VALUE TRANSFORMATION FRAMEWORK
Action Guide

HEALTH CENTER

INFRASTRUCTURE	CARE DELIVERY	PEOPLE

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CARE MANAGEMENT & VIRTUAL COMMUNICATION SERVICES

WHY
structure care management services to meet CMS reimbursement requirements?

Care management services are an essential population health service 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 has the potential to help fund systems change as health centers transition from a volume to value-based payment model.

CMS allows for the billing of care management services and virtual communication services (not a care management service) by Federally Qualified Health Centers (FQHC) including:

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

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

Care management services are billed within a calendar month, in an addition to the claim 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

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billed in the same month as care management services (e.g., CCM, TCM, BHI, or CoCM) 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. 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 this care. FQHC face-to-face requirements are waived for many care management services (see specific Reimbursement Tips for more details).

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)*	Commercial/ Medicaid Payers & Plans*
Chronic Care Management (CCM)	99490 (20 mins, non-complex; ancillary staff + provider)	G0511	$66.77	99490 = $42.22
	99487 (60 mins, complex; ancillary staff + provider)			99487 = $92.39
	99491 (30 mins; provider only)			99491 = $84.09
	+99489 (each add'l 30 mins; only added to complex/99487)			99489 = $44.75
Transitional Care Management (TCM)	CPT: 99495 (moderate complexity) CPT: 99496 (high complexity)	CPT 99495/ CPT 99496	$187.67 $247.94	99495 = $187.67 99496 = $247.94
General Behavioral Health Integration (BHI)	99484 (20 minutes)	G0511	$66.77	99484 = $48
Psychiatric Collaborative Care Model (CoCM)	99492 (70 mins, initial) 99493 (60 mins, subsequent) +99494 (Each add'l 30 mins)	G0512	$141.83	99492 = $156.99 99493 = $126.31 99494 = $63.88
Virtual Communication Services (VCS)	G2010 (remote evaluation services) G2012 (5 mins; communication technology-based services)	G0071	$24.75*	G2010= $12.27 G2012 = $14.80

Note: Some commercial/Medicaid plans may prefer either the CPT codes or the G-codes for proper billing pending their unique participation rules. Please refer to their billing guidance/manuals for confirmation. For example, though CMS will only pay for 20+ minutes per month of CCM, other carriers may pay for codes with higher time thresholds.

Note: Any code with a "+" before it (called an "add-on code") is reported in addition to the primary code which precedes the add-on code.

*Claims submitted with G0071 on/after March 1, and for the duration of the PHE, will be paid at this new rate instead of the 2020 FFS rate of $13.53

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A comprehensive initiating visit is required before CCM, 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, general BHI, or Psychiatric CoCM.

What provider codes	Services	What FQHC bills to CMS	CMS/Medicare 2020 Fees*
G0402	Initial Preventive Physical Examination (IPPE): initial face-to-face visit during first 12 months of Medicare Part B enrollment.	G0468	$232.77*
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	$232.77* $173.50*

Note: Rates in the coding tables above 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.

Note: $173.50 and $232.77 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/clm104c18.pdf fds
- CMS Medicare Learning Network. Chronic Care Management Services. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
- CMS Chronic Care Management FAQs https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf
- CMS Medicare Learning Network. Transition Care Management Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
- CMS Medicare Learning Network. Behavioral Health Integration Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
- CMS Behavioral Health Integration FAQs https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf
- CMS Medicare Learning Network. Communication Technology Based Services and Payment for RHCs and FQHCs https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10843.pdf
- CMS Virtual Communication Services FAQ's https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf
- CMS Initial Preventive Physical Exam Fact Sheet https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/mps_qri_ippe001a.pdf
- CMS Annual Wellness Visit Fact Sheet https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf
- CMS Frequently Asked Questions on the IPPE and AWV https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/IPPE-AWV-FAQs.pdf
- Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS)". https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf
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- Electronic Code of Federal Regulations https://www.ecfr.gov/cgi-bin/text-idx?SID=33784afa5665f473e5981f0e67d77957&mc=true&node=pt42.2.410&rgn=div5#se42.2.410_126
- 1995 Documentation Guidelines for Evaluation and Management Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
- 1997 Documentation Guidelines for Evaluation and Management Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf