CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1899	**Date: August 11, 2017**
	Change Request 10175

NOTE: This Transmittal is no longer sensitive and is being re-communicated 1899. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

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

I. SUMMARY OF CHANGES: This Change Request (CR) 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.

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1899	Date: August 11, 2017	Change Request: 10175

NOTE: This Transmittal is no longer sensitive and is being re-communicated 1899. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

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

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

I. GENERAL INFORMATION

A. Background: This Change Request (CR) 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.

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 Calendar Year (CY) 2016 Medicare Physician Fee Schedule (PFS) Final Rule (80 FR 71080), 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 is proposing in the CY 2018 PFS Proposed 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 on or after January 1, 2018, will be denied

B. Policy: Effective for services furnished 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 (HCPCS code G0507). 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 services furnishing 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 (HCPCS code G0502 and HCPCS code G0503). 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.

C. 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 Preventative Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistant (PA), or Certified Nurse Midwife (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); and
- 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 Electronic Health Record (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; and

- 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); and

- Continuity of care with a designated member of the care team.
  D. 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); and

- 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; and

- 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; and

- 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; and

- Facilitate referral for direct provision of psychiatric care when clinically indicated.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	**Requirement**	**Responsibility**								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10175.1	Contractors shall accept Care Coordination services, HCPCS codes G0511 and G0512 on all RHC (71X) and FQHC (77X) claims.	X								
10175.2	Contractors shall pay RHCs (with or without modifier CG) and FQHCs the rate from the MPFS for HCPCS code G0511. **NOTE**: Payment is based on the rate, regardless of the charges.					X				
10175.2.1	Contractors shall pay RHCs (with or without modifier CG) and FQHCs the rate from the MPFS for HCPCS code G0512.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: Payment is based on the rate, regardless of the charges.									
10175.3	Contractors shall allow payment for Care Coordination services, HCPCS codes G0511 or G0512 with or without an encounter/visit on RHC and FQHC claims. **NOTE**: Modifier CG is not required for payment on RHC claims.					X				IOCE
10175.4	The IOCE shall send a payment indicator flag of '2' for Care Coordination services, HCPCS codes G0511 and G0512 for FQHC PPS claims.									IOCE
10175.5	Contractors shall apply coinsurance and deductible to Care Coordination services, HCPCS codes G0511 and G0512 on RHC claims.					X				
10175.6	Contractors shall apply coinsurance to Care Coordination services, HCPCS codes G0511 and G0512 on FQHC claims.					X				
10175.7	Contractors shall suppress the MSN for Care Coordination services, HCPCS codes G0511 and G0512 for all Tribal FQHCs claims.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10175.8	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Simone Dennis, 410-786-8409 or Simone.Dennis@cms.hhs.gov , Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Corinne Axelrod, 410-786-5620 or Corinne.Axelrod@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0