NATIONAL ASSOCIATION OF Community Health Centers®

PAYMENT

Reimbursement Tips:

FQHC Requirements for Medicare Chronic Care Mgmt. (CCM)

The Chronic Care Management (CCM) model of care refers to personalized and supportive services for individuals with multiple (two or more) chronic conditions to coordinate care and develop a care plan to achieve health goals.

Program Requirements

Chronic Care Management (CCM) refers to a comprehensive set of services administered to help a patient coordinate and manage multiple chronic conditions. CCM services are typically provided outside of face-to-face visits. CCM services include:

- Comprehensive assessment
- Comprehensive care plan
- Medication management
- Preventive care
- Care plan sharing
- Care coordination
- Continuity of care
- Care transition management
- 24/7 access
- Resources
- Electronic communication options
- Electronic health record documentation

Patient Eligibility & Consent

Eligible patients include those who have multiple (two or more) chronic 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.

A FQHC provider (i.e., MD, DO, NP, PA, CNM, or CNS) determines if the patient meets the criteria for care management services and if they are likely to benefit from care management services.

CCM may be furnished by auxiliary personnel under general supervision. With general supervision, the billing practitioner provides overall direction and control, but their physical presence is not required during the provision of services.

The patient must provide consent prior to initiating services. 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., s/he will be responsible for co-insurance).

Timeframe & Services

CMS/Medicare covers several types of chronic care management services. These include CCM and complex CCM. These 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. CCM services include:

Non-complex (CPT 99490)	20 mins or more of CCM services in a month (ancillary staff + provider)
Complex (CPT 99487)	60 mins or more of CCM services in a month (ancillary staff + provider)
Provider only (CPT 99491)	30 mins or more of CCM services in a month (provider only)
Additional time (CPT +99489)	Each add'l 30 mins; only added to complex/99487 (ancillary staff + provider)

While the above CPT codes represent the CCM services, FQHCs must **crosswalk the provider-entered CPT code to the billable G0511 code** (see page 2).

CCM 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 must be coordinated with home and community-based providers and include the management of transitions between and among health care providers and settings. (See Transitional Care Management information for reimbursement guidance.) Patients/caregivers are to be offered the ability to communicate with the provider through a variety of electronic communication options, including: secure messaging, internet, and other asynchronous non-face-to-face consultation methods.

CCM 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.

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Initiating Visit

Prior to the start of CCM services, a comprehensive initiating visit is required for new patients or patients not seen within one year. 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 CCM services and is billed separately. While CCM services do not have to be discussed during the initiating visit, this visit must occur during the year (12 months) prior to the start of CCM.

At FQHCs 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

Twenty (20) or more minutes of CCM may be furnished in the calendar month under the direction of (a) a FQHC employed provider (i.e., MD, DO, NP, PA, CNM, CNS), or (b) by clinical personnel under the general supervision of the practitioner. State law, licensure, and scope of practice definitions must be considered for non-primary care service providers.

TREATING (BILLING) PROVIDER				
Physicians (MD or DO)	Non-Physician Practictioners			
	NP	PA	CNM	CNS
x	x	x	x	x

- *Medical Doctor (MD) or Doctor Osteopathy (DO)*
- *Non-Physician Practitioners include: Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Clinical Nurse Specialists (CNS).*

Documentation

Document all CCM services (for 20 or more 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.

CCM 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

A comprehensive initiating visit (e.g., IPPE, AWV, or E/M) within the past 12 months is required before the start of CCM services. 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 service initiation if TCM face-to-face requirements are met.

Time that is counted towards reporting a CCM service code cannot be counted toward any other billed code. For billing, the 20 minutes or more of CCM services 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. Monthly contact with the patient is not necessary to bill for care management services.

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*CMS/ Medicare 2020 Fees*
99490	20 mins or more (non-complex/ancillary staff & provider)	G0511	$66.77
99487	60 mins or more (complex/ ancillary staff & provider)		
99491	30 mins or more (provider only)		

Notes: Rates here are based on the 2020 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.

A 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 CCM 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. 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

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or any date before the last day of the month. Do not report 99491 in the same calendar month as 99487, 99489, or 99490.

Care management costs such as software or management oversight can be included on the cost report. Any cost incurred as a result of the provision of FQHC services, including care management, is a reportable cost and must be included in the Medicare cost report. CCM should be reported on 837-I with revenue code 052x and corresponding HCPCS (e.g., CPT) code.

Checklist/Requirements to bill for CCM	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 CMM 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, 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. 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. 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.		
Care Coordination Services. 20 or more minutes of care coordination services are documented; furnished in the calendar month (a) under the direction of the FQHC employed practitioner (i.e., MD, DO, NP, PA, CNS or CNM), and (b) by a FQHC practitioner, or by clinical personnel under general supervision. 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 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.		

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Checklist/Requirements to bill for CCM	Completed Yes	Missing No
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. This plan includes, but is not limited to, the following elements: • Problem list • Expected outcome and prognosis • Measurable treatment goals • Symptom management • Planned interventions, including responsible individuals • Medication management • 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		
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.		
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 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. Frequently Asked Questions about Physician Billing for Chronic Care Management (CCM) Services. Accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.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