



## Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)

MLN Matters Number: MM10175 **Revised**      Related Change Request (CR) Number: 10175

Related CR Release Date: August 11, 2017      Effective Date: January 1, 2018

Related CR Transmittal Number: R1899OTN      Implementation Date: January 2, 2018

**Note:** This article was revised on November 13, 2017, to correct statements on page 2 (**in bold**). All other information is unchanged.

### PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

### PROVIDER ACTION NEEDED

Change Request (CR) 10175 provides instructions for payment to Rural Health Clinics (RHCs) billing under the all-inclusive rate (AIR), and Federally Qualified Health Centers (FQHCs) billing under the prospective payment system (PPS), for care coordination services for dates of service on or after January 1, 2018.

### BACKGROUND

As authorized by §1861(aa) of the Social Security Act, RHCs and FQHCs are paid for physician services and services and supplies incident to physician services. Care coordination services are RHC and FQHC services, but payment for the additional costs associated with certain care coordination services are not included in the RHC AIR or the FQHC PPS rate. In the CY 2016 Medicare Physician Fee Schedule (PFS) final rule (80 FR 71080), Centers for Medicare & Medicaid Services (CMS) finalized requirements and a payment methodology for Chronic Care Management (CCM) services furnished by RHCs and FQHCs. Effective January 1, 2016, CCM payment to RHCs and FQHCs is based on the Medicare PFS national non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim. The rate is updated annually and there is no geographic adjustment. Revisions to the CCM requirements for

RHCs and FQHCs were in the CY 2017 PFS final rule (81 FR 80256) for services furnished on or after January 1, 2017.

In the CY 2017 PFS final rule (81 FR 80225), CMS established separate payment, beginning January 1, 2017, for practitioners billing under the PFS, for complex CCM services, General Behavioral Health Integration (BHI) services, and a psychiatric collaborative care model (CoCM). To allow payment to RHCs and FQHCs for these new services, CMS finalized in the CY 2018 Physician Fee Schedule Final Rule to revise payment for care coordination services in RHCs and FQHCs by establishing 2 new G codes for use by RHCs and FQHCs, effective January 1, 2018. **The first new G code will be a General Care Management code for RHCs and FQHCs with the payment amount set at the average of the 3 national non-facility PFS payment rates for the CCM and general BHI codes. The second new G code for RHCs and FQHCs will be a Psychiatric CoCM code with the payment amount set at the average of the 2 national non-facility PFS payment rates for psychiatric CoCM services.** RHC or FQHC claims submitted using CPT 99490 for dates of service on or after January 1, 2018, will be denied.

Effective for dates of service on or after January 1, 2018, RHCs and FQHCs will be paid for General Care Management services when G0511 is billed alone or with other payable services on a RHC or FQHC claim. Payment for G0511 is set at the average of the 3 national non-facility PFS payment rates for the CCM (CPT code 99490 and CPT code 99487) and general BHI (CPT code 99484). The rate is updated annually based on the PFS amounts and coinsurance applies. 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.

Effective for dates of service on or after January 1, 2018, RHCs and FQHCs will be paid for Psychiatric CoCM services when G0512 is billed alone or with other payable services on an RHC or FQHC claim. Payment for G0512 is set at the average of the 2 national non-facility PFS payment rates for CoCM (CPT code 99492 and CPT code 99493). The rate is updated annually based on the PFS amounts and coinsurance applies. 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.

**General Care Management (G0511) Requirements: RHCs and FQHCs can bill the new General Care Management G code when the following requirements are met:**

1. Initiating Visit: An Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred no more than one-year prior to commencing care coordination services. This would be billed as an RHC or FQHC visit.
2. Beneficiary Consent: Has been obtained during or after the initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff;

can be written or verbal, must be documented in the medical record and includes information:

- On the availability of care coordination services and applicable cost-sharing
- That only one practitioner can furnish and be paid for care coordination services during a calendar month
- On the right to stop care coordination services at any time (effective at the end of the calendar month)
- Permission to consult with relevant specialists.

3. Billing Requirements: At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the RHC or FQHC physician, NP, PA, or CNM, and b) by an RHC or FQHC practitioner, or by clinical personnel under general supervision.

4. Patient Eligibility: Patient must have:

- 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.

5. Requirement Service Elements

For patients meeting the eligibility requirements of Option A, the RHC or FQHC must meet all of the following requirements:

- Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care
- 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
- Comprehensive care management including 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; and oversight of patient self-management of medications

- Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed
- Care plan information made available electronically (including fax) in a timely manner within and outside the RHC or FQHC as appropriate and a copy of the plan of care given to the patient and/or caregiver
- Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;
- Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits in the patient's medical record
- Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

For patients meeting the eligibility requirements of Option B, the RHC or FQHC must meet all of the following 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 CoCM (G0512) Requirements: RHCs and FQHCs can bill the Psychiatric CoCM G code when the following requirements are met:**

1. Initiating Visit: An E/M, AWV, or IPPE visit furnished by a physician, NP, PA, or CNM has occurred no more than one-year prior to commencing psychiatric CoCM services. This would be billed as an RHC or FQHC visit.

2. Beneficiary Consent: Has been obtained during or after the initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff; can be written or verbal, must be documented in the medical record and include:

- Information on the availability of care coordination services and applicable cost-sharing
- That only one practitioner can furnish and be paid for care coordination services during a calendar month
- That the patient has the right to stop care coordination services at any time (effective at the end of the calendar month)
- The patient is giving permission to consult with relevant specialists

3. 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.

4. Patient Eligibility: Patient must have a behavioral health or psychiatric condition that is being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants psychiatric CoCM services.

5. Requirement Service Elements: Psychiatric CoCM requires a team that includes the following:

RHC or 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

Behavioral Health Care Manager who:

- Provides assessment and care management services, including the administration of 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; provision of brief psychosocial interventions; ongoing collaboration with the RHC or FQHC practitioner; maintenance of the registry;

acting 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
- Is available to contact the patient outside of regular RHC or FQHC hours as necessary to conduct the behavioral health care manager's duties

Psychiatric Consultant who:

- 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; managing any negative interactions between beneficiaries' behavioral health and medical treatments
- Facilitate referral for direct provision of psychiatric care when clinically indicated

MACs will apply coinsurance and deductible to HCPCS codes G0511 and G0512 on FQHC claims.

## ADDITIONAL INFORMATION

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The official instruction, CR 10175, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1899OTN.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

## DOCUMENT HISTORY

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Date of Change	Description
November 13, 2017	The article was revised to correct statements on page 2 ( <b>in bold</b> ).
November 8, 2017	Initial article released

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