Fact Sheet on FQHCs Billing Medicare for Chronic Care Management and Advance Care Planning

Starting January 1, 2016, FQHCs can bill Medicare for two new services

- Chronic Care Management (CCM)
- Advance Care Planning (ACP)

Chronic Care Management (CCM):

- CCM refers to the non-face-to-face work that providers do to coordinate care for chronically ill patients -- e.g., writing care plans, coordinating with other providers, and being accessible 24 hours a day to patients and other providers.
- In order for an FQHC to be eligible to bill for CCM services, numerous requirements must be met. These include, *but are not limited to*:
  - The patient must have two or more chronic conditions that are expected to last at least 12 months, or until the patient's death.
  - The patient must agree in writing to receive CCM services.
  - The provider can bill for CCM once a month for each patient, as long as he or she provides at least 20 minutes of CCM services during that month.
  - Only one provider may be paid for the CCM service for each patient for a given month.
  - The provider must furnish a comprehensive E&M visit, Annual Wellness Visit, or Initial Preventive Physical Examination (IPPE) to the patient prior to billing the CCM service, and must initiate the CCM service as part of this visit/ exam.
  - The provider must meet a range of other requirements related to the scope of services and Electronic Health Records. A full list of these requirements is available on pages 6-7 of the Medicare CCM Fact Sheet.
- Medicare patients without supplemental insurance will be charged coinsurance for CCM services. Some patients may be surprised to receive a bill for a service that did not involve seeing the provider face-to-face.

Advance Care Planning (ACP):

- Advance Care Planning (ACP) involves discussions between patients and providers about future care decisions that may need to be made, how the beneficiary can let others know about care preferences, and explanation of advance directives; it also may involve the completion of standard forms.
- Beginning January 1, 2016, all FQHCs will be permitted to count ACP service as a stand-alone billable visit. While some non-FQHC providers may be unable to bill for ACP, based on where they are located, all FQHCs will be able to bill for ACP.
- If ACP services furnished on the same day as another billable visit, only one visit will be paid.
- Coinsurance will be applied.

For additional information on these services:

- NACHC is developing trainings to address these and other Medicare issues (e.g., the new cost reporting format) – information coming soon.
- CMS will be releasing sub-regulatory guidance on how to bill for these services. NACHC will send out alerts when this information is available.

Summary prepared by NACHC, November 2015.
For complete information, see the 2016 Medicare Physician Fee Schedule Final Rule