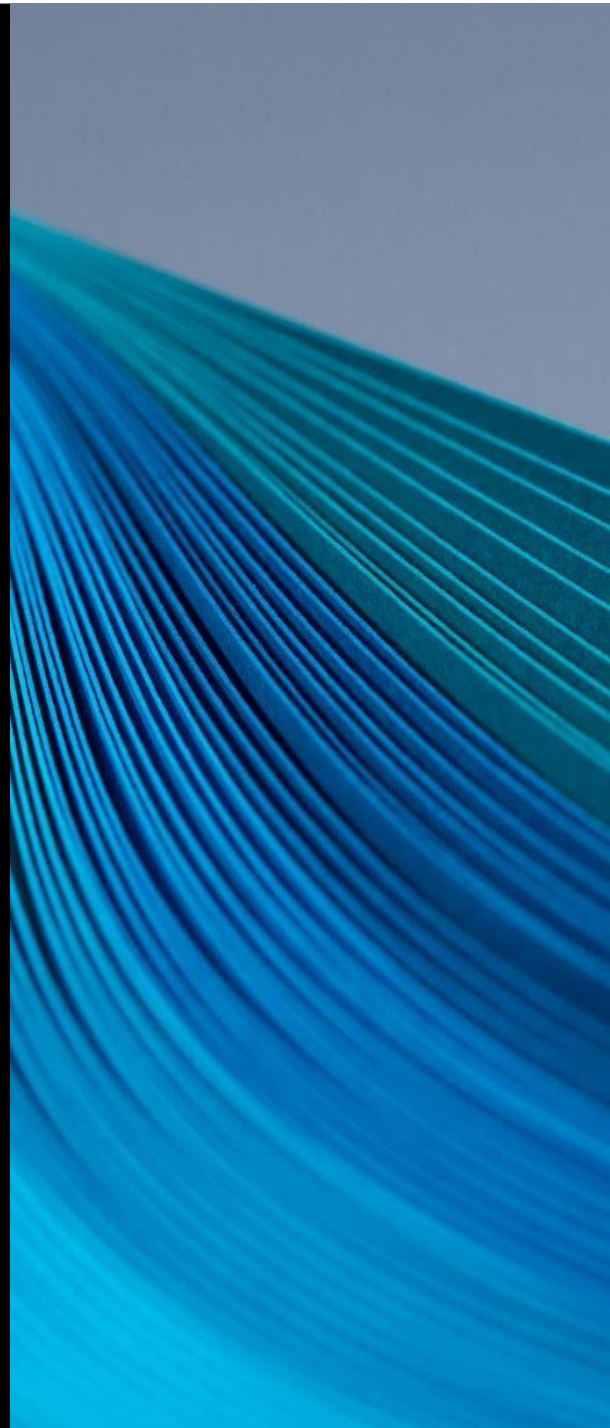
Care Management Services for RHCs 2023



Coordination of Care Services

Care management services are RHC and FQHC services and include:

- ✓ Transitional Care Management (TCM),
- ✓ Chronic Care Management (CCM),
- ✓ Principal Care Management (PCM),
- ✓ General Behavioral Health Integration (BHI),
- ✓ Psychiatric Collaborative Care Model (CoCM) services.

The RHC and FQHC face-to-face requirements are waived for these care management services.

Care Management

Care management services furnished by auxiliary personnel may be furnished under general supervision. (Note: General supervision does not require the RHC or FQHC practitioner to be in the same building or immediately available, but it does require the services to be furnished under the overall supervision and control of the RHC or FQHC practitioner.)

Care Management Payments

Except for TCM services, care management services are paid separately from the RHC AIR or FQHC PPS payment methodology.

RHCs and FQHCs may not bill for care management services for a beneficiary if another practitioner or facility has already billed for care management services for the same beneficiary during the same time period.

TCM and Care Management

- ✓ RHCs and FQHCs may bill for care management and TCM services and other care management services (outside of the RHC AIR or FQHC PPS payment), for the same beneficiary during the same time period.
- ✓ Coinsurance and deductibles are applied as applicable to RHC claims, and coinsurance is applied as applicable to FQHC claims.

Transitional Care Management

TCM services must be furnished within 30 days of the date of the patient's discharge from a hospital, (including outpatient observation or partial hospitalization), SNF, or community mental health center.

TCM Patient Communication

Communication (direct contact, telephone, or electronic) with the patient or caregiver must commence within 2 business days of discharge, and a face-to-face visit must occur within 14 days of discharge for moderate complexity decision making (99495),or within 7 days of discharge for high complexity decision making (99496).

TCM Patient Visit

The TCM visit is billed on the day that the TCM visit takes place, and only one TCM visit may be paid per beneficiary for services furnished during that 30-day post-discharge period.

TCM Visit Payment

TCM services are billed by adding CPT code 99495 or CPT code 99496 to an RHC or FQHC claim, either alone or with other payable services. If it is the only medical service provided on that day with an RHC or FQHC practitioner, it is paid as a stand-alone billable visit. If it is furnished on the same day as another visit, only one visit is paid.

General Care Management for RHCs

General Care Management Services include: Chronic Care Management (CCM), Principal Care Management (PCM), Chronic Pain Management (CPM) and general Behavioral Health Integration (BHI) services.

Comprehensive Care Management

Comprehensive Care Management

- ✓ Systematic assessment of the patient's medical, functional, and psychosocial needs
- ✓ System-based approaches to ensure timely receipt of all recommended preventive care services
- ✓ Medication reconciliation with review of adherence and potential interactions
- ✓ Oversight of patient self-management of medications
- ✓ Coordinating care with home- and community-based clinical service providers

Care Management Service Requirements

- ✓ Structured recording of patient health information using Certified EHR.
- ✓ 24/7 access to physicians or other qualified health care professionals or clinical staff.
- ✓ Comprehensive care management including systematic assessment of the patient's medical, functional, and psychosocial needs.
- ✓ ***Comprehensive care plan***
- ✓ Care plan information made available electronically (including fax) in a timely manner within and outside the RHC or FQHC.
- ✓ Management of care transitions between and among health care providers and settings, including referrals to other clinicians.
- ✓ Coordination with home- and community-based clinical service providers.
- ✓ Enhanced opportunities to communicate through telephone access, secure messaging, Internet, or other asynchronous non-face-to-face consultation methods (patient portal).

ComprehensiveCare Plan

Comprehensive Care Plan

A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and identification of the individuals responsible for each intervention
- Medication management
- Community/social services ordered
- A description of how services of agencies and specialists outside the practice are directed/coordinated
- Schedule for periodic review and, when applicable, revision of the care plan

A person-centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues, with particular focus on the chronic conditions being managed).

Coordination of Care Services: Initiating Visit

A separately billable initiating visit with an RHC or FQHC primary care practitioner (physician, NP, PA, or CNM) is required before care management services can be furnished.

This visit can be an E/M, AWV, or IPPE visit, and must occur no more than one-year prior to commencing care management services.

Initiating Visit Discussion

Care management services do not need to have been discussed during the initiating visit, and the same initiating visit can be used for CCM, PCM, CPM and general BHI services as long as it occurs with an RHC or FQHC primary care practitioner within one year of commencement of care management services.

Beneficiary Consent

Beneficiary consent to receive care management services must be obtained either by or under the direct supervision of the RHC or FQHC primary care practitioner, may be written or verbal and must be documented in the patient's medical record before CCM, PCM, CPM or general BHI services are furnished.

Beneficiary Consent

The medical record should document that the beneficiary has been informed about the availability of care management services, has given permission to consult with relevant specialists as needed, and has been informed of all of the following:

- There may be cost-sharing (e.g. deductible and coinsurance in RHCs, and coinsurance in FQHCs) for both in-person and non-face-to-face services that are provided;
- Only one practitioner/facility can furnish and be paid for these services during a calendar month; and
- They can stop care management services at any time, effective at the end of the calendar month.

Beneficiary Consent

Beneficiary consent remains in effect unless the beneficiary opts out of receiving care management services. If the beneficiary chooses to resume care management services after opting out, beneficiary consent is required before care management services can resume. If the beneficiary has not opted out of care management services but there has been a period where no care management services were furnished, a new beneficiary consent is not required.

Chronic Care Management Requirements

230.2.1 – Chronic Care Management Services

CCM services may be furnished to patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Principal Care Management Requirements

230.2.2 – Principal Care Management Services

Effective January 1, 2021, RHCs and FQHCs are paid for PCM services when a minimum of 30 minutes of qualifying PCM services are furnished during a calendar month. PCM services may be furnished to patients with a single high-risk or complex condition that is expected to last at least 3 months and may have led to a recent hospitalization, and/or placed the patient at significant risk of death.

Principal Care Management Requirements

PCM service requirements include:

- A single complex chronic condition lasting at least 3 months, which is the focus of the care plan;
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization;
- The condition requires development or revision of disease-specific care plan;
- The condition requires frequent adjustments in the medication regiment; and
- The condition is unusually complex due to comorbidities.

Chronic Pain Management

230.2.3– Chronic Pain Management (CPM) Services

Effective January 1, 2023, RHCs and FQHCs are paid for CPM services when a minimum of 30 minutes of qualifying non-face-to-face CPM services are furnished during a calendar month. CPM services may be furnished to patients with multiple chronic conditions that involve chronic pain, and may include a person-centered plan of care, care coordination, medication management, and other aspects of pain care.

General Behavioral Health Integration

230.2.4– General Behavioral Health Integration (BHI) Services

A minimum of 20 minutes of qualifying general BHI services during a calendar month is furnished to patients with one or more new or pre-existing behavioral health or psychiatric conditions being treated by the RHC or FQHC primary care practitioner, *including substance use disorders*, that, in the clinical judgment of the RHC or FQHC primary care practitioner, warrants BHI services.

G0511 Payments

CCM, PCM, CPM or general BHI services furnished on or after January 1, 2023 are paid at the average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99484, 99491, 99424 and 99426.

G0511: General Care Management Payment

G0511: General Care Management Services

- ✓ billed alone or with other payable services on a RHC or FQHC claim.
- ✓ This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period.
- ✓ **The *current* 2023 *payment rate is* $$77.94.**
- ✓ The rate is updated annually based on the PFS amounts and coinsurance applies.

G0511 Patient Eligibility

Option A: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, OR

Option B: Any behavioral health or psychiatric condition being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services.

G0511: BHI Service Requirements

Option B Requirements

- ✓ Initial assessment or follow-up monitoring, including the use of applicable validated rating scales.
- ✓ Behavioral health care planning in relation to behavioral/psychiatric health problems.
- ✓ including revision for patients who are not progressing or whose status changes.
- ✓ Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation).
- ✓ Continuity of care with a designated member of the care team.

Psychiatric Coordination of Care:

230.3 – Psychiatric Collaborative Care Model (CoCM) Services

Psychiatric CoCM is a specific model of care provided by a primary care team consisting of a primary care provider and a health care manager who work in collaboration with a psychiatric consultant to integrate primary health care services with care management support for patients receiving behavioral health treatment.

Psychiatric Coordination of Care Billing Requirements

Billing Requirements: At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of Psychiatric CoCM services, furnished:

a. under the direction of the RHC or FQHC practitioner, and

b. by an RHC or FQHC practitioner or Behavioral Health Care Manager under general supervision.

G0512 Payment

Psychiatric CoCM are paid at the average of the national non-facility PFS payment rate for CPT codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT code 99493 (60 minutes or more of subsequent psychiatric CoCM services)

G0512: Psychiatric Coordination of Care Management

G0512: Psychiatric Coordination of Care Management

- ✓ billed alone or with other payable services on a RHC or FQHC claim.
- ✓ This code could only be billed once per month per beneficiary and could not be billed if other care management services are billed for the same time period.
- ✓ The CY 2023 rate for G0512 is $147.07.

G0512: Practitioner Requirements

RHC/FQHC Practitioner (Physician, NP, PA, or CNM) who:

- ✓ Directs the behavioral health care manager or clinical staff.
- ✓ Oversees the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.
- ✓ Remains involved through ongoing oversight, management, collaboration and reassessment.

G0512: Behavioral Health Care Manager

The behavioral health care manager is a designated individual with formal education or specialized training in behavioral health, including social work, nursing, or psychology, and has a minimum of a bachelor's degree in a behavioral health field (such as in clinical social work or psychology), or is a clinician with behavioral health training, including RNs and LPNs."

G0512: Behavioral Health Care Manager

"The behavioral health care manager furnishes both face-to-face and non-face-to-face services under the general supervision of the RHC or FQHC practitioner and may be employed by or working under contract to the RHC or FQHC."

G0512: Behavioral Health Care Manager

- ✓ Provides assessment and care management services, including the administration of validated rating scales;
- ✓ Provides behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- ✓ provision of brief psychosocial interventions;

G0512: Behavioral Health Care Manager

- ✓ Collaborates with the RHC or FQHC practitioner;
- ✓ Maintains a registry that tracks patient follow-up and progress;
- ✓ Acts in consultation with the psychiatric consultant
- ✓ Is available to provide services face- to-face with the beneficiary;
- ✓ has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team.

G0512: Psychiatric Consultant

- ✓ Participates in regular reviews of the clinical status of patients receiving CoCM services;
- ✓ Advises the RHC or FQHC practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing;

G0512: Psychiatric Consultant

- ✓ Manages any negative interactions between beneficiaries' behavioral health and medical treatments.
- ✓ Facilitates referral for direct provision of psychiatric care when clinically indicated.

Care Management Claim Example

CoCM Service - No Other Services to Report

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Psychiatric CoCM	G0512	10/01/2023	1	$170.00
0001	Total Charge				$170.00

Care Management Services Fact Sheet

Care Management Services Fact Sheet. Centers for Medicare and Medicaid Services.

ICN MLN909188. July 2019. Accessed 12/18/2022.

RHC - CMS Resources

Medicare Benefit Policy Manual – Chapter 13 RHC/FQHC
www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

Medicare Claims Processing Manual UB04 Completion
www.cms.gov/manuals/downloads/clm104c25.pdf

Medicare Benefit Policy Manual- Chapter 15 Other Services
www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

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