February 19, 2016

Chronic Care Management (CCM) Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Frequently Asked Questions

Beginning on January 1, 2016, RHCs and FQHCs may receive payment for CCM services furnished to Medicare beneficiaries having multiple (two or more) chronic conditions that are 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. Information on program requirements can be found in:

MLN Matters MM9234 - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9234.pdf, and

Chapter 13 of the CMS Benefit Policy Manual - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

CCM Payment, Billing, and Claims Processing

Q1. What is the payment rate for CCM services in RHCs and FQHC?

The 2016 rate for CCM services in RHCs and FQHCs is $40.82. The rate is available using the PFS Lookup tool at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSLookup/index.html?redirect=/pfslookup/02_pfssearch.asp.

Q2. How is the rate set?

The rate is the average non-facility payment rate paid under the Physician Fee Schedule (PFS) for CPT code 99490.

Q3. Will the rate change throughout the year?

No, the rate is set annually and will be applied to CCM claims from January 1 to December 31. However, the final rate may not be available until mid-January when the PFS Correction Notice is published.

Q4. Is there a geographic adjustment?

No, this rate is not geographically adjusted for RHCs/FQHCs.

Q5. Is the coinsurance/deductible waived for CCM services?

No. The coinsurance/deductible applies to CCM services.

Q6. Is it a one-time or monthly copayment?

Patients will be assessed a copayment and deductible (where applicable) whenever CCM services are billed by the RHC/FQHC.

Q7. Does CCM have to be billed on a claim with a RHC/FQHC visit?

No. CCM services can be billed alone or on the same claim as a billable visit.

Q8. If a RHC submits a claim for a billable visit and CCM services, would the total payment be subject to the RHC payment limit?

No. The RHC would be paid 80% of their rate for the billable visit, subject to the RHC payment limit, plus 80% of the CCM payment. The CCM payment is paid separately and not factored in to the RHC payment rate.

Q9. If a FQHC submits a claim with a billable visit for $150, and has CCM charges of $50 on the same claim, would these be added together to determine the payment?

No. The FQHC would be paid 80% of the lesser of its charges ($150) or the fully adjusted PPS rate for a billable visit, plus 80% of the CCM payment rate. The CCM payment is paid separately and not factored in to the PPS payment.

Q10. What revenue code should be used for CCM services?

The most common revenue code to bill CCM services is 052X, however, CMS does not have a revenue code restriction for CCM services.

Q11. What date of service should be used on the claim?

The service period for CCM services is one calendar month. The date of service can be the date that the minimum of 20 minutes has been met, or any date after that but on or before the last day of the month.

Q12. When should the claim be submitted?

The claim can be submitted when the minimum of 20 minutes of qualified CCM services has been furnished, or any time after that within the filing requirement period.

Q13. What diagnosis code should be used when billing for CCM services? Are there specific chronic conditions that qualify?

All claims must include a diagnosis code and providers shall use the most appropriate diagnosis code for that patient. As long as the patient has two or more chronic

conditions that are expected to last at least 12 months or until their death, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, the patient would qualify.

Q14. Can CCM costs such as software or management oversight be included on the cost report?

Yes. Any cost incurred as a result of the provision of RHC and FQHC services, including CCM, is a reportable cost and must be included in the Medicare cost report. CMS will be adding a line to both the RHC (CMS-222-92) and FQHC (CMS-224-14) cost report on Worksheet A to specifically report costs associated with the provision of CCM.

Q15. Can CCM services and Transitional Care Management (TCM) services be billed during the same month for the same patient?

Possibly. 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. If the 30 day period ends before the end of the calendar month, and at least 20 minutes of CCM services are subsequently provided during that month, both TCM and CCM could be billed. There can be no overlap between the time that TCM and CCM are billed.

Q16. Can a RHC/FQHC bill for CCM services furnished to a patient in a skilled nursing facility (SNF)?

No. RHCs/FQHCs cannot bill for CCM services provided to SNF inpatients in Medicare Part A covered stays, because the facility is being paid under Part A for extensive care planning and care coordination services. However, if the patient is not in the Part A SNF for the entire month, the time spent by the RHC/FQHC furnishing CCM services to the patient while the patient is not in the Part A SNF could be counted towards the minimum 20 minutes of service time that is required to bill CCM for that month.

Q17. Can RHCs/FQHCs bill for CCM services provided to beneficiaries in nursing facilities or assisted living facilities?

Yes. If all the CCM billing requirements are met and the facility is not receiving payment for care management services, RHCs/FQHCs can bill for CCM services furnished to beneficiaries in nursing facilities or assisted living facilities.

Q18. Are there other restrictions on when CCM services can be billed?

RHCs/FQHCs cannot bill for CCM services during the same service period that care management is being provided by another facility or practitioner. This includes home

health care supervision, hospice care supervision, certain ESRD services, etc., or any other services that would result in duplicative billing.

Q19. Can RHCs/FQHCs bill CCM services for Medicare Advantage patients?

RHCs/FQHCs would need to check with the MA plan.

Furnishing CCM Services

Q20. Are RHCs/FQHCs required to provide CCM services?

No, RHCs/FQHCs are not required to provide these services.

Q21. Who can determine that a patient is eligible for CCM services?

A RHC/FQHC practitioner must make the determination that a patient meets the criteria for CCM services and initiate CCM services during a comprehensive evaluation and management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit. Only a RHC/FQHC practitioner who can furnish an E/M, AWV, or IPPE visit can determine that a patient is eligible for CCM services and initiate this service.

Q22. How does a RHC/FQHC practitioner initiate CCM services?

If the RHC/FQHC practitioner determines that the patient is eligible for CCM services, the RHC/FQHC practitioner would discuss CCM services with the patient during an E/M, AWV, or IPPE visit. If the RHC/FQHC practitioner does not discuss CCM services with the patient during an E/M, AWV, or IPPE visit, the visit would not be considered as an initiating visit for CCM services.

Q23. The list of Medicare telehealth services includes E/M services and the AWV. Would an E/M or AWV visit furnished via telehealth, in which CCM services are discussed, be considered an initiating visit?

No. RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished.

Q24. If the RHC/FQHC practitioner discusses CCM services with the patient during an E/M, AWV, or IPPE visit, but the patient isn't sure and doesn't decide until the following week that he/she wants this service, can the patient still get CCM services or would he/she have to wait until a subsequent E/M or AWV visit?

Written consent is not required to be obtained at the initiating visit, but CCM services has to have been discussed at that time and consent must be obtained prior to start of CCM services time and documented in the patient's medical record.

Q25. Does the time spent during the E/M, AWV, or IPPE discussing CCM services count towards the minimum 20 minutes?

No. The E/M, AWV, or IPPE is separately paid and the time cannot be counted for CCM services.

Q26. If the RHC/FQHC practitioner initiates the discussion of CCM services during an E/M, AWV, or IPPE visit, can a nurse or other auxiliary staff person continue the discussion, including the consent requirements?

Yes. As long as the RHC/FQHC practitioner discusses CCM services with the patient during an E/M, AVW, or IPPE visit, qualified auxiliary staff (clinicians such as nurses, medical assistants, and others who furnish services incident to a RHC/FQHC visit) who are subject to direct supervision requirements can complete the consent process.

Q27. What are the requirements for direct supervision?

Direct supervision requires that a RHC/FQHC practitioner be present in the RHC/FQHC and immediately available to furnish assistance and direction. The RHC/FQHC practitioner does not need to be present in the room when the service is furnished. There is no exception to the direct supervision requirement at this time for CCM services furnished by auxiliary staff in RHCs/FQHCs.

Q28. Does CMS have any forms or templates for the consent form or care plan?

No, CMS does not provide any forms or templates for the CCM services consent form or care plan.

Q29. Once the patient has consented to receive CCM services, can other staff furnish CCM services?

Yes. Once the RHC/FQHC practitioner initiates discussion of CCM services with the patient and the patient has consented to receive this service, any RHC/FQHC practitioner (physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), or clinical social worker (CSW)), or qualified auxiliary staff (in accordance with the direct supervision requirements) can furnish the CCM services.

Q30. Can a pharmacist furnish CCM services?

Yes. Pharmacists are considered auxiliary staff and can provide CCM services under direct supervision once the service is initiated by a RHC/FQHC practitioner.

Q31. Can CCM services be contracted out to a company that provides case management services?

Yes. There is no prohibition or restrictions on contracting out CCM services once the RHC/FQHC practitioner has initiated CCM services.

Q32. Since the services furnished by auxiliary staff are non-face to face, how should their time be documented?

Non-face to face services should be documented in a manner that substantiates the time claimed as furnishing CCM services.

Q33. Does the patient need to be present when CCM services are furnished?

The patient only needs to be present when CCM services are initiated by the RHC/FQHC practitioner during an E/M, AWV, or IPPE visit. The face-to-face requirement for RHC/FQHC services is waived for CCM services once they have been initiated.

Q34. Do face-to-face activities count toward the 20 minutes of CCM time?

Services that are furnished as part of a billable visit cannot be counted toward the 20 minutes of CCM time. However, if there is no billable visit, and CCM services happen to be done with the patient present, the time can be counted towards the 20 minute minimum.

Q35. Is contact with the patient every month necessary to bill for CCM if the 20 minutes of clinical staff time is otherwise met?

No, although we expect that RHCs/FQHCs will want to keep the patient informed about their care management, especially since this is a service that the patient is paying for but is not typically visible to them.

Q36. If a RHC/FQHC provides 40 minutes of CCM services during a calendar month, can the RHC/FQHC bill twice for this service?

No. CCM services are paid once per month per beneficiary for 20 minutes or more of CCM services.

Q37. If a RHC/FQHC provides 10 minutes of CCM services in one month, and 10 minutes the following month, can the RHC/FQHC bill for CCM services?

No. A minimum of 20 minutes of CCM services is required to be furnished in one calendar month for CCM to be billed. If only 10 minutes of services were furnished, the RHC/FQHC cannot bill for the service.

Q38. If a RHC/FQHC practitioner or auxiliary staff person discusses the patient's care coordination with another RHC/FQHC practitioner or auxiliary staff person for 5 minutes, would that count as 5 minutes or 10 minutes?

If 2 or more people are discussing the patient's care coordination, only one person's time would be counted, so in this example, it would be 5 minutes.

Q39. Would the time spent performing secure messaging or other asynchronous non face-to-face consultation methods such as email count toward the 20 minutes required?

Activities that are within the CCM scope of service elements may be counted toward the minimum 20 minutes required for billing if they are measurable and can be documented.

Q40. Would smartphone medication adherence reporting from individual patient or caregiver back to their specific chronic care management physician count towards the 20 minutes of non-face to face time?

Patient or caregiver time is not counted towards the 20 minutes required to bill for CCM services.

Q41. Once a patient has consented to receive CCM services, does CCM services have to be provided every month, even if no follow-up or additional assistance?

CCM services should only be furnished on an as-needed basis. The consent for receiving CCM services remains in effect until revoked, even if no CCM services are furnished.

Q42. Does the care plan have to be completed before CCM time can be counted and billed?

CCM services must be initiated and the consent form signed before time can be counted. The development of the care plan can be counted towards the minimum 20 minutes required for billing.

Q43. How often does the care plan need to be reviewed and updated?

There are no specific requirements for updating the care plan. It should be reviewed and updated as appropriate for the patient's care.

Q44. Does the supervising practitioner have to be the same practitioner who is managing the patient's care?

No. As long as an RHC/FQHC practitioner is providing direct supervision, the supervision requirement is met.

Q45. When is a new patient consent form required?

If a patient continues to receive CCM services from the same RHC or FQHC, a consent form is only required when CCM services are initiated.

Q46. How does a patient opt out of CCM services?

A patient can opt out of CCM services by notifying the RHC/FQHC that he/she does not want to continue this service. The date of revocation must be recorded in the patient's medical record, and the RHC/FQHC must give the patient written confirmation that it will not be providing CCM services beyond the current calendar month.

Q47. Can phone calls be made from another location or do they need to be done in the RHC/FQHC?

Telephone calls and other CCM activities can be done in a location other than the RHC/FQHC, but any service furnished by a non-RHC/FQHC practitioner would be subject to direct supervision requirements.

Q48. If the RHC/FQHC has the ability to send clinical summaries or the electronic care plan via an acceptable electronic technology other than fax, but the receiving practice/provider (which is not billing for CCM services) can only receive the required information via fax, can the RHC/FQHC fax the information and still meet the transmission requirements for billing CCM services?

If the receiving entity who is not billing for CCM services is unable to receive a clinical summary using acceptable electronic technology other than fax, then the clinical summary can be electronically transmitted to a third party, who can then transmit the clinical summary via fax.

If the receiving entity who is not billing for CCM services is unable to receive care plan information using acceptable electronic technology other than fax, then the care plan information may be transmitted via fax.

Q49. Does the RHC/FQHC have to provide 24/7 access to care management or 24/7 to an electronic care plan that may be reviewed by other practitioners furnishing care to address a patient's urgent chronic care needs?

The RHC/FQHC must ensure that there is 24/7 access to care management services. This includes providing the patient with a means to make timely contact with RHC/FQHC practitioners who have access to the patient's electronic care plan to address his or her

urgent chronic care needs, and the RHC/FQHC must ensure the care plan is available electronically 24/7 to anyone within the RHC/FQHC who is providing CCM services.

Q50. Does the RHC/FQHC have to focus only on the patient's chronic conditions, or can the RQHC/FQHC spend some time treating pressing/relevant problems?

CCM payment is for the management of chronic illnesses only and does not include time spent on acute care services.