



Providing and Billing Medicare for Chronic Care Management Services

(and Other Fee-For-Service Population Health Management Services)

Updated March 2018



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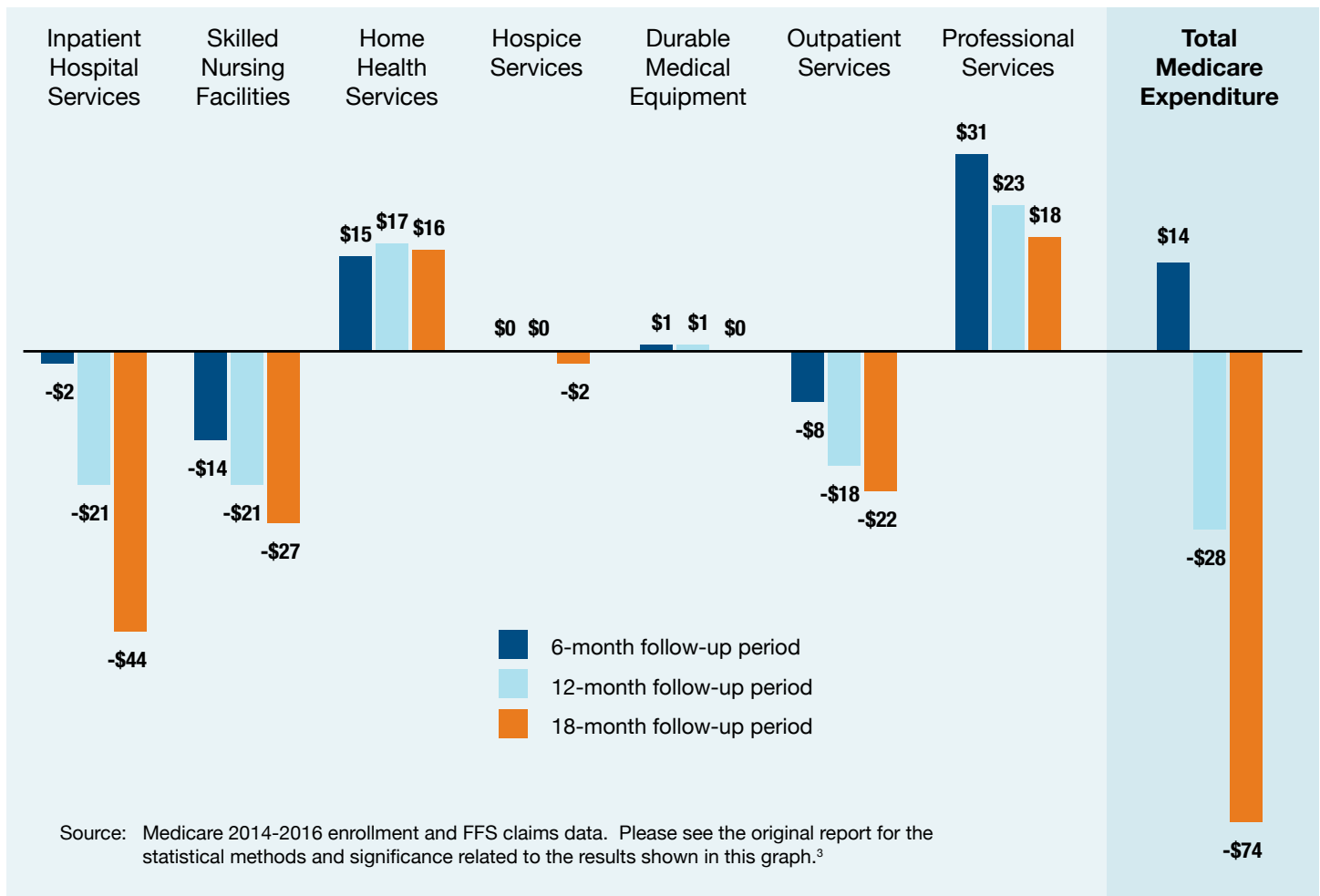
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January 2018 Update

Medicare began reimbursing physicians for chronic care management (CCM) services in January 2015 under CPT® 99490¹ in response to anecdotal evidence that care management services reduce the total costs of care and improve patient outcomes.

The Centers for Medicare & Medicaid Services' (CMS) evaluation contractor, Mathematica, recently published its analysis,² of CCM's impact on Medicare spending from 2014 to 2016. The results are impressive: per-beneficiary-per-month (PBPM) expenditures **decreased by \$74** for CCM beneficiaries after 18 months. Most of these savings were realized in inpatient and post-acute care, while Medicare payments to physicians actually increased.

Estimated PBPM impact of CCM on total expenditures and by expenditure category: follow-up periods of 6,12, and 18 months



1 Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association.

2 Schurrer, J. et al. *Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report*. November 2, 2017. Mathematica Policy Research.

3 *Ibid.*

These results make a compelling case for CCM for providers engaged in shared savings arrangements and those otherwise preparing for a post-fee-for-service world.

Initially, complicated CCM billing rules promulgated by CMS discouraged physicians from providing these services. Although two-thirds of traditional Medicare beneficiaries – about 35-million individuals – suffer from multiple chronic conditions, only 684,000 beneficiaries had received CCM services through the end of 2016.

For this reason, CMS significantly simplified CCM billing rules, effective January 1, 2017, and began paying for additional types of ambulatory care management services, including complex CCM and care plan development. The response to CMS' changes for 2017 were well-received, and thus, CMS made few changes to CCM policies effective January 1, 2018.

Most notably, beginning in 2018, CMS implemented exclusive codes and payment for care management services delivered at rural health clinics (RHC) and federally qualified health centers (FQHC) to address these facilities' unique circumstances. We have added a section to our white paper to address these changes for RHCs and FQHCs.

To help providers understand the rules for billing CCM, complex CCM, and care plan development, we have condensed the regulations and related agency guidance (*i.e.*, webinar presentations, FAQs, and Medicare Learning Network fact sheets) into the following summary.

In addition, PYA has released an updated “Chronic Care Management Clinical Services Manual” that reflects new 2018 CCM billing rules and offers guidance to providers developing and implementing compliant CCM programs. For more information about the manual, contact Martie Ross at PYA, (800) 270-9629.

Section One: Chronic Care Management (CPT® 99490)

Potential Revenue

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| What is the Medicare reimbursement for CCM? | As of January 1, 2018, the national average payment rates for CPT® 99490 are \$42.84 (non-facility) and \$32.76 (facility). |
| Does CCM qualify as a preventive service exempt from beneficiary cost sharing? | No. CMS determined it does not have the statutory authority to exempt CCM from cost-sharing requirements. A beneficiary will be responsible for any co-payments or deductible amounts. If a beneficiary has a Medicare Supplemental Insurance (MediGap) policy, these amounts will be covered in the same manner as co-payments and deductibles for regular office visits and other Part B services. |
| Will Medicare Advantage (MA) plans reimburse for CCM? Commercial payers? | <p>An MA plan must offer its enrollees at least traditional Medicare benefits, which now will include CCM. Many MA plans are paying for CCM in the same manner as they now pay for other physician services. Some MA plans, however, are not paying for CCM, claiming the plan itself is providing care management services directly to beneficiaries.</p> <p>Whether other commercial payers will pay for CCM remains to be seen, although the fact CMS is paying for this service makes it more likely.</p> |
| Are there other financial benefits associated with developing a CCM program? | <p>In addition to direct revenue, CCM offers practitioners a bridge over the chasm between fee-for-service and value-based reimbursement. By developing and implementing a CCM program, a practitioner will grow skill sets and internal processes critical to population health management, all the while receiving fee-for-service payment to support those activities.</p> <p>For providers now participating in Medicare alternative payment models (shared savings, episodic payments), new research demonstrates that CCM contributes to reducing total cost of care.⁴</p> |

4 Schurrer, J. et al. *Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report*. November 2, 2017. Mathematica Policy Research.

Eligible Practitioners

Which practitioners are eligible to bill Medicare for CCM?

Physicians (regardless of specialty), advanced practice registered nurses, physician assistants, clinical nurse specialists, and certified nurse midwives (or the provider to which such individual has reassigned his/her billing rights) are eligible to bill Medicare for CCM. Other non-physician practitioners and limited-license practitioners (e.g., clinical psychologists, social workers) are not eligible.

Can more than one practitioner bill for CCM for the same beneficiary for the same calendar month?

No. CMS will pay only one claim for CCM per beneficiary per calendar month. CMS has not stated how competing claims will be resolved, but presumably the practitioner with the most recent valid written consent will receive payment.

Must a practice be recognized as a patient-centered medical home (PCMH) to provide CCM?

At one point, CMS proposed PCMH recognition as a condition to provide CCM, but the final regulations do not include this requirement. Instead, CMS requires a practice to have five specific capabilities listed in the regulations. Each of these capabilities is discussed in detail later.

That said, the transformation to PCMH should position a practice to successfully provide CCM. Also, many commercial payers offer financial incentives for PCMH-recognized practices.

There are at least four accreditation organizations that have established specific standards and are offering formal recognition for PCMH practices: National Committee on Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAHC), Joint Commission, and URAC (formerly known as the Utilization Review Accreditation Commission).

Eligible Practitioners continued

Are there specific services the billing practitioner must furnish to a beneficiary as a prerequisite to providing CCM for that beneficiary?

If the practitioner has not seen the beneficiary in the last 12 months (or if the beneficiary is a new patient), the billing practitioner must discuss CCM with the beneficiary as part of a face-to-face visit (e.g., regular office visit, annual wellness visit [AWV], or initial preventive physical exam [IPPE]) prior to billing for CCM for that beneficiary. The face-to-face visit is not a component of the CCM service, and thus may be billed separately.

An initiating visit is not required for the practitioner to begin billing for CCM services as long as he or she (1) has beneficiary consent and (2) has seen the patient within the last 12 months.

Are there services for which the same practitioner cannot bill for the same beneficiary during the same calendar month as CCM?

The same practitioner cannot bill Medicare for CCM and any of the following four services for the same beneficiary in the same calendar month (with one exception noted below): (1) transitional care management (TCM) (CPT® 99495 and 99496), (2) home healthcare supervision (HCPCS G0181), (3) hospice care supervision (HCPCS G0182), and (4) certain end-stage renal disease (ESRD) services (CPT® 90951-90970).

In the case of TCM, that service and CCM may be billed by the same practitioner in the same calendar month for the same beneficiary if the 30-day post-discharge service period for TCM concludes prior to the end of that calendar month, and at least 20 minutes of CCM services are furnished between that time and the end of that month.

Is CCM recognized as an RHC service and/or an FQHC service?

Yes, but the RHC or FQHC will not receive its all-inclusive rate for CCM; instead, the RHC or FQHC will be paid under a separate care management code specifically for RHCs and FQHCs, as described in **Section 3**.

Can Medicare Shared Savings Program (MSSP) participants bill for CCM?

Physician practices participating in CMS' new Comprehensive Primary Care Plus (CPC+) program cannot bill CCM for their attributed beneficiaries. Otherwise, participation in other CMS initiatives – including the MSSP – does not disqualify a practitioner from billing CCM for any beneficiary. All CCM payments will be included in CMS' calculations of total costs of care for purposes of shared savings and bundled payment programs.

Eligible Beneficiaries

Who is an eligible beneficiary?

A beneficiary is eligible to receive CCM if he or she has been diagnosed with two or more chronic conditions, expected to persist at least 12 months (or until death), that place the individual at significant risk of death, acute exacerbation/decompensation, or functional decline.

CMS has not provided a definition or definitive list of “chronic conditions” for purposes of CCM. Nor has the agency offered guidance on how to determine or document the specified acuity level. However, CMS has stated it intends for CCM services to be broadly available.

Is there a list of chronic conditions on which a practitioner can rely?

CMS maintains a Chronic Condition Warehouse (CCW) which organizes data for approximately 60 specified chronic conditions and potentially disabling conditions. However, the CCW list is not an exclusive list of chronic conditions; CMS may recognize other conditions for purposes of providing CCM.



Beneficiary Consent

What type of consent is required?

Prior to January 1, 2017, a practitioner could not bill for CCM unless, and until, the beneficiary had signed a written consent form. Now, a signed consent form is no longer required as a condition of payment. Instead, the practitioner must inform the beneficiary of the availability of CCM services, that only one physician can furnish and be paid for CCM during a calendar month, and that the beneficiary has the right to stop CCM services at any time, effective at the end of the calendar month. The practitioner must document in the beneficiary's medical record that the required information was provided and that the beneficiary accepted the services.

When and how must the consent be obtained from the beneficiary?

A practitioner should follow his or her practice's existing policies and procedures for obtaining consent for treatment. If the beneficiary is not competent to give his or her consent to receive CCM, the required information should be provided to an individual with legal authority under applicable state law to consent to treatment on behalf of the beneficiary.

What happens if a beneficiary revokes his or her consent?

If a beneficiary revokes his or her consent to receive CCM from a specific practitioner, that practitioner cannot bill for CCM after the then-current calendar month. The practitioner may bill for CCM for the month in which the revocation is made, if the practitioner has furnished the minimum number of minutes of non-face-to-face care management services for the beneficiary.

How does a beneficiary revoke consent?

CMS does not specify the manner in which a beneficiary must revoke consent. Presumably, if a beneficiary gives written or verbal consent to a second practitioner to furnish CCM, that action will revoke the consent given to the first practitioner. However, this can create confusion (and billing issues) if the first practitioner is unaware of the consent given to the second practitioner. CMS will make payment on the first claim it receives, and deny a claim subsequently received from another provider. It would be up to this provider to appeal the denial and raise the issue of beneficiary consent.

Five Specified Capabilities

What are the five specified capabilities a practitioner must have to bill for CCM?

The five specified capabilities include: (1) using a certified EHR for specified purposes; (2) maintaining an electronic care plan; (3) ensuring beneficiary access to care; (4) facilitating transitions of care; and (5) coordinating care.

When a practitioner submits a claim for CCM, the practitioner is, in effect, attesting to having each of these capabilities for providing CCM. Each of these capabilities is discussed in the following sections.

For what purposes must a practitioner use a certified EHR in furnishing CCM (1st capability)?

A practitioner is not required to be a meaningful user of a certified EHR technology, but is required to use “CCM certified technology” to meet the following core technology capabilities:

1. Structured recording of demographics, problems, medications, and medication allergies, all consistent with 45 CFR 170.314(a)(3)-(7)
2. Creation of summary care record consistent with 45 CFR 170.314(e)(2)

The practitioner must be able to transmit the summary care record electronically for purposes of care coordination. CMS does not specify acceptable methods of transmission.

Additionally, the following must be documented in the beneficiary’s medical record, but effective January 1, 2017, the regulations no longer require the use of a qualifying certified EHR to record this information:

1. Beneficiary consent
2. Communication to, and from, home- and community-based practitioners regarding beneficiary’s psychosocial needs and functional deficits (care coordination)

Five Specified Capabilities continued

What is the requirement for an electronic care plan (2nd capability)?

The practitioner must develop and regularly update (at least annually) an electronic patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment of the beneficiary's needs.

The plan should include a list of current practitioners and suppliers who are regularly involved in providing medical care to the beneficiary, the assessment of the beneficiary's functional status related to chronic health conditions, the assessment of whether the beneficiary suffers from any cognitive limitations or mental health conditions that could impair self-management, and an assessment of the beneficiary's preventive healthcare needs.

The plan should address all health issues (not just chronic conditions) and be congruent with the beneficiary's choices and values.

What items are typically included in a care plan?

CMS has identified the following as items typically included in a care plan (although the regulations do not specifically require a care plan to include each):

- Problem list; expected outcome and prognosis; measurable treatment goals
- Symptom management and planned interventions (including all recommended preventive care services)
- Community/social services to be accessed
- Plan for care coordination with other providers
- Medication management (including list of current medications and allergies; reconciliation with review of adherence and potential interactions; oversight of patient self-management)
- Responsible individual for each intervention
- Requirements for periodic review/revision

Five Specified Capabilities continued

Does the care plan have to be created, maintained, and updated using a certified EHR?

CMS requires a practitioner to “use some form of electronic technology tool or services in fulfilling the care plan element,” but acknowledges that “certified EHR technology is limited in its ability to support electronic care planning at this time.” Accordingly, practitioners “must have flexibility to use a wide range of tools and services beyond EHR technology now available in the market to support electronic care planning.”

Who must have access to the electronic care plan?

The regulations impose two requirements with respect to access to the beneficiary’s care plan:

1. The practitioner should timely share the care plan electronically (including by facsimile transmission) with individuals involved in the beneficiary’s care, both within and outside the billing practice.
2. The practitioner must provide a copy of the care plan to the beneficiary and/or caregiver in a format consistent with patient/caregiver preference (e.g., hard copy, electronic, verbal).

What is required with respect to beneficiary access to care (3rd capability)?

A practitioner furnishing CCM must:

1. Provide a means for the beneficiary to access a member of the care team (who qualifies as a “member of the care team” is discussed below) on a 24/7 basis to address acute/urgent needs in a timely manner.
2. Ensure the beneficiary can receive successive routine appointments with a designated practitioner or member of the care team.
3. Provide enhanced opportunities for beneficiary-provider (or caregiver-provider) communication by telephone and asynchronous consultation methods (e.g., secure messaging).

Five Specified Capabilities continued

What is required with respect to transitions of care (4th capability)?

A practitioner must have the capability to do the following:

1. Follow up with the beneficiary after an ER visit.
2. Provide post-discharge transitional care management (TCM) services as necessary (although the practitioner cannot bill for TCM and CCM during the same month).
3. Coordinate referrals to other clinicians.
4. Create and exchange timely continuity of care documents with other practitioners and providers (see prior discussion of summary care record and electronic care plan).

What is required with respect to coordination of care (5th capability)?

The practitioner must have the capability to coordinate with home- and community-based clinical service providers to meet the beneficiary's psychosocial needs and functional deficits (including providers of home health and hospice, outpatient therapies, durable medical equipment, transportation services, and nutrition services).

The practitioner's communication with these service providers must be documented in the beneficiary's medical record.



20+ Minutes of Non-Face-to-Face Care Management Services

What level of service must be furnished to bill for CCM?

At least 20 minutes of non-face-to-face care management services must be performed on a beneficiary's behalf during a calendar month for a practitioner to bill for CCM for that month.

What types of services constitute non-face-to-face care management services?

In the context of CCM, CMS identifies the following types of services performed on a beneficiary's behalf as counting toward the 20-minute time requirement: (1) performing medication reconciliation and overseeing the beneficiary's self-management of medications; (2) ensuring receipt of all recommended preventive services; and (3) monitoring the beneficiary's condition (physical, mental, social).

This list, however, is not exclusive; other types of services may count toward the 20-minute requirement. In the context of TCM, for example, CMS identified the following additional services as non-face-to-face care management services: providing education and addressing questions from patient, family, guardian, and/or caregiver; identifying and arranging for needed community resources; and communicating with home health agencies and other community service providers utilized by the beneficiary.



20+ Minutes of Non-Face-to-Face Care Management Services continued

Who may perform non-face-to-face care management services?

CMS anticipates “clinical staff will provide CCM services incident to the services of the billing physician” or non-physician practitioner. However, if the billing practitioner provides these services directly, that time also counts toward the 20-minute minimum.

The agency references the CPT® definition of “clinical staff:” “a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.”

CMS clarifies that “time spent by clinical staff may only be counted if Medicare’s ‘incident to’ rules are met such as supervision, applicable State law, licensure and scope of practice.” It is the responsibility of the billing practitioner to determine if a clinical staff member is competent and capable of performing a specific service under appropriate supervision. CMS also notes that “other staff may help facilitate CCM services, but only time spent by clinical staff may be counted towards the 20-minute minimum time.”

The agency also explains that a billing practitioner may arrange to have clinical staff external to the practice (e.g., a case management company) provide the non-face-to-face care management services for his or her patients, but only if all requirements for “incident to” billing are satisfied, including general supervision (see following section). However, Medicare rules prohibit billing for services furnished by individuals located outside the U.S.

20+ Minutes of Non-Face-to-Face Care Management Services continued

What level of supervision is required for clinical staff providing non-face-to-face management services?

Initially, CMS proposed to require direct supervision of clinical staff (*i.e.*, physician or other practitioner present in the same suite of offices and immediately available to provide assistance while non-face-to-face care management services were being provided), with a limited exception for services furnished outside normal business hours.

However, the regulations now require only general supervision (*i.e.*, physician or other practitioner available by telephone to provide assistance as required). To comply with the “incident to” rule, however, the physician or other practitioner billing for the service must be the same individual who provides general supervision of the clinical staff.

Effective January 1, 2017, CCM services furnished by an RHC or FQHC may be performed by clinical staff under general supervision; prior to that date, the relevant regulation required direct supervision.

What documentation is required?

CMS does not list explicit documentation requirements for non-face-to-face care management services. In the event of an audit, a practitioner would be well-served to have the following documentation available in the beneficiary’s record:

1. Date and amount of time spent providing non-face-to face services (preferably start/stop time, although this is not explicitly required)
2. Clinical staff furnishing services (with credentials)
3. Brief description of services

What time counts toward the 20-minute minimum requirement?

Time spent providing services on different days, or by different clinical staff members in the same calendar month, may be aggregated to total 20 minutes, depending on the CCM code. However, if two staff members are furnishing services at the same time, only the time spent by one individual may be counted. Time of less than 20 minutes during a calendar month cannot be rounded up to meet this requirement; nor may time be carried over from a prior month.

20+ Minutes of Non-Face-to-Face Care Management Services continued

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| Can face-to-face activities be counted toward the 20-minute minimum requirement? | According to CMS, CCM involves activities not typically or ordinarily furnished face-to-face. If these activities occasionally are provided by clinical staff face-to-face with a beneficiary, the time may be counted toward the 20-minute minimum requirement. |
| Can CCM services furnished on the same day as an office visit be counted toward the 20-minute minimum requirement? | CMS has stated that “[f]ace-to-face time that would otherwise be considered part of the E/M service that was furnished cannot be counted toward [CCM]. Time spent by clinical staff providing non-face-to-face services within the scope of the CCM service can be counted... If both an E/M and the CCM code are billed on the same day, modifier -25 must be reported on the CCM claim.” |
| Can CCM services furnished while the beneficiary is an inpatient be counted toward the 20-minute minimum requirement? | CCM cannot be billed for services furnished to an inpatient at a hospital or skilled nursing facility, or a resident at a facility that receives Medicare payment for that individual. However, if the beneficiary is not an inpatient or resident for the entire month, time spent furnishing CCM services while he or she is not an inpatient or resident can be counted toward the 20-minute minimum requirement for that month. |
| Can a practitioner practicing in a hospital outpatient department bill for CCM? Can the hospital bill for CCM? | <p>As discussed below, CCM is billed with the site of service at which the supervising practitioner primarily practices. If that site is a hospital outpatient department, CMS will pay for the service at the facility rate, which is less than the non-facility rate (<i>i.e.</i>, the payment made to a practitioner practicing in an outpatient office setting). This payment compensates the practitioner for providing direction to hospital staff furnishing non-face-to-face care management services for the beneficiary (who is considered a hospital outpatient for this purpose).</p> <p>CMS also has clarified a hospital outpatient department is eligible to bill under OPPS in these circumstances. This payment compensates the hospital for the costs associated with the clinical staff furnishing the non-face-to-face care management services and related expenses.</p> |

20+ Minutes of Non-Face-to-Face Care Management Services continued

Can remote monitoring be counted as part of the 20-minute time requirement?

According to CMS, “[p]ractitioners who engage in remote monitoring of patient physiological data of eligible beneficiaries may count the time they spend reviewing the reported data towards the monthly minimum time for billing the CCM code, but cannot include the entire time the beneficiary spends under monitoring or wearing a monitoring device.”

CMS has clarified that “in order to bill CPT® 99490, such activity cannot be the only work that is done – all other requirements for billing CPT® 99490 must be met in order to bill the code. . . .”

As of January 1, 2018, CMS now offers separate reimbursement (the national payment rate is \$58.66) for CPT® 99091 – RPM, or remote patient monitoring. RPM involves collection and interpretation of physiological data requiring at least 30 minutes of practitioner time.

CMS describes RPM as “complementary to CCM,” and therefore, can be billed once per patient during the same service period as CCM, as long as requirements for both codes are met independently.

Remember, time spent furnishing these services cannot be counted toward both codes for a single month.

20+ Minutes of Non-Face-to-Face Care Management Services continued

What payment is available for time spent by a physician or non-physician practitioner outside usual office visits addressing an individual patient's needs?

CCM is intended to compensate for time spent by clinical staff, not physicians or non-physician practitioners, providing non-face-to-face care management services. To compensate these providers for non-face-to-face services, CMS now makes payments under two new CPT® codes, effective January 1, 2017:

| Code | Description | National Payment (non-facility) |
|-------|--|---------------------------------|
| 99358 | Prolonged E/M service before and/or after direct patient care, first 60 minutes | \$113.76 |
| 99359 | Prolonged E/M service before and/or after direct patient care, each additional 30 minutes (listed separately with 99358) | \$54.72 |

Rather than developing its own billing rules (as it did for CCM), CMS adopted the CPT® rules for these two codes. These include the following: (1) these codes do not have to be billed on the same day as a face-to-face visit; (2) different periods of time during the same day may be aggregated to meet the time requirements, but time from different days cannot; (3) these services cannot be reported during the same month as complex CCM or TCM; and (4) because a unit of time is attained when the mid-point is passed, CPT® 99358 may be reported when 31 minutes have been spent, and CPT® 99359 may be reported at 76 minutes. (The mid-point rule does not apply to CCM because CMS specifically requires 20 minutes of services per month.)

In discussing these services, CMS warns the time counted toward these codes must be separate and distinct from time spent providing any other service reimbursable under the Medicare Physician Fee Schedule, including, but not limited to, new and established patient office visits, transitional or CCM services, or care plan development.

RHCs and FQHCs cannot bill for CPT® 99358 or 99359.

Billing for CCM

When filing a claim for CCM, what should be listed as the date of service?

The billing practitioner may list as the date of service the day on which the 20-minute minimum requirement is satisfied or any day thereafter through the end of the calendar month. If the beneficiary dies during the month, the claim for CCM will be paid only if the date of service is prior to the date of death.

What should be listed as the place of service?

The billing practitioner must list as the place of service the location at which he or she would furnish a face-to-face office visit with the beneficiary. Thus, a practitioner who practices in a hospital outpatient department must list “22” as the place of service on the CCM claim form, triggering payment at the facility rate.

Under whose provider number should the service be billed?

Effective January 1, 2016, services billed “incident to” – including CCM – must be billed under the provider number of the practitioner who supervises the person(s) actually providing the service.



Section 2: Complex CCM (CPT® 99487 and 99489)

What if the care team spends more than the 20-minute minimum non-face-to-face time for 99490?

Effective January 1, 2017, practitioners can bill CPT® 99487 for complex CCM. The billing rules for CCM (CPT® 99490) and complex CCM are the same, except (1) complex CCM requires 60 minutes of non-face-to-face care management services per month, as compared to 20 minutes for CCM; and (2) the beneficiary's condition must be such as to require medical decision-making of moderate-to-high complexity on the part of the billing physician. (CMS has not yet provided guidance on how to demonstrate compliance with this requirement.)

Is there additional reimbursement available if more than 60 minutes of non-face-to-face care management services are provided?

CMS will pay for an add-on code, CPT® 99489, with complex CCM (CPT® 99487), for each 30-minute increment that goes beyond the initial 60 minutes of non-face-to-face care management services in a given month.

Neither CPT® 99487 nor CPT® 99489 may be billed in the same month as CPT® 99490.

What is the reimbursement for complex CCM?

| Code | Non-Facility Payment | Facility Payment |
|-------|----------------------|------------------|
| 99487 | \$94.68 | \$53.28 |
| 99489 | \$47.16 | \$26.64 |

What guidance is available to providers regarding complex CCM?

All of the billing rules for CCM (CPT® 99490) apply to complex CCM, except the time and medical decision-making requirements.

Section 3: Care Management for RHCs and FQHCs

Can RHCs and FQHCs bill for CCM (CPT® 99490)?

Previously, RHCs and FQHCs could bill Medicare for CPT® 99490 and were paid the national payment amount for that code. Given several additions to care management payments under the physician fee schedule, CMS proposed revisions to CCM payments to RHCs and FQHCs.

Effective January 1, 2018, CMS has established a new general care management code, G0511, for exclusive use by RHCs and FQHCs.

Can RHCs and FQHCs bill for complex CCM?

No. RHCs and FQHCs will only be reimbursed for the new general care management code, G0511.

What requirements must be met for RHCs and FQHCs to bill for G0511?

An RHC or FQHC must meet the same requirements as other providers to bill for CCM, complex CCM, or behavioral health integration, including those requirements regarding use of a certified EHR.

What is the payment for G0511?

Payment for G0511 in 2018 is \$62.28. This rate is an average of the non-facility national payment amounts for CPT® 99490 (simple CCM), CPT® 99487 (complex CCM), and CPT® 99484 (general behavioral health integration) paid under the physician fee schedule.



Section 4: Care Plan Development

How are practitioners reimbursed for their time and effort in developing a patient's care plan?

Prior to January 1, 2017, CMS considered the reimbursement for E/M services to include care plan development. Now, CMS will pay practitioners for care plan development under a new code, G0506. This add-on code is to be listed separately in addition to the CCM-initiating visit and billed separately from monthly care management services.

There is no specific time requirement associated with G0506. However, CMS cautions providers that this code should be billed only if the time and effort involved in care plan development is beyond the usual time and effort involved in the underlying E/M service. Also, the code may be billed only one time, at the outset of CCM services. Time and effort involved in revising a beneficiary's care plan still is not separately reimbursed.

CMS has clarified that the date of service for G0506 should be the same as the base initiating visit code. The face-to-face assessment should be performed the same day as the initiating visit, although CMS recognizes that some, or all, care planning could be completed on a subsequent day.

RHCs and FQHCs cannot bill for G0506.

What is the reimbursement for care plan development?

The national average payment rates for G0506 are \$64.44 (non-facility) and \$46.44 (facility).

Section 5: Potential Practice Revenue

For what population health services does CMS now provide fee-for-service reimbursement?

Between 2011 and 2017, CMS added fee-for-service payments for several population health services, including annual wellness visits, TCM, advance care planning, CCM, complex CCM, and care plan development.

How much revenue could a primary care provider generate by providing these services for his or her Medicare beneficiaries?

Assuming an average panel of 550 Medicare beneficiaries (per Medical Group Management Association survey data), and applying the 2018 national average payment rates, we calculated the following:

| Service Type | Low End | High End |
|-----------------------|-----------|-----------|
| Annual Wellness Visit | \$39,780 | \$49,475 |
| CCM and Complex CCM | \$55,250 | \$86,695 |
| Care Plan Development | \$7,475 | \$11,728 |
| TCM | \$6,430 | \$8,003 |
| Advance Care Planning | \$4,282 | \$7,491 |
| Total ⁵ | \$113,217 | \$163,392 |

Please see our white paper, [“Fee-For-Service Population Health Management: Getting Paid Now to Prepare for the Future,”](#) for a more complete explanation of this opportunity.

⁵ The low-end vs. high-end numbers are based on the percentage of beneficiaries receiving the specified service. This analysis also assumes any MA plan pays at the same rate as traditional Medicare for the same service.

Section 6: Getting Started

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| Who can help your organization design and implement an ambulatory care management program? | PYA has the experience and know-how to assist your organization in developing an effective and efficient ambulatory care management program. We pride ourselves on our ability to translate complicated rules and regulations into practical, straightforward strategies. |
| Who are the members of PYA's team? | Our integrated delivery team includes experienced clinicians, certified case managers, regulatory specialists, data analysts, process improvement professionals, and IT specialists. |
| What specific services does PYA provide? | <p>Our CCM-related services include:</p> <ul style="list-style-type: none">• Gap analysis (current capabilities and resources vs. CCM requirements)• Business plan development and ROI analysis• Staffing plans• Staff training• Identification and stratification of eligible beneficiaries• Development and implementation of beneficiary enrollment process• Workflow design• Electronic care plan development• Documentation tools• Internal/patient communication strategies• Selection of supportive technologies• Strategies to achieve PCMH recognition• Coding and billing processes• Compliance reviews |

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