NATIONAL ASSOCIATION OF Community Health Centers®

ELEVATE NATIONAL LEARNING FORUM

elevate

Care Management & Reimbursement
March 11, 2025

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NATIONAL ASSOCIATION OF Community Health Centers®

NACHC Quality Center

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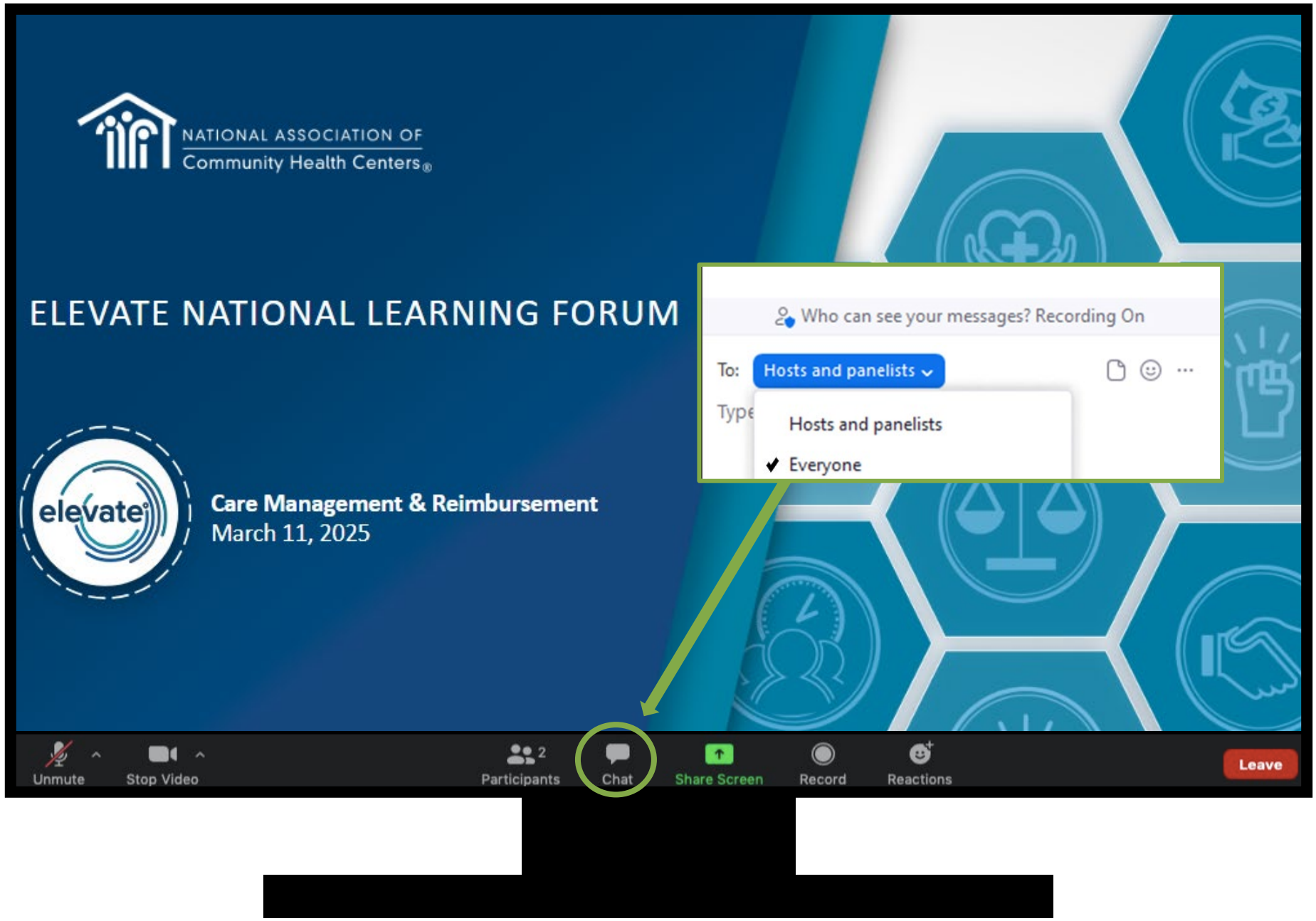


During today's session:

- Type your questions in the chat feature.
- Be sure to select "Everyone"!
- There will be Q&A and discussion at the end.

Agenda

Welcome

HCC coding correction from February Learning Forum

Bringing it all together – AWVs, HCC coding, Care Management

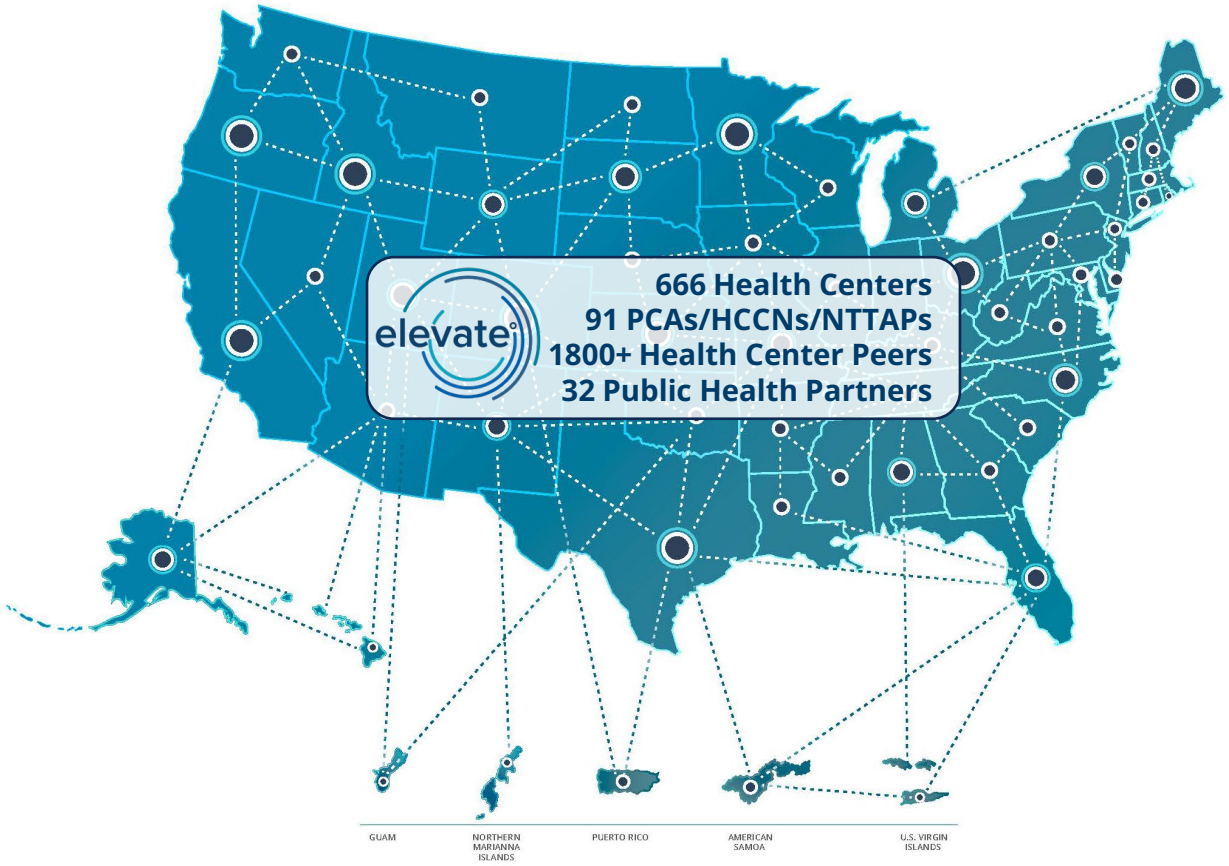
Medicare care management – with FAQs answered by Lisa Messina, Messina Consulting

- ***Community Health Integration***
- ***Chronic Care Management***

Discussion and Q&A

Closing

Elevate 2025



Share Elevate 2025 with others!

(bit.ly/Elevate2025Registration)

Elevate **is NACHC's national learning forum supporting health centers and partners to transform systems and enhance value**

Registration data from 1/1/2025 - 3/10/25

Want to Learn More?

Elevate informational video (1 min)

Also visit NACHC's Elevate webpage

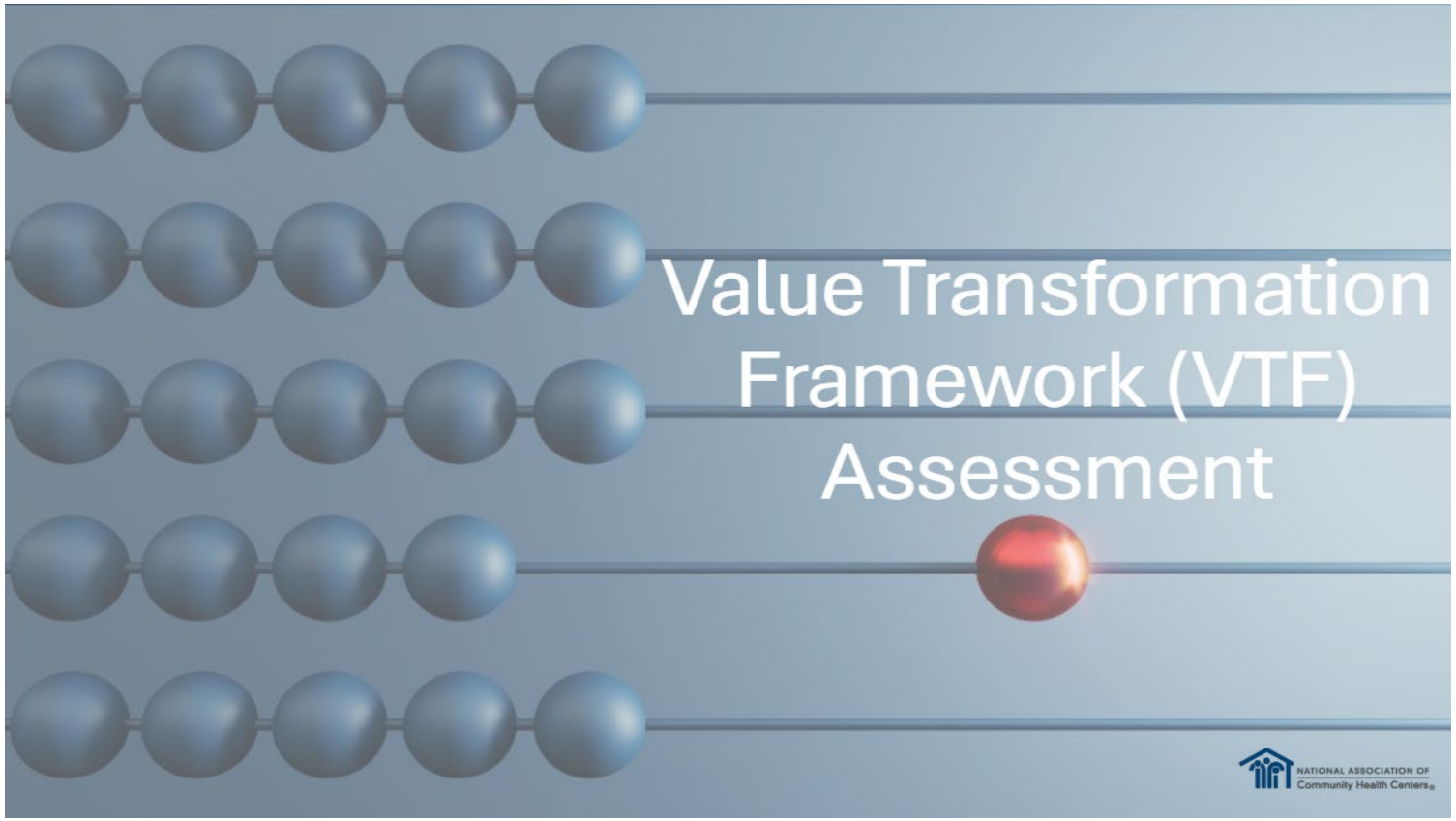
Value Transformation Framework (VTF) video (1 min)

Also visit NACHC's VTF webpage

Assess Progress Toward Value!

Value Transformation Framework (VTF) Assessment video (3 mins)

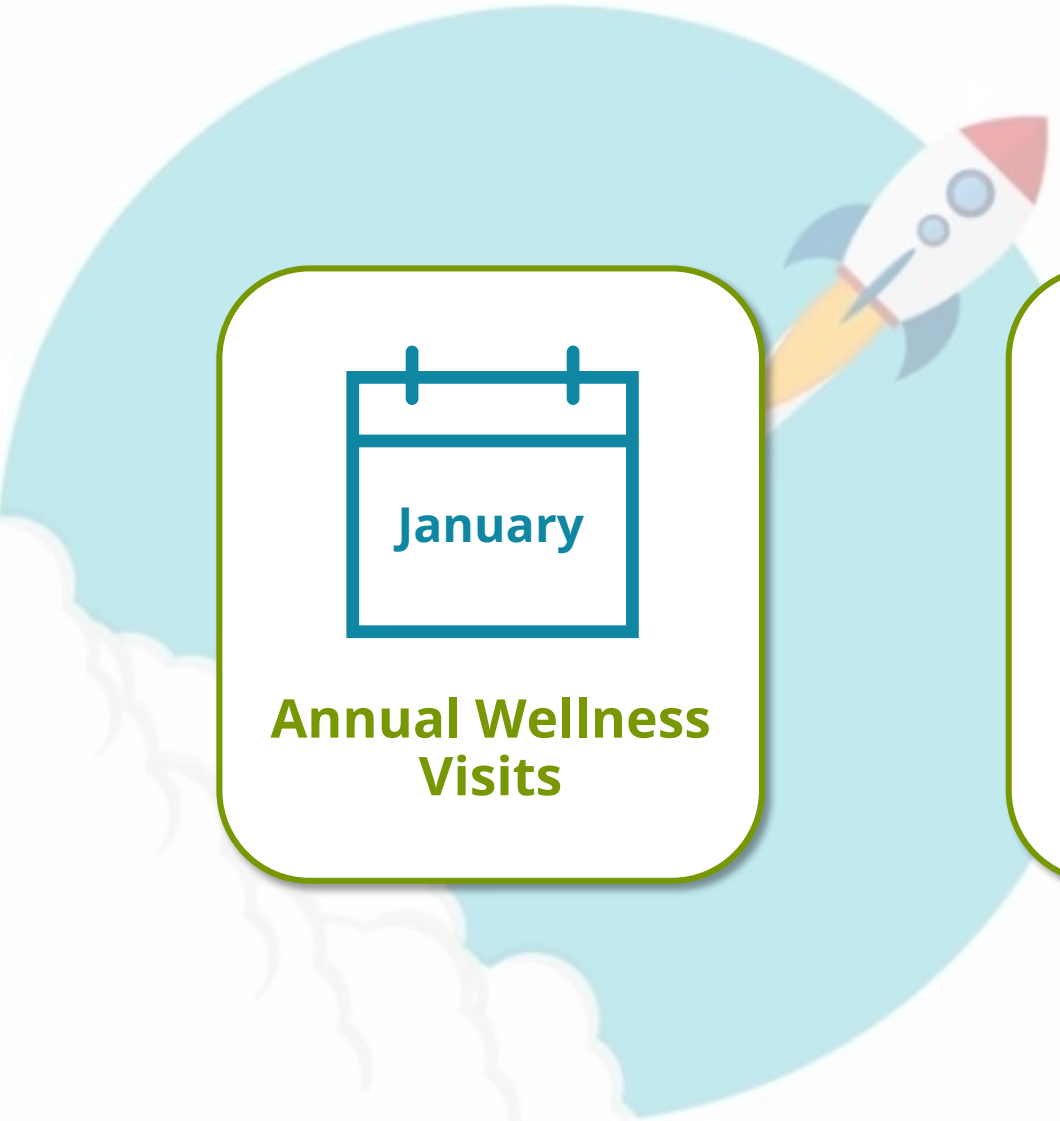
Value Transformation Framework (VTF) Assessment Instructions



Elevate 2025 Launch

Elevate 2025 Launch:

Quarter 1 Medicare Focus!



January

Annual Wellness Visits

February

HCC Coding & Risk Adjustment

March

Care Management

February Correction!

Updates to the 2025 CMS HCC coding model (version 28) do not include Social Drivers of Health (SDOH) codes mapped to payment HCCs.

While it is still recommended to assess for SDOH and utilize ICD-10-CM codes (Z codes) for documentation, they will not contribute to a higher Medicare risk adjustment at this time. For more information on 2025 ICD-10-CM mappings, view this CMS resource.

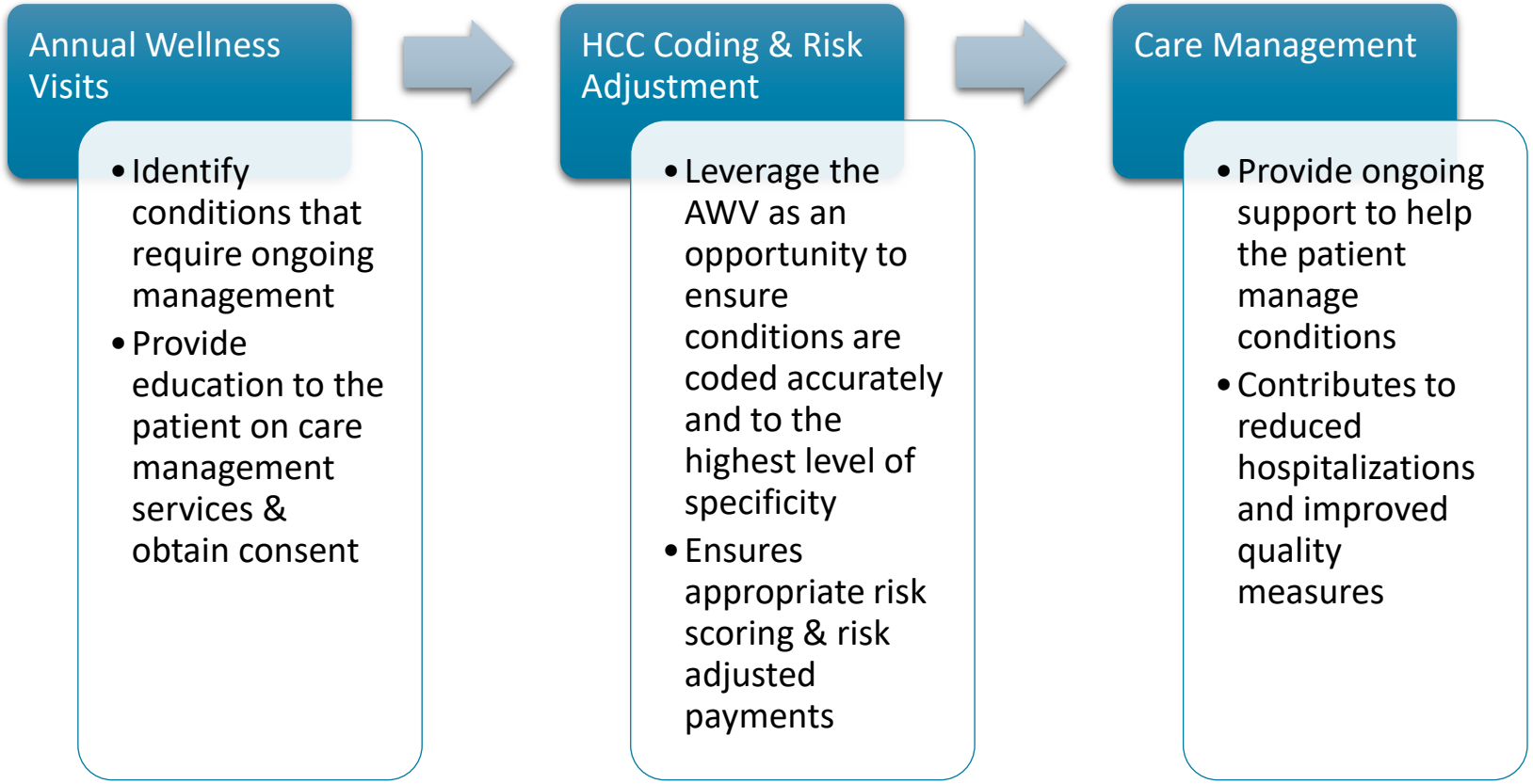
It is our highest priority to provide Elevate attendees with accurate information, and we offer our sincere apologies for this error. We have made the necessary corrections to the slide deck and the recording to prevent any further distribution of incorrect information.

Why Medicare?

Why Medicare?

- ✓ Your feedback!
- ✓ Increasing segment of health center patient populations
- ✓ Increasing involvement of health centers in Medicare VBP arrangements
- ✓ Opportunities for reimbursement led by care team members other than the provider
- ✓ Workflows/promising practices can be extended to other patient segments (modifying as needed)

Bringing it all Together

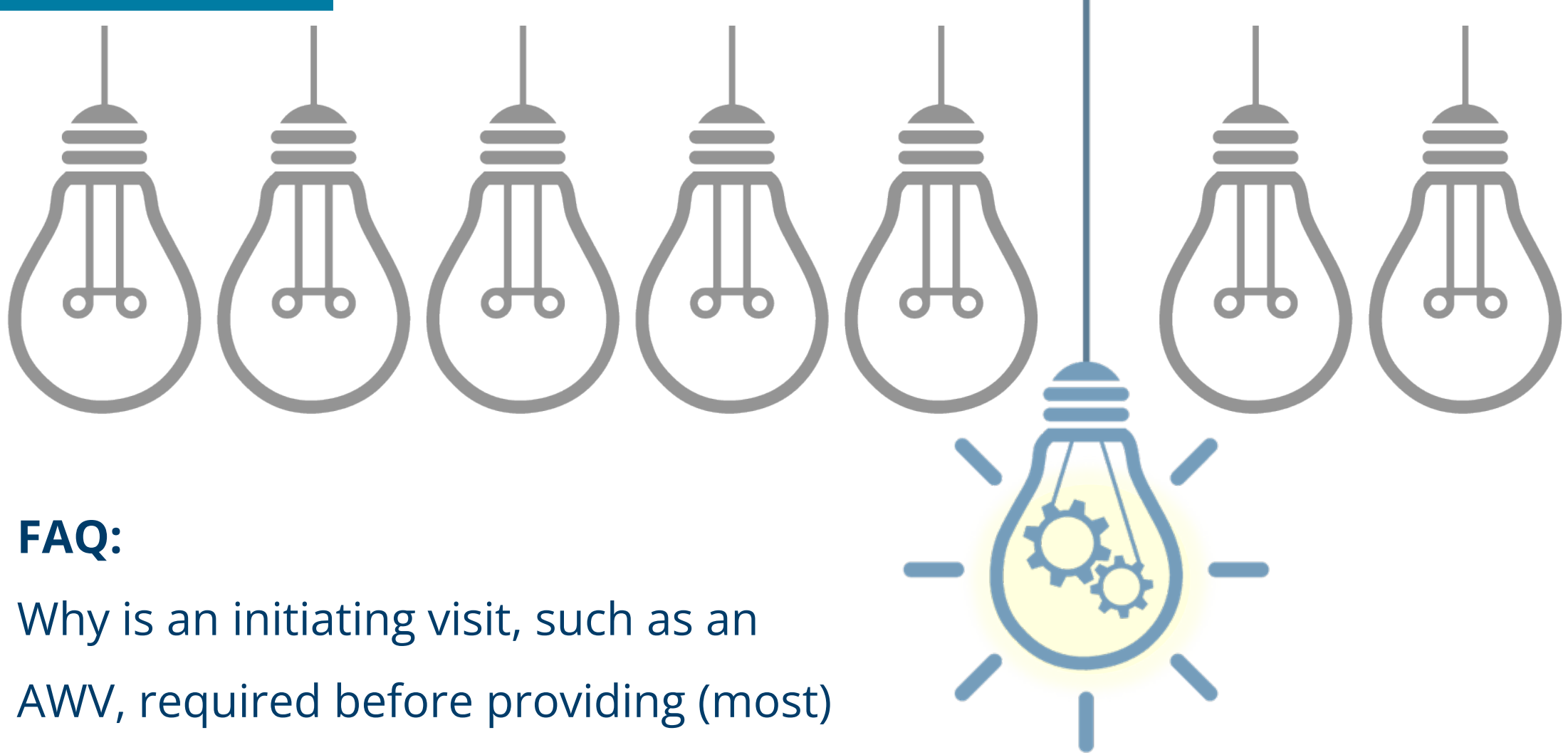


Value-based care revenue opportunities that reward health centers for managing high-risk patients effectively!

Featured Speaker

Lisa Messina, MPH, CPC, CPCO
Messina Consulting, LLC

Lisa Messina is an independent consultant and the Compliance Lead for the FQHC division of Coronis Health. Lisa has over 20 years of health care health information management and operations experience working in the inpatient, outpatient, community clinic, and physician practice arenas. She has conducted research and authored dozens of articles and blogs on coding, billing, and general compliance specific to community health centers.

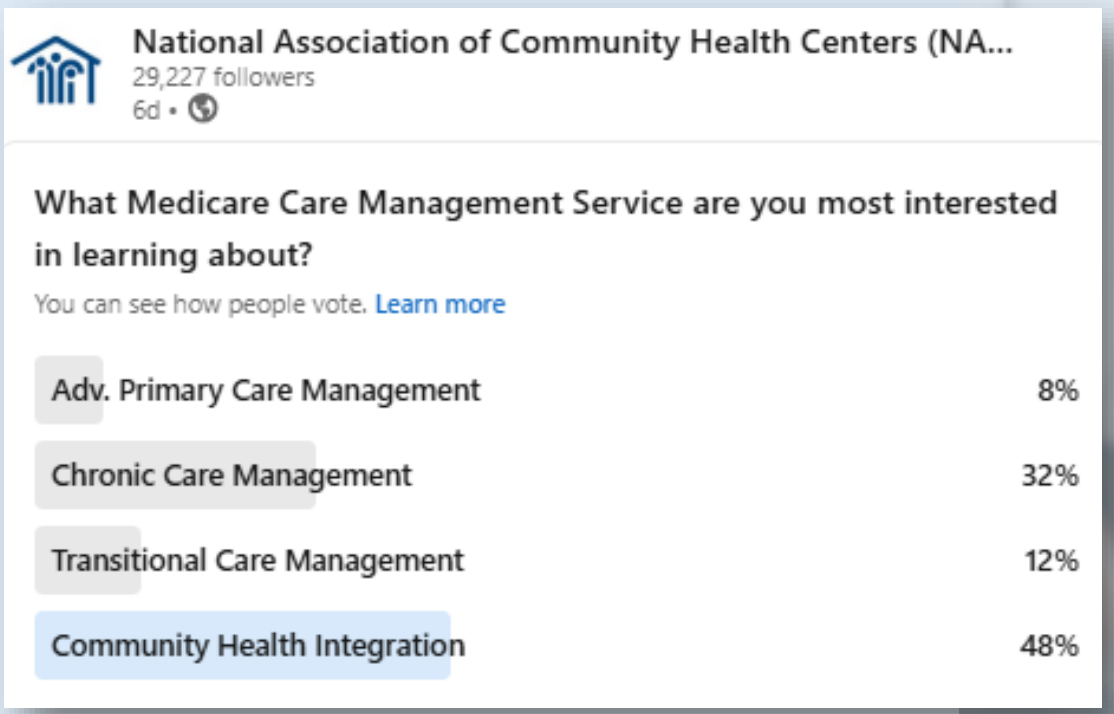


FAQ:

Why is an initiating visit, such as an AWV, required before providing (most) Medicare care management services?

Medicare Care Management Services

The Poll Responses Are In!



Community Health Integration

What are Community Health Integration (CHI) services?

Personalized and supportive services provided to patients with unmet social drivers of health (SDOH) needs that interfere with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.

Eligible Patients:

- ✓ Medicare Part B beneficiaries.
- ✓ Provide consent for services.
- ✓ Have unmet SDOH need(s) that interfere with, or present a barrier to, the diagnosis and treatment of the problems identified during an initiating visit.
- ✓ Have been seen for an initiating visit prior to the start of services.

Community Health Integration

What are the service elements of CHI?

Services may be billed once per calendar month after at least **60 minutes** of services, including:

- Patient-centered assessment
- Coordination with home- and community-based resources
- Health education
- Developing self-advocacy skills
- Health care access and navigation
- Patient behavioral change facilitation
- Facilitate and provide social & emotional patient support

Community Health Integration

Who may provide CHI services?

Authorized Billing Providers

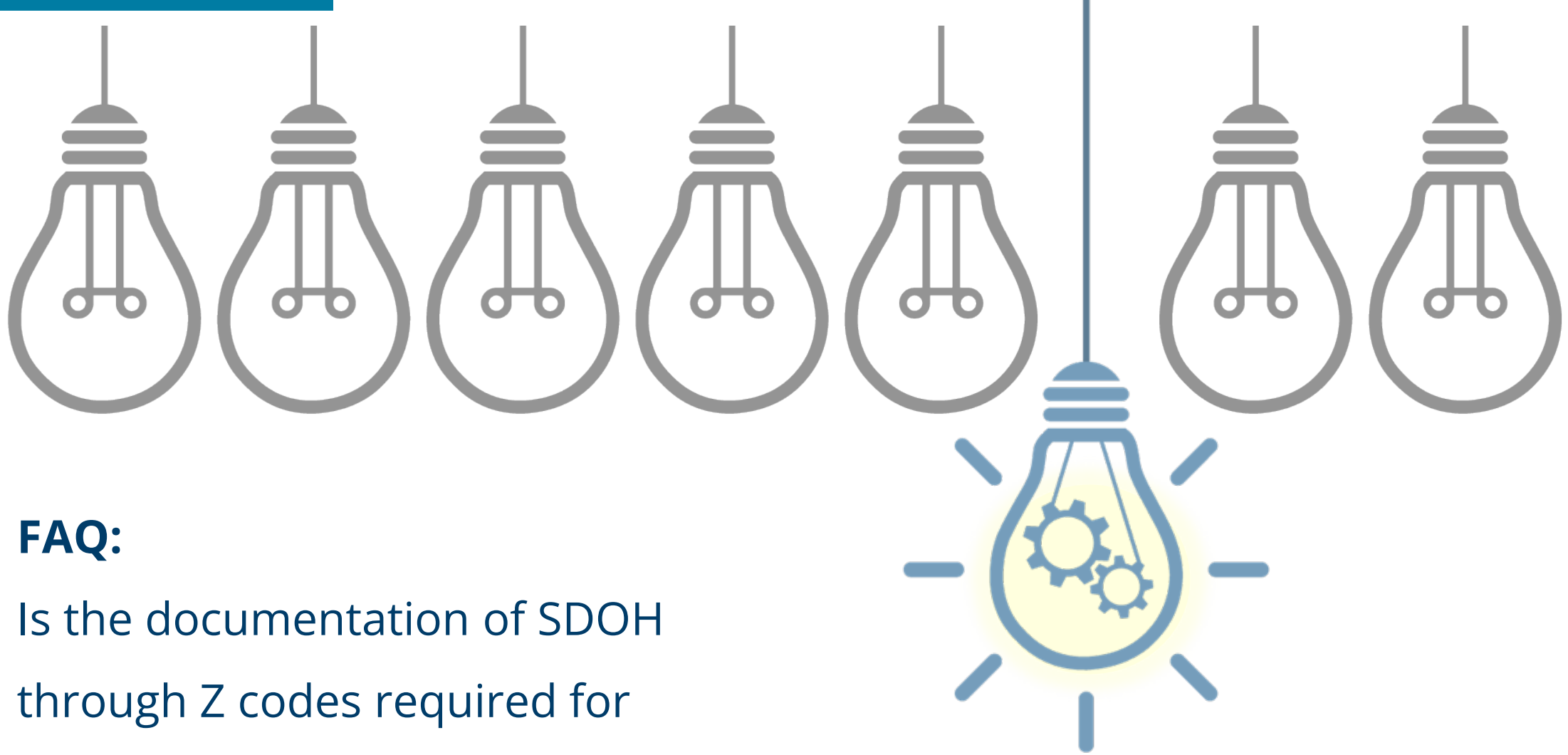
Who they are:
- Physicians (MD,DO)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Certified Nurse Midwives (CNM)

What they do:
- ✓ Perform the initiating visit
- ✓ Determine medical necessity of CHI and order services.
- ✓ Obtain patient consent for services (verbal or written). If not obtained by billing provider, consent may also be obtained by auxiliary personnel under general supervision.
- ✓ Furnish services personally and/or via general supervision of auxiliary personnel as indicated by the service CPT code.
- ✓ Reviews any unmet SDOH identified by auxiliary personnel during their delivery of CHI services to determine if they should be included as part of the treatment plan.

Auxiliary Personnel

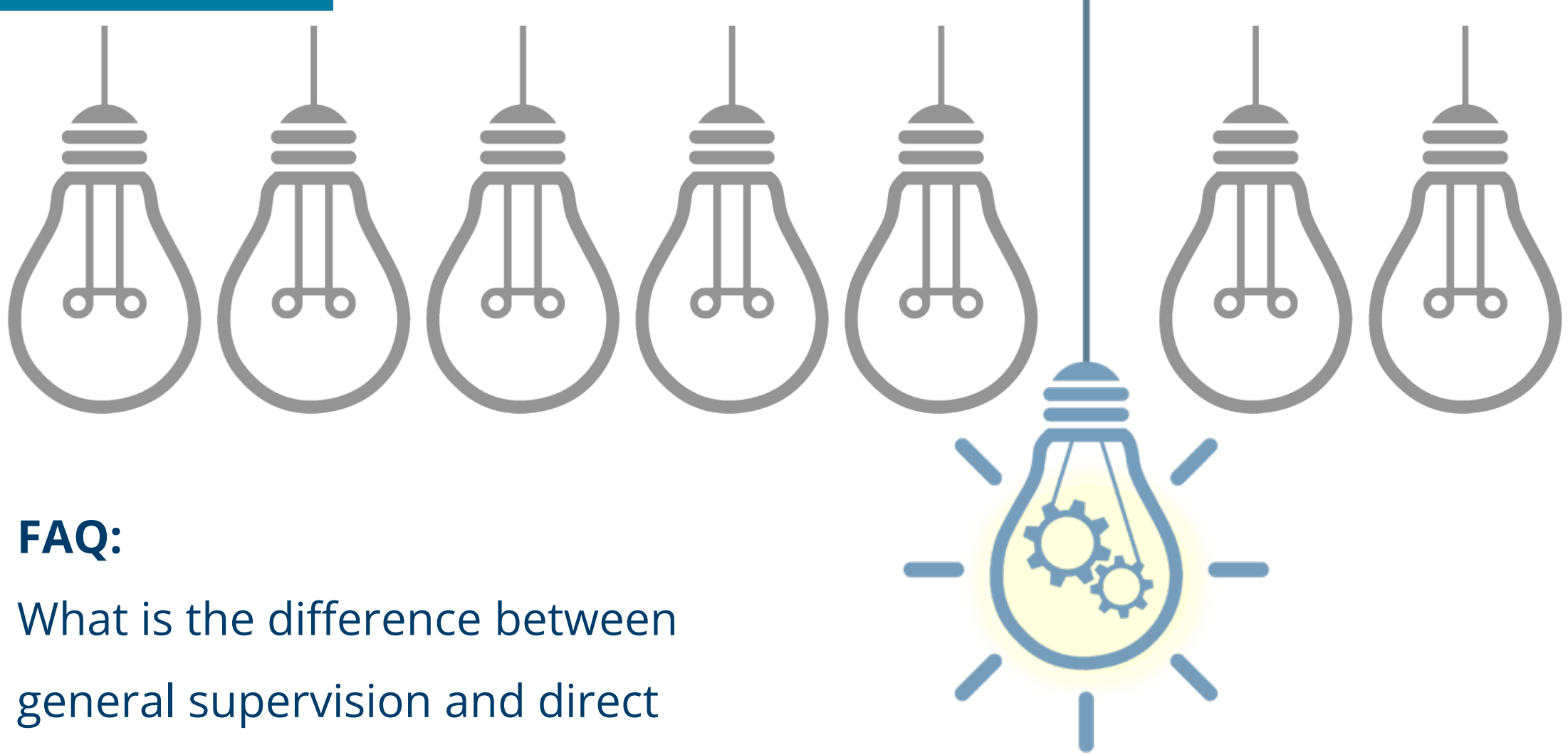
Who they are (examples):
- Community Health Workers
- Nurses (nurse care manager, CNS, RN, LPN)
- Social Workers

What they may do (under general supervision, and after the initiating visit has taken place):
- ✓ Obtain patient consent for services (verbal or written)
- ✓ Provide CHI services
- ✓ Document CHI service activities and time spent on such activities in the medical record.
- ✓ Communicate any newly identified SDOH concerns to the billing practitioner for review.



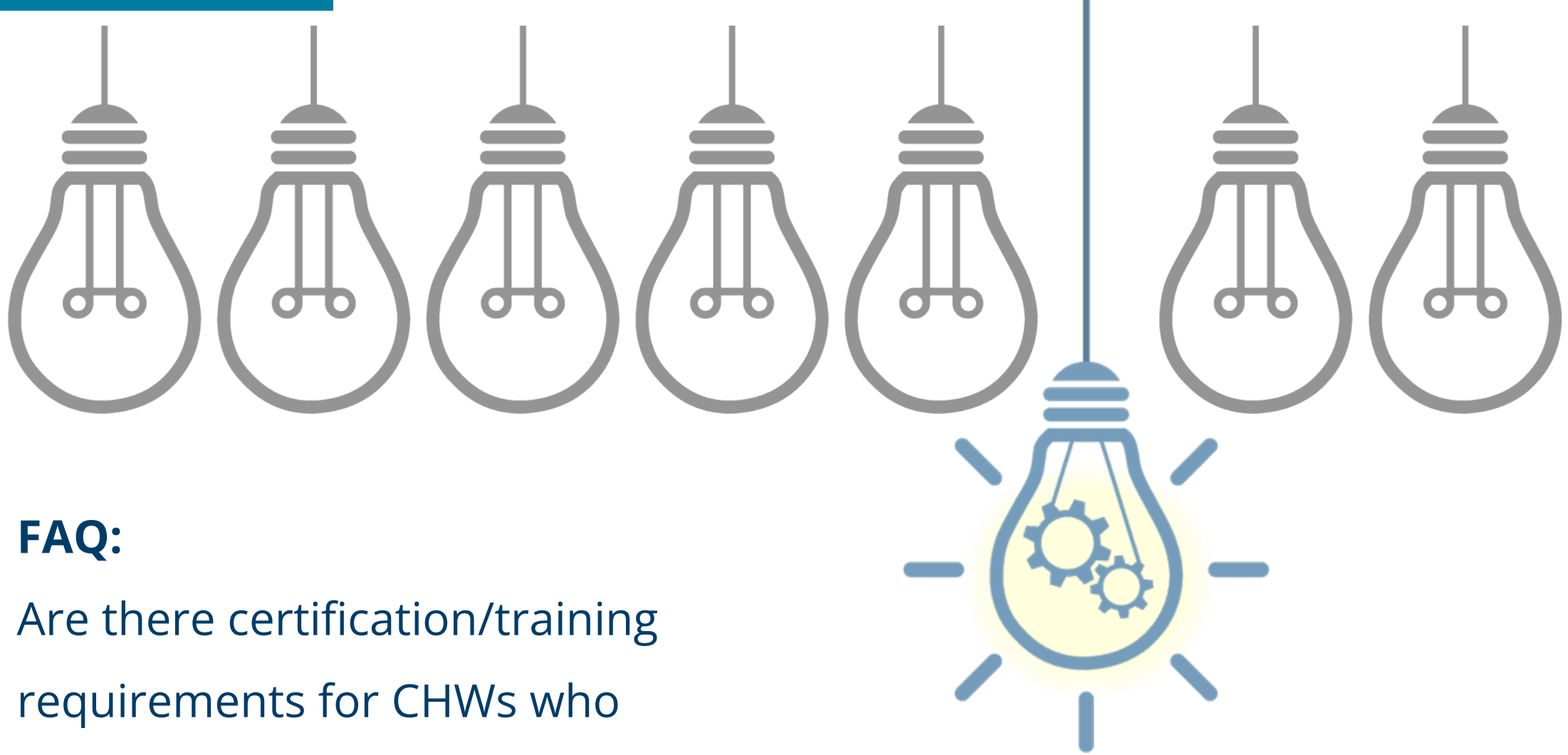
FAQ:

Is the documentation of SDOH through Z codes required for patient eligibility?



FAQ:

What is the difference between general supervision and direct supervision of auxiliary personnel?



FAQ:

Are there certification/training requirements for CHWs who provide CHI services?

Community Health Integration

Certification and training requirements for auxiliary personnel:

CMS specifically requires that in states where requirements for auxiliary personnel do not exist, they must be certified and trained in:

- ✓ Applicable knowledge of services, including community-based resources
- ✓ Communication (family and patient) and relationship-building skills
- ✓ Patient advocacy and facilitation
- ✓ Professionalism and ethical conduct
- ✓ Care coordination and health care/community systems navigation and assessment
- ✓ Patient advocacy and its facilitation
- ✓ Individual patient and community assessment
- ✓ Develop and strengthen the skills and abilities of the patient and family to improve access to health care and community services

Medicaid Opportunities for CHW Reimbursement

There are state-wide initiatives to amend Medicaid plans to authorize reimbursement for CHW activities!

Many states recognize the value CHWs provide in key areas like patient engagement, care coordination, and increasing access to clinical and support services for Medicaid patients.

Several states have received approval from the Centers for Medicare & Medicaid Services (CMS) for Medicaid State Plan Amendments (SPAs) that allow reimbursement for Community Health Worker (CHW) services.

This is a great source for health centers that would like to know what's happening in their states.

Chronic Care Management

What are Chronic Care Management (CCM) services?

Personalized and supportive services provided to patients with multiple chronic conditions to coordinate care and develop a care plan to achieve health goals.

Eligible Patients:

- ✓ Medicare Part B beneficiaries.
- ✓ Provide consent for services.
- ✓ 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; and, for which the authorized billing provider determines that CCM services are medically necessary.
- ✓ Have been seen for an initiating visit prior to the start of services.

Chronic Care Management

What are the service elements of CCM?

Services may be billed once per calendar month after at least **20 minutes** of services of services provided by auxiliary personnel, or at least **30 minutes** of services of services provided by the authorized billing provider, including:

- 24/7 access to clinical support staff
- Continuity of care with designated care team member
- Comprehensive assessment of medical, functional, and psychosocial needs
- Preventive care
- Medication management
- A comprehensive care plan created, monitored, revised, and shared with the patient/caregiver and other internal/external members of the patient's care team.
- Patient education and resources
- Care coordination

Chronic Care Management

Who may provide CCM services?

Authorized Billing Providers

Who they are:
- Physicians (MD,DO)
- Nurse Practitioners (NP)
- Physician Assistants (PA)
- Certified Nurse Midwives (CNM)

What they do:
- ✓ Perform the initiating visit
- ✓ Determine medical necessity of CCM and order services.
- ✓ Obtain patient consent for services (verbal or written). If not obtained by billing provider, consent may also be obtained by auxiliary personnel under general supervision.
- ✓ Furnish services personally and/or via general supervision of auxiliary personnel as indicated by the service CPT code.

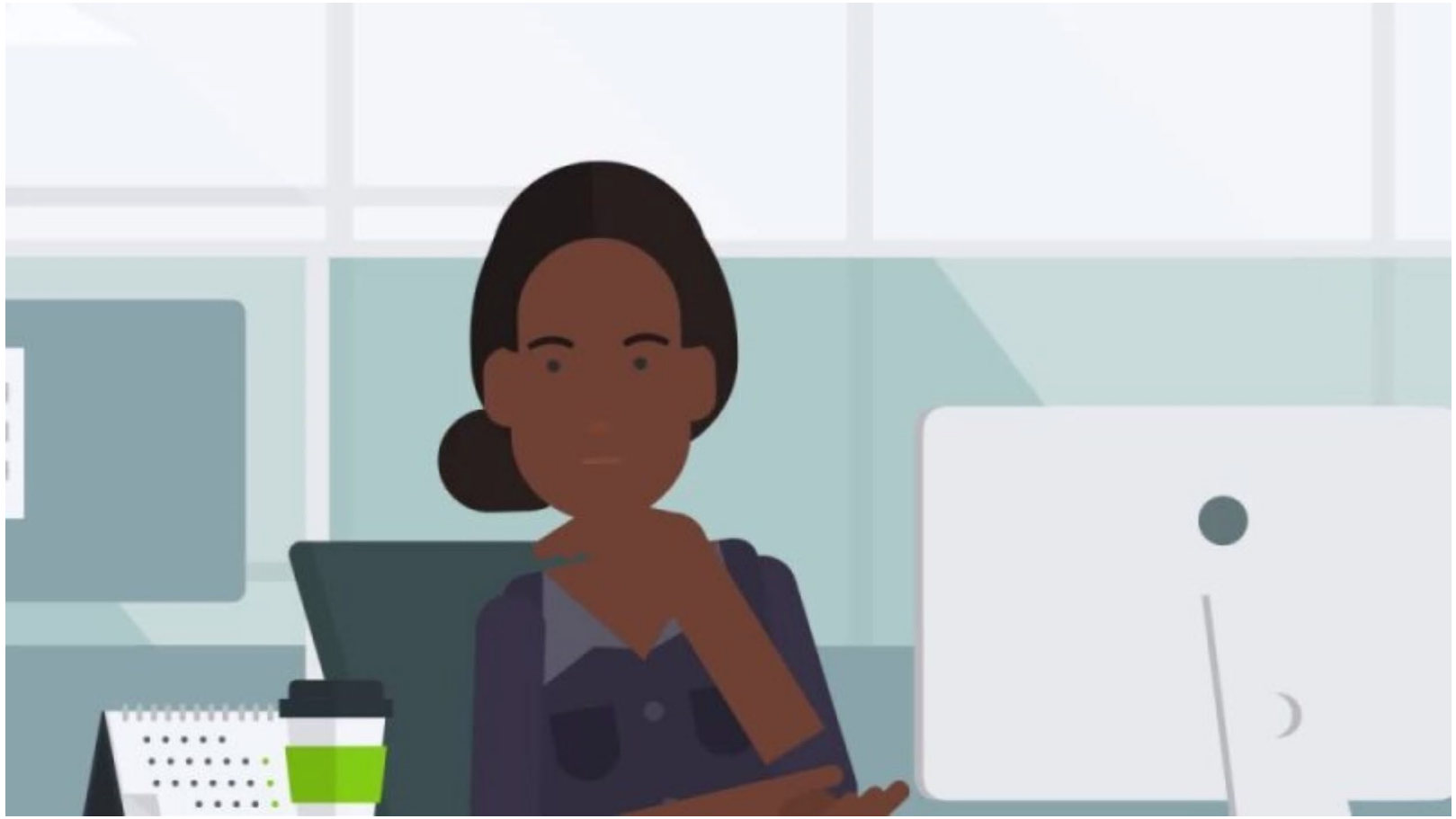
Auxiliary Personnel

Who they are (examples):
- Nurses (nurse care manager, CNS, RN, LPN)
- Social Workers

What they may do (under general supervision, and after the initiating visit has taken place):
- ✓ Obtain patient consent for services (verbal or written)
- ✓ Provide CCM services
- ✓ Collect data relative to patient demographics, assessments, interviews, and outcomes
- ✓ Maintain and update, within scope of practice, the patient-centered care plan
- ✓ Provide 24/7 access to care

Meet Maria! An Elevate 2025 Patient Persona

Meet Maria video (2 mins)



Which Medicare services might Maria benefit from?

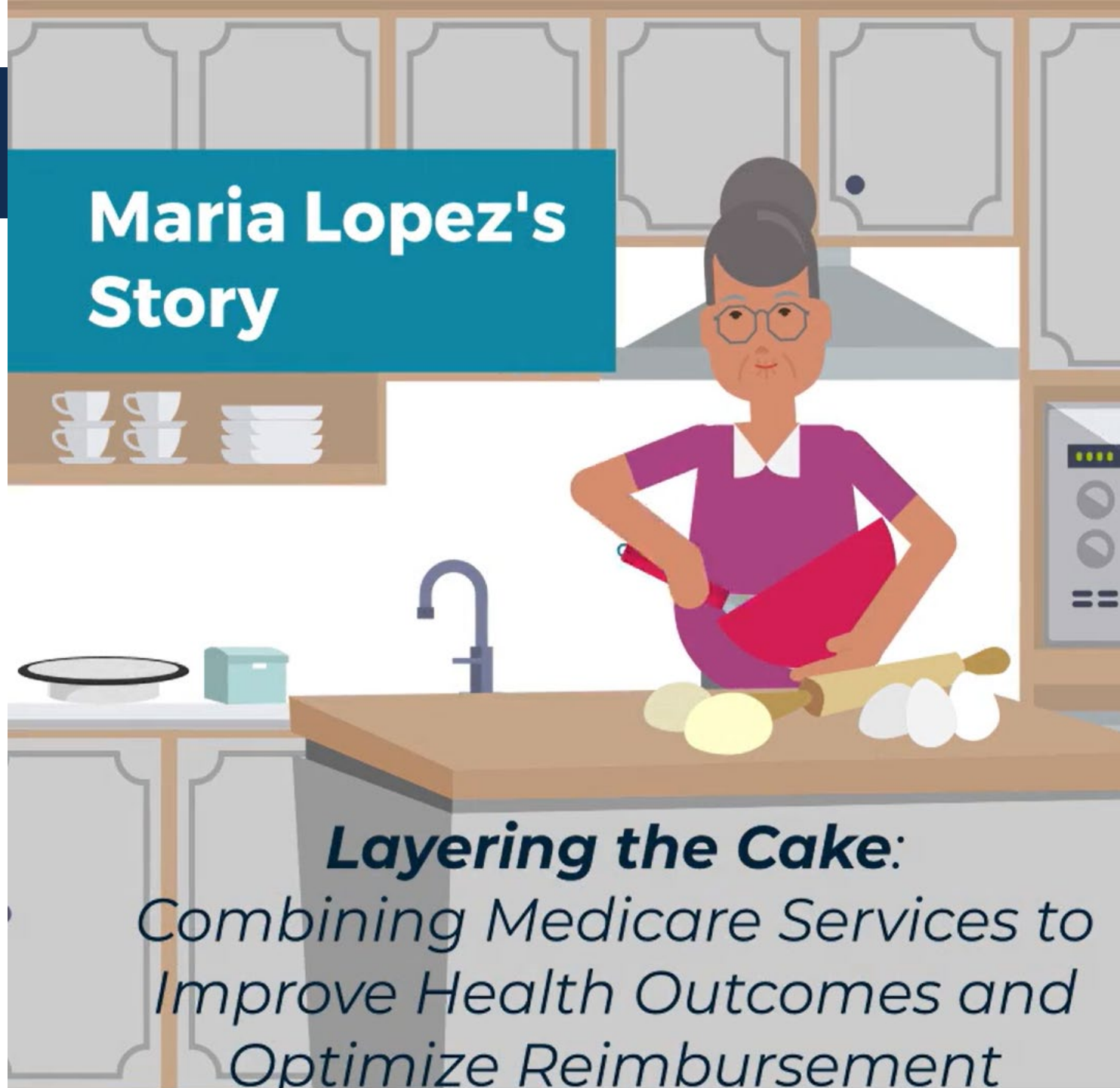
Let us know in the chat!

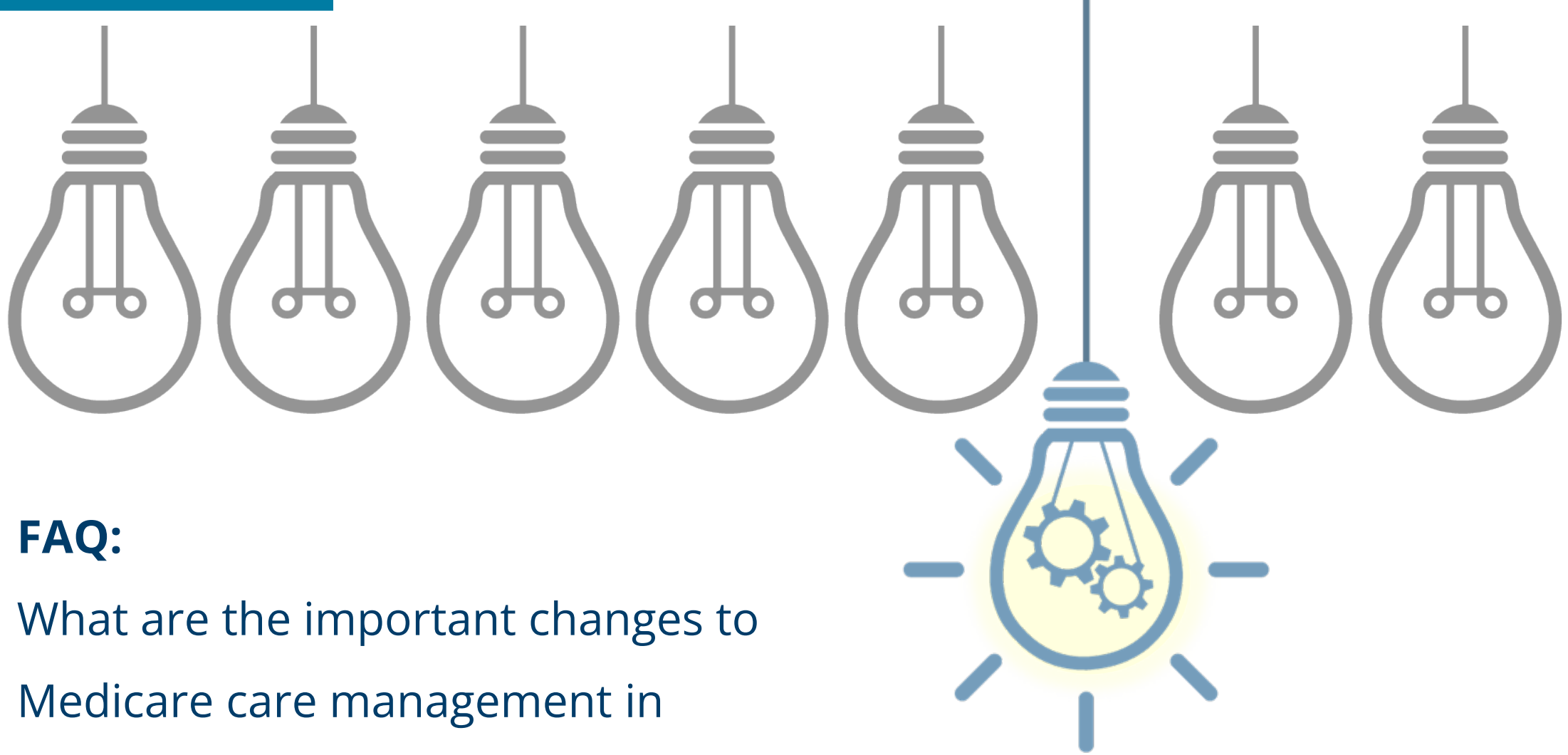
Maria's Example

How These Services Work Together: ‘Layering the Cake’

Maria’s Layer Cake video (3 mins)

Video developed by NACHC based on the ‘layer cake’ concept for layering Medicare services originated by Lisa Messina, Messina Consulting, LLC.





FAQ:

What are the important changes to Medicare care management in 2025?

2025 Medicare Care Management

Unbundling of G0511, add-on codes, reimbursement amounts

CHI

G0019: **$77.95** (60 mins)

+G0022: **$48.52** (each additional 30 min)

Or continue billing G0511: $54.67
until July 1, 2025

CCM

99490: **$60.49** (20 min, aux. personnel)
+99439: **$45.93** (each additional 20 min, aux. personnel)

99491: **$82.16** (30 min, auth. billing provider)
+99437: **$57.58** (each additional 30 min, auth. billing provider)

Or continue billing G0511: $54.67
until July 1, 2025

*See Reimbursement Tip Sheets for full descriptions of CPT codes and documentation requirements

Medicare Care Management

Resources!

NATIONAL ASSOCIATION OF Community Health Centers®

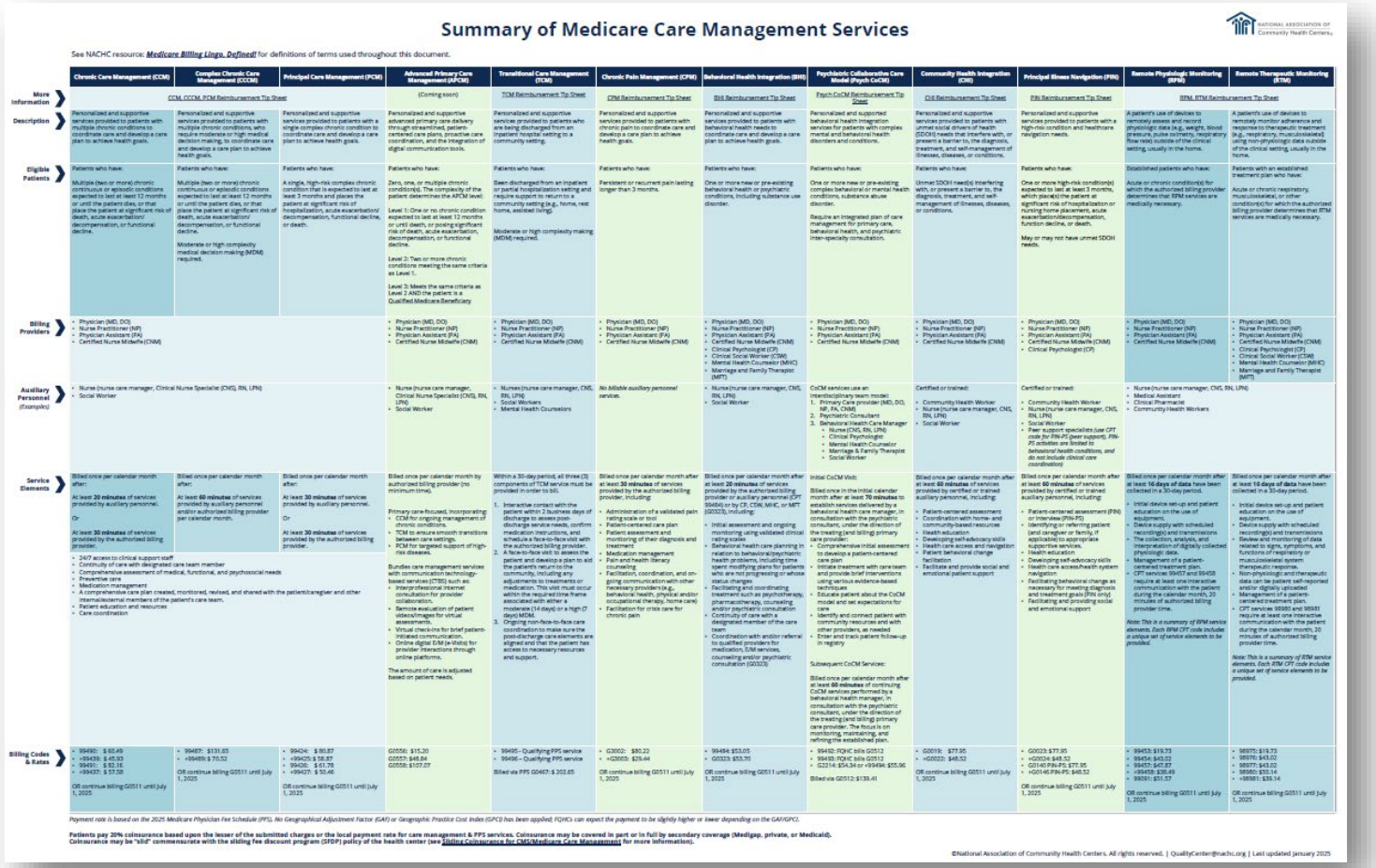
Summary of Medicare Care Management Services

Medicare Care Management Services:

- ✓ Chronic Care Management
- ✓ Complex Chronic Care Management
- ✓ Principal Care Management
- ✓ Transitional Care Management
- ✓ Chronic Pain Management
- ✓ Behavioral Health Integration
- ✓ Psychiatric Collaborative Care Model
- ✓ Community Health Integration
- ✓ Principal Illness Navigation
- ✓ Remote Physiologic Monitoring
- ✓ Remote Therapeutic Monitoring
- ✓ Advanced Primary Care Management

Summary Includes:

- ✓ Description
- ✓ Eligible patients
- ✓ Authorized billing providers
- ✓ Examples of auxiliary personnel
- ✓ Service elements
- ✓ Billing codes and rates



Summary of Medicare Care Management Services

See NACHC resource: *Medicare Billing Lingo, Defined!* for definitions of terms used throughout this document.

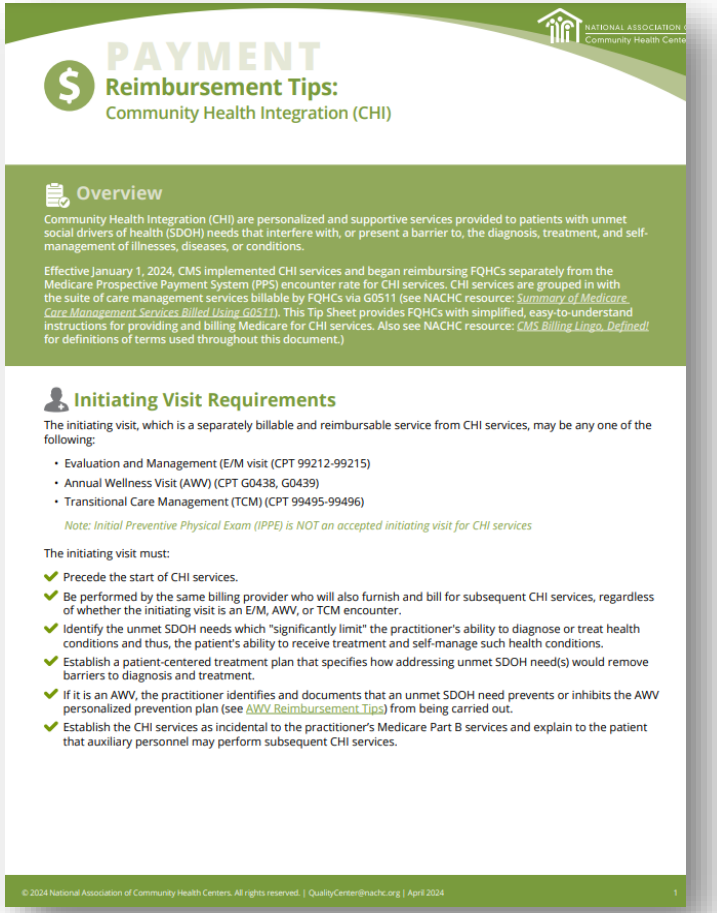
	Chronic Care Management (CCM)	Complex Chronic Care Management (CCCM)	Principal Care Management (PCM)	Advanced Primary Care Management (APCM)	Transitional Care Management (TCM)	Chronic Pain Management (CPM)	Behavioral Health Integration (BHI)	Psychiatric Collaborative Care Model (Psych CoCM)	Community Health Integration (CHI)	Principal Illness Navigation (PIN)	Remote Physiologic Monitoring (RPM)	Remote Therapeutic Monitoring (RTM)
More Information	CCM, CCCM, PCM Reimbursement Tip Sheet			(Coming soon)	TCM Reimbursement Tip Sheet	CPM Reimbursement Tip Sheet	BHI Reimbursement Tip Sheet	Psych CoCM Reimbursement Tip Sheet	CHI Reimbursement Tip Sheet	PIN Reimbursement Tip Sheet	RPM, RTM Reimbursement Tip Sheet	
Description	Personalized and supportive services provided to patients with multiple chronic conditions to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with multiple chronic conditions, who require moderate or high medical decision making, to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with a single complex chronic condition to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive advanced primary care delivery through streamlined, patient-centered care plans, proactive care coordination, and the integration of digital communication tools.	Personalized and supportive services provided to patients who are being discharged from an inpatient hospital setting to a community setting.	Personalized and supportive services provided to patients with chronic pain to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with behavioral health needs to coordinate care and develop a care plan to achieve health goals.	Personalized and supported behavioral health integration services for patients with complex mental and behavioral health disorders and conditions.	Personalized and supportive services provided to patients with unmet social drivers of health (SDOH) needs that interfere with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.	Personalized and supportive services provided to patients with a high-risk condition and healthcare navigation needs.	A patient's use of devices to remotely assess and record physiologic data (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate) outside of the clinical setting, usually in the home.	A patient's use of devices to remotely monitor adherence and response to therapeutic treatment (e.g., respiratory, musculoskeletal) using non-physiologic data outside of the clinical setting, usually in the home.
Eligible Patients	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.	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. Moderate or high complexity medical decision making (MDM) required.	Patients who have: A single, high-risk 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.	Patients who have: Zero, one, or multiple chronic condition(s). The complexity of the patient determines the APCM level: Level 1: One or no chronic condition expected to last at least 12 months or until death, or posing significant risk of death, acute exacerbation, decompensation, or functional decline. Level 2: Two or more chronic conditions meeting the same criteria as Level 1. Level 3: Meets the same criteria as Level 2 AND the patient is a Qualified Medicare Beneficiary.	Patients who have: Been discharged from an inpatient or partial hospitalization setting and require support to return to a community setting (e.g., home, rest home, assisted living). Moderate or high complexity making (MDM) required.	Patients who have: Persistent or recurrent pain lasting longer than 3 months.	Patients who have: One or more new or pre-existing behavioral health or psychiatric conditions, including substance use disorder.	Patients who have: One or more new or pre-existing complex behavioral or mental health conditions, substance abuse disorder. Requires an integrated plan of care management for primary care, behavioral health, and psychiatric inter-specialty consultation.	Patients who have: Unmet SDOH need(s) interfering with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.	Patients who have: One or more high-risk condition(s) expected to last at least 3 months, which place(s) the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, function decline, or death. May or may not have unmet SDOH needs.	Established patients who have: Acute or chronic condition(s) for which the authorized billing provider determines that RPM services are medically necessary.	Patients with an established treatment plan who have: Acute or chronic respiratory, musculoskeletal, or other condition(s) for which the authorized billing provider determines that RTM services are medically necessary.
Billing Providers	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)			• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM) • Clinical Psychologist (CP) • Clinical Social Worker (CSW) • Mental Health Counselor (MHC) • Marriage and Family Therapist (MFT)	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM) • Clinical Psychologist (CP) • Clinical Social Worker (CSW) • Mental Health Counselor (MHC) • Marriage and Family Therapist (MFT)
Auxiliary Personnel (Examples)	• Nurse (nurse care manager, Clinical Nurse Specialist (CNS), RN, LPN) • Social Worker			• Nurse (nurse care manager, Clinical Nurse Specialist (CNS), RN, LPN) • Social Worker	• Nurses (nurse care manager, CNS, RN, LPN) • Social Workers • Mental Health Counselors	*No billable auxiliary personnel services.*	• Nurse (nurse care manager, CNS, RN, LPN) • Social Worker	CoCM services use an interdisciplinary team model: 1. Primary Care provider (MD, DO, NP, PA, CNM) 2. Psychiatric Consultant 3. Behavioral Health Care Manager • Nurse (CNS, RN, LPN) • Clinical Psychologist • Mental Health Counselor • Marriage & Family Therapist • Social Worker	Certified or trained: • Community Health Worker • Nurse (nurse care manager, CNS, RN, LPN) • Social Worker	Certified or trained: • Community Health Worker • Nurse (nurse care manager, CNS, RN, LPN) • Social Worker • Peer support specialists *(use CPT code for PIN-PS (peer support). PIN-PS activities are limited to behavioral health conditions, and do not include clinical care coordination)*	• Nurse (nurse care manager, CNS, RN, LPN) • Medical Assistant • Clinical Pharmacist • Community Health Workers	
Service Elements	Billed once per calendar month after: At least **20 minutes** of services provided by auxiliary personnel. Or At least **30 minutes** of services provided by the authorized billing provider. • 24/7 access to clinical support staff • Continuity of care with designated care team member • Comprehensive assessment of medical, functional, and psychosocial needs • Preventive care • Medication management • A comprehensive care plan created, monitored, revised, and shared with the patient/caregiver and other internal/external members of the patient's care team. • Patient education and resources • Care coordination	Billed once per calendar month after: At least **60 minutes** of services provided by auxiliary personnel and/or authorized billing provider per calendar month.	Billed once per calendar month after: At least **30 minutes** of services provided by auxiliary personnel. Or At least **30 minutes** of services provided by the authorized billing provider.	Billed once per calendar month by authorized billing provider (no minimum time). Primary care-focused, incorporating: • CCM for ongoing management of chronic conditions • TCM to ensure smooth transitions between care settings. • PCM for targeted support of high-risk diseases. Bundles care management services with communication technology-based services (CTBS) such as: • Interprofessional internet consultation for provider collaboration. • Remote evaluation of patient videos/images for virtual assessments. • Virtual check-ins for brief patient-initiated communication. • Online digital E/M (e-Visits) for provider interactions through online platforms. The amount of care is adjusted based on patient needs.	Within a 30-day period, all three (3) components of TCM service must be provided in order to bill: 1. Interactive contact with the patient within 2 business days of discharge to assess post-discharge service needs, confirm medication instructions, and schedule a face-to-face visit with the authorized billing provider. 2. A face-to-face visit to assess the patient and develop a plan to aid the patient's return to the community, including any adjustments to treatments or medication. This visit must occur within the required time frame associated with either a moderate (14 days) or a high (7 days) MDM. 3. Ongoing non-face-to-face care coordination to make sure the post-discharge care elements are aligned and that the patient has access to necessary resources and support.	Billed once per calendar month after at least **30 minutes** of services provided by the authorized billing provider, including: • Administration of a validated pain rating scale or tool • Patient-centered care plan • Patient assessment and monitoring of their diagnosis and treatment • Medication management • Pain and health literacy counseling • Facilitation, coordination, and on-going communication with other necessary providers (e.g., behavioral health, physical and/or occupational therapy, home care) • Facilitation for crisis care for chronic pain	Billed once per calendar month after at least **20 minutes** of services provided by the authorized billing provider or auxiliary personnel (CPT 99484) or by CP, CSW, MHC, or MFT (G0323), including: • Initial assessment and ongoing monitoring using validated clinical rating scales • Behavioral health care planning in relation to behavioral/psychiatric health problems, including time spent modifying plans for patients who are not progressing or whose status changes • Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation • Continuity of care with a designated member of the care team • Coordination with and/or referral to qualified providers for medication, E/M services, counseling and/or psychiatric consultation (G0323)	Initial CoCM Visit: Billed once in the initial calendar month after at least **70 minutes** to establish services delivered by a behavioral health care manager, in consultation with the psychiatric consultant, under the direction of the treating (and billing) primary care provider: • Comprehensive initial assessment to develop a patient-centered care plan • Initiate treatment with care team and provide brief interventions using various evidence-based techniques • Educate patient about the CoCM model and set expectations for care • Identify and connect patient with community resources and with other providers, as needed • Enter and track patient follow-up in registry Subsequent CoCM Services: Billed once per calendar month after at least **60 minutes** of continuing CoCM services performed by a behavioral health manager, in consultation with the psychiatric consultant, under the direction of the treating (and billing) primary care provider. The focus is on monitoring, maintaining, and refining the established plan.	Billed once per calendar month after at least **60 minutes** of services provided by certified or trained auxiliary personnel, including: • Patient-centered assessment • Coordination with home- and community-based resources • Health education • Developing self-advocacy skills • Health care access and navigation • Patient behavioral change facilitation • Facilitate and provide social and emotional patient support	Billed once per calendar month after at least **60 minutes** of services provided by certified or trained auxiliary personnel, including: • Patient-centered assessment (PIN) or interview (PIN-PS) • Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. • Health education • Developing self-advocacy skills • Health care access/health system navigation • Facilitating behavioral change as necessary for meeting diagnosis and treatment goals (PIN only) • Facilitating and providing social and emotional support	Billed once per calendar month after at least **16 days of data** have been collected in a 30-day period. • Initial device set-up and patient education on the use of equipment. • Device supply with scheduled recording(s) and transmissions • The collection, analysis, and interpretation of digitally collected physiologic data. • Management of a patient-centered treatment plan. • CPT services 99457 and 99458 require at least one interactive communication with the patient during the calendar month, 20 minutes of authorized billing provider time. *Note: This is a summary of RPM service elements. Each RPM CPT code includes a unique set of service elements to be provided.*	Billed once per calendar month after at least **16 days of data** have been collected in a 30-day period. • Initial device set-up and patient education on the use of equipment. • Device supply with scheduled recording(s) and transmissions • Review and monitoring of data related to signs, symptoms, and functions of respiratory or musculoskeletal system therapeutic response. • Non-physiologic and therapeutic data can be patient self-reported and/or digitally uploaded. • Management of a patient-centered treatment plan. • CPT services 98980 and 98981 require at least one interactive communication with the patient during the calendar month, 20 minutes of authorized billing provider time. *Note: This is a summary of RTM service elements. Each RTM CPT code include a unique set of service elements to be provided.*
Billing Codes & Rates	• 99490: $ 62.49 • +99439: $ 45.93 • 99491: $ 82.16 • +99437: $ 57.58 OR continue billing G0511 until July 1, 2025	• 99487: $131.65 • +99489: $ 70.52 OR continue billing G0511 until July 1, 2025	• 99424: $ 80.87 • +99425: $ 58.87 • 99426: $ 61.78 • +99427: $ 50.46 OR continue billing G0511 until July 1, 2025	G0556: $15.20 G0557: $48.84 G0558: $107.07	• 99495 - Qualifying FPS service • 99496 - Qualifying FPS service Billed via FPS G0467: $ 202.65	• G3002: $80.22 • +G3003: $29.44 OR continue billing G0511 until July 1, 2025	• 99484: $53.05 • G0323: $53.70 OR continue billing G0511 until July 1, 2025	• 99492: FQHC bills G0512 • 99493: FQHC bills G0512 • G2214: $54.34 or +99484: $55.96 Billed via G0512: $139.41	• G0019: $77.95 • +G0022: $48.52 OR continue billing G0511 until July 1, 2025	• G0023: $77.95 • +G0024: $48.52 • G0140 PIN-PS: $77.95 • +G0146 PIN-PS: $48.52 OR continue billing G0511 until July 1, 2025	• 99453: $19.73 • 99454: $43.02 • 99457: $47.87 • +99458: $38.49 • 99091: $51.57 OR continue billing G0511 until July 1, 2025	• 98975: $19.73 • 98976: $43.02 • 98977: $43.02 • 98980: $53.14 • +98981: $39.14 OR continue billing G0511 until July 1, 2025

Payment rate is based on the 2025 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.

Patients pay 20% coinsurance based upon the lesser of the submitted charges or the local payment rate for care management & PFS services. Coinsurance may be covered in part or in full by secondary coverage (Medigap, private, or Medicaid). Coinsurance may be "slid" commensurate with the sliding fee discount program (SFDP) policy of the health center (see Sliding Coinsurance for CMS/Medicare Care Management for more information).

Summary of Medicare Care Management Services

Reimbursement Tip Sheets



PAYMENT

Reimbursement Tips:

Community Health Integration (CHI)

Overview

Community Health Integration (CHI) are personalized and supportive services provided to patients with unmet social drivers of health (SDOH) needs that interfere with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.

Effective January 1, 2024, CMS implemented CHI services and began reimbursing FQHCs separately from the Medicare Prospective Payment System (PPS) encounter rate for CHI services. CHI services are grouped in with the suite of care management services billable by FQHCs via G0511 (see NACHC resource: *Summary of Medicare Care Management Services Billed Using G0511*). This Tip Sheet provides FQHCs with simplified, easy-to-understand instructions for providing and billing Medicare for CHI services. Also see NACHC resource: *CMS Billing Lingo, Defined!* for definitions of terms used throughout this document.)

Initiating Visit Requirements

The initiating visit, which is a separately billable and reimbursable service from CHI services, may be any one of the following:

- Evaluation and Management (E/M visit (CPT 99212-99215)
- Annual Wellness Visit (AWV) (CPT G0438, G0439)
- Transitional Care Management (TCM) (CPT 99495-99496)

Note: Initial Preventive Physical Exam (IPPE) is NOT an accepted initiating visit for CHI services

The initiating visit must:

- ✔ Precede the start of CHI services.
- ✔ Be performed by the same billing provider who will also furnish and bill for subsequent CHI services, regardless of whether the initiating visit is an E/M, AWV, or TCM encounter.
- ✔ Identify the unmet SDOH needs which "significantly limit" the practitioner's ability to diagnose or treat health conditions and thus, the patient's ability to receive treatment and self-manage such health conditions.
- ✔ Establish a patient-centered treatment plan that specifies how addressing unmet SDOH need(s) would remove barriers to diagnosis and treatment.
- ✔ If it is an AWV, the practitioner identifies and documents that an unmet SDOH need prevents or inhibits the AWV personalized prevention plan (see AWV Reimbursement Tips) from being carried out.
- ✔ Establish the CHI services as incidental to the practitioner's Medicare Part B services and explain to the patient that auxiliary personnel may perform subsequent CHI services.

Reimbursement Tip Sheets:

Detailed guidance

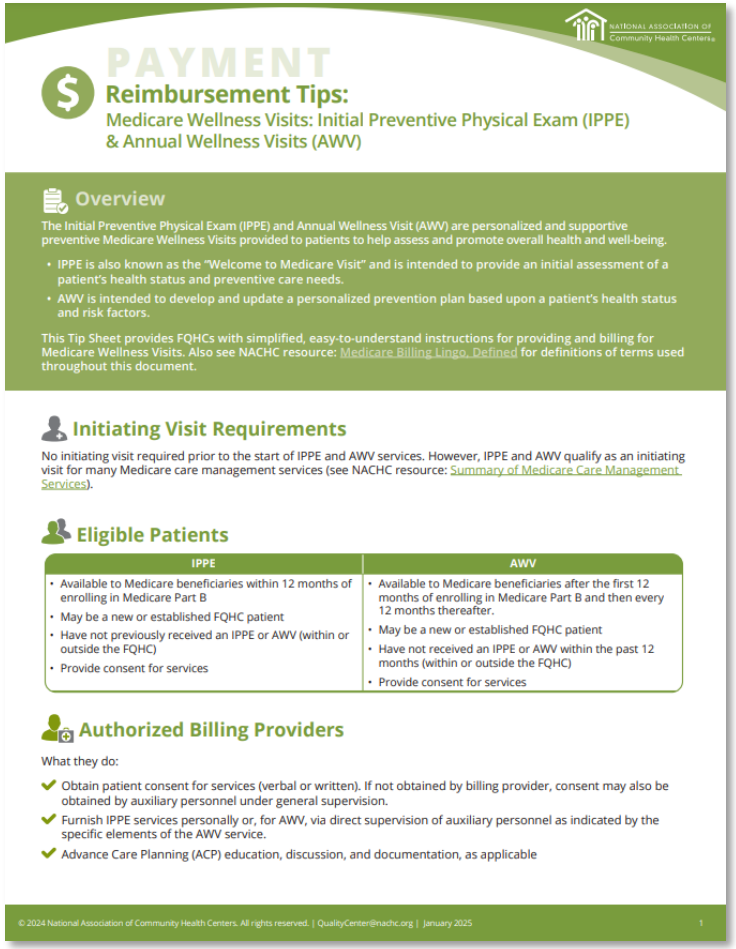
Simplified language

Aligned with 2025 Medicare Physician Fee Schedule Final Rule

Care Management:

- ✓ Chronic Care Management, Complex Chronic Care Management & Principal Care Management
- ✓ Transitional Care Management
- ✓ Chronic Pain Management
- ✓ Behavioral Health Integration
- ✓ Psychiatric Collaborative Care Management
- ✓ Community Health Integration
- ✓ Principal Illness Navigation
- ✓ Remote Physiologic Monitoring & Remote Therapeutic Monitoring
- ✓ **COMING SOON: Advanced Primary Care Management**

Reimbursement Tip Sheets



PAYMENT

Reimbursement Tips:
Medicare Wellness Visits: Initial Preventive Physical Exam (IPPE) & Annual Wellness Visits (AWV)

Overview

The Initial Preventive Physical Exam (IPPE) and Annual Wellness Visit (AWV) are personalized and supportive preventive Medicare Wellness Visits provided to patients to help assess and promote overall health and well-being.

- IPPE is also known as the "Welcome to Medicare Visit" and is intended to provide an initial assessment of a patient's health status and preventive care needs.
- AWV is intended to develop and update a personalized prevention plan based upon a patient's health status and risk factors.

This Tip Sheet provides FQHCs with simplified, easy-to-understand instructions for providing and billing for Medicare Wellness Visits. Also see NACHC resource: Medicare Billing Lingo, Defined for definitions of terms used throughout this document.

Initiating Visit Requirements

No initiating visit required prior to the start of IPPE and AWV services. However, IPPE and AWV qualify as an initiating visit for many Medicare care management services (see NACHC resource: Summary of Medicare Care Management Services).

Eligible Patients

IPPE	AWV
• Available to Medicare beneficiaries within 12 months of enrolling in Medicare Part B • May be a new or established FQHC patient • Have not previously received an IPPE or AWV (within or outside the FQHC) • Provide consent for services	• Available to Medicare beneficiaries after the first 12 months of enrolling in Medicare Part B and then every 12 months thereafter. • May be a new or established FQHC patient • Have not received an IPPE or AWV within the past 12 months (within or outside the FQHC) • Provide consent for services

Authorized Billing Providers

What they do:

- ✔ Obtain patient consent for services (verbal or written). If not obtained by billing provider, consent may also be obtained by auxiliary personnel under general supervision.
- ✔ Furnish IPPE services personally or, for AWV, via direct supervision of auxiliary personnel as indicated by the specific elements of the AWV service.
- ✔ Advance Care Planning (ACP) education, discussion, and documentation, as applicable

Reimbursement Tip Sheets:

Detailed guidance

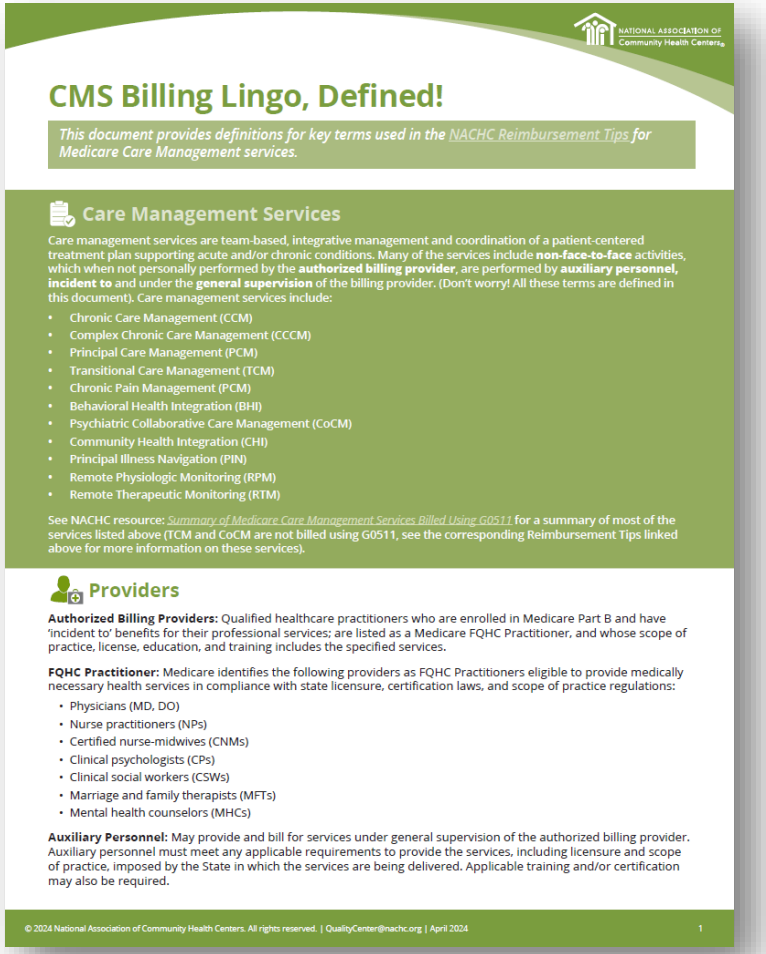
Simplified language

Aligned with 2025 Medicare Physician Fee Schedule Final Rule

Other Reimbursable Medicare Services:

- ✓ Initial Preventive Physical Exam & Annual Wellness Visits
- ✓ Advance Care Planning
- ✓ Diabetes Self-Management Training & Medical Nutritional Therapy
- ✓ Tobacco Cessation
- ✓ Mental Health Telehealth
- ✓ Extended FQHC Telehealth Services
- ✓ Virtual Communication Services

Medicare Billing Lingo, Defined!



CMS Billing Lingo, Defined!

This document provides definitions for key terms used in the NACHC Reimbursement Tips for Medicare Care Management services.

Care Management Services

Care management services are team-based, integrative management and coordination of a patient-centered treatment plan supporting acute and/or chronic conditions. Many of the services include **non-face-to-face** activities, which when not personally performed by the **authorized billing provider**, are performed by **auxiliary personnel, incident to** and under the **general supervision** of the billing provider. (Don't worry! All these terms are defined in this document). Care management services include:

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)
- Principal Care Management (PCM)
- Transitional Care Management (TCM)
- Chronic Pain Management (PCM)
- Behavioral Health Integration (BHI)
- Psychiatric Collaborative Care Management (CoCM)
- Community Health Integration (CHI)
- Principal Illness Navigation (PIN)
- Remote Physiologic Monitoring (RPM)
- Remote Therapeutic Monitoring (RTM)

See NACHC resource: *Summary of Medicare Care Management Services Billed Using G0511* **for a summary of most of the services listed above (TCM and CoCM are not billed using G0511, see the corresponding Reimbursement Tips linked above for more information on these services).**

Providers

Authorized Billing Providers: Qualified healthcare practitioners who are enrolled in Medicare Part B and have 'incident to' benefits for their professional services; are listed as a Medicare FQHC Practitioner, and whose scope of practice, license, education, and training includes the specified services.

FQHC Practitioner: Medicare identifies the following providers as FQHC Practitioners eligible to provide medically necessary health services in compliance with state licensure, certification laws, and scope of practice regulations:

- Physicians (MD, DO)
- Nurse practitioners (NPs)
- Certified nurse-midwives (CNMs)
- Clinical psychologists (CPs)
- Clinical social workers (CSWs)
- Marriage and family therapists (MFTs)
- Mental health counselors (MHCs)

Auxiliary Personnel: May provide and bill for services under general supervision of the authorized billing provider. Auxiliary personnel must meet any applicable requirements to provide the services, including licensure and scope of practice, imposed by the State in which the services are being delivered. Applicable training and/or certification may also be required.

Medicare Billing Lingo, Defined!

Supervision

General Supervision: Services provided by auxiliary personnel under a qualified practitioner's overall direction and control, but the practitioner's physical presence is not required during the performance of the service.

Direct "Incident To" Supervision: Services provided by auxiliary personnel, under a qualified practitioner's direction and control, and the practitioner must be physically present in the office suite, but not in the examination room, and immediately available to furnish assistance. Through December 31, 2024, direct supervision requirements may be met by the immediate availability of the supervising practitioner through real-time audio-visual technology.

Types of Visits

Visit: An FQHC visit must be a medically necessary, face-to-face, interactive medical or mental health or qualified preventive encounter between the FQHC practitioner and patient where one or more qualified FQHC services are provided.

Face-to-Face Services: One or more services furnished during a one-on-one, in-person encounter between a practitioner or as permitted, by auxiliary personnel, and a patient. (A telehealth visit is a substitution for a face-to-face visit.)

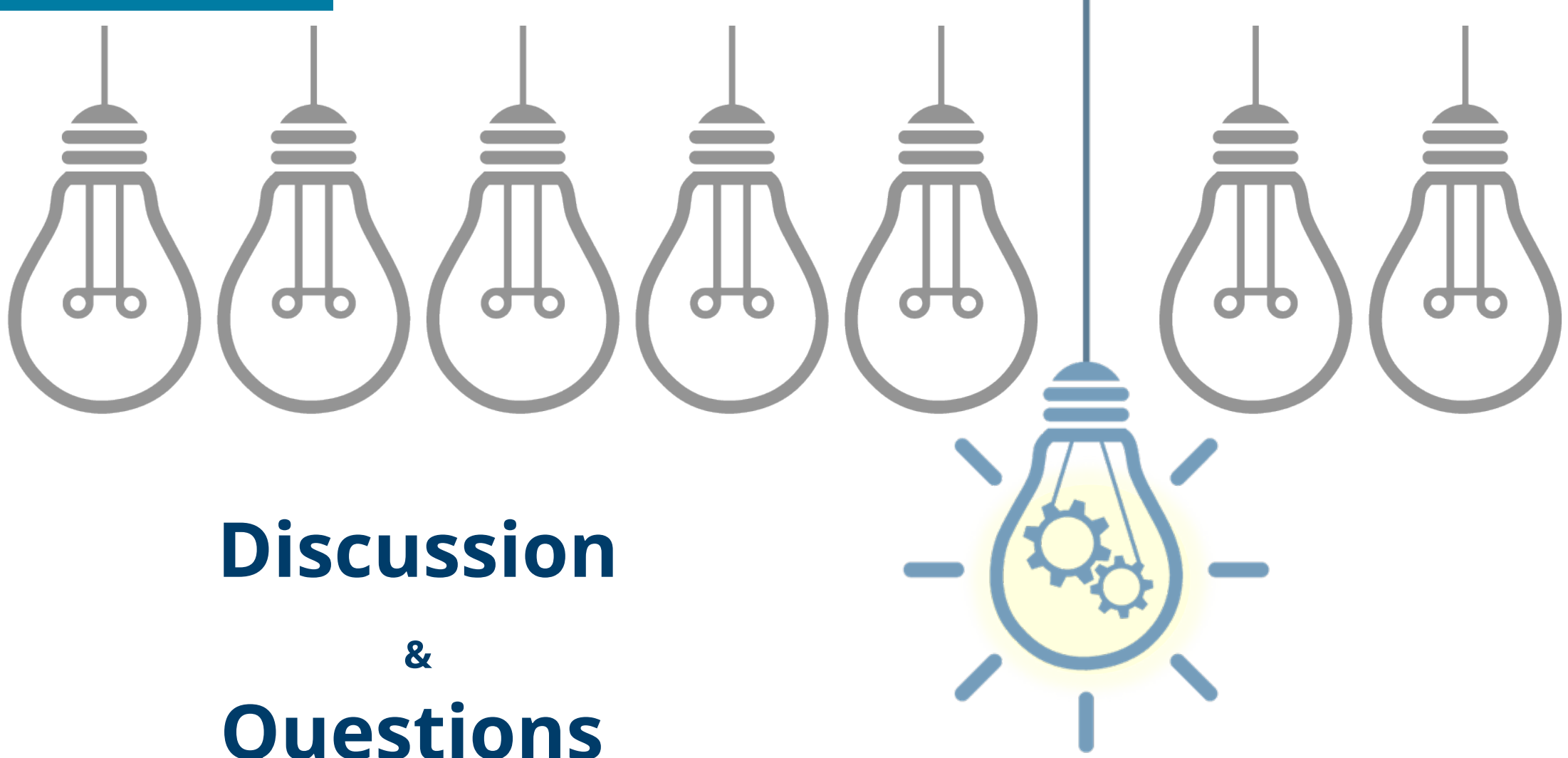
Non-Face-to-Face Services: One or more activities performed with or for a patient by a practitioner or, as permitted, by auxiliary personnel between office visits and as part of an established treatment plan. Examples of non-face-to-face activities may include phone calls, digital communication, questionnaire completion, and care management and coordination.

New Patient: Under Medicare, this is an FQHC patient 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.

Established Patient: Under Medicare, this is an FQHC patient who has received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, within the previous 3 years from the date of service.

Telehealth Visit: Uses interactive audio and video telecommunications technology which permits two-way, real-time communication between the provider and patient. A telehealth visit is a substitution for a face-to-face visit. Flexibilities provided during the COVID-19 Public Health Emergency and extended through December 31, 2024 permit eligible FQHC practitioners to furnish qualified services on the Medicare Telehealth Service List as distant site including from the practitioner's home to a patient located in their home. During this extended period, telephone-only E/M services are included on the approved service list.

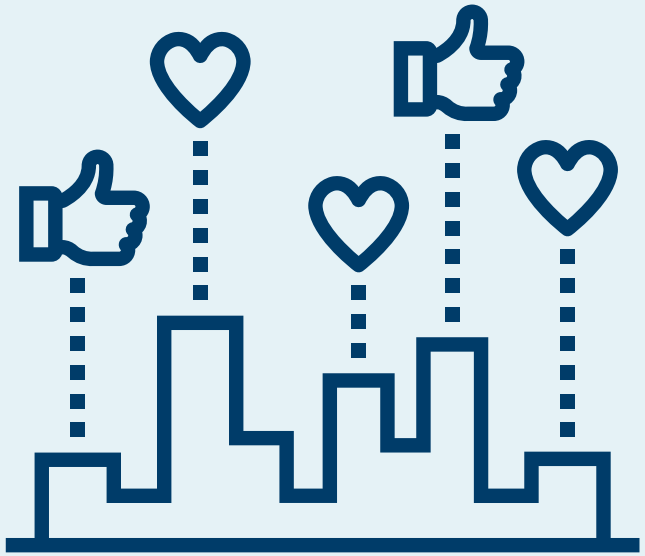
Originating Site: The location of the patient at the time the telehealth service is provided. Through December 31, 2024, the originating site includes the patient's home. Outside the PHE flexibilities and extension, only the FQHC and not the patient's home may be the originating site location for medical telehealth visits.



Discussion

&

Questions



Provide Us Feedback

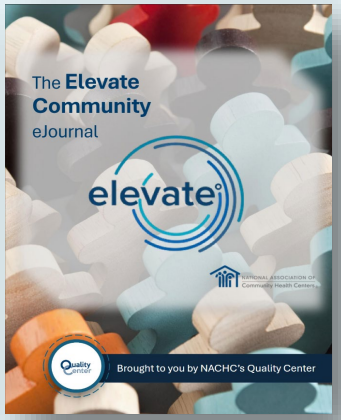
Elevate Communications

NACHC newsletters have been streamlined!

All future Elevate related communications can be found in

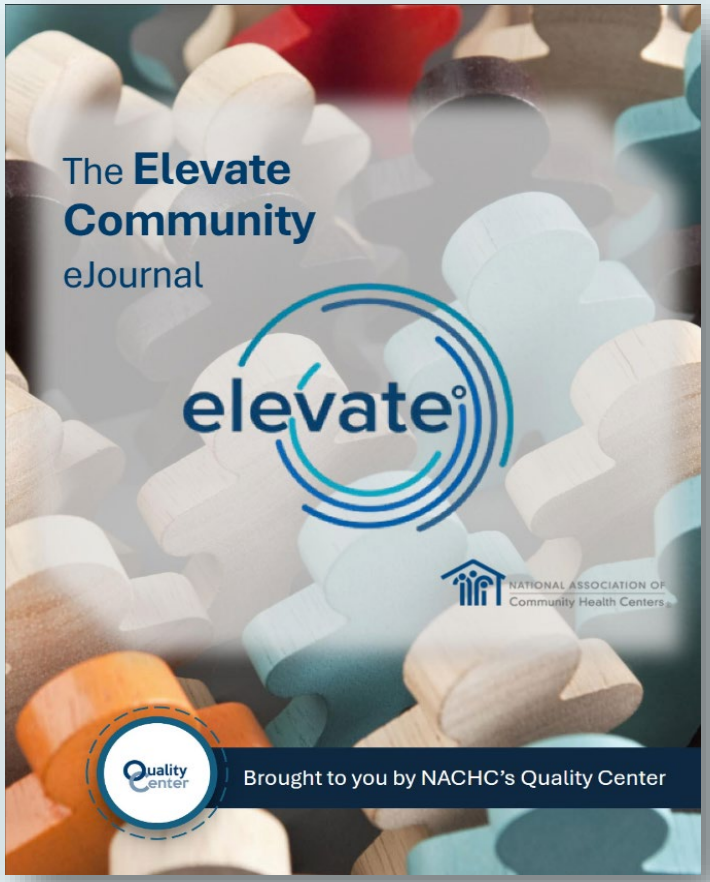
'NACHC News You Need to Know' sent out every Wednesday.

Including the NEW **Elevate Community eJournal**!



(All Elevate registrants have been added to the distribution list.)

Elevate Community eJournal



Includes:

- ✓ Elevate session slides & recordings
- ✓ Helpful resources
- ✓ Audience FAQs

Content will be added for every Elevate Learning Forum.

Bookmark the link for early access to session recordings and more!

Elevate Community eJournal

FOR MORE INFORMATION CONTACT

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Next Monthly Learning Forum:

Workforce: Trauma Informed Culture

elevate

April 8, 2024
1:00 – 2:00 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

elevate°

Together, our voices elevate° all.

The Quality Center Team

Cheryl Modica, Cassie Lindholm, Holly Nicholson, Tristan Wind

qualitycenter@nachc.org