NATIONAL ASSOCIATION OF Community Health Centers®

PAYMENT Reimbursement Tips:

FQHC Requirements for Medicare Chronic Care Management (CCM) and Principal Care Management (PCM)

The Chronic Care Management (CCM) model of care refers to personalized and supportive services for individuals with multiple (two or more) chronic conditions to coordinate care and develop a care plan to achieve health goals. Principal Care Management (PCM) is for individuals with a single, high-risk condition.

Program Requirements

In addition to Chronic Care Management (CCM), effective January 1, 2021, CMS will reimbursement for two new codes under a service called Principal Care Management (PCM). Both care management options refer to a comprehensive set of services administered to help a patient coordinate and manage chronic conditions. CCM and PCM services are typically provided outside of face-to-face visits and include:

- Comprehensive assessment
- Comprehensive care plan
- Medication management
- Preventive care
- Care plan sharing
- Care coordination
- Continuity of care
- Care transition management
- 24/7 access
- Resources
- Electronic communication options
- Electronic health record documentation

Patient Eligibility & Consent

Patients eligible for **CCM** include those who have multiple (two or more) chronic conditions expected to last at least 12 months or until the patient dies, or that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.

Patients eligible for **PCM** include those who have a qualifying condition that is expected to last between 3 months and 1 year, or until the death of the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. CMS anticipates these services will be billed by specialists focused on managing patients with a single complex condition requiring substantial care management.

A FQHC provider (i.e., MD, DO, NP, PA, or CNM) determines if the patient meets the criteria for care management services and if they are likely to benefit from care management services.

CCM may be furnished by auxiliary personnel under general supervision. With general supervision, the billing practitioner provides overall direction and control, but their physical presence is not required during the provision of services. **PCM** may be furnished by a physician or qualified health provider (QHP), or by clinical staff supervised a physician or QHP.

The patient must provide consent prior to initiating services but during the COVID-19 Public Health Emergency (PHE), consent may be obtained at the same time services are provided. Patient consent may be written or verbal but must be documented in the medical record. The billing provider must inform the beneficiary that cost sharing applies (i.e., s/he will be responsible for co-insurance).

Timeframe & Services

CMS/Medicare covers several types of chronic care management services. These include CCM and complex CCM. These services vary in the amount of clinical staff time provided, the level of involvement of the billing practitioner, and the extent of care planning performed. CCM services include:

Non-complex (CPT 99490) *New!*	First 20 mins of CCM clinical staff time directed, or personally provided, by a physician or QHP.
Non-complex additional time (CPT 99439) *New!*	Each add'l 20 mins of clinical staff time directed by physician or QHP; added to 99490 (clinical staff time). Up to 60 mins in a calendar month.
Complex (CPT 99487)	60 mins of CCM clinical staff time direction by a physician or QHP.
Complex additional time (CPT 99489)	Each add'l 30 mins of clinical staff time directed by physician or QHP; added to 99487.
Provider only (CPT +99491)	30 mins or more of CCM services in a month provided personally by a physician or QHP.

**Codes 99490, 99439, 99487, and 99489 are reported only once per calendar month. Code 99491 are reported no more than twice per calendar month.*

While the above CPT codes represent the CCM/PCM services, FQHCs must **crosswalk the provider-entered CPT code to the billable G codes** (see page 3).

CCCM/PCM services (see Program Requirements) are extensive and require the development of a care plan that is shared with outside providers, the patient, and/or caregiver. The care plan must be coordinated with home and community-based providers and include the management of transitions between and among health care providers and settings (see Transitional Care Management information for reimbursement guidance). Patients/caregivers are to be offered the ability to communicate with the provider through a variety of electronic communication options, including: secure messaging, internet, and other asynchronous non-face-to-face consultation methods.

CCM/PCM should only be furnished on an as-needed basis. There are no specific requirements for updating the care plan. It should be reviewed and updated as appropriate for the patient's care.

Initiating Visit

Prior to the start of CCM/PCM services, a comprehensive initiating visit is required for new patients or patients not seen within one year. 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 CCM/PCM services and is billed separately. While CCM/PCM services do not have to be discussed during the initiating visit, this visit must occur during the year (12 months) prior to the start of CCM/PCM.

At FQHCs under **Medicare**, a new patient is someone 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. Dental service would not count as dental is not covered by Medicare. This definition differs from the traditional CPT definition of a new patient. FQHCs are encouraged to educate staff of the variance and may choose to use a single definition.

Authorized Provider/Staff

Twenty (20) or more minutes of CCM/PCM clinical staff time may be furnished in a calendar month directed by a physician or qualified health provider (i.e., MD, DO, NP, PA, CNM). State law, licensure, and scope of practice definitions must be considered for non-primary care service providers.

TREATING (BILLING) PROVIDER			
Physicians (MD or DO)	Non-Physician Practictioners		
	NP	PA	CNM
x	x	x	x

- *Medical Doctor (MD) or Doctor Osteopathy (DO)*
- *Non-Physician Practitioners include: Nurse Practitioners (NP), Physician Assistants (PA), and Certified Nurse Midwives (CNM).*

Documentation

Document all CCM/PCM services (for 20 or more minutes per calendar month). Structured recording of patient health information using Certified EHR Technology includes: demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care.

CCM/PCM documentation requirements:

- Comprehensive assessment of medical, functional, and psychosocial needs
- Preventive care
- Medication management
- Comprehensive care plan
- Continuity of care
- Coordination with home- and community-based providers
- 24/7 access to providers or clinical staff

Coding & Billing

In calendar year 2021, CMS added two new Principal Care Management reimbursement codes, G2064 and G2065. These codes are for services by clinical staff, typically specialists, focused on managing patients with a single complex chronic condition requiring substantial care management. The new PCM codes are billable by FQHCs under G5011 but may not be billed concurrently with CCM services by the same billing practitioner. A comprehensive initiating visit (e.g., IPPE, AWV, or E/M) within the past 12 months is required before the start of CCM/PCM services. The face-to-face visit included in Transitional Care Management (TCM) services (CPT codes 99495 and 99496) also qualifies as a "comprehensive" visit for CCM/PCM service initiation if TCM face-to-face requirements are met.

Time that is counted towards reporting a CCM/PCM service code cannot be counted toward any other billed code. For billing, the 20 minutes or more of CCM/PCM services must be delivered and totaled within each calendar month, not during a 30-day period that overlaps with the start and end of consecutive months.

Reimbursement Tips: FQHC Requirements for Medicare CCM and PCM

Monthly contact with the patient is not necessary to bill for care management services. CPT 99439, to be used with CPT 99490, is defined as non-complex, chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other QHP, per calendar month. For health centers, CPT 99439 will crosswalk to G0511.

Complex CCM (CPT 99487) shares service elements common to CCM, but has different requirements for:

- Amount of clinical staff service time provided (at least 60 minutes)
- Complexity of medical decision making involved (moderate to high complexity)
- Establishment or substantial revision of a comprehensive care plan

CCM

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*CMS/ Medicare 2021 Fees*
99490	First 20 min (non-complex/ clinical staff)	G0511	$65.25
99439	Each addt'l 20 min (non-complex/clinical staff)		
99487	60 min (complex/clinical staff)		
99489	Each addt'l 30 min (complex/ clinical staff)		
99491	30 minutes or more (physician or QHP only)		

Notes: Rates here are based on the 2021 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. The payment rate for HCPCS G0511 is the average of the national non-facility PFS payment rate for FQHC care management and general behavioral health codes (CPT codes 99490, 99487, 99484, and 99491). FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI.

A FQHC may submit a Medicare claim for a billable CMS PPS "G" code visit and a care management service on a single claim. If billing for CCM/PCM and a CMS PPS "G" code on the same claim, payment for the PPS "G" code will be the lesser of its charges or the fully adjusted PPS rate for the billable visit plus 80% of the charges for CCM/PCM. The date of service (DOS) used on the claim may be the date when the requirements to bill for the service have been met for that month or any date before the last day of the month. Do not report 99491 in the same calendar month as 99490, 99439, 99487, or 99489. CPT 99491 is used to report CCM services provided by a physician or QHP.

Care management costs such as software or management oversight can be included on the cost report. Any cost incurred as a result of the provision of FQHC services, including care management, is a reportable cost and must be included in the Medicare cost report. CCM should be reported on 837-I with revenue code 052x and corresponding HCPCS (e.g., CPT) code.

PCM

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*CMS/ Medicare 2021 Fees*
G2064	Comprehensive care management services for a single high-risk disease, 30 minutes or more of physician or other QHP time per calendar month.	G0511	$65.25
G2065	Comprehensive care management services for a single high-risk disease, 30 minutes or more of clinical staff time directed by a **physician or other QHP** time per calendar month.		

Program Requirements to bill for CCM/PCM	Completed Yes	Missing No
Initiating Visit. An Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit has been furnished by a FQHC employed MD, DO, NP, PA, or CNM. This is required for patients not seen within one year of the start of CMM services, or new patients (not seen within the last three years by a FQHC provider covered by Medicare). The face-to-face visit included in transitional care management (TCM) services (CPT codes 99495 and 99496) also qualifies as a "comprehensive" visit for CCM, general Behavioral Health, or Psychiatric CoCM service initiation*.		
Beneficiary Consent. Consent is obtained during or after the initiating visit and before provision of care coordination services by clinical staff. During the COVID-19 PHE, consent may be obtained at the same time services are provided. Consent can be written or verbal but must be documented in the medical record and: • Include the availability of care coordination services and applicable cost-sharing. • Inform the patient that only one practitioner can furnish and be paid for care coordination services during a calendar month. • Communicate the patient's right to stop care coordination services at any time (effective at the end of the calendar month). • Provide the patient with permission to consult with relevant specialists.		

Reimbursement Tips: FQHC Requirements for Medicare CCM and PCM

Program Requirements to bill for CCM/PCM	Completed Yes	Missing No
Patient Eligibility. **CCM:** A patient with multiple (two or more) chronic conditions expected to last at least 12 months or until the patient dies, or places the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. **PCM:** A patient with a qualifying condition that is expected to last between 3 months and 1 year, or until the death of the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.		
Care Coordination Services. Tweny (20) or more minutes of CCM/PCM clinical staff time directed by a physician or qualified health provider (i.e., MD, DO, NP, PA, or CNM) or personally by the provider. State law, licensure, and scope of practice definitions must be considered for non-primary care service providers.		
Electronic Health Record Documentation. The patient's health information has been structurally recorded with Certified EHR Technology, including: demographics, problems, medications and medication allergies that inform the care plan, care coordination, and ongoing clinical care.		
24/7 Access. The patient has 24/7 access to physicians or other qualified health care professionals or clinical staff and the means to contact health care professionals in the practice to address urgent needs regardless of the time of day or day of week.		
Continuity of Care. The patient is offered continuity of care with a designated member of the care team with whom the patient can schedule successive routine appointments.		
Comprehensive Assessment. Comprehensive care management is offered, including a systematic assessment of the patient's medical, functional, and psychosocial needs.		
Preventive Care. System-based approaches are applied to ensure the patient receives all recommended preventive care services in a timely manner.		
Medication Management. Medication reconciliation includes the review of adherence, potential interactions, and oversight of the patient's self-management.		
Comprehensive Care Plan. A comprehensive care plan is created, including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment. The comprehensive care plan covers all health issues with particular focus on the chronic conditions being managed. This plan includes, but is not limited to, the following elements: • Problem list • Expected outcome and prognosis • Measurable treatment goals • Symptom management • Planned interventions, including responsible individuals • Medication management • Community/social services ordered • A description of how outside services/agencies are directed/coordinated • Schedule for periodic review and, where appropriate, revision of the care plan		
Resources and Support. An inventory of resources and supports are provided to the patient.		
Care Plan Sharing. Care plan information is made available electronically (including by fax) in a timely manner for internal FQHC staff and external stakeholders, as appropriate. A copy of the care plan is given to the patient and/or caregiver.		
Care Transition Management. Care transitions between and among health care providers and settings are managed, including referrals to other clinicians. Follow-up is provided after an emergency department visit, a hospital discharge, or with skilled nursing facilities and other health care facilities being utilized. The creation and exchange/transmission of continuity of care document(s) is shared with other practitioners and providers in a timely manner.		
Coordination of Care. Care is coordinated with home- and community-based clinical service providers, and communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits is documented in the patient's medical record.		
Electronic Communication Options. Enhanced opportunities are available for the patient and caregiver to communicate with the practitioner regarding the patient's care through telephone access, secure messaging, internet, and/or other asynchronous non-face-to-face consultation methods.		
Coding & Billing. Documentation has been made to support using G0511 for General Care Management. Payment for G0511 code may only be billed once per month per beneficiary, and cannot be billed if other care management services are billed for the same time period.		

References

- CMS. Benefits Policy Manual, Chapter 13. Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). FAQ. December 2019. Accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf
- CMS. Medicare Learning Network. Chronic Care Management Services. July 2019. Accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
- CMS 2021 PFS Final Rule https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf
- CMS FAQs Provider Billing for CCM Services https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf