Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). FAQ. December 2019. Accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf
- CMS. Medicare Learning Network. Chronic Care Management Services. July 2019. Accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
- CMS 2022 PFS Final Rule https://public-inspection.federalregister.gov/2021-23972.pdf
- CMS Frequently Asked Questions, Care Management Services in Rural Health Clinics and Federally Qualified Health Centers. December 2019. Accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf
- CMS Frequently Asked Questions about Practitioner Billing for CCM Services. August, 2022. Accessed at https://www.cms.gov/files/document/chronic-care-management-faqs.pdf