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 can help fund systems transformation as well as be an important part of a health center's value-based care model.

CMS allows Federally Qualified Health Centers (FQHCs) to separately bill for care management services and virtual communication services (not a care management service), including:

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)
- 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*, is designed to support health centers in this process of establishing and obtaining reimbursement for care management and virtual communication services.

**Centers for Medicare and Medicaid Services (CMS)*

 | QualityCenter@nachc.org | | May 2023

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WHAT
can health centers do to obtain payment for care management services?

Care management services (e.g., CCM, CCCM, PCM, TCM, BHI, or CoCM) can be billed once per calendar month, in addition to claims submitted with other FQHC patient care visits in the same period. Only one practitioner/facility can bill for one care management service at a time during the same calendar month. VCS, which is not a care management service, can be billed in the same month as care management services as long as the requirements of both are met. VCS is different than telehealth, which is a substitute for an in-person visit.

Most care management services are paid under Medicare fee-for-services. TCM services are paid under the PPS encounter rate, which is the same as a FQHC visit. 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. Coinsurance is applicable to all care management services.

HOW
to identify, implement, and bill for care management services?

Using risk stratification strategies, health centers can identify patients in need of care management services. (See Population Health: Risk Stratification Action Guide). Where allowable, auxiliary staff can be assigned to provide care management services. FQHC face-to-face requirements are waived for many care management services (see specific *Reimbursement Tips* for more details).

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Proper documentation of care management services in the electronic record is required in order to bill CMS for allowable services, as defined in the following charts:

Care Management Services	FQHC Provider Codes *(billing maps to CPT codes)*	What FQHC bills to CMS	What CMS pays *(Physician Fee Schedule)*
Chronic Care Management (CCM)	99490 (First 20 mins, ***non-complex***; clinical staff)	G0511	$79.25
	+99439 (each add'l 20 mins; clinical staff. Only added to ***non-complex***/99490)		
	99491 (30 mins; physician or QHP only)		
	+99437 (each add'l 30 mins; physician or QHP. Only added to non-complex 99491)		
Complex Care Management (CCCM)	99487 (60+ mins, **complex**; clinical staff)	G0511	$79.25
	+99489 (each add'l 30 mins; clinical staff. Only added to **complex**/99487)		
Principal Care Management (PCM)	CPT: 99424 (30 mins, physician or QHP, single high-risk disease) CPT: 99425 (each add'l 30 min; physician or QHP) CPT: 99426 (30 mins, clinical staff directed by physician or QHP, single high-risk disease) CPT: 99427 (each add'l 30 mins; clinical staff directed by physician or QHP)	G0511	$79.25
Transitional Care Management (TCM)	CPT: 99495 (moderate complexity) CPT: 99496 (high complexity)	G0467	$180.16 $97.24, if telehealth (bill using G2025)
General Behavioral Health Integration (BHI)	99484 (20 minutes)	G0511	$79.25
Psychiatric Collaborative Care Model (CoCM)	99492 (70 mins, initial) 99493 (60 mins, subsequent) Each add'l 30 minutes not billable by FQHC G2214 (CPT +99494: 30 mins, initial/subsequent. FQHCs not eligible to bill for G2214.)	G0512 (for 70 min initial; 60 min subsequent)	$151.23
Virtual Communication Services (VCS)	G2010 (remote evaluation services) G2012 (5 mins; communication technology-based services) During COVID-19 PHE: CPT 99421 CPT 99422 CPT 99423	G0071	$23.88

+Rates are from the CY2022 CMS Physician Fee Schedule. This is a national fee schedule and may not reflect the actual payments from Commercial payers.

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A comprehensive initiating visit is required before CCM, CCCM, PCM, BHI, or CoCM services can be provided. Initiating visits can include: Initial Preventive Physical Examination (IPPE), Annual Wellness Visit (AWV), or Evaluation and Management service (E/M). This initiating visit is not part of care management services and is billed separately. The face-to-face visit included in transitional care management (TCM) services (CPT codes 99495 and 99496) also qualifies as an initiating visit for CCM, CCCM, PCM, general BHI, or Psychiatric CoCM.

What provider codes	Services	What FQHC bills to CMS	CMS/Medicare 2021 Fees*
G0402	Initial Preventive Physical Examination (IPPE): initial face-to-face visit during first 12 months of Medicare Part B enrollment.	G0468	$241.71*
G0438	Annual Wellness Visit (AWV) billable after the first 12 months of Medicare Part B enrollment.		
G0439	Annual Wellness Visit (AWV), subsequent visit, billable once every 12 months after the Initial AWV.		
Varies	Initiating Visit: A comprehensive Evaluation and Management service qualifies for new patients (not seen within the past 3 years by a FQHC provider covered by Medicare) or patients not seen in more than a year prior to service commencement. Levels 2 through 5 E/M visits (CPT codes 99202-99205 and 99212-99215) also qualify.	G0466 G0467	$241.71* $180.16*

Note: Rates in the coding tables above are based on the 2022 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI.

Note: $180.16 and $241.71 are the FQHC unadjusted CMS PPS rate ceilings for established and new patients, respectively. FQHCs are paid either their PPS G Code charge or these fees; whichever is less.

References:

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- CMS Benefits Policy Manual Chapter 18 Preventive and Screening Services https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf
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- CMS Virtual Communication Services FAQ's https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf
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