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.

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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.

Distant Site: The location of the provider furnishing services via telehealth to a patient. FQHCs may serve as a distant site through December 31, 2024. The practitioner may furnish telehealth services from home. Outside the PHE flexibilities and extension, the FQHC may not serve as a distant site telehealth provider.

Mental Health Telehealth: The CMS definition of a mental health visit expanded from being a face-to-face encounter between a practitioner and patient to include the use of interactive, real-time audio and video telecommunications technology or, audio-only technology. Audio-only technology can only be used when a patient does not consent to or does not have access to audio-visual technology. The FQHC may furnish qualifying mental health services as a distant site to patients located in their homes. Through December 31, 2024 any in-person visit requirements have been waived.

Payment

Prospective Payment System: Medicare reimburses FQHCs under the Prospective Payment System (PPS). PPS is a payment methodology for reimbursing qualifying visit services at a predetermined encounter rate.

PPS Encounter rate: CMS establishes a national FQHC PPS encounter rate to which a geographic adjustment factor (GAF) is applied to calculate the local FQHC PPS rate. The GAF may lower or raise the PPS rate at the local level. FQHCs receive an additional rate adjustment of 34.16% for new, Initial Preventive Physical Exam (IPPE), and Annual Wellness Visit (AWV) services. Medicare reimburses FQHCs at 80% of the lesser of the FQHC charges or the local FQHC PPS rate.

PPS Qualifying Visit: CMS requires FQHCs to bill PPS encounters using specific HCPCS payment codes for medical, mental health, and preventive care visits. Under each HCPCS payment code is a list of services, in the form of CPT service codes, known as qualifying visits. One of the qualifying visit services must be included on a claim in order for the encounter to qualify as a billable FQHC visit. When reporting G0511 and G0512 services, a qualifying visit code is not also required.

Physician Fee Schedule-based Payment: Payment for G0511 care management services is based upon the weighted average of care management base service and add-on code pairs using the national Physician Fee Schedule (PFS) rates. G0512 is reimbursed at the average national PFS rate. G0511 and G0512 services are reimbursed to FQHCs separate from the PPS encounter services and rates.

Coinsurance: When patient cost share for an encounter applies to an FQHC service, it is usually in the form of coinsurance. The coinsurance is 20% the lesser of the FQHC charges or the PPS rate for the services. Coinsurance applies to PPS services, distant site telehealth services (G2025), G0511 and G0512 care management services, but is waived for certain preventive services, including those provided using telehealth technology (G2025), under the Affordable Care Act (i.e., IPPE, AWV).

Deductible: The Medicare Part B deductible does not apply to costs for FQHC-covered services, including care management and virtual communication services. A deductible does apply to originating site telehealth services.

References

- AMA. 2024 CPT 2024 Codebook
- AAPC. 2024 HCPCS Level II Codebook
- CMS. CY 2024 Physician Fee Schedule Final Rule https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other
- CMS. Benefits Policy Manual, Chapter 13 https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c13.pdf
- CMS. Medicare Claims Processing Manual, Chapter 9 https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c09.pdf
- Specific Payment Codes for FQHC PPS https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf