NATIONAL ASSOCIATION OF Community Health Centers®

Action Guide

PAYMENT

CARE MANAGEMENT & VIRTUAL COMMUNICATION SERVICES

WHY

structure care management services to meet CMS* reimbursement requirements?

Care management services are an essential population health activity 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 Prospective Payment System (PPS) encounter rate for medically necessary, allowable care management services. This additional revenue can help fund systems transformation as well as be an important part of a health center's value-based care model.

CMS allows Federally Qualified Health Centers (FQHCs) to separately bill for care management services and virtual communication services (not a care management service), including:

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)
- Principal Care Management (PCM)
- Transitional Care Management (TCM)
- General Behavioral Health Integration (BHI)
- Psychiatric Collaborative Care Model (CoCM)
- Community Health Intervention (CHI)
- Principal Illness Investigation (PIN)
- Remote Physiologic Monitoring (RPM)
- Remote Therapeutic Monitoring (RTM)
- Virtual Communication Services (VCS)

To obtain revenue for care management services that benefit at-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*, is designed to support health centers in this process of establishing and obtaining reimbursement for care management and virtual communication services. Additionally, see the NACHC resource CMS Billing Lingo, Defined! for definitions of terms used throughout this document.

**Centers for Medicare and Medicaid Services (CMS)*

PAYMENT
CARE MANAGEMENT & VIRTUAL COMMUNICATION SERVICES

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

Care management services may be billed once per patient for the same CPT code service, per practitioner, per calendar month; however, G0511 may be billed more than once per patient, per calendar month, for separately identifiable care management services. VCS, which is not a care management service, can be billed in the same month as care management services as long as the requirements of both are separately met. Like a telehealth service, VCS uses digital communication technology, but unlike a telehealth service is not a substitute for an in-person visit. RPM and RTM may not be billed in the same service period but can be billed for in conjuction with other separately identifiable, medically necessary care management services. The CPT codebook provides the criteria for services which may or may not be billed concurrently.

Most care management services are paid under Medicare fee-for-service codes G0511 and G0512. See Summary of Medicare G0511 Care Management Services. TCM services are paid under the PPS encounter rate, which is the same as a FQHC visit. FQHCs may 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. 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 care management services. CMS has waived direct supervision requirements of clinical and auxiliary personnel, allowing for the general supervision of these services incident to the professional services of a physician or other qualified healthcare practitioner. FQHC face-to-face requirements are waived for many care management services (see specific *Reimbursement Tips* for more details).

PAYMENT
CARE MANAGEMENT & VIRTUAL COMMUNICATION SERVICES

Proper documentation of care management services in the electronic record is required in order to bill CMS for allowable services. Refer to the coding manual for full code descriptions and requirements. The following table represents a limited description of the services.

Care Management Services	**FQHC Provider Codes** *(billing maps to CPT codes)*	**What FQHC bills to CMS**	**What CMS pays** *(Physician Fee Schedule)*
Chronic Care Management (CCM)	99490 (First 20 mins, ***non-complex***; clinical staff)	G0511	$71.70
	+99439 (each add'l 20 mins; clinical staff. Only added to ***non-complex***/99490)		
	99491 (30 mins; physician or QHP only)		
	+99437 (each add'l 30 mins; physician or QHP. Only added to non-complex 99491)		
Complex Care Management (CCCM)	99487 (60+ mins, **complex**; clinical staff)	G0511	$71.70
	+99489 (each add'l 30 mins; clinical staff. Only added to **complex**/99487)		
Principal Care Management (PCM)	CPT: 99424 (30 mins, physician or QHP, single high-risk disease) CPT: +99425 (each add'l 30 min; physician or QHP) CPT: 99426 (30 mins, clinical staff directed by physician or QHP, single high-risk disease) CPT: +99427 (each add'l 30 mins; clinical staff directed by physician or QHP)	G0511	$71.70
Chronic Pain Management (CPM)	G3002 (30 mins, physician or QHP) +G3003 (each add'l 15 mins; physician or QHP)	G0511	$71.70
Transitional Care Management (TCM)	CPT: 99495 (Face-to-face visit within 14 days of discharge, moderate complexity) CPT: 99496 (Face-to-face visit within 7 days of discharge, high complexity)	G0467	$195.99 $95.27, if telehealth (bill using G2025)
General Behavioral Health Integration (BHI)	99484 (20 minutes, clinical staff time directed by physician or QHP) G0323 (BHI, clinical psychologist, clinical social worker, mental health counselor, marriage and family therapist)	G0511	$71.70
Psychiatric Collaborative Care Model (CoCM)	99492 (70 mins, initial) 99493 (60 mins, subsequent) G2214 (CPT +99494: 30 mins, initial/subsequent)	G0512 (for 70 min initial; 60 min subsequent)	$144.05
Virtual Communication Services (VCS)	G2010 (remote evaluation services) G2012 (5 mins; communication technology-based services)	G0071	$13.10

PAYMENT
CARE MANAGEMENT & VIRTUAL COMMUNICATION SERVICES

Care Management Services	FQHC Provider Codes *(billing maps to CPT codes)*	What FQHC bills to CMS	What CMS pays *(Physician Fee Schedule)*
Community Health Integration (CHI)	G0019 (60 mins, CHW or other auxiliary personnel, activities addressing unmet SDOH needs) +G0022 (each add'l 30 mins, CHW or other auxiliary personnel)	G0511	$71.70
Principal Illness Navigation (PIN)	G0023 (60 mins, certified or trained auxiliary personnel, PIN activities) +G0024 (each add'l 30 mins, auxiliary personnel, PIN activities) G0140 PIN-PS (60 mins, peer support by certified or trained auxiliary personnel, PIN activities) +G0146 PIN-PS (each add'l 30 mins, auxiliary personnel, PIN activities)	G0511	$71.70
Remote Physiologic Monitoring (RPM)	99453 (RPM, initial set-up and patient education on equipment) 99454 (RPM, supply of device with daily recordings, each 30 days) 99457 (First 20 mins, remote physiologic treatment management, interactive communication with patient) +99458 (each add'l 30 mins, remote physiologic treatment management) 99091 (30 mins, collection and interpretation of physiologic data)	G0511	$71.70
Remote Therapeutic Monitoring (RTM)	98975 (RTM, initial set-up and patient education on equipment) 98976 (RTM, supply of device with scheduled recordings for respiratory system monitoring, each 30 days) 98977 (RTM, supply of device with scheduled recordings for musculoskeletal system monitoring each 30 days) 98980 (First 20 mins, RTM treatment management services, interactive communication with patient) +98981 (each add'l 30 mins, RTM treatment management)	G0511	$71.70

Rates are from the CY2024 CMS Physician Fee Schedule. This is a national fee schedule and may not reflect the actual payments from Commercial payers.

Note: CMS does not include CPT©98978, device(s) supply with scheduled recording(s) and/or programmed alert transmissions, to monitor cognitive behavioral therapy as one of the FQHC RTM billable services.

*Once the minimum CPT service time threshold is reached, FQHCs are expected to continue providing services, as applicable, during the calendar month and are **not permitted to bill for any additional time via add-on service codes.** Add-on service codes are denoted in this chart with a plus (+) symbol.*

PAYMENT
CARE MANAGEMENT & VIRTUAL COMMUNICATION SERVICES

A comprehensive initiating visit is required before CCM, CCCM, PCM, BHI, CHI, PIN or CoCM services can be provided. Initiating visits may include: Initial Preventive Physical Examination (IPPE), Annual Wellness Visit (AWV), or Evaluation and Management service (E/M). What qualifies as an initiating visit may vary by program and provider type, so please refer to the individual Reimbursement Tips for details. 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, CCCM, PCM, CHI, PIN, general BHI, or Psychiatric CoCM.

What provider codes	Services	What FQHC bills to CMS	CMS/Medicare 2024 Fees*
G0402	Initial Preventive Physical Examination (IPPE): initial face-to-face visit during first 12 months of Medicare Part B enrollment.	G0468	$262.94*
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	$262.94* $195.99*

Note: Rates in the coding tables above are based on the 2024 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: $195.99 and $262.94 are the FQHC unadjusted CMS PPS rate ceilings for established and new patients, respectively. FQHCs are paid either their PPS G Code charge or their local fees; whichever is less.

References:

- *American Medical Association, CPT® 2024 Professional Edition*
- CMS Benefits Policy Manual Chapter 18 Preventive and Screening Services https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf
- CMS Medicare Learning Network. Chronic Care Management Services. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.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 Medicare Wellness Visits https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html
- 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
- CMS Medicare Learning Network. Evaluation and Management Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf
- 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
- Update to the FQHC PPS for CY 2024 – Recurring File Update https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2023-transmittals/r12267cp
- CMS COVID_19 PHE FQHC New & Expanded Flexibilities https://www.cms.gov/files/document/se20016-new-expanded-flexibilities-rhcs-fqhcs-during-covid-19-phe.pdf