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 moderate or high medical decision making.

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
- Medication management
- Preventive care
- Care transition management (see related Reimbursement Tips)
- Continuity of care
- 24/7 access
- Resources
- Electronic communication options
- Electronic health record documentation
- Social drivers of health

Patient Eligibility & Consent

CCM. Patients who have multiple (two or more) chronic continuous or episodic 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.

CCCM. Patient must be at moderate or high complexity medical decision making (MDM) and require a longer threshold of time than for CCM patients (see Coding & Billing below).

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 AMA CPT manual for a comprehensive list of requirements.

BILLING REQUIREMENTS	CCM	CCCM	PCM
Initiating Visit required prior to start.	X	X	X
2 or more chronic conditions lasting at least 12 months or until patient death.	X	X	
1 complex chronic disease lasting at least 3 months.			X
Patient at risk of death, acute exacerbation/decompensation, or functional decline.	X	X	X
Patient at significant risk of hospitalization.			X
Comprehensive Care plan developed, implemented, revised or monitored. Address, as needed, all medical conditions, psychosocial needs, ADLs.	X	X	X
Moderate or high complexity MDM		X	X
Frequent adjustments to medication regime and/or care management.			X
Ongoing communication and care coordination with other care providers.			X

An FQHC practitioner (i.e., MD, DO, NP, PA, or CNM) determines if the patient meets the criteria for, and is likely to benefit from, chronic care management services. A patient who is eligible for CCCM may receive PCM if the provider chooses to manage a single disease.

The patient must provide consent prior to receiving care management 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., they will be responsible for co-insurance).

Timeframe & Services

CCM, CCCM, and PCM 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.

These care management services (see Program Requirements) are extensive and require the development of a care plan that is shared with outside providers, the patient, and/or caregiver. The care plan, appropriate to the individual, must be coordinated with home and community-based providers and include the management of transitions between and among health care providers and settings (see Reimbursement Tips: Transitional Care Management). Patients/caregivers are to be offered the ability to communicate with the provider through a variety of electronic communication options, including: secure messaging via SMS or patient portal, internet, and other asynchronous non-face-to-face consultation methods.

CCM/CCCM/PCM should only be furnished on an as-needed basis. There are no specific requirements for updating the care plan. It should be reviewed and updated, as appropriate, for the patient's care.

Initiating Visit

Prior to the start of care management services, a comprehensive initiating visit is required for new patients or patients not seen within the last year (12 months) and must include discussion of care management services (CMS, August 2022). Initiating visits can include: Initial Preventive Physical Examination (IPPE), Annual Wellness Visit (AWV), Evaluation and Management service (E/M) visits (CPT codes 99212-99215), or Transitional Care Management (TCM) services (CPT codes 99495-99496). The initiating visit is not part of care management services and is billed separately. The care management visit must occur within 12 months of the initiating visit and the practitioner must discuss care management services with the patient for a visit to count as an initiating visit for care management services.

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

CCM, CCCM, and PCM services focus on the time and resources used to manage a patient's health between face-to-face visits and are furnished primarily by clinical staff. Under general supervision, the billing practitioner provides overall direction and control, but their physical presence is not required during the provision of services.

State law, licensure, and scope of practice definitions must be considered for clinical staff.

TREATING (BILLING) PROVIDER				UNDER GENERAL SUPERVISION
Physicians (MD or DO)	Non-Physician Practictioners			Clinical staff*
	NP	PA	CNM	RN, Pharmacist, other licensed practitioner

- *Medical Doctor (MD) or Doctor Osteopathy (DO)*
- *Non-Physician Practitioners include: Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife (CNM)*
- *Clinical staff include licensed practitioners working under the supervision of a physician or qualified health professional (QHP)*

Documentation

Document all CCM/CCCM/PCM services as well as the time spent providing services (for required minutes per calendar month). Structured recording of patient health information using Certified EHR Technology includes: demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care.

Documentation requirements:

- Comprehensive assessment of medical, functional, and psychosocial needs
- Preventive care
- Medication management
- Comprehensive care plan
- Continuity of care
- Coordination with home- and community-based providers
- 24/7 access to providers or clinical staff

Coding & Billing

For federally qualified health centers, the CPT® care management codes crosswalk to HCPCS G0511.

G0511 is defined as the 20 minutes or more of clinical staff time for chronic care management services directed by an FQHC practitioner (physician, NP, PA, or CNM), per calendar month.

Both CCCM and PCM have a minimum service time of 30 minutes per calendar month and that threshold must be met to bill the services.

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 99424, 99425, 99484, 99487, 99490, and 99491). FQHCs can expect the payment to be slightly higher or lower depending on the Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI). See coding tables for more information.

PCM are services focused on managing patients with a single, complex chronic condition requiring substantial care management. The PCM codes are billable by FQHCs under G0511 and, new for 2023, can be billed more than once in a calendar month, either alone or with other payable services, if the requirements for each of the care management services are met.

Time that is counted towards reporting a CCM/CCCM/PCM service code cannot be counted toward any other billed code. For billing, the minimum time for each care management service must be delivered and totaled within each calendar month, not during a 30-day period that overlaps with the start and end of consecutive months.

New in 2023, CMS is allowing FQHCs to bill G0511 more than one time per calendar month for multiple, distinct care management services furnished for the same beneficiary during the same period. The requirements for billing each service must be met (Physician Fee Schedule).

Monthly contact with the patient is not necessary to bill for care management services. Care management activities which are part of the scope of service elements, such as coordination with community services, may occur without patient contact and may be billed in a calendar month even if no other direct patient contact or care management services are provided.

Add-on codes, identified with the + symbol in the CPT manual, offer providers in a fee-for-service setting (i.e., non-FQHC) a mechanism for reporting and receiving reimbursement for professional service time spent with a patient above the time allocated in the primary care management service code when service is furnished by the same provider. FQHCs do not receive additional Medicare PPS payment for additional time spent with patients. CMS views the higher FQHC reimbursement associated with the encounter rate as adequate compensation for the service time spent with the patient. However, it is important for FQHCs to capture the add-on codes in order to accurately capture the cost of providing these services. Note the add-on codes in the tables on page 4.

CCCM (CPT® 99487) shares service elements common to CCM, but has different requirements for:

- Amount of clinical staff service time provided (at least 60 minutes)
- Complexity of medical decision making involved (moderate to high complexity)

See tables on the next page for a summary of CCM, CCCM, and PCM billing and coding.

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

CCM

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*CMS/ Medicare 2023 Fees*
Non-complex (CPT® 99490)	First 20 mins of CCM clinical staff time directed by a physician or QHP.	G0511	$77.94
Non-complex additional time (CPT® +99439)	Each add'l 20 mins of clinical staff time directed by physician or QHP; added to 99490 (clinical staff time).		
Provider only (CPT® 99491)	30 mins or more of CCM services in a month provided personally by a physician or QHP.		
Provider only (CPT® +99437)	Each add'l 30 mins of CCM services provided personally by a physician or QHP; added to 99491.		

Notes:

- *Codes 99490 and 99491 are reported only once per calendar month.*
- *Codes 99439 and 99437 are reported no more than twice per calendar month.*
- *Clinical staff and provider service codes cannot be reported in the same calendar month.*
- *If a physician or QHP furnishes any of the clinical staff services, that time may be counted toward the total required clinical staff time for billing the service, but not be also counted towards any physician or QHP time.*

CCCM

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*CMS/ Medicare 2023 Fees*
Complex (CPT® 99487)	First 60 mins of CCCM clinical staff time directed by a physician or QHP.	G0511	$77.94
Complex additional time (CPT® +99489)	Each add'l 30 mins of clinical staff time directed by physician or QHP; added to 99487.		

Notes:

- *Code 99487 is reported only once per calendar month.*
- *Code 99489 is reported no more than twice per calendar month.*
- *If a physician or QHP furnishes any of the clinical staff services, that time may be counted toward the total required clinical staff time for billing the service*

PCM

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*CMS/ Medicare 2023 Fees*
CPT® 99424	Comprehensive care management services for a single high-risk disease; first 30 mins of PCM personally provided by a physician or QHP.	G0511	$77.94
CPT® +99425	Each add'l 30 mins of PCM services provided personally by a physician or QHP; added to 99424.		
CPT® 99426	First 30 mins of PCM clinical staff time directed by a physician or QHP.		
CPT® 99427	Each add'l 30 mins of PCM clinical staff time directed by physician or QHP; added to 99426.		

Notes:

- *Codes 99424, 99426 are reported only once per calendar month.*
- *Codes 99425, 99427 are reported no more than twice per calendar month.*
- *Clinical staff and provider service codes cannot be reported in the same calendar month.*
- *If a physician or QHP furnishes any of the clinical staff services, that time may be counted toward the total required clinical staff time for billing the service, but not be also counted towards any physician or QHP time.*

An FQHC may submit a Medicare claim for a billable CMS PPS "G" code visit and a care management service on a single claim. If billing for CCCM or CCM or 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/CCCM/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. Please refer to the CPT® manual for descriptions of limitations for reporting certain services during the same calendar month as the care management services listed in this manual.

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 the initiating visit for CCM, CCCM, PCM, General Behavioral Health, or Psychiatric CoCM care management services.		
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. Medical decision making (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		

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

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 CMS general care management services. G0511 can be billed more than once in a calendar month, either alone or with other payable services, if the requirements for each of the care management services are met.		

References

- CMS. Benefits Policy Manual, Chapter 13. Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). FAQ. February 2023. Accessed at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf
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- CMS 2023 Physician Fee Schedule Final Rule https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.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

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